Assembly Bill No. 203

CHAPTER 188

An act to add Section 13343 to the Government Code, to amend Sections 1250.8, 1266, 1279, 1280.1, 1280.3, 1324.21, 1324.23, 1324.28, 1324.29, 1324.30, 1422, 101317, 101320, 120955, 124910, 124977, and 130542 of, and to add Section 1204.5 to, the Health and Safety Code, to amend and repeal Section 12693.981 of the Insurance Code, to amend Sections 4640.6, 4643, 4648.4, 4681.5, 4691.6, 4781.5, 10020, 10022, 10024, 14011.6, 14043.1, 14043.15, 14043.2, 14043.26, 14043.27, 14043.28, 14043.36, 14043.46, 14043.47, 14043.61, 14043.62, 14043.65, 14043.7, 14087.305, 14087.5, 14088, 14088.14, 14088.25, 14089, 14091.21, 14100.95, 14105.2, 14105.3, 14105.45, 14105.47, 14105.8, 14105.85, 14110, 14124.70, 14124.76, 14124.78, 14124.89, 14124.90, 14124.94, 14125, 14125.2, 14125.8, 14126.027, 14126.033, 14132.100, 14134.5, 14166.4, 14199.2, 14199.3, 14464.5, 14495.10, 14499.5, 16809, and 24005 of, to add Sections 4474.4, 4474.5, 4474.8, 4781.6, 14011.65b, 14105.475, 14124.785, 14124.792, and 14301.1 to, to amend and repeal Section 14262 of, and to repeal and add Section 14043.45 of, the Welfare and Institutions Code, relating to health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor August 24, 2007. Filed with Secretary of State August 24, 2007.]

LEGISLATIVE COUNSEL'S DIGEST

AB 203, Committee on Budget. Health.

Existing law prescribes various duties and responsibilities of the Department of Finance with respect to the preparation of the annual state budget.

This bill would require the department and the State Department of Public Health to provide specified budget information concerning designated programs administered by the State Department of Public Health.

Existing law prescribes the procedures for the licensure and regulation of clinics, including primary care clinics, by the State Department of Public Health.

This bill would authorize pimary care clinics to submit verification of certification to the Licensing and Certification Division of the State Department of Public Health for specified purposes.

Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health.

Existing law contains ratesetting provisions governing fees for the licensure of health facilities by the State Department of Public Health. Existing law requires that the Licensing and Certification Division of the

department be supported entirely by federal funds and special funds no later than the beginning of the 2009–10 fiscal year, unless specified by law or unless funds are appropriated from the General Fund for that purpose.

This bill would specify that for the 2007–08 fiscal year General Fund support shall be provided in an amount of not less than $2,782,000, and would prescribe additional requirements to be used in calculating licensure fees.

Existing law requires periodic inspection of health facilities by the department as part of licensing and certification of those facilities. Existing law specifies that the department shall inspect for compliance with state law and regulations during a state or federal periodic inspection.

This bill would, instead, require inspections for compliance with state law and regulations to occur during a state periodic inspection or at the same time as a federal periodic inspection.

Existing law authorizes the department to assess a licensee of a general acute care hospital, an acute psychiatric hospital, or a special hospital an administrative penalty not to exceed $25,000 if the licensee receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction.

Existing law provides, however, that, upon the adoption of specified regulations, the administrative penalty for such a violation shall be up to $50,000, and that, if the violation does not constitute such an immediate jeopardy violation the penalty may be up to $17,500, except that no penalty shall be assessed for a minor violation.

Existing law, as a condition of licensure, requires every hospital to maintain written policies about discount payment and charity care for qualified patients.

This bill would, upon the effective date of the regulations referred to above, expressly provide that the penalties for a violation that is not an immediate jeopardy violation, apply to the provisions relating to discount payment and charity care policies.

Existing law provides that inspections and investigations of long-term health care facilities that are certified by the Medicare Program or the Medicaid Program shall determine compliance with state law and federal standards.

This bill would provide that those inspections and investigations shall determine compliance to the extent that California law provides greater protection to residents or is more precise than federal standards.

Existing law requires the department to impose a uniform quality assurance fee on each skilled nursing facility, with certain exceptions, in accordance with a prescribed formula. The formula is based on the determination of the projected net revenues of skilled nursing facilities. The fee will cease to be assessed and collected on and after July 31, 2008.

This bill would extend the assessment and collection of the uniform quality assurance fee until July 31, 2009, and change the percentage to 5.5% effective January 1, 2008. The bill would make other conforming

changes. It would also modify the manner in which the maximum aggregate amount of the fee is determined.

Existing law establishes procedures and requirements to govern the allocation to, and expenditure by, local health jurisdictions and treatment facilities, designated pursuant to a federally approved plan, of federal funding received for the prevention of, and response to, bioterrorist attacks and other public health emergencies. Existing law requires a local health jurisdiction receiving funds under these provisions to deposit the money in a special Local Public Health Preparedness Trust Fund. These provisions provide that federal funding received by the State Department of Public Health for bioterrorism preparedness and emergency response is subject to appropriation in the annual Budget Act. These provisions become inoperative on September 1, 2007, and are repealed as of January 1, 2008.

This bill would extend the inoperative and repeal dates to September 1, 2010, and January 1, 2011, respectively. It would also modify reporting provisions with which local public health districts must comply.

Existing law requires the development of a list of drugs to be provided under the AIDS Drug Assistance Program, which is administered by the State Department of Public Health.

This bill would require the list to be developed in consultation with the AIDS Drug Assistance Program Medical Advisory Committee, would exempt changes to the list from the Administrative Procedure Act, and would require the department to make a prescribed notification concerning these changes to the fiscal and policy committees of the Legislature.

Existing law requires each licensed primary care clinic that applies to the department for funds for the delivery of medical services to demonstrate that it is an active Medi-Cal provider by having a Medi-Cal provider number.

This bill would, instead, require the applicant to demonstrate that it is an active Medi-Cal provider by being enrolled in Medi-Cal for a period of 3 months.

Existing law, the Birth Defects Monitoring Program, requires the Director of Health Services to maintain a system for the collection of prescribed information on birth defects and other activities. The program is funded by prenatal screening fees which are deposited in the continuously appropriated Genetic Disease Testing Fund.

This bill would, instead, require that those fees be deposited in the Genetic Disease Testing Fund, except for moneys to fund activities related to the Birth Defect Monitoring Program, which would be deposited in the Birth Defects Monitoring Fund, to be created by the bill, and that would be available for expenditure upon appropriation by the Legislature.

Existing law establishes the California Discount Prescription Drug Program Fund for the deposit of all payments under that program and makes money available to the department when appropriated by the Legislature for the purposes of the program.

This bill would provide that the fund is continuously appropriated to the department without regard to fiscal year for the purpose of providing

payment to participating pharmacies and administrative costs of the program, thereby making an appropriation.

Existing law establishes the Healthy Families-to-Medi-Cal Bridge Benefits Program to provide any person enrolled for coverage under the Healthy Families Program who meets certain criteria with a 2 calendar-month period of health care benefits to provide the person with an opportunity to apply for Medi-Cal. The program is administered by the Managed Risk Medical Insurance Board.

This bill would provide for the repeal of this program on the date that the Director of Health Care Services executes a declaration stating that implementation of the presumptive Medi-Cal eligibility program, which the bill would create, has commenced. It would provide that this presumptive eligibility program would apply to children meeting specified criteria, with the program to be implemented to the extent that federal financial participation is available. Because each county is required to administer the eligibility process, and the bill would require additional duties to be performed in this regard, it would create a state-mandated local program.

Existing law requires the board, if a federal waver is obtained, to expand eligibility under the Healthy Families Program, to include uninsured parents of children enrolled in the Healthy Families Program or, under certain circumstances, the Medi-Cal program.

Existing law requires, to the extent that federal financial participation is available, that the department implement an option provided for under the federal Social Security Act for a program for accelerated enrollment of children into the Medi-Cal program. The department is, however, prohibited from implementing this option unless the federal waiver for expansion of Healthy Families Program benefits to uninsured parents, as described above, is obtained.

This bill would repeal the requirement that the accelerated enrollment program be implemented only if the Healthy Families Program waiver for the inclusion of uninsured parents is obtained.

Existing law establishes various state developmental centers, including Agnews Developmental Center, for the care of developmentally disabled persons.

This bill would require the Secretary of California Health and Human Services to verify that the State Department of Developmental Services and the State Department of Health Care Services have established protocols for the provision of services to people with developmental disabilities transitioning from the Agnews Developmental Center. The bill would provide that, subject to the receipt of federal financial participation, services rendered to Medi-Cal beneficiaries transitioning from Agnews Developmental Center to the community shall be provided by Medi-Cal managed care plan. The bill would also require the State Department of Developmental Services to continue the operation of the Agnews Outpatient Clinic until the department is no longer responsible for the property.

Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to allocate funds

to private nonprofit regional centers for the provision of community services and support for persons with developmental disabilities and their families and sets forth the duties of regional centers in that regard. Existing law requires the department to develop a plan for the proposed closure of any developmental center. Existing law also authorizes the department to engage in activities that will meet the goal of an orderly closure of Agnews Developmental Center.

Existing law requires through June 30, 2007, that contracts between the department and regional centers for persons with developmental disabilities specify certain coordinator-to-consumer ratios.

This bill would extend that requirement to June 30, 2008.

Existing law provides for the assessment of certain individuals for whom benefits are provided by regional centers. Existing law provides that if assessment is needed, prior to July 1, 2007, 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, 2008.

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 July 1, 2006, except as provided.

This bill would, instead, apply that limit to the 2007–08 fiscal year, and would limit the rate to that in effect on or after July 1, 2007, subject to the specified exception.

Existing law provides that, during the 2006–07 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 July 1, 2006.

This bill would make that limitation applicable during the 2007–08 fiscal year, and would base the limitation on the rate in effect on June 30, 2007.

Existing law prohibits, during the 2006–07 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 July 1, 2006, or making other specified changes or adjustments that would result in a rate increase.

This bill would base that prohibition for the 2007–08 fiscal year on the rate in effect on or after July 1, 2007.

Existing law provides that, for the 2006–07 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 provide that, for the 2007–08 fiscal year only, a regional center shall not expend any purchase of service funds for the startup of any new program unless the expenditure is necessary to protect the consumer's health or safety or because of other extraordinary circumstances and the department has granted prior written authorization.

The bill would also require the State Department of Developmental Services to develop a plan of options to better control regional center costs of operating and providing state-supported services. The bill would require the department to submit the plan to the Joint Legislative Budget Committee and the fiscal and policy committees of the Legislature no later than October 1, 2007.

Existing law provides that no person having private health care coverage, as defined, is entitled to receive the same health care furnished or paid for by a publicly funded health care program.

This bill would redefine private health care coverage for purposes of these provisions.

Existing law entitles publicly funded health care programs that furnish or pay for health care for a person having private health care coverage to be subrogated to the rights the person has against the carrier of that private health care coverage within 3 years of rendering the service.

This bill would require that an entity providing private health care coverage, as a condition of doing business in the state, accept the state's right of recovery, as specified.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons.

Under existing Medi-Cal provisions "business address" is defined as the location where an applicant or provider provides services, goods, supplies, or merchandise to a Medi-Cal beneficiary. The business address of a vehicle or vessel owned, operated, and used to provide Medi-Cal services and other items is either the applicant or provider's pay-to-address or the business address location for which a separate provider number is issued.

This bill would delete the business address location for which there is a separate provider number and, instead, use the business address location listed on the provider's application as the location where similar services and items would be provided.

Existing law requires information about Medi-Cal providers, or applicants to be providers, for enrollment purposes, submission of claims, and similar purposes to include the provider's number.

This bill would, except as provided, eliminate the requirement for separate provider numbers for each business address of the provider and would make conforming changes.

This bill would also eliminate various references to the need for a provider number in order to obtain Medi-Cal reimbursement, and instead, refer in this regard to enrollment in the Medi-Cal program.

Existing law permits the Director of Health Services to issue a Medi-Cal provider a unique identification number or numbers notwithstanding the National Provider Identifier (NPI) issued by the federal government.

This bill would, instead, authorize the department to require a Medi-Cal applicant or provider to submit an NPI number, or to issue a unique identification number or numbers for transactions not identified as covered

transactions under the rules of the Health Insurance Portability and Accountability Act of 1996.

Under existing law, the department is authorized to contract for the provision of Medi-Cal services through certain managed health care options.

Under existing law, each Medi-Cal beneficiary or eligible applicant is required to be provided with information as to these health care options in receiving Medi-Cal benefits, including certain provider information.

This bill would revise the provider information to be provided, including specifying that it be for the geographic area in which the beneficiary or applicant resides through a specialized provider directory for the beneficiary or applicant to be implemented as a pilot project in 2 counties, as specified.

Existing law provides the California Medical Assistance Commission with the authority to negotiate exclusive contracts with county organized health systems to provide health care services under the Medi-Cal program.

This bill would provide, on and after the effective date of this bill, that the State Department of Health Care Services rather than the commission has exclusive authority to negotiate those contracts. The bill would require the department to disclose those contracts upon request as public records.

Existing law requires the department to enter into demonstration contracts with manufacturers of medical supplies for 4 items of its own selection of medical supplies existing on the pharmacy claims processing system to establish rebates or other cost-saving mechanisms and to report to the Legislature on the outcomes of the contracts no later than January 1, 2007.

This bill would require the department to evaluate the products and execute the contracts pursuant to specified criteria and would require the report to be made no later than January 1, 2009.

Existing law authorizes the department to enter into exclusive or nonexclusive contracts on a bid or negotiated basis with manufacturers, distributors, dispensers, or suppliers of appliances, durable medical equipment, medical supplies, and other product-type health care services and with laboratories for clinical laboratory services, as specified.

Existing law contains provisions governing the reimbursement of hearing aids under the Medi-Cal program.

This bill would require the department, on or before June 30, 2008, to enter into exclusive or nonexclusive contracts, on a bid or negotiated basis, for purchasing hearing aid appliances.

Existing law requires the department to reimburse Medi-Cal pharmacy providers for legend and nonlegend drugs pursuant to specified criteria including the average sales price of a drug calculated by certain factors.

This bill would delete the term “average sales price” and substitute the term “average manufacturer’s price,” as defined and make related changes.

Existing law permits the department to enter into contracts with manufacturers of enteral formulae for Medi-Cal patients whose condition precludes the full use of regular food.

This bill would, instead, permit contracts with the manufacturers of enteral nutrition products and specify the criteria those products shall meet.

The bill would also modify various procedures, including ratesetting provision, governing the provision of medical supplies under the Medi-Cal program.

Existing law authorizes the director, as well as the Attorney General, and other specified officials, to bring an action to recover the reasonable value of benefits provided or that will be provided to a Medi-Cal recipient against a 3rd party, including an insurance carrier, because of any injury for which the 3rd party is liable.

Existing law contains procedures governing these actions, as well as provisions pertaining to the director's right to claim reimbursement when the claim against a 3rd party is brought by another person, including the recipient. Existing law prohibits the director's claim for exceeding one-half of the beneficiary's recovery after deducting fees and costs.

This bill would define the term "lien" as the director's claim for recovery, from a beneficiary's tort action or claim, of the reasonable value of benefits provided on behalf of the beneficiary. This bill would limit recovery of the director's lien from an injured beneficiary's action or claim to what the beneficiary receives after deducting attorney's fees and litigation costs of a settlement, judgment, or award.

Under existing law, when benefits are provided or will be provided to a Medi-Cal beneficiary because of an injury for which another person or carrier is liable, the director may recover from that person or carrier the reasonable value of benefits so provided. In connection with that recovery, existing law requires insurers to provide specified information upon request of the department.

This bill would redefine "insurer" for these purposes.

Existing law establishes a formula for provider reimbursement rates for incontinence medical supplies covered by the Medi-Cal program.

This bill would revise that formula and would specify the criteria for evaluating products for the department's list of incontinence medical supplies. It would also permit the department to enter into contracts, as specified, for the purchase of these supplies.

Under existing law, in order to qualify for Medi-Cal coverage an incontinence medical supply product shall be in general retail distribution. General retail distribution includes when the product is on display and available for purchase at retail outlets.

This bill would, instead, specify that the product is on display and available for purchase at licensed pharmacies or licensed medical supply dealers within California.

Existing law, the Medi-Cal Long-Term Care Reimbursement Act, requires the department to implement a facility specific ratesetting system for facilities providing long-term care services. The director may implement the act by provider bulletins until July 31, 2007, by which time the director shall have adopted regulations.

This bill would change that date to July 31, 2008.

Existing law provides that, beginning with the 2007–08 rate year, the maximum increase in the weighted average Medi-Cal reimbursement rate required for purposes of these provisions shall not exceed 5.5% of the weighted average Medi-Cal reimbursement rate for the proceeding fiscal year, adjusted as prescribed.

This bill would extend that rate through the 2008–09 rate year.

Existing law, administered by the department, provides for the HIV/AIDS Pharmacy Pilot Program, as described, to evaluate the provision of medication therapy management services, as defined, for people with HIV/AIDS. Existing law provides for the repeal of these provisions on January 1, 2008.

This bill would authorize the department to seek federal financial participation under specified conditions and would extend the repeal date of the HIV/AIDS Pharmacy Pilot Program to June 30, 2008.

Existing law specifies the procedures by which the department determines prospective per capita rates of payment of services for Medi-Cal beneficiaries enrolled in a prepaid health plan.

This bill would require that, for rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program, and permit the department to utilize a county and health plan specific rate methodology to develop Medi-Cal managed care capitation rates for contracts between the department and case management plans, county health systems, and a geographic managed care pilot project.

It would require the department and the commission to report to the Legislature, through budget subcommittee hearings to be convened in 2008, regarding changes implemented in the 2007–08 fiscal year regarding Medi-Cal Managed Care reimbursement rates negotiated under the Geographic Managed Care model concerning the use of health plan specific encounter and claims data, and the application of actuarial methods.

Existing law defines actuarial methods and related terms for purposes of these Medi-Cal prepaid health plan provisions.

This bill would make these provisions inoperative on August 1, 2007, and repeal them on January 1, 2008.

Existing law requires the department to impose annually, until January 1, 2009, a quality improvement fee on each Medi-Cal managed care plan in the amount of 6% of the plan's total operating revenues, as defined, to be deposited in the General Fund, with the revenue derived from this fee to be used to increase Medi-Cal managed care plan capitation rates.

This bill would extend the provisions pertaining to the fee until October 1, 2009, and would provide that the amount of the fee shall be up to 6% of the plans total operating revenue.

Existing law requires the department to establish a pilot program to provide continuous skilled nursing care as a benefit under the Medi-Cal program when those services are provided pursuant to a federal waiver. This provision is repealed as of January 1, 2008.

This bill would extend the repeal date to January 1, 2010.

Existing law, relating to the operation of a pilot program in Santa Barbara County for the delivery of Medi-Cal services, among other things, authorizes the California Medical Assistance Commission to negotiate exclusive contracts and rates with the Santa Barbara Regional Health Authority and requires the contracts to be approved by the Department of Finance.

This bill would instead authorize the State Department of Health Care Services to negotiate those contracts and would delete the requirement of approval by the Department of Finance.

Existing law provides that the board of supervisors of a county that contracted with the department 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 the 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 2006–07 fiscal year, state and county financial responsibilities for certain increases in the County Medical Services Program.

This bill would further extend that provision to include the 2007–08 fiscal year.

This bill would reallocate certain amounts appropriated in the Budget Act of 2007 from the Cigarette and Tobacco Products Surtax Fund, with these revenues to be allocated to certain county health services programs.

This bill would require the State Department of Mental Health, in collaboration with the State Department of Health Care Services to provide specified material to the fiscal and policy committees of the Legislature regarding a prescribed State Department of Mental Health workplan and materials concerning certain mental health programs in San Mateo County.

This bill would require the State Department of Health Care Services to issue an All County Welfare Directors Letter and a Medi-Cal Provider Bulletin regarding the Conlan v. Shewry Beneficiary Reimbursement process, as specified.

This bill would authorize the Managed Risk Medical Insurance Board and the State Department of Health Care Services to adopt emergency regulations to implement applicable provisions of the bill.

Existing law provides for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, which provides certain mental health and other medical services to Medi-Cal beneficiaries and other qualified persons.

This bill would require the State Department of Mental Health to develop a plan for the EPSDT Program, as provided, and would require the department to, in developing the plan, provide program efficiencies while protecting clients, to consult with counties, and to consider the role of counties in providing services under the program. The bill would require the department to submit the plan to the Joint Legislative Budget Commit-

tee and the fiscal and policy committees of the Legislature no later than March 1, 2008.

The bill would also require the department to work with the Legislature to develop an appropriate administrative structure for the EPSDT Program for implementation in the 2008–09 fiscal year.

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 13343 is added to the Government Code, to read:

13343. (a) The Department of Finance shall revise the Governor's Budget documents display for the State Department of Public Health to include a display of the supplemental local assistance appropriation summary, including actual past year, estimated current year, and proposed budget year expenditures for each branch in the department.

(b) No later than January 20 of each year, the State Department of Public Health shall annually provide expenditure information for actual past year, estimated current year, and proposed budget year for the following:

(1) The Cigarette and Tobacco Products Surtax Fund and the accounts contained therein as established by Proposition 99 as approved by the voters at the November 8, 1988, statewide general election.

(2) Statewide AIDS/HIV programs.

(3) AIDS Drug Assistance Program.

(4) Title V Maternal, Child, and Adolescent Health Grant funds.

(5) Women, Infants, and Children Supplemental Nutrition Program.

(6) Federal Health and Human Services Hospital Preparedness Program funds.

(7) Centers for Disease Control and Prevention Public Health Emergency Preparedness Grant funds.

SEC. 2. Section 1204.5 is added to the Health and Safety Code, to read:

1204.5. Primary care clinics may submit verification of Joint Commission on Accreditation of Healthcare Organization (JCAHO) certification to the Licensing and Certification Division within the State Department of Public Health for entry into the electronic Licensing Management System for purposes of data collection and extraction for licensing and certification fee calculations.

SEC. 3. Section 1250.8 of the Health and Safety Code is amended to read:

1250.8. (a) Notwithstanding subdivision (a) of Section 437.10, the department, upon application of a general acute care hospital which meets all the criteria of subdivision (b), and other applicable requirements of licensure, shall issue a single consolidated license to a general acute care hospital which includes more than one physical plant maintained and operated on separate premises or which has multiple licenses for a single health facility on the same premises. A single consolidated license shall not be issued where the separate freestanding physical plant is a skilled nursing facility or an intermediate care facility, whether or not the location of the skilled nursing facility or intermediate care facility is contiguous to the general acute care hospital unless the hospital is exempt from the requirements of subdivision (b) of Section 1254, or the facility is part of the physical structure licensed to provide acute care.

(b) The issuance of a single consolidated license shall be based on the following criteria:

(1) There is a single governing body for all of the facilities maintained and operated by the licensee.

(2) There is a single administration for all of the facilities maintained and operated by the licensee.

(3) There is a single medical staff for all of the facilities maintained and operated by the licensee, with a single set of bylaws, rules, and regulations, which prescribe a single committee structure.

(4) Except as provided otherwise in this paragraph, the physical plants maintained and operated by the licensee which are to be covered by the single consolidated license are located not more than 15 miles apart. If an applicant provides evidence satisfactory to the department that it can comply with all requirements of licensure and provide quality care and adequate administrative and professional supervision, the director may issue a single consolidated license to a general acute care hospital that operates two or more physical plants located more than 15 miles apart under any of the following circumstances:

(A) One or more of the physical plants is located in a rural area, as defined by regulations of the director.

(B) One or more of the physical plants provides only outpatient services, as defined by the department.

(C) If Section 14105.986 of the Welfare and Institutions Code is implemented and the applicant meets all of the following criteria:

(i) The applicant is a nonprofit corporation.

(ii) The applicant is a children's hospital listed in Section 10727 of the Welfare and Institutions Code.

(iii) The applicant is affiliated with a major university medical school, and located adjacent thereto.

(iv) The applicant operates a regional tertiary care facility.

(v) One of the physical plants is located in a county that has a consolidated and county government structure.

(vi) One of the physical plants is located in a county having a population between 1 million and 2 million.

(vii) The applicant is located in a city with a population between 50,000 and 100,000.

(c) In issuing the single consolidated license, the state department shall specify the location of each supplemental service and the location of the number and category of beds provided by the licensee. The single consolidated license shall be renewed annually.

(d) To the extent required by Part 1.5 (commencing with Section 437) of Division 1, a general acute care hospital which has been issued a single consolidated license:

(1) Shall not transfer from one facility to another a special service described in Section 1255 without first obtaining a certificate of need.

(2) Shall not transfer, in whole or in part, from one facility to another, a supplemental service, as defined in regulations of the director pursuant to this chapter, without first obtaining a certificate of need, unless the licensee, 30 days prior to the relocation, notifies the Office of Statewide Health Planning and Development, the applicable health systems agency, and the state department of the licensee's intent to relocate the supplemental service, and includes with this notice a cost estimate, certified by a person qualified by experience or training to render the estimates, which estimates that the cost of the transfer will not exceed the capital expenditure threshold established by the Office of Statewide Health Planning and Development pursuant to Section 437.10.

(3) Shall not transfer beds from one facility to another facility, without first obtaining a certificate of need unless, 30 days prior to the relocation, the licensee notifies the Office of Statewide Health Planning and Development, the applicable health systems agency, and the state department of the licensee's intent to relocate health facility beds, and includes with this notice both of the following:

(A) A cost estimate, certified by a person qualified by experience or training to render the estimates, which estimates that the cost of the relocation will not exceed the capital expenditure threshold established by the Office of Statewide Health Planning and Development pursuant to Section 437.10.

(B) The identification of the number, classification, and location of the health facility beds in the transferor facility and the proposed number, classification, and location of the health facility beds in the transferee facility.

Except as otherwise permitted in Part 1.5 (commencing with Section 437) of Division 1, or as authorized in an approved certificate of need pursuant to that part, health facility beds transferred pursuant to this section shall be used in the transferee facility in the same bed classification as defined in Section 1250.1, as the beds were classified in the transferor facility.

Health facility beds transferred pursuant to this section shall not be transferred back to the transferor facility for two years from the date of

the transfer, regardless of cost, without first obtaining a certificate of need pursuant to Part 1.5 (commencing with Section 437) of Division 1.

(e) All transfers pursuant to subdivision (d) shall satisfy all applicable requirements of licensure and shall be subject to the written approval, if required, of the state department. The state department may adopt regulations which are necessary to implement the provisions of this section. These regulations may include a requirement that each facility of a health facility subject to a single consolidated license have an onsite full-time or part-time administrator.

(f) As used in this section, "facility" means any physical plant operated or maintained by a health facility subject to a single, consolidated license issued pursuant to this section.

(g) For purposes of selective provider contracts negotiated under the Medi-Cal program, the treatment of a health facility with a single consolidated license issued pursuant to this section shall be subject to negotiation between the health facility and the California Medical Assistance Commission. A general acute care hospital which is issued a single consolidated license pursuant to this section may, at its option, be enrolled in the Medi-Cal program as a single business address or as separate business addresses for one or more of the facilities subject to the single consolidated license. Irrespective of whether the general acute care hospital is enrolled at one or more business addresses, the department may require the hospital to file separate cost reports for each facility pursuant to Section 14170 of the Welfare and Institutions Code.

(h) For purposes of the Annual Report of Hospitals required by regulations adopted by the state department pursuant to this part, the state department and the Office of Statewide Health Planning and Development may require reporting of bed and service utilization data separately by each facility of a general acute care hospital issued a single consolidated license pursuant to this section.

(i) The amendments made to this section during the 1985–86 Regular Session of the Legislature pertaining to the issuance of a single consolidated license to a general acute care hospital in the case where the separate physical plant is a skilled nursing facility or intermediate care facility shall not apply to the following facilities:

(1) Any facility which obtained a certificate of need after August 1, 1984, and prior to February 14, 1985, as described in this subdivision. The certificate of need shall be for the construction of a skilled nursing facility or intermediate care facility which is the same facility for which the hospital applies for a single consolidated license, pursuant to subdivision (a).

(2) Any facility for which a single consolidated license has been issued pursuant to subdivision (a), as described in this subdivision, prior to the effective date of the amendments made to this section during the 1985–86 Regular Session of the Legislature.

Any facility which has been issued a single consolidated license pursuant to subdivision (a), as described in this subdivision, shall be granted

renewal licenses based upon the same criteria used for the initial consolidated license.

(j) If the state department issues a single consolidated license pursuant to this section, the state department may take any action authorized by this chapter, including, but not limited to, any action specified in Article 5 (commencing with Section 1294), with respect to any facility, or any service provided in any facility, which is included in the consolidated license.

(k) The eligibility for participation in the Medi-Cal program (Chapter 7 (commencing with Section 14000), Part 3, Division 9, Welfare and Institutions Code) of any facility that is included in a consolidated license issued pursuant to this section, provides outpatient services, and is located more than 15 miles from the health facility issued the consolidated license shall be subject to a determination of eligibility by the state department. This subdivision shall not apply to any facility that is located in a rural area and is included in a consolidated license issued pursuant to subparagraphs (A), (B), and (C) of paragraph (4) of subdivision (b). Regardless of whether a facility has received or not received a determination of eligibility pursuant to this subdivision, this subdivision shall not affect the ability of a licensed professional, providing services covered by the Medi-Cal program to a person eligible for Medi-Cal in a facility subject to a determination of eligibility pursuant to this subdivision, to bill the Medi-Cal program for those services provided in accordance with applicable regulations.

(*l*) Notwithstanding any other provision of law, the director may issue a single consolidated license for a general acute care hospital to Children's Hospital Oakland and San Ramon Regional Medical Center.

(m) Notwithstanding any other provision of law, the director may issue a single consolidated license for a general acute care hospital to Children's Hospital Oakland and the John Muir Medical Center, Concord campus.

(n) (1) To the extent permitted by federal law, payments made to Children's Hospital Oakland pursuant to Section 14166.11 of the Welfare and Institutions Code shall be adjusted as follows:

(A) The number of Medi-Cal payment days and net revenues calculated for the John Muir Medical Center Concord campus under the consolidated license shall not be used for eligibility purposes for the private hospital disproportionate share hospital replacement funds for Children's Hospital Oakland.

(B) The number of Medi-Cal payment days calculated for hospital beds located at John Muir Medical Center Concord campus that are included in the consolidated license beginning in the 2007–08 fiscal year shall only be used for purposes of calculating disproportionate share hospital payments authorized under Section 14166.11 of the Welfare and Institutions Code at Children's Hospital Oakland to the extent that the inclusion of those days does not exceed the total Medi-Cal payment days used to calculate Children's Hospital Oakland payments for the 2006–07 fiscal year disproportionate share replacement.

(2) This subdivision shall become inoperative in the event that the two facilities covered under the consolidated license described in subdivision (a) are located within a 15-mile radius of each other.

SEC. 4. Section 1266 of the Health and Safety Code is amended to read:

1266. (a) The Licensing and Certification Division shall be supported entirely by federal funds and special funds by no earlier than the beginning of the 2009–10 fiscal year unless otherwise specified in statute, or unless funds are specifically appropriated from the General Fund in the annual Budget Act or other enacted legislation. For the 2007–08 fiscal year, General Fund support shall be provided to offset licensing and certification fees in an amount of not less than two million seven hundred eighty-two thousand dollars ($2,782,000).

(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 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 shall 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. Amounts actually received for new licensure applications, including change of ownership applications, and late payment penalties, pursuant to Section 1266.5, during each fiscal year shall be calculated and 95 percent shall be applied to the appropriate fee categories in determining Licensing and Certification Program fees for the second fiscal year following receipt of those funds. The remaining 5 percent shall be retained in the fund as a reserve until appropriated.

(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. 5. Section 1279 of the Health and Safety Code is amended to read:

1279. (a) Every health facility for which a license or special permit has been issued shall be periodically inspected by the department, or by another governmental entity under contract with the department. The frequency of inspections shall vary, depending upon the type and complexity of the health facility or special service to be inspected, unless

otherwise specified by state or federal law or regulation. The inspection shall include participation by the California Medical Association consistent with the manner in which it participated in inspections, as provided in Section 1282 prior to September 15, 1992.

(b) Except as provided in subdivision (c), inspections shall be conducted no less than once every two years and as often as necessary to ensure the quality of care being provided.

(c) For a health facility specified in subdivision (a), (b), or (f) of Section 1250, inspections shall be conducted no less than once every three years, and as often as necessary to ensure the quality of care being provided.

(d) During the inspection, the representative or representatives shall offer such advice and assistance to the health facility as they deem appropriate.

(e) For acute care hospitals of 100 beds or more, the inspection team shall include at least a physician, registered nurse, and persons experienced in hospital administration and sanitary inspections. During the inspection, the team shall offer advice and assistance to the hospital as it deems appropriate.

(f) The department shall ensure that a periodic inspection conducted pursuant to this section is not announced in advance of the date of inspection. An inspection may be conducted jointly with inspections by entities specified in Section 1282. However, if the department conducts an inspection jointly with an entity specified in Section 1282 that provides notice in advance of the periodic inspection, the department shall conduct an additional periodic inspection that is not announced or noticed to the health facility.

(g) Notwithstanding any other provision of law, the department shall inspect for compliance with provisions of state law and regulations during a state periodic inspection or at the same time as a federal periodic inspection, including, but not limited to, an inspection required under this section. If the department inspects for compliance with state law and regulations at the same time as a federal periodic inspection, the inspection shall be done consistent with the guidance of the federal Centers for Medicare and Medicaid Services for the federal portion of the inspection.

SEC. 6. Section 1280.1 of the Health and Safety Code is amended to read:

1280.1. (a) Prior to the effective date of regulations adopted to implement Section 1280.3, if a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars ($25,000) per violation.

(b) If the licensee disputes a determination by the department regarding the alleged deficiency or the alleged failure to correct a deficiency, or regarding the reasonableness of the proposed deadline for correction or the amount of the penalty, the licensee may, within 10 days, request a hearing

pursuant to Section 100171. Penalties shall be paid when appeals have been exhausted and the department's position has been upheld.

(c) For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.

(d) This section shall apply only to incidents occurring on or after January 1, 2007.

(e) No new regulations are required or authorized for implementation of this section.

(f) This section shall become inoperative on the effective date of regulations promulgated by the department pursuant to Section 1280.3.

SEC. 7. Section 1280.3 of the Health and Safety Code is amended to read:

1280.3. (a) Commencing on the effective date of the regulations adopted pursuant to this section, the director may assess an administrative penalty in an amount of up to fifty thousand dollars ($50,000) per immediate jeopardy violation against a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250.

(b) Except as provided in subdivision (c), for a violation of this chapter or the rules and regulations promulgated thereunder that does not constitute a violation of subdivision (a), the department may assess an administrative penalty in an amount of up to seventeen thousand five hundred dollars ($17,500) per violation. This subdivision shall also apply to violation of regulations set forth in Article 3 (commencing with Section 127400) of Chapter 2 of Part 2 of Division 107 or the rules and regulations promulgated thereunder.

The department shall promulgate regulations establishing the criteria to assess an administrative penalty against a health facility licensed pursuant to subdivisions (a), (b), or (f) of Section 1250. The criteria shall include, but need not be limited to, the following:

(1) The patient's physical and mental condition.

(2) The probability and severity of the risk that the violation presents to the patient.

(3) The actual financial harm to patients, if any.

(4) The nature, scope, and severity of the violation.

(5) The facility's history of compliance with related state and federal statutes and regulations.

(6) Factors beyond the facility's control that restrict the facility's ability to comply with this chapter or the rules and regulations promulgated thereunder.

(7) The demonstrated willfulness of the violation.

(8) The extent to which the facility detected the violation and took steps to immediately correct the violation and prevent the violation from recurring.

(c) The department shall not assess an administrative penalty for minor violations.

(d) The regulations shall not change the definition of immediate jeopardy as established in this section.

(e) The regulations shall apply only to incidents occurring on or after the effective date of the regulations.

(f) If the licensee disputes a determination by the department regarding the alleged deficiency or alleged failure to correct a deficiency, or regarding the reasonableness of the proposed deadline for correction or the amount of the penalty, the licensee may, within 10 working days, request a hearing pursuant to Section 100171. Penalties shall be paid when all appeals have been exhausted and the department's position has been upheld.

(g) Moneys collected by the department as a result of administrative penalties imposed under this section and Section 1280.1 shall be deposited into the Licensing and Certification Program Fund established pursuant to Section 1266.9. These moneys shall be tracked and available for expenditure, upon appropriation by the Legislature, to support internal departmental quality improvement activities.

(h) For purposes of this section, "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.

SEC. 8. Section 1324.21 of the Health and Safety Code is amended to read:

1324.21. (a) For facilities licensed under subdivision (c) of Section 1250, there shall be imposed each state fiscal year a uniform quality assurance fee per resident day. The uniform quality assurance fee shall be based upon the entire net revenue of all skilled nursing facilities subject to the fee, except an exempt facility, as defined in Section 1324.20, calculated in accordance with subdivision (b).

(b) The amount of the uniform quality assurance fee to be assessed per resident day shall be determined based on the aggregate net revenue of skilled nursing facilities subject to the fee, in accordance with the methodology outlined in the request for federal approval required by Section 1324.27 and in regulations, provider bulletins, or other similar instructions. The uniform quality assurance fee shall be calculated as follows:

(1) (A) For the rate year 2004–05, the net revenue shall be projected for all skilled nursing facilities subject to the fee. The projection of net revenue shall be based on prior rate year data. Once determined, the aggregate projected net revenue for all facilities shall be multiplied by 2.7 percent, as determined under the approved methodology, and then divided by the projected total resident days of all providers subject to the fee.

(B) Notwithstanding subparagraph (A), the Director of Health Services may increase the amount of the fee up to 3 percent of the aggregate projected net revenue if necessary for the implementation of Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(2) For the rate year 2005–06 and subsequent rate years through and including the 2008–09 rate year, the net revenue shall be projected for all skilled nursing facilities subject to the uniform quality assurance fee. The projection of net revenue shall be based on the prior rate year's data. Once determined, the aggregate projected net revenue for all facilities shall be multiplied by 6 percent, as determined under the approved methodology, and then divided by the projected total resident days of all providers subject to the fee. The amounts so determined shall be subject to the provisions of subdivision (d).

(c) The director may assess and collect a nonuniform fee consistent with the methodology approved pursuant to Section 1324.27.

(d) In no case shall the fees collected annually pursuant to this article, taken together with applicable licensing fees, exceed the amounts allowable under federal law.

(e) If there is a delay in the implementation of this article for any reason, including a delay in the approval of the quality assurance fee and methodology by the federal Centers for Medicare and Medicaid Services, in the 2004–05 rate year or in any other rate year, all of the following shall apply:

(1) Any facility subject to the fee may be assessed the amount the facility will be required to pay to the department, but shall not be required to pay the fee until the methodology is approved and Medi-Cal rates are increased in accordance with paragraph (2) of subdivision (a) of Section 1324.28 and the increased rates are paid to facilities.

(2) The department may retroactively increase and make payment of rates to facilities.

(3) Facilities that have been assessed a fee by the department shall pay the fee assessed within 60 days of the date rates are increased in accordance with paragraph (2) of subdivision (a) of Section 1324.28 and paid to facilities.

(4) The department shall accept a facility's payment notwithstanding that the payment is submitted in a subsequent fiscal year than the fiscal year in which the fee is assessed.

SEC. 9. Section 1324.23 of the Health and Safety Code is amended to read:

1324.23. (a) The Director of Health Services, or his or her designee, shall administer this article.

(b) The director may adopt regulations as are necessary to implement this article. These regulations may be adopted as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). For purposes of this article, 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. The regulations shall include, but need not be limited to, any regulations necessary for any of the following purposes:

(1) The administration of this article, including the proper imposition and collection of the quality assurance fee not to exceed amounts reasonably necessary for purposes of this article.

(2) The development of any forms necessary to obtain required information from facilities subject to the quality assurance fee.

(3) To provide details, definitions, formulas, and other requirements.

(c) As an alternative to subdivision (b), and notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this article, in whole or in part, by means of a provider bulletin, or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, 2008. It is the intent of the Legislature that the regulations adopted pursuant to subdivision (b) shall be adopted on or before July 31, 2008.

SEC. 10. Section 1324.28 of the Health and Safety Code is amended to read:

1324.28. (a) This article shall be implemented as long as both of the following conditions are met:

(1) The state receives federal approval of the quality assurance fee from the federal Centers for Medicare and Medicaid Services.

(2) Legislation is enacted in the 2004 legislative session making an appropriation from the General Fund and from the Federal Trust Fund to fund a rate increase for skilled nursing facilities, as defined under subdivision (c) of Section 1250, for the 2004–05 rate year in an amount consistent with the Medi-Cal rates that specific facilities would have received under the rate methodology in effect as of July 31, 2004, plus the proportional costs as projected by Medi-Cal for new state or federal mandates.

(b) This article shall remain operative only as long as all of the following conditions are met:

(1) The federal Centers for Medicare and Medicaid Services continues to allow the use of the provider assessment provided in this article.

(2) The Medi-Cal Long Term Care Reimbursement Act, Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, as added during the 2003–04 Regular Session by the act adding this section, is enacted and implemented on or before July 31, 2005, or as extended as provided in that article, and remains in effect thereafter.

(3) The state has continued its maintenance of effort for the level of state funding of nursing facility reimbursement for rate year 2005–06, and for every subsequent rate year continuing through the 2008–09 rate year, in an amount not less than the amount that specific facilities would have received under the rate methodology in effect on July 31, 2004, plus Medi-Cal's projected proportional costs for new state or federal mandates, not including the quality assurance fee.

(4) The full amount of the quality assurance fee assessed and collected pursuant to this article remains available for the purposes specified in Section 1324.25 and for related purposes.

(c) If all of the conditions in subdivision (a) are met, this article is implemented, and subsequently, any one of the conditions in subdivision (b) is not met, on and after the date that the department makes that determination, this article shall not be implemented, notwithstanding that the condition or conditions subsequently may be met.

(d) Notwithstanding subdivisions (a), (b), and (c), in the event of a final judicial determination made by any state or federal court that is not appealed, or by a court of appellate jurisdiction that is not further appealed, in any action by any party, or a final determination by the administrator of the federal Centers for Medicare and Medicaid Services, that federal financial participation is not available with respect to any payment made under the methodology implemented pursuant to this article because the methodology is invalid, unlawful, or contrary to any provision of federal law or regulations, or of state law, this section shall become inoperative.

SEC. 11. Section 1324.29 of the Health and Safety Code is amended to read:

1324.29. The quality assurance fee shall cease to be assessed and collected on or after July 31, 2009.

SEC. 12. Section 1324.30 of the Health and Safety Code is amended to read:

1324.30. This article shall become inoperative on July 31, 2009, and, as of January 1, 2010, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2010, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 13. Section 1422 of the Health and Safety Code, as amended by Section 6 of Chapter 895 of the Statutes of 2006, is amended to read:

1422. (a) The Legislature finds and declares that it is the public policy of this state to ensure that long-term health care facilities provide the highest level of care possible. The Legislature further finds that inspections are the most effective means of furthering this policy. It is not the intent of the Legislature by the amendment of subdivision (b) enacted by Chapter 1595 of the Statutes of 1982 to reduce in any way the resources available to the state department for inspections, but rather to provide the state department with the greatest flexibility to concentrate its resources where they can be most effective. It is the intent of the Legislature to create a survey process that includes state-based survey components and that determines compliance with federal and California requirements for certified long-term health care facilities. It is the further intent of the Legislature to execute this inspection in the form of a single survey process, to the extent that this is possible and permitted under federal law. The inability of the state to conduct a single survey in no way exempts the state from the requirement under this section that state-based components be inspected in long-term health care facilities as required by law.

(b) (1) (A) Notwithstanding Section 1279 or any other provision of law, without providing notice of these inspections, the department, in addition to any inspections conducted pursuant to complaints filed pursuant to Section 1419, shall conduct inspections annually, except with regard to those facilities which have no class "AA," class "A," or class "B" violations in the past 12 months. The state department shall also conduct inspections as may be necessary to ensure the health, safety, and security of patients in long-term health care facilities. Every facility shall be inspected at least once every two years. The department shall vary the cycle in which inspections of long-term health care facilities are conducted to reduce the predictability of the inspections.

(B) Inspections and investigations of long-term health care facilities that are certified by the Medicare Program or the Medicaid Program shall determine compliance with federal standards and California statutes and regulations to the extent that California statutes and regulations provide greater protection to residents, or are more precise than federal standards, as determined by the department. Notwithstanding any other provision of law, the department may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific this paragraph by means of an All Facilities Letter (AFL) or similar instruction. Prior to issuing an AFL or similar instruction, the department shall consult with interested parties and shall inform the appropriate committees of the Legislature. The department shall also post the AFL or similar instruction on its Web site so that any person may observe which California laws and regulations provide greater protection to its residents or are more precise than federal standards. Nothing in this subdivision is intended to change existing statutory or regulatory requirements governing the care provided to long-term health care facility residents.

(C) In order to ensure maximum effectiveness of inspections conducted pursuant to this article, the department shall identify all state law standards for the staffing and operation of long-term health care facilities. Costs of the additional survey and inspection activities required by Chapter 895 of the Statutes of 2006 shall be included as Licensing and Certification Program activities for the purposes of calculating fees in accordance with Section 1266.

(2) The state department shall submit to the federal Department of Health and Human Services on or before July 1, 1985, for review and approval, a request to implement a three-year pilot program designed to lessen the predictability of the long-term health care facility inspection process. Two components of the pilot program shall be (A) the elimination of the present practice of entering into a one-year certification agreement, and (B) the conduct of segmented inspections of a sample of facilities with poor inspection records, as defined by the state department. At the conclusion of the pilot project, an analysis of both components shall be conducted by the state department to determine effectiveness in reducing

inspection predictability and the respective cost benefits. Implementation of this pilot project is contingent upon federal approval.

(c) Except as otherwise provided in subdivision (b), the state department shall conduct unannounced direct patient care inspections at least annually to inspect physician and surgeon services, nursing services, pharmacy services, dietary services, and activity programs of all the long-term health care facilities. Facilities evidencing repeated serious problems in complying with this chapter or a history of poor performance, or both, shall be subject to periodic unannounced direct patient care inspections during the inspection year. The direct patient care inspections shall assist the state department in the prioritization of its efforts to correct facility deficiencies.

(d) All long-term health care facilities shall report to the state department any changes in the nursing home administrator or the director of nursing services within 10 calendar days of the changes.

(e) Within 90 days after the receipt of notice of a change in the nursing home administrator or the director of nursing services, the state department may conduct an abbreviated inspection of the long-term health care facilities.

(f) If a change in a nursing home administrator occurs and the Board of Nursing Home Administrators notifies the state department that the new administrator is on probation or has had his or her license suspended within the previous three years, the state department shall conduct an abbreviated survey of the long-term health care facility employing that administrator within 90 days of notification.

SEC. 14. Section 101317 of the Health and Safety Code is amended to read:

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

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

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

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

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

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

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

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

(1) Each fiscal year, upon the submission of an application for funding by the administrative body of a local health jurisdiction, the department shall make the first quarterly payment to each eligible local health jurisdiction. Initially, that application shall include a plan and budget for the local program that is in accordance with the department's plans and priorities for bioterrorism preparedness and response, and other public health threats and emergencies, and a certification by the chairperson of the board of supervisors or the mayor of a city with a local health department that the funds received pursuant to this article will not be used to supplant other funding sources in violation of subdivision (d) of Section 101315. In subsequent years, the department shall develop a streamlined process for continuation of funding that will address new federal requirements and will assure the continuity of local plan activities.

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

risdiction's progress in implementing the provisions of the local health jurisdiction's plan, as determined by the department.

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

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

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

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

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

(3) It is the intent of the Legislature that the department shall audit the cost reports every three years, commencing in January 2007, to determine compliance with federal requirements and consistency with local health jurisdiction budgets, contingent upon the availability of federal funds for this activity, and contingent upon the continuation of federal funding for emergency preparedness and bioterrorism preparedness. All cost-compliance reports and audit exceptions or related analyses or reports issued by the State Department of Public Health regarding the expenditure of funding for emergency and bioterrorism preparedness by local health jurisdictions shall be made available to the Legislature upon request.

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

The funds appropriated pursuant to this article and retained by the department pursuant to this subdivision are available for expenditure and encumbrance for the purposes of support or local assistance.

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

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

SEC. 15. Section 101320 of the Health and Safety Code is amended to read:

101320. This article shall become inoperative on September 1, 2010, and, as of January 1, 2011, is repealed, unless a later enacted statute that is enacted before January 1, 2011, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 16. Section 120955 of the Health and Safety Code is amended to read:

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

(2) The director, in consultation with the AIDS Drug Assistance Program Medical Advisory Committee, shall develop, maintain, and update as necessary a list of drugs to be provided under this program. The list shall be exempt from the requirements of the Administrative Procedures Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commenc-

ing with Section 11370), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law. In addition, the director shall notify the fiscal and policy committees of the Legislature of any additions, deletions, or restrictions to the list within 15 business days of the action. At a minimum, this notification shall describe the specific change to the formulary, the reason for the action taken, the estimated number of people it may affect, and any estimate of costs or savings where applicable.

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

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

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

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

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

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

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

(i) The department may also subsidize certain cost-sharing requirements for persons otherwise eligible for the AIDS Drug Assistance Program (ADAP) with existing non-ADAP drug coverage by paying for prescription drugs included on the ADAP formulary within the existing ADAP operational structure up to, but not exceeding, the amount of that cost-sharing obligation. This cost sharing may only be applied in circumstances in which the other payer recognizes the ADAP payment as counting toward the individual's cost-sharing obligation.

SEC. 17. Section 124910 of the Health and Safety Code is amended to read:

124910. (a) (1) Each licensed primary care clinic, as specified in subdivision (a) of Section 124900, applying for funds under this article, shall demonstrate in its application that it meets all of the following conditions, at a minimum:

(A) Provides medical diagnosis and treatment.

(B) Provides medical support services of patients in all stages of illness.

(C) Provides communication of information about diagnosis, treatment, prevention, and prognosis.

(D) Provides maintenance of patients with chronic illness.

(E) Provides prevention of disability and disease through detection, education, persuasion, and preventive treatment.

(F) Meets one or both of the following conditions:

(i) Is located in an area or a facility federally designated as a health professional shortage area, medically underserved area, or medically underserved population.

(ii) Is a clinic in which at least 50 percent of the patients served are persons with incomes at or below 200 percent of the federal poverty level.

(2) Any applicant who has applied for and received a federal or state designation for serving a health professional shortage area, medically underserved area, or population shall be deemed to meet the requirements of subdivision (a) of Section 124900.

(b) Each applicant shall also demonstrate to the satisfaction of the department that the proposed services supplement, and do not supplant, those primary care services to program beneficiaries that are funded by any county, state, or federal program.

(c) Each applicant shall demonstrate that it is an active Medi-Cal provider by being enrolled in Medi-Cal and diligently billing the Medi-Cal program for services rendered to Medi-Cal eligible patients during the past three months prior to the application due date. This subdivision shall not apply to clinics that are not currently Medi-Cal providers, and were funded participants pursuant to this article during the 1993–94 fiscal year.

(d) Each application shall be evaluated by the state department prior to funding to determine all of the following:

(1) The applicant shall provide its most recently audited financial statement to verify budget information.

(2) The applicant's ability to deliver basic primary care to program beneficiaries.

(3) A description of the applicant's operational quality assurance program.

(4) The applicant's use of protocols for the most common diseases in the population served under this article.

SEC. 18. 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 genetic disease testing 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 and deposited in the Genetic Disease Testing Fund or the Birth Defects Monitoring Fund consistent with this section, 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) 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.

(4) The department shall charge a fee for prenatal screening to support the pregnancy blood sample storage, testing, and research activities of the Birth Defects Monitoring Program.

(5) The initial prenatal screening fee increase for activities of the Birth Defects Monitoring Program shall be ten dollars ($10).

(6) The only funds from the Genetic Disease Testing Fund that may be used for the purpose of supporting the pregnancy blood sample storage, testing, and research activities of the Birth Defects Monitoring Program are those prenatal screening fees assessed and collected prior to the creation of the Birth Defects Monitoring Program Fund specifically to support those Birth Defects Monitoring Program activities.

(7) The Birth Defects Monitoring Program Fund is hereby created as a special fund in the State Treasury. Fee revenues collected pursuant to paragraph (4) shall be deposited into the fund and shall be available upon appropriation by the Legislature to support the pregnancy blood sample storage, testing, and research activities of the Birth Defects Monitoring Program. Notwithstanding Section 16305.7 of the Government Code, interest earned on funds in the Birth Defects Monitoring Program Fund shall be deposited as revenue into the fund to support the Birth Defects Monitoring Program.

(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. 19. Section 130542 of the Health and Safety Code is amended to read:

130542. (a) The department shall deposit all payments the department receives pursuant to this division into the California Discount Prescription Drug Program Fund, which is hereby established in the State Treasury.

(b) Notwithstanding Section 13340 of the Government Code, the fund is hereby continuously appropriated to the department without regard to fiscal year for the purpose of providing payment to participating pharmacies pursuant to this division and for defraying the costs of administering this division.

(c) Notwithstanding any other provision of law, no money in the fund is available for expenditure for any other purpose or for loaning or trans-

ferring to any other fund, including the General Fund. The fund shall also contain any interest accrued on moneys in the fund.

SEC. 20. Section 12693.981 of the Insurance Code is amended to read:

12693.981. (a) (1) The Healthy Families-to-Medi-Cal Bridge Benefits Program is hereby established to provide any person enrolled for coverage under this part who meets the criteria set forth in subdivision (b) with a two calendar-month period of health care benefits in order to provide the person with an opportunity to apply for Medi-Cal.

(2) The Healthy Families-to-Medi-Cal Bridge Benefits Program shall be administered by the board.

(b) (1) Any person who meets all of the following requirements shall be eligible for two additional calendar months of Healthy Families benefits:

(A) He or she has been receiving, but is no longer eligible for, benefits under the program.

(B) He or she appears to be income eligible for full-scope Medi-Cal benefits without a share of cost.

(2) The two additional calendar months of benefits under this chapter shall begin on the first day of the month following the last day of the person's eligibility for benefits under the program.

(c) The two-calendar-month period of Healthy Families benefits provided under this chapter shall be identical to the scope of benefits that the person was receiving under the program.

(d) Nothing in this section shall be construed to provide Healthy Families benefits for more than a two calendar-month period under any circumstances, including the failure to apply for benefits under the Medi-Cal program or the failure to be made aware of the availability of the Medi-Cal program unless the circumstances described in subdivision (b) reoccur.

(e) This section shall become inoperative if an unappealable court decision or judgment determines that any of the following apply:

(1) The provisions of this section are unconstitutional under the United States Constitution or the California Constitution.

(2) The provisions of this section do not comply with the State Children's Health Insurance Program, as set forth in Title XXI of the federal Social Security Act.

(3) The provisions of this section require that the health care benefits provided pursuant to this section are required to be furnished for more than two calendar months.

(f) The board shall cease to provide the benefits described in this section to any additional individuals on the date that the State Department of Health Care Services implements the presumptive eligibility program established pursuant to Section 14011.65b of the Welfare and Institutions Code and the Director of Health Care Services executes a declaration pursuant to subdivision (d) of that section stating that the program of presumptive eligibility has commenced. The board shall consult and coordinate with the State Department of Health Care Services in implement-

ing presumptive eligibility under Section 14011.65b of the Welfare and Institutions Code for these individuals.

(g) This section shall be repealed six months after the board ceases to provide benefits to additional individuals pursuant to this section.

SEC. 21. Section 4474.4 is added to the Welfare and Institutions Code, to read:

4474.4. Notwithstanding any other provision of law to the contrary, the Secretary of California Health and Human Services shall verify that the State Department of Developmental Services and the State Department of Health Care Services have established protocols in place between the departments, as well as with the regional centers and health care plans participating in the Medi-Cal Program who will be providing services, including health, dental, and vision care, to people with developmental disabilities transitioning from Agnews Developmental Center.

The Secretary of California Health and Human Services shall provide written verification of the establishment of these protocols to the Joint Legislative Budget Committee, as well as to the fiscal and policy committees of the Legislature that oversee health and human services programs.

The purpose of the protocols is to ensure that a mutual goal of providing appropriate, high-quality care and services to children and adults who have developmental disabilities in order to optimize the health and welfare of each individual. Further, the purpose of the protocols is to ensure that all involved parties, including consumers and families, the state, regional centers, and providers, are clear as to their roles and responsibilities, and are appropriately accountable for optimizing the health and welfare of each individual.

The protocols, at a minimum, shall address enrollment for services, all referral practices, including those to specialty care, authorization practices for services of all involved parties, coordination of case management services, education and training services to be provided, the management of medical records, and provider reimbursement methods. These protocols shall be provided to the consumers and their families, and be made available to the public upon request.

SEC. 22. Section 4474.5 is added to the Welfare and Institutions Code, to read:

4474.5. (a) In order to meet the unique medical health needs of consumers transitioning from Agnews Developmental Center into Alameda, San Mateo, and Santa Clara Counties pursuant to the Plan for the Closure of Agnews Developmental Center, whose individual program plans document the need for coordinated medical and specialty care that cannot be met using the traditional Medi-Cal Fee-For-Service system, services provided under the contract shall be provided by Medi-Cal managed care health plans that are currently operational in these counties as a county organized health system or a local initiative if consumers, where applicable, choose to enroll. Reimbursement shall be by the State Department of Health Care Services for all Medi-Cal services provided under the contract that are not reimbursed by the Medicare program.

(b) Medi-Cal managed care health plans enrolling members referred to in subdivision (a) shall be further reimbursed for the reasonable cost of administrative services. Administrative services pursuant to this subdivision include, but are not limited to, coordination of care and case management not provided by a regional center, provider credentialing and contracting, quality oversight, assuring member access to covered services, consultation with Agnews Developmental Center staff, regional center staff, Department of Developmental Services staff, contractors, and family members, and financial management of the program, including claims processing. Reasonable cost is defined as the actual cost incurred by the Medi-Cal managed care health plan, including both direct and indirect costs incurred by the Medi-Cal managed care health plan, in the performance of administrative services, but shall not include any incurred costs found by the State Department of Health Care Services to be unnecessary for the efficient delivery of necessary health services. Payment for administrative services shall continue on a reasonable cost basis until sufficient cost experience exists to allow these costs to be part of an all-inclusive capitation rate covering both administrative services and direct patient care services.

(c) Until the State Department of Health Care Services is able to determine by actuarial methods, prospective per capita rates of payment for services for those members who enroll in the Medi-Cal managed care health plans specified in subdivision (a), the State Department of Health Care Services shall reimburse the Medi-Cal managed care health plans for the net reasonable cost of direct patient care services and supplies set forth in the scope of services in the contract between the Medi-Cal managed care health plans and the State Department of Health Care Services and that are not reimbursed by the Medicare Program. Net reasonable cost is defined as the actual cost incurred by the Medi-Cal managed care health plans, as measured by the Medi-Cal managed care health plan's payments to providers of services and supplies, less payments made to the plans by third parties other than Medicare, and shall not include any incurred cost found to be unnecessary by the State Department of Health Care Services in the efficient delivery of necessary health services. Reimbursement shall be accomplished by the State Department of Health Care Services making estimated payments at reasonable intervals, with these estimates being reconciled to actual net reasonable cost at least semiannually.

(d) The State Department of Health Care Services shall seek any approval necessary for implementation of this section from the federal government, for purposes of federal financial participation under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.). Notwithstanding any other provision of law, this section shall be implemented only to the extent that federal financial participation is available pursuant to necessary federal approvals.

SEC. 23. Section 4474.8 is added to the Welfare and Institutions Code, to read:

4474.8. Notwithstanding any other provision of law to the contrary, the State Department of Developmental Services shall continue the operation of the Agnews Outpatient Clinic until such time as the State Department of Developmental Services is no longer responsible for the property.

SEC. 24. 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, 2008, 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. 25. Section 4643 of the Welfare and Institutions Code is amended to read:

4643. (a) If assessment is needed, prior to July 1, 2008, 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, 2008, 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. 26. 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 2007–08 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, 2007, unless the increase is required by a contract between the regional center and the vendor that is in effect on June 30, 2007, 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. 27. 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 2007–08 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, 2007, 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. 28. 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 2007–08 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, 2007, if the permanent payment rate would be greater than the temporary payment rate in effect on or after July 1, 2007, unless the re-

gional 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 2007–08 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, 2007, 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 2007–08 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, 2007, 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 2007–08 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, 2007, 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. 29. 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 for the 2006–07 fiscal year only 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. 30. Section 4781.6 is added to the Welfare and Institutions Code, to read:

4781.6. (a) For the 2007–08 fiscal year only, a regional center shall not expend any purchase of service funds for the startup of any new program unless the expenditure is necessary to protect the consumer's health or safety or because of extraordinary circumstances, and the department has granted prior written authorization for the expenditures.

(b) This section does not apply to the purchase of services funds allocated as part of the department's community placement plan process.

SEC. 32. Section 10020 of the Welfare and Institutions Code is amended to read:

10020. (a) No person having private health care coverage shall be entitled to receive the same health care items or services furnished or paid for by a publicly funded health care program.

(b) As used in this chapter:

(1) "Publicly funded health care program" shall mean care or services rendered by a local government or any facility thereof, or health care services for which payment is made under the California Medical Assistance Program established by Chapter 7 (commencing with Section 14000) of Part 3 of this division by the State Department of Health Services or by its fiscal intermediary, or by a carrier or other organization with which the State Department of Health Services has contracted to furnish those services or to pay providers who furnish those services.

(2) As used in this chapter, "private health care coverage" means any health insurer, self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, including health care service plans as defined in subdivision (f) of Section 1345 of the Health and Safety Code, licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(c) If a person receives health care furnished or paid for by a publicly funded health care program, the carrier of the person's private health care coverage shall reimburse the publicly funded health care program the cost incurred in rendering that care to the extent of the benefits provided under the terms of the policy for the items provided or the services rendered.

SEC. 33. Section 10022 of the Welfare and Institutions Code is amended to read:

10022. (a) Each publicly funded health care program that furnishes or pays for health care items or services under this division to a person having private health care coverage shall be entitled to be subrogated to the rights that person has against the carrier of the coverage to the extent of the health care items provided or services rendered.

(b) An entity providing private health care coverage, as defined in paragraph (2) of subdivision (b) of Section 10020, shall do all of the following:

(1) Accept the state's right of recovery and the assignment to the state of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the state plan.

(2) Respond to any inquiry by the state regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of that health care item or service.

(3) Agree not to deny a claim submitted by the state solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim if both of the following occur:

(A) The claim is submitted by the state within the three-year period beginning on the date on which the item or service was furnished.

(B) Any action by the state to enforce its rights with respect to that claim is commenced within six years of the state's submission of the claim.

SEC. 34. Section 10024 of the Welfare and Institutions Code is amended to read:

10024. Every contract or agreement for private health care coverage entered into or renewed after January 1, 1972, is deemed to provide for payment to a publicly funded health care program for the actual cost that the program incurs in providing health care items or rendering health care services to any party or beneficiary of that contract or agreement to the extent of the benefits provided under the terms of the policy for the items provided or services rendered.

SEC. 35. Section 14011.6 of the Welfare and Institutions Code is amended to read:

14011.6. (a) To the extent federal financial participation is available, the department shall exercise the option provided in Section 1920a of the federal Social Security Act (42 U.S.C. Sec. 1396r-1a) to implement a program for accelerated enrollment of children.

(b) The department shall designate the single point of entry, as defined in subdivision (c), as the qualified entity for determining eligibility under this section.

(c) For purposes of this section, "single point of entry" means the centralized processing entity that accepts and screens applications for benefits under the Medi-Cal Program for the purpose of forwarding them to the appropriate counties.

(d) The department shall implement this section only if, and to the extent that, federal financial participation is available.

(e) The department shall seek federal approval of any state plan amendments necessary to implement this section. When federal approval of the state plan amendment or amendments is received, the department shall commence implementation of this section on the first day of the second month following the month in which federal approval of the state plan amendment or amendments is received, or on July 1, 2002, whichever is later.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means of all-county letters. Thereafter, 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.

(g) Upon the receipt of an application for a child who has coverage pursuant to the accelerated enrollment program, a county shall determine whether the child is eligible for Medi-Cal benefits. If the county determines that the child does not meet the eligibility requirements for participation in the Medi-Cal program, the county shall report this finding to the Medical Eligibility Data System so that accelerated enrollment coverage benefits are discontinued. The information to be reported shall consist of the minimum data elements necessary to discontinue that coverage for the child. This subdivision shall become operative on July 1, 2002, or the date that the program for accelerated enrollment coverage for children takes effect, whichever is later.

SEC. 36. Section 14011.65b is added to the Welfare and Institutions Code, to read:

14011.65b. (a) To the extent federal financial participation is available, the department shall exercise the option provided in Section 1920a of the federal Social Security Act (42 U.S.C. Sec. 1396r-1a) to implement a program of presumptive eligibility for any child who meets both of the following criteria:

(1) He or she has been receiving, but is no longer eligible for, benefits under the Healthy Families Program.

(2) He or she appears to be income-eligible for full-scope Medi-Cal without a share of cost.

(b) The department shall designate the Managed Risk Medical Insurance Board or any agent designated by the Managed Risk Medical Insurance Board, including, but not limited to, the single point of entry defined in subdivision (c) of Section 14011.6, as the qualified entity for determining eligibility under this section.

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

(d) The department shall commence implementation of this section on July 1, 2007, or after all necessary federal approvals are obtained, whichever date is later. Upon implementation of the presumptive eligibility program described in this section, the Director of Health Care Services shall executive a declaration, which shall be retained by the director, stating that implementation of the program has commenced.

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

(f) Upon the receipt of a timely and complete Medi-Cal application for a child who has coverage pursuant to the presumptive eligibility program authorized under this section, a county shall determine whether the child is eligible for Medi-Cal benefits. If the county determines that the child does not meet the eligibility requirements for participation in the Medi-Cal program, the county shall timely report this finding to the Medical Eligibility Data System so that presumptive eligibility benefits are discontinued.

SEC. 37. Section 14043.1 of the Welfare and Institutions Code is amended to read:

14043.1. As used in this article:

(a) "Abuse" means either of the following:

(1) Practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the federal medicaid and Medicare programs, the Medi-Cal program, another state's medicaid program, or other health care programs operated, or financed in whole or in part, by the federal government or any state or local agency in this state or any other state.

(2) Practices that are inconsistent with sound medical practices and result in reimbursement by the federal medicaid and Medicare programs, the Medi-Cal program or other health care programs operated, or financed in whole or in part, by the federal government or any state or local agency in this state or any other state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

(b) "Applicant" means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents thereof, that applies to the department for enrollment as a provider in the Medi-Cal program.

(c) "Application or application package" means a completed and signed application form, signed under penalty of perjury or notarized pursuant to Section 14043.25, a disclosure statement, a provider agreement, and all attachments or changes in the form, statement, or agreement.

(d) "Appropriate volume of business" means a volume that is consistent with the information provided in the application and any supplemental information provided by the applicant or provider, and is of a quality and type that would reasonably be expected based upon the size and type of business operated by the applicant or provider.

(e) "Business address" means the location where an applicant or provider provides services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary. A post office box or commercial box is not a business address. The business address for the location of a vehicle or vessel owned and operated by an applicant or provider enrolled in the Medi-Cal program and used to provide services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary shall either be the business address location listed on the provider's application as the location where similar services, goods, supplies, or merchandise would be provided or, the applicant's or provider's pay-to-address.

(f) "Convicted" means any of the following:

(1) A judgment of conviction has been entered against an individual or entity by a federal, state, or local court, regardless of whether there is a posttrial motion or an appeal pending or the judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed.

(2) A federal, state, or local court has made a finding of guilt against an individual or entity.

(3) A federal, state, or local court has accepted a plea of guilty or nolo contendere by an individual or entity.

(4) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgment of conviction has been withheld.

(g) "Debt due and owing" means 60 days have passed since a notice or demand for repayment of an overpayment or other amount resulting from an audit or examination, for a penalty assessment, or for any other amount due the department was sent to the provider, regardless of whether the provider is an institutional provider or a noninstitutional provider and regardless of whether an appeal is pending.

(h) "Enrolled or enrollment in the Medi-Cal program" means authorized under any processes by the department or its agents or contractors to receive, directly or indirectly, reimbursement for the provision of services, goods, supplies, or merchandise to a Medi-Cal beneficiary.

(i) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(j) "Location" means a street, city, or rural route address or a site or place within a street, city, or rural route address, and the city, county, state, and nine digit ZIP Code.

(k) "Not currently enrolled at the location for which the application is submitted" means either of the following:

(1) The provider is changing location and moving to a different location than that for which the provider was issued a provider number.

(2) The provider is adding a business address.

(*l*) "Preenrollment period" or "preenrollment" includes the period of time during which an application package for enrollment, continued enrollment, or for the addition of or change in a location is pending.

(m) "Professionally recognized standards of health care" means statewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is an issue recognize as applying to those peers practicing or providing care within a state. When the United States Department of Health and Human Services has declared a treatment modality not to be safe and effective, practitioners that employ that treatment modality shall be deemed not to meet professionally recognized standards of health care. This subdivision shall not be construed to mean that all other treatments meet professionally recognized standards of care.

(n) "Provider" means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of any partnership, group association, corporation, institution, or entity, that provides services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary and that has been enrolled in the Medi-Cal program.

(o) "Unnecessary or substandard items or services" means those that are either of the following:

(1) Substantially in excess of the provider's usual charges or costs for the items or services.

(2) Furnished, or caused to be furnished, to patients, whether or not covered by Medicare, medicaid, or any of the state health care programs to which the definitions of applicant and provider apply, and which are substantially in excess of the patient's needs, or of a quality that fails to meet professionally recognized standards of health care. The department's determination that the items or services furnished were excessive or of unacceptable quality shall be made on the basis of information, including sanction reports, from the following sources:

(A) The professional review organization for the area served by the individual or entity.

(B) State or local licensing or certification authorities.

(C) Fiscal agents or contractors, or private insurance companies.

(D) State or local professional societies.

(E) Any other sources deemed appropriate by the department.

SEC. 38. Section 14043.15 of the Welfare and Institutions Code is amended to read:

14043.15. (a) The department may adopt regulations for certification of each applicant and each provider in the Medi-Cal program. No certification shall be required for natural persons licensed or certificated under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act or the Chiropractic Initiative Act.

(b) (1) An applicant or provider who is a natural person, and is licensed or certificated pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or is a professional corporation, as defined in subdivision (b) of Section 13401 of the Corporations Code, shall comply with Section 14043.26 and shall be enrolled in the Medi-Cal program as either an individual provider or as a rendering provider in a provider group for each application package submitted and approved pursuant to Section 14043.26, notwithstanding that the applicant or provider meets the requirements to qualify as exempt from clinic licensure under subdivision (a) or (m) of Section 1206 of the Health and Safety Code.

(2) A provider enrolled in the Medi-Cal program pursuant to paragraph (1), who has disclosed in the application package for enrollment that the provider's practice includes the rendering of services, goods, supplies, or merchandise solely at one, or at more than one, health facility, as defined in Section 1250 of the Health and Safety Code, or clinic, as defined in Section 1204 of the Health and Safety Code, or medical therapy unit, for purposes of Section 123950 of the Health and Safety Code, or residence of the provider's patient, or office of a physician and surgeon involved in the care and treatment of the provider's patients, shall not be required to enroll at each such health facility, clinic, medical therapy unit, patient's residence or physician and surgeon's office location and may utilize the business addresses listed on the application for enrollment pursuant to paragraph (1) to claim reimbursement from the Medi-Cal program for services rendered by the provider to Medi-Cal beneficiaries at all of those health facilities, clinics, medical therapy units, residences, or physician offices.

(3) This subdivision shall not be interpreted to allow the violation of any state or federal law governing fiscal intermediaries or Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act. This subdivision does not remove the requirement that each claim for reimbursement from the Medi-Cal program identify the place of service and the rendering provider.

(c) An applicant or provider licensed as a clinic pursuant to Chapter 1 (commencing with Section 1200) of, or a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of, Division 2 of the Health and Safety Code may be enrolled in the Medi-Cal program as a clinic or a health facility and need not comply with Section 14043.26 if the clinic or health facility is certified by the department to participate in the Medi-Cal program.

(d) An applicant or provider that meets the requirements to qualify as exempt from clinic licensure under subdivisions (b) to (*l*), inclusive, or subdivisions (n) to (p), inclusive, of Section 1206 of the Health and Safety Code shall comply with Section 14043.26 and may be enrolled in the Medi-Cal program as either a clinic or within any other provider category for which the applicant or provider qualifies. An applicant or

provider to which any of the clinic licensure exemptions specified in this subdivision apply shall identify the licensure exemption category and document in its application package the legal and factual basis for the clinic license exemption claimed.

(e) Notwithstanding subdivisions (a), (b), (c), and (d), an applicant or provider that meets the requirements to qualify as exempt from clinic licensure pursuant to subdivision (h) of Section 1206 of the Health and Safety Code, including an intermittent site that is operated by a licensed primary care clinic or an affiliated mobile health care unit licensed or approved under Chapter 9 (commencing with Section 1765.101) of Division 2 of the Health and Safety Code, and that is operated by a licensed primary care clinic, and for which intermittent site or mobile health unit the licensed primary care clinic directly or indirectly provides all staffing, protocols, equipment, supplies, and billing services, need not enroll in the Medi-Cal program as a separate provider and need not comply with Section 14043.26 if the licensed primary care clinic operating the applicant, provider clinic, or mobile health care unit has notified the department of its separate locations, premises, intermittent sites, or mobile health care units.

SEC. 39. Section 14043.2 of the Welfare and Institutions Code is amended to read:

14043.2. (a) Whether or not regulations for certification are adopted under Section 14043.15, in order to be enrolled as a provider, or for enrollment as a provider to continue, an applicant or provider may be required to sign a provider agreement and shall disclose all information as required in federal medicaid regulations and any other information required by the department. Applicants, providers, and persons with an ownership or control interest, as defined in federal medicaid regulations, shall submit their social security number or numbers to the department, to the full extent allowed under federal law. The director may designate the form of a provider agreement by provider type. Failure to disclose the required information, or the disclosure of false information, shall result in denial of the application for enrollment or shall make the provider subject to temporary suspension from the Medi-Cal program, which shall include temporary deactivation of the provider's number or numbers, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program.

(b) The director shall notify the provider of the temporary suspension and deactivation of the provider's number or numbers, including all business addresses used by the provider, and the effective date thereof. Notwithstanding Section 100171 of the Health and Safety Code and Section 14123, proceedings after the imposition of sanctions provided for in subdivision (a) shall be in accordance with Section 14043.65.

SEC. 40. Section 14043.26 of the Welfare and Institutions Code is amended to read:

14043.26. (a) (1) On and after January 1, 2004, an applicant that is not currently enrolled in the Medi-Cal program, or a provider applying

for continued enrollment, upon written notification from the department that enrollment for continued participation of all providers in a specific provider of service category or subgroup of that category to which the provider belongs will occur, or a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, shall submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location.

(2) Clinics licensed by the department pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(3) Health facilities licensed by the department pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(4) Adult day health care providers licensed pursuant to Chapter 3.3 (commencing with Section 1570) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(5) Home health agencies licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(6) Hospices licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(b) Within 30 days after receiving an application package submitted pursuant to subdivision (a), the department shall provide written notice that the application package has been received and, if applicable, that there is a moratorium on the enrollment of providers in the specific provider of service category or subgroup of the category to which the applicant or provider belongs. This moratorium shall bar further processing of the application package.

(c) (1) If the applicant package submitted pursuant to subdivision (a) is from an applicant or provider who meets the criteria listed in paragraph (2), the applicant or provider shall be considered a preferred provider and shall be granted preferred provisional provider status pursuant to this section and for a period of no longer than 18 months, effective from the date on the notice from the department. The ability to request consideration as a preferred provider and the criteria necessary for the consideration shall be publicized to all applicants and providers. An applicant or provider who desires consideration as a preferred provider pursuant to this subdivision shall request consideration from the department by making a notation to that effect on the application package, by cover letter, or by other means identified by the department in a provider bulletin. Request for

consideration as a preferred provider shall be made with each application package submitted in order for the department to grant the consideration. An applicant or provider who requests consideration as a preferred provider shall be notified within 90 days whether the applicant or provider meets or does not meet the criteria listed in paragraph (2). If an applicant or provider is notified that the applicant or provider does not meet the criteria for a preferred provider, the application package submitted shall be processed in accordance with the remainder of this section.

(2) To be considered a preferred provider, the applicant or provider shall meet all of the following criteria:

(A) Hold a current license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California, which license shall not have been revoked, whether stayed or not, suspended, placed on probation, or subject to other limitation.

(B) Be a current faculty member of a teaching hospital or a children's hospital, as defined in Section 10727, accredited by the Joint Commission for Accreditation of Healthcare Organizations or the American Osteopathic Association, or be credentialed by a health care service plan that is licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code; the Knox-Keene Act) or county organized health system, or be a current member in good standing of a group that is credentialed by a health care service plan that is licensed under the Knox-Keene Act.

(C) Have full, current, unrevoked, and unsuspended privileges at a Joint Commission for Accreditation of Healthcare Organizations or American Osteopathic Association accredited general acute care hospital.

(D) Not have any adverse entries in the Healthcare Integrity and Protection Databank.

(3) The department may recognize other providers as qualifying as preferred providers if criteria similar to those set forth in paragraph (2) are identified for the other providers. The department shall consult with interested parties and appropriate stakeholders to identify similar criteria for other providers so that they may be considered as preferred providers.

(d) Within 180 days after receiving an application package submitted pursuant to subdivision (a), or from the date of the notice to an applicant or provider that the applicant or provider does not qualify as a preferred provider under subdivision (c), the department shall give written notice to the applicant or provider that any of the following applies, or shall on the 181st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 181st day:

(1) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(2) The application package is incomplete. The notice shall identify any additional information or documentation that is needed to complete the application package.

(3) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7, and is conducting background checks, preenrollment inspections, or unannounced visits.

(4) The application package is denied for any of the following reasons:

(A) Pursuant to Section 14043.2 or 14043.36.

(B) For lack of a license necessary to perform the health care services or to provide the goods, supplies, or merchandise directly or indirectly to a Medi-Cal beneficiary, within the applicable provider of service category or subgroup of that category.

(C) The period of time during which an applicant or provider has been barred from reapplying has not passed.

(D) For other stated reasons authorized by law.

(e) (1) If the application package that was noticed as incomplete under subdivision (d) is resubmitted with all requested information and documentation, and received by the department within 35 days of the date on the notice, the department shall, within 60 days of the resubmission, send a notice that any of the following applies:

(A) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) The application package is denied for any other reasons provided for in paragraph (4) of subdivision (d).

(C) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits.

(2) (A) If the application package that was noticed as incomplete under paragraph (2) of subdivision (d) is not resubmitted with all requested information and documentation and received by the department within 35 days of the date on the notice, the application package shall be denied by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to resubmit is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the notice of an incomplete application package included a request for information or documentation related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider may not reapply for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years.

(f) (1) If the department exercises its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits, the applicant or provider shall receive notice, from the department, after the conclusion of the background check, preenrollment inspections, or unannounced visit of either of the following:

(A) The applicant or provider is granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) Discrepancies or failure to meet program requirements, as prescribed by the department, have been found to exist during the preenrollment period.

(2) (A) The notice shall identify the discrepancies or failures, and whether remediation can be made or not, and if so, the time period within which remediation must be accomplished. Failure to remediate discrepancies and failures as prescribed by the department, or notification that remediation is not available, shall result in denial of the application by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to remediate is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the discrepancies or failure to meet program requirements, as prescribed by the director, included in the notice were related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider may not reapply for three years.

(g) If provisional provider status or preferred provisional provider status is granted pursuant to this section, a provider number shall be used by the provider for each business address for which an application package has been approved. This provider number shall be used exclusively for the locations for which it is issued, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods, supplies, or merchandise are rendered or delivered at locations other than the provider's business address and this practice or delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status or preferred provisional provider status was granted.

(h) Except for providers subject to subdivision (c) of Section 14043.47, a provider currently enrolled in the Medi-Cal program at one or more locations who has submitted an application package for enrollment at a new location or a change in location pursuant to subdivision (a) may submit claims for services, goods, supplies, or merchandise rendered at the new location until the application package is approved or denied under this section, and shall not be subject, during that period, to deactivation, or be subject to any delay or nonpayment of claims as a result of billing for services rendered at the new location as herein authorized. However, the provider shall be considered during that period to have been granted provisional provider status or preferred provisional provider status and be subject to termination of that status pursuant to Section 14043.27. A provider that is subject to subdivision (c) of Section 14043.47 may come within the scope of this subdivision upon submitting documentation in the application package that identifies the physician providing supervision

for every three locations. If a provider submits claims for services rendered at a new location before the application for that location is received by the department, the department may deny the claim.

(i) An applicant or a provider whose application for enrollment, continued enrollment, or a new location or change in location has been denied pursuant to this section, may appeal the denial in accordance with Section 14043.65.

(j) (1) Upon receipt of a complete and accurate claim for an individual nurse provider, the department shall adjudicate the claim within an average of 30 days.

(2) During the budget proceedings of the 2006–07 fiscal year, and each fiscal year thereafter, the department shall provide data to the Legislature specifying the timeframe under which it has processed and approved the provider applications submitted by individual nurse providers.

(3) For purposes of this subdivision, "individual nurse providers" are providers authorized under certain home- and community-based waivers and under the state plan to provide nursing services to Medi-Cal recipients in the recipients' own homes rather than in institutional settings.

SEC. 41. Section 14043.27 of the Welfare and Institutions Code is amended to read:

14043.27. (a) If an applicant or provider is granted provisional provider status or preferred provisional provider status pursuant to Section 14043.26 and, if at any time during the provisional provider status period or preferred provisional provider status period, the department conducts any announced or unannounced visits or any additional inspections or reviews pursuant to this chapter or Chapter 8 (commencing with Section 14200), or the regulations adopted thereunder, or pursuant to Section 100185.5 of the Health and Safety Code, and discovers or otherwise determines the existence of any ground to deactivate the provider's number and business addresses or suspend the provider from the Medi-Cal program pursuant to this chapter or Chapter 8 (commencing with Section 14200), or the regulations adopted thereunder, or pursuant to Section 100185.5 of the Health and Safety Code, or if any of the circumstances listed in subdivision (c) occur, the department shall terminate the provisional provider status or preferred provisional provider status of the provider, regardless of whether the period of time for which the provisional provider status or preferred provisional provider status was granted under Section 14043.26 has elapsed.

(b) Termination of provisional provider status or preferred provisional provider status shall include deactivation of the provider's number, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program and removal of the provider from enrollment in the Medi-Cal program, except where the termination is based upon a ground related solely to a specific location for which provisional provider status was granted. Termination of provisional provider status based upon grounds related solely to a specific location may include failure to have an established place of business, failure to possess the business or zoning

permits or other approvals necessary to operate a business, or failure to possess the appropriate licenses, permits, or certificates necessary for the provider of service category or subcategory identified by the provider in its application package. Where the grounds relate solely to a specific location, the termination of provisional provider status shall include only deactivation of the specific locations that the grounds apply to and shall include removal of the provider from enrollment in the Medi-Cal program only if, after deactivation of the specific locations, the provider does not have any business address that is not deactivated.

(c) The following circumstances are grounds for termination of provisional provider status or preferred provisional provider status:

(1) The provider, persons with an ownership or control interest in the provider, or persons who are directors, officers, or managing employees of the provider have been convicted of any felony, or convicted of any misdemeanor involving fraud or abuse in any government program, related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse, or have been found liable for fraud or abuse in any civil proceeding, or have entered into a settlement in lieu of conviction for fraud or abuse in any government program within 10 years of the date of the application package.

(2) There is a material discrepancy in the information provided to the department, or with the requirements to be enrolled, that is discovered after provisional provider status or preferred provisional provider status has been granted and that cannot be corrected because the discrepancy occurred in the past.

(3) The provider has provided material information that was false or misleading at the time it was provided.

(4) The provider failed to have an established place of business at the business address for which the application package was submitted at the time of any onsite inspection, announced or unannounced visit, or any additional inspection or review conducted pursuant to this article or a statute or regulation governing the Medi-Cal program, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods, supplies, or merchandise are rendered or delivered at locations other than the business address and this practice or delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status or preferred provisional provider status was granted.

(5) The provider meets the definition of a clinic under Section 1200 of the Health and Safety Code, but is not licensed as a clinic pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code and fails to meet the requirements to qualify for at least one exemption pursuant to Section 1206 or 1206.1 of the Health and Safety Code.

(6) The provider performs clinical laboratory tests or examinations, but it or its personnel do not meet CLIA, and the regulations adopted thereunder, and the state clinical laboratory law, do not possess valid CLIA certificates and clinical laboratory registrations or licenses pursuant to Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code, or are not exempt from licensure as a clinical laboratory under Section 1241 of the Business and Professions Code.

(7) The provider fails to possess either of the following:

(A) The appropriate licenses, permits, certificates, or other approvals needed to practice the profession or occupation, or provide the services, goods, supplies, or merchandise the provider identified in the application package approved by the department when the provisional provider status or preferred provisional provider status was granted and for the location for which the application was submitted.

(B) The business or zoning permits or other approvals necessary to operate a business at the location identified in its application package approved by the department when the provisional provider status or preferred provisional provider status was granted.

(8) The provider, or if the provider is a clinic, group, partnership, corporation, or other association, any officer, director, or shareholder with a 10 percent or greater interest in that organization, commits two or more violations of the federal or state statutes or regulations governing the Medi-Cal program, and the violations demonstrate a pattern or practice of fraud, abuse, or provision of unnecessary or substandard medical services.

(9) The provider commits any violation of a federal or state statute or regulation governing the Medi-Cal program or of a statute or regulation governing the provider's profession or occupation and the violation represents a threat of immediate jeopardy or significant harm to any Medi-Cal beneficiary or to the public welfare.

(10) The provider submits claims for payment that subject a provider to suspension under Section 14043.61.

(11) The provider submits claims for payment for services, goods, supplies, or merchandise rendered at a location other than the business address or addresses listed on the application for enrollment, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods, supplies, or merchandise are rendered or delivered at locations other than the business address and this practice or delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status was granted.

(12) The provider has not paid its fine, or has a debt due and owing, including overpayments and penalty assessments, to any federal, state, or local government entity that relates to Medicare, medicaid, Medi-Cal, or any other federal or state health care program, and has not made satisfactory arrangements to fulfill the obligation or otherwise been excused by legal process from fulfilling the obligation.

(d) If, during a provisional provider status period or a preferred provisional provider status period, the department conducts any announced or unannounced visits or any additional inspections or reviews pursuant to this chapter or Chapter 8 (commencing with Section 14200), or the regulations adopted thereunder, and commences an investigation for fraud or abuse, or discovers or otherwise determines that the provider is under investigation for fraud or abuse by any other state, local, or federal government law enforcement agency, the provider shall be subject to termination of provisional provider status or preferred provisional provider status, regardless of whether the period of time for which the provisional provider status or preferred provisional provider status was granted under Section 14043.26 has elapsed.

(e) A provider whose provisional provider status or preferred provisional provider status has been terminated pursuant to this section may appeal the termination in accordance with Section 14043.65.

(f) Any department-recovered fine or debt due and owing, including overpayments, that are subsequently determined to have been erroneously collected shall be promptly refunded to the provider, together with interest paid in accordance with subdivision (e) of Section 14171 and Section 14172.5.

SEC. 42. Section 14043.28 of the Welfare and Institutions Code is amended to read:

14043.28. (a) (1) If an application package is denied under Section 14043.26 or provisional provider status or preferred provisional provider status is terminated under Section 14043.27, the applicant or provider may not reapply for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years from the date the application package is denied or the provisional provider status is terminated, or from the date of the final decision following an appeal from that denial or termination, except as provided otherwise in paragraph (2) of subdivision (e), or paragraph (2) of subdivision (f), of Section 14043.26 and as set forth in this section.

(2) If the application is denied under paragraph (2) of subdivision (e) of Section 14043.26 because the applicant failed to resubmit an incomplete application package or is denied under paragraph (2) of subdivision (f) of Section 14043.26 because the applicant failed to remediate discrepancies, the applicant may resubmit an application in accordance with paragraph (2) of subdivision (d) or paragraph (2) of subdivision (f), respectively.

(3) If the denial of the application package is based upon a conviction for any offense or for any act included in Section 14043.36 or termination of the provisional provider status or preferred provisional provider status is based upon a conviction for any offense or for any act included in paragraph (1) of subdivision (c) of Section 14043.27, the applicant or provider may not reapply for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program admin-

istered by the department or its agents or contractors for a period of 10 years from the date the application package is denied or the provisional provider status or preferred provisional provider status is terminated or from the date of the final decision following an appeal from that denial or termination.

(4) If the denial of the application package is based upon two or more convictions for any offense or for any two or more acts included in Section 14043.36 or termination of the provisional provider status or preferred provisional provider status is based upon two or more convictions for any offense or for any two acts included in paragraph (1) of subdivision (c) of Section 14043.27, the applicant or provider shall be permanently barred from enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors.

(5) The prohibition in paragraph (1) against reapplying for three years shall not apply if the denial of the application or termination of provisional provider status or preferred provisional provider status is based upon any of the following:

(A) The grounds provided for in paragraph (4), or subparagraph (B) of paragraph (7), of subdivision (c) of Section 14043.27.

(B) The grounds provided for in subdivision (d) of Section 14043.27, if the investigation is closed without any adverse action being taken.

(C) The grounds provided for in paragraph (6) of subdivision (c) of Section 14043.27. However, the department may deny reimbursement for claims submitted while the provider was noncompliant with CLIA.

(b) (1) If an application package is denied under subparagraph (A), (B), or (D) of paragraph (4) of subdivision (d) of Section 14043.26, or with respect to a provider described in subparagraph (B) of paragraph (2) of subdivision (e), or subparagraph (B) of paragraph (2) of subdivision (f), of Section 14043.26, or provisional provider status or preferred provisional provider status is terminated based upon any of the grounds stated in subparagraph (A) of paragraph (7), or paragraphs (1), (2), (3), (5), and (8) to (12), inclusive, of subdivision (c) of Section 14043.27, all business addresses of the applicant or provider shall be deactivated and the applicant or provider shall be removed from enrollment in the Medi-Cal program by operation of law.

(2) If the termination of provisional provider status is based upon the grounds stated in subdivision (d) of Section 14043.27 and the investigation is closed without any adverse action being taken, or is based upon the grounds in subparagraph (B) of paragraph (7) of subdivision (c) of Section 14043.27 and the applicant or provider obtains the appropriate license, permits, or approvals covering the period of provisional provider status, the termination taken pursuant to subdivision (c) of Section 14043.27 shall be rescinded, the previously deactivated provider numbers shall be reactivated, and the provider shall be reenrolled in the Medi-Cal program, unless there are other grounds for taking these actions.

(c) Claims that are submitted or caused to be submitted by an applicant or provider who has been suspended from the Medi-Cal program for any reason or who has had its provisional provider status terminated or had its application package for enrollment or continued enrollment denied and all business addresses deactivated may not be paid for services, goods, merchandise, or supplies rendered to Medi-Cal beneficiaries during the period of suspension or termination or after the date all business addresses are deactivated.

SEC. 43. Section 14043.36 of the Welfare and Institutions Code is amended to read:

14043.36. (a) The department shall not enroll any applicant that has been convicted of any felony or misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care related fraud or abuse or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years. In addition, the department may deny enrollment to any applicant that, at the time of application, is under investigation by the department or any state, local, or federal government law enforcement agency for fraud or abuse pursuant to Subpart A (commencing with Section 455.12) of Part 455 of Title 42 of the Code of Federal Regulations. The department shall not deny enrollment to an otherwise qualified applicant whose felony or misdemeanor charges did not result in a conviction solely on the basis of the prior charges. If it is discovered that a provider is under investigation by the department or any state, local, or federal government law enforcement agency for fraud or abuse, that provider shall be subject to temporary suspension from the Medi-Cal program, which shall include temporary deactivation of the provider's number, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program.

(b) The director shall notify in writing the provider of the temporary suspension and deactivation of the provider's number, which shall take effect 15 days from the date of the notification. Notwithstanding Section 100171 of the Health and Safety Code, proceedings after the imposition of sanctions provided for in subdivision (a) shall be in accordance with Section 14043.65.

SEC. 44. Section 14043.45 of the Welfare and Institutions Code is repealed.

SEC. 45. Section 14043.45 is added to the Welfare and Institutions Code, to read:

14043.45. (a) Notwithstanding whether a National Provider Identification (NPI) number is required by the rules issued by the Centers for Medicare and Medicaid Services implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the department may require that an applicant or provider submit an NPI number.

(b) For transactions not specifically identified as covered transactions under the HIPAA NPI rules, the department may require that a provider use a National Provider Identification number on those transactions, or the department may issue the provider a unique identification number or numbers that shall be used on all transactions.

(c) Notwithstanding any other provisions of law, the department may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific this section by means of a provider bulletin or similar instruction. The department shall notify and consult with interested parties and appropriate stakeholders in implementing, interpreting, or making specific this statute, including taking all of the following actions:

(1) Notifying provider representatives of the proposed action or change. The notice shall occur at least 10 business days prior to the meeting provided for in paragraph (2).

(2) Scheduling at least one meeting with interested parties and appropriate stakeholders to discuss the action or change.

(3) Allowing for written input regarding the action or change.

(4) Providing at least 30 days' advance notice of the effective date of the action or change.

(d) This section shall apply to any health care program administered by the department or its agents or contractors.

SEC. 46. 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 as reported in the California Long Term Care County Data Book, 2002:

(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. 47. Section 14043.47 of the Welfare and Institutions Code is amended to read:

14043.47. (a) A provider doing business as a sole proprietorship, partnership, or professional corporation under Part 4 (commencing with Section 13400) of Division 3 of the Corporations Code or a rendering physician provider in a group who utilizes nonphysician medical practitioners to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries shall meet the specific supervisory requirements applicable

to such providers, pursuant to the Business and Professions Code or other state or federal law.

(b) A provider doing business as a sole proprietorship, partnership, or professional corporation under Part 4 (commencing with Section 13400) of Division 3 of the Corporations Code or a rendering physician provider in a group who fails to comply with the requirements of this section is subject to temporary suspension from the Medi-Cal program and deactivation of the provider's number, including all business addresses.

(c) A physician doing business as a sole proprietorship, partnership, or professional corporation under Part 4 (commencing with Section 13400) of Division 3 of the Corporations Code or a rendering physician provider in a group may not be enrolled at more than three business addresses unless there is a ratio of at least one physician providing supervision for every three locations.

(d) A physician doing business as a sole proprietorship, partnership, or professional medical corporation under Part 4 (commencing with Section 13400) of Division 3 of the Corporations Code or a rendering physician provider in a group who fails to comply with the requirements of this section is subject to temporary suspension from the Medi-Cal program and deactivation of all of his or her number, including all business addresses.

SEC. 48. Section 14043.61 of the Welfare and Institutions Code is amended to read:

14043.61. (a) A provider shall be subject to suspension if claims for payment are submitted for the services, goods, supplies, or merchandise provided, directly or indirectly, to a Medi-Cal beneficiary, by an individual or entity that is suspended, excluded, or otherwise ineligible because of a sanction to receive, directly or indirectly, reimbursement from the Medi-Cal program and the individual or entity is listed on either the Suspended and Ineligible Provider List, published by the department, to identify suspended and otherwise ineligible providers, or any list published by the federal Office of Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and medicaid programs, to identify suspended, excluded, or otherwise ineligible providers.

(b) Notwithstanding Section 100171 of the Health and Safety Code, the imposition of the sanction provided for in subdivision (a) shall be appealable in accordance with Section 14043.65.

SEC. 49. Section 14043.62 of the Welfare and Institutions Code is amended to read:

14043.62. (a) The department shall deactivate, immediately and without prior notice, the provider's number, including all business addresses used by a provider to obtain reimbursement from the Medi-Cal program when warrants or documents mailed to a provider's mailing address or its pay to address, if any, or its service or business address, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the Medi-Cal program

for one year. Prior to taking this action the department shall use due diligence in attempting to contact the provider at its last known telephone number and ascertain if the return by the United States Postal Service is by mistake or shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in this article or the regulations adopted thereunder.

(b) For purposes of this section:

(1) "Mailing address" means the address that the provider has identified to the department in its application for enrollment as the address at which it wishes to receive general program correspondence.

(2) "Pay to address" means the address that the provider has identified to the department in its application for enrollment as the address at which it wishes to receive warrants.

(3) "Service or business address" means the address that the provider has identified to the department in its application for enrollment as the address at which the provider will provide services to program beneficiaries.

SEC. 50. Section 14043.65 of the Welfare and Institutions Code is amended to read:

14043.65. (a) Notwithstanding any other provision of law, any applicant whose application for enrollment as a provider or whose certification is denied; or any provider who is denied continued enrollment or certification, or denied enrollment for a new location, who has been temporarily suspended, who has had payments withheld, who has had one or more business addresses used to obtain reimbursement from the Medi-Cal program deactivated, or whose provisional provider status or preferred provisional provider status has been terminated pursuant to this article or Section 14107.11, or Section 100185.5 of the Health and Safety Code, or who has had a civil penalty imposed pursuant to subdivision (a) of Section 14123.25; or any billing agent, as defined in Section 14040, when the billing agent's registration has been denied pursuant to subdivision (e) of Section 14040.5, may appeal this action by submitting a written appeal, including any supporting evidence, to the director or the director's designee. Where the appeal is of a withholding of payment pursuant to Section 14107.11, the appeal to the director or the director's designee shall be limited to the issue of the reliability of the evidence supporting the withhold and shall not encompass fraud or abuse. The appeal procedure shall not include a formal administrative hearing under the Administrative Procedure Act and shall not result in reactivation of any deactivated provider numbers during appeal. An applicant, provider, or billing agent that files an appeal pursuant to this section shall submit the written appeal along with all pertinent documents and all other relevant evidence to the director or to the director's designee within 60 days of the date of notification of the department's action. The director or the director's designee shall review all of the relevant materials submitted and shall issue a deci-

sion within 90 days of the receipt of the appeal. The decision may provide that the action taken should be upheld, continued, or reversed, in whole or in part. The decision of the director or the director's designee shall be final. Any further appeal shall be required to be filed in accordance with Section 1085 of the Code of Civil Procedure.

(b) No applicant whose application for enrollment as a provider has been denied pursuant to Section 14043.2, 14043.36, or 14043.4 may reapply for a period of three years from the date the application is denied. If the provider has appealed the denial, the three-year period shall commence upon the date of final action by the director or the director's designee.

SEC. 51. Section 14043.7 of the Welfare and Institutions Code is amended to read:

14043.7. (a) The department may make unannounced visits to any applicant or to any provider for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, or as necessary for the administration of the Medi-Cal program. At the time of the visit, the applicant or provider shall be required to demonstrate an established place of business appropriate and adequate for the services billed or claimed to the Medi-Cal program, as relevant to his or her scope of practice, as indicated by, but not limited to, the following:

(1) Being open and available to the general public.

(2) Having regularly established and posted business hours.

(3) Having adequate supplies in stock on the premises.

(4) Meeting all local laws and ordinances regarding business licensing and operations.

(5) Having the necessary equipment and facilities to carry out day-to-day business for his or her practice.

(b) An unannounced visit pursuant to subdivision (a) shall be prohibited with respect to clinics licensed under Section 1204 of the Health and Safety Code, clinics exempt from licensure under Section 1206 of the Health and Safety Code, health facilities licensed under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, and natural persons licensed or certified under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, unless the department has reason to believe that the provider will defraud or abuse the Medi-Cal program or lacks the organizational or administrative capacity to provide services under the program.

(c) Failure to remediate significant discrepancies in information provided to the department by the provider or significant discrepancies that are discovered as a result of an announced or unannounced visit to a provider, for purposes of enrollment, continued enrollment, or certification pursuant to subdivision (a) shall make the provider subject to temporary suspension from the Medi-Cal program, which shall include temporary deactivation of the provider's number, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program. The director

shall notify in writing the provider of the temporary suspension and deactivation of provider numbers, which shall take effect 15 days from the date of the notification. Notwithstanding Section 100171 of the Health and Safety Code, proceedings after the imposition of sanctions in this paragraph shall be in accordance with Section 14043.65.

SEC. 52. Section 14087.305 of the Welfare and Institutions Code is amended to read:

14087.305. (a) In areas specified by the director for expansion of the Medi-Cal managed care program under Section 14087.3 and where the department is contracting with a prepaid health plan that is contracting with, governed, owned or operated by a county board of supervisors, a county special commission or county health authority authorized by Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96, a Medi-Cal or California Work Opportunity and Responsibility for Kids (CalWORKs) applicant or beneficiary shall be informed of the health care options available regarding methods of receiving Medi-Cal benefits. The county shall ensure that each beneficiary is informed of these options and informed that a health care options presentation is available.

(b) The managed care options information described in subdivision (a) shall include the following elements:

(1) Each beneficiary or eligible applicant shall be provided, at a minimum, with the name, address, telephone number, and specialty, if any, of each primary care provider, by specialty, or clinic, participating in each managed care health plan option through a personalized provider directory for that beneficiary or applicant. This information shall be presented under the geographic area designations, by the name of the primary care provider and clinic and shall be updated based on information electronically provided monthly by the health care plans to the department, setting forth any changes in the health care plan's provider network. The geographic areas shall be based on the applicant's residence address, the minor applicant's school address, the applicant's work address, or any other factor deemed appropriate by the department, in consultation with health plan representatives, legislative staff, and consumer stakeholders. In addition, directories of the entire service area of the local initiative and commercial plan provider networks, including, but not limited to, the name, address, and telephone number of each primary care provider and hospital, shall be made available to beneficiaries or applicants who request them from the health care options contractor. Each personalized provider directory shall include information regarding the availability of a directory of the entire service area, provide telephone numbers for the beneficiary to request a directory of the entire service area, and include a postage-paid mail card to send for a directory of the entire service area. The personalized provider directory shall be implemented as a pilot project in Los Angeles County pursuant to this article, and in Sacramento County (Geographic Managed Care Model) pursuant to Article 2.91 (commencing with Section 14089). The content, form, and the geographic areas used in the personalized provider directories shall be determined by the department, in con-

sultation with a workgroup to include health plan representatives, legislative staff, and consumer stakeholders, with an emphasis on the inclusion of stakeholders from Los Angeles and Sacramento Counties. The personalized provider directories may include a section for each health plan. Prior to implementation of the pilot project, the department, in consultation with consumer stakeholders, legislative staff, and health plans, shall determine the parameters, methodology, and evaluation process of the pilot project. The pilot project shall thereafter be in effect for a minimum of two years. Three months prior to the end of the first two years of the pilot project, the department shall promptly provide the fiscal and policy committees of the Legislature with an evaluation of the personalized provider directory pilot project and its impact on the Medi-Cal managed care program, including whether the pilot project resulted in a reduction of default assignments and a more informed choice process for beneficiaries, and its overall cost-benefit to the state. Following two years of operation as a pilot project in two counties and submission of the evaluation to the Legislature, the department, in consultation with consumer stakeholders, legislative staff, and health plans, shall determine whether to implement personalized provider directories as a permanent program statewide. This determination shall be based on the outcomes set forth in the evaluation provided to the Legislature. If necessary, the pilot project shall continue beyond the initial two-year period until this determination is made. This pilot project shall only be implemented to the extent that it is budget neutral to the department.

(2) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider or clinic contracting with any of the prepaid health plan options available and has available capacity and agrees to continue to treat that beneficiary or applicant.

(3) Each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, he or she shall be assigned to, and enrolled in, a prepaid health plan.

(c) No later than 30 days following the date a Medi-Cal or CalWORKs beneficiary or applicant is determined eligible for Medi-Cal, the beneficiary shall indicate his or her choice, in writing, from among the available prepaid health plans in the region and his or her choice of primary care provider or clinic contracting with the selected prepaid health plan. Notwithstanding the 30-day deadline set forth in this subdivision, if a beneficiary requests a directory for the entire service area within 30 days of receiving an enrollment form, the deadline for choosing a plan shall be extended an additional 30 days from the date of the request.

(d) At the time the beneficiary or eligible applicant selects a prepaid health plan, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider or clinic contracting with the selected prepaid health plan.

(e) In areas specified by the director for expansion of the Medi-Cal managed care program under Section 14087.3, and where the department is contracting with a prepaid health plan that is contracting with, governed, owned or operated by a county board of supervisors, a county special commission or county health authority authorized by Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96, a Medi-Cal or CalWORKs beneficiary who does not make a choice of managed care plans, shall be assigned to and enrolled in an appropriate Medi-Cal prepaid health plan providing service within the area in which the beneficiary resides.

(f) If a beneficiary or eligible applicant does not choose a primary care provider or clinic, or does not select any primary care provider who is available, the prepaid health plan that was selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.

(g) Any Medi-Cal or CalWORKs beneficiary dissatisfied with the primary care provider or prepaid health plan shall be allowed to select or be assigned to another primary care provider within the same prepaid health plan. In addition, the beneficiary shall be allowed to select or be assigned to another prepaid health plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides, in accordance with Section 1903(m)(2)(F)(ii) of the Social Security Act.

(h) The department or its contractor shall notify a prepaid health plan when it has been selected by or assigned to a beneficiary. The prepaid health plan that has been selected by or assigned to a beneficiary shall notify the primary care provider that has been selected or assigned. The prepaid health plan shall also notify the beneficiary of the prepaid health plan and primary care provider or clinic selected or assigned.

(i) (1) The managed health care plan shall have a valid Medi-Cal contract, adequate capacity, and appropriate staffing to provide health care services to the beneficiary.

(2) The department shall establish standards for all of the following:

(A) The maximum distances a beneficiary is required to travel to obtain primary care services from the managed care plan, in which the beneficiary is enrolled.

(B) The conditions under which a primary care service site shall be accessible by public transportation.

(C) The conditions under which a managed care plan shall provide nonmedical transportation to a primary care service site.

(3) In developing the standards required by paragraph (2) the department shall take into account, on a geographic basis, the means of transportation used and distances typically traveled by Medi-Cal beneficiaries to obtain fee-for-service primary care services and the experience of managed care plans in delivering services to Medi-Cal enrollees. The department shall also consider the provider's ability to render culturally and linguistically appropriate services.

(j) To the extent possible, the arrangements for carrying out subdivision (e) shall provide for the equitable distribution of Medi-Cal beneficiaries among participating prepaid health plans, or managed care plans.

(k) This section shall be implemented in a manner consistent with any federal waiver required to be obtained by the department in order to implement this section.

SEC. 53. Section 14087.5 of the Welfare and Institutions Code is amended to read:

14087.5. (a) The California Medical Assistance Commission may negotiate exclusive contracts with any county which seeks to provide, or arrange for the provision of the health care services provided under this chapter. The California Medical Assistance Commission shall establish regulations concerning the time for submittal of proposed plans for a contract by a county, and for the time by which the California Medical Assistance Commission shall decide whether or not to accept the county's proposal.

(b) The department shall seek all federal waivers necessary to allow for federal financial participation in expenditures under this article. This article shall not be implemented until all necessary waivers have been approved by the federal government.

(c) (1) Notwithstanding subdivision (a) or any other provision of law, on and after the effective date of the act adding this subdivision, the department shall have exclusive authority to negotiate the rates, terms, and conditions of county organized health systems contracts and contract amendments under this article or under Article 7 (commencing with Section 14490) of Chapter 8. As of that date, all references in this article to the negotiator or the California Medical Assistance Commission shall mean the department.

(2) For contracts executed pursuant to this article, the department shall disclose, upon request, each negotiated contract or contract amendment executed by both parties after July 1, 2007, which shall be considered public records for the purposes of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), including contracts that reveal the department's rates of payment for health care services, the rates themselves, and rate manuals.

SEC. 54. Section 14088 of the Welfare and Institutions Code is amended to read:

14088. (a) It is the purpose of this article to ensure that the Medi-Cal program shall be operated in the most cost-effective and efficient manner possible with the optimum number of Medi-Cal providers and shall assure quality of care and known access to services.

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

(1) "Primary care provider" means either of the following:

(A) Any internist, general practitioner, obstetrician/gynecologist, pediatrician or family practice physician or any primary care clinic, rural health clinic, community clinic or hospital outpatient clinic currently en-

rolled in the Medi-Cal program, which agrees to provide case management to Medi-Cal beneficiaries.

(B) A county or other political subdivision that employs, operates, or contracts with, any of the primary care providers listed in subparagraph (A), and that agrees to use that primary care provider for the purposes of contracting under this article.

(2) "Primary care case management" means responsibility for the provision of referral, consultation, ordering of therapy, admission to hospitals, follow up care, and prepayment approval of referred services.

(3) "Designation form" or "form" means a form supplied by the department to be executed by a Medi-Cal beneficiary and a primary care provider or other entity eligible pursuant to this article who has entered into a contract with the department pursuant to this article, setting forth the beneficiary's choice of contractor and an agreement to be limited by the case management decisions of that contractor and the contractor's agreement to be responsible for that beneficiary's case management and medical care, as specified in this article.

(4) "Emergency services" means health care services rendered by an eligible Medi-Cal provider to a Medi-Cal beneficiary for those health services required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions which if not immediately diagnosed and treated could lead to disability or death.

(5) "Modified primary care case management" means primary care case management wherein capitated services are limited to primary care physician office visits only.

(6) "Service area" means an area designated by either a single federal Postal ZIP Code or by two or more Postal ZIP Codes that are contiguous.

SEC. 55. Section 14088.14 of the Welfare and Institutions Code is amended to read:

14088.14. The department may enter into contracts pursuant to this article with nurse practitioners, acting within the scope of practice of a nurse practitioner, certified nurse midwives, acting within the scope of practice of a certified nurse midwife, and, for the purpose of providing services to populations with special medical problems, with any physician who has specialized in an area of medicine relevant to the special population to be served and who is currently enrolled in the Medi-Cal program.

SEC. 56. Section 14088.25 of the Welfare and Institutions Code is amended to read:

14088.25. (a) The department may conduct onsite reviews of a provider or facility that has agreed with the primary care case management contractor or a potential contractor to provide services to beneficiaries enrolled with the contractor. These reviews may be for purposes such as evaluating the capabilities of potential contractors, monitoring quality of care, investigating complaints, and ensuring contractor compliance with the terms of the contract entered into pursuant to this article.

(b) Prior to adding a provider or facility to an existing network of providers and facilities, the primary care case management contractor

shall submit a complete prequalification package to the department. The department shall provide to the contractor written acknowledgment that the package is complete within 10 working days.

(c) (1) If the provider or facility proposed for addition to the contractor's existing network is currently enrolled in the Medi-Cal program, the provider or facility may begin treating beneficiaries enrolled with the contractor immediately upon the contractor's receipt of the acknowledgment required by subdivision (b), subject to paragraph (2) and subdivision (d).

(2) Whenever warranted, the department may rescind the privilege provided for in paragraph (1) by advance notification to the contractor, pending the onsite review required by subdivision (d). Notification shall be in writing and describe the conditions that support the rescission of the privilege.

(d) (1) The department shall conduct an onsite review of the provider or facility within a reasonable period of time after receipt of the package, which shall be not more than 60 days after receipt of the package, unless there are extenuating circumstances.

(2) The department shall notify the contractor in writing of the department's final decision on the request to add the provider or facility to the contractor's existing network within 10 working days of the date of the review.

(e) In the conduct of the onsite review of the provider or facility, the department shall not condition approval of the site on adherence by the provider or facility to requirements that are not contained in any statute, regulation, or commonly accepted community standard of medical practice that directly applies to the category of provider or facility being inspected. This subdivision does not, however, relieve the contractor of any obligations under the contract entered into pursuant to this article.

SEC. 57. Section 14089 of the Welfare and Institutions Code is amended to read:

14089. (a) The purpose of this article is to provide a comprehensive program of managed health care plan services to Medi-Cal recipients residing in clearly defined geographical areas. It is, further, the purpose of this article to create maximum accessibility to health care services by permitting Medi-Cal recipients the option of choosing from among two or more managed health care plans or fee-for-service managed case arrangements, including, but not limited to, health maintenance organizations, prepaid health plans, primary care case management plans. Independent practice associations, health insurance carriers, private foundations, and university medical centers systems, not-for-profit clinics, and other primary care providers, may be offered as choices to Medi-Cal recipients under this article if they are organized and operated as managed care plans, for the provision of preventive managed health care plan services.

(b) The negotiator may seek proposals and then shall contract based on relative costs, extent of coverage offered, quality of health services to be provided, financial stability of the health care plan or carrier, recipient

access to services, cost-containment strategies, peer and community participation in quality control, emphasis on preventive and managed health care services and the ability of the health plan to meet all requirements for both of the following:

(1) Certification, where legally required, by the Director of the Department of Managed Health Care and the Insurance Commissioner.

(2) Compliance with all of the following:

(A) The health plan shall satisfy all applicable state and federal legal requirements for participation as a Medi-Cal managed care contractor.

(B) The health plan shall meet any standards established by the department for the implementation of this article.

(C) The health plan receives the approval of the department to participate in the pilot project under this article.

(c) (1) (A) The proposals shall be for the provision of preventive and managed health care services to specified eligible populations on a capitated, prepaid or postpayment basis.

(B) Enrollment in a Medi-Cal managed health care plan under this article shall be voluntary for beneficiaries eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).

(2) The cost of each program established under this section shall not exceed the total amount which the department estimates it would pay for all services and requirements within the same geographic area under the fee-for-service Medi-Cal program.

(d) The department shall enter into contracts pursuant to this article, and shall be bound by the rates, terms, and conditions negotiated by the negotiator.

(e) (1) An eligible beneficiary shall be entitled to enroll in any health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides. The department shall make available to recipients information summarizing the benefits and limitations of each health care plan available pursuant to this section in the geographic area in which the recipient resides. A Medi-Cal or CalWORKs applicant or beneficiary shall be informed of the health care options available regarding methods of receiving Medi-Cal benefits. The county shall ensure that each beneficiary is informed of these options and informed that a health care options presentation is available.

(2) No later than 30 days following the date a Medi-Cal or CalWORKs recipient is informed of the health care options described in paragraph (1), the recipient shall indicate his or her choice in writing of one of the available health care plans and his or her choice of primary care provider or clinic contracting with the selected health care plan. Notwithstanding the 30-day deadline set forth in this paragraph, if a beneficiary requests a directory for the entire service area within 30 days of the date of receiving an enrollment form, the deadline for choosing a plan shall be extended an additional 30 days from the date of that request.

(3) The health care options information described in this subdivision shall include the following elements:

(A) Each beneficiary or eligible applicant shall be provided, at a minimum, with the name, address, telephone number, and specialty, if any, of each primary care provider, by specialty or clinic participating in each managed health care plan option through a personalized provider directory for that beneficiary or applicant. This information shall be presented under the geographic area designations by the name of the primary care provider and clinic, and shall be updated based on information electronically provided monthly by the health care plans to the department, setting forth any changes in the health care plan provider network. The geographic areas shall be based on the applicant's residence address, the minor applicant's school address, the applicant's work address, or any other factor deemed appropriate by the department, in consultation with health plan representatives, legislative staff, and consumer stakeholders. In addition, directories of the entire service area, including, but not limited to, the name, address, and telephone number of each primary care provider and hospital, of all Geographic Managed Care health plan provider networks shall be made available to beneficiaries or applicants who request them from the health care options contractor. Each personalized provider directory shall include information regarding the availability of a directory of the entire service area, provide telephone numbers for the beneficiary to request a directory of the entire service area, and include a postage-paid mail card to send for a directory of the entire service area. The personalized provider directory shall be implemented as a pilot project in Sacramento County pursuant to this article, and in Los Angeles County (Two-Plan Model) pursuant to Article 2.7 (commencing with Section 14087.305). The content, form, and geographic areas used shall be determined by the department in consultation with a workgroup to include health plan representatives, legislative staff, and consumer stakeholders, with an emphasis on the inclusion of stakeholders from Los Angeles and Sacramento Counties. The personalized provider directories may include a section for each health plan. Prior to implementation of the pilot project, the department, in consultation with consumer stakeholders, legislative staff, and health plans, shall determine the parameters, methodology, and evaluation process of the pilot project. The pilot project shall thereafter be in effect for a minimum of two years. Three months prior to the end of the first two years of the pilot project, the department shall promptly provide the fiscal and policy committees of the Legislature with an evaluation of the personalized provider directory pilot project and its impact on the Medi-Cal managed care program, including whether the pilot project resulted in a reduction of default assignments and a more informed choice process for beneficiaries, and its overall cost-benefit to the state. Following two years of operation as a pilot project in two counties and submission of the evaluation to the Legislature, the department, in consultation with consumer stakeholders, legislative staff, and health plans, shall determine whether to implement personalized provider directories as a permanent

program statewide. This determination shall be based on the outcomes set forth in the evaluation provided to the Legislature. If necessary, the pilot project shall continue beyond the initial two-year period until this determination is made. This pilot project shall only be implemented to the extent that it is budget neutral to the department.

(B) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider or clinic contracting with any of the health plans available and has the available capacity and agrees to continue to treat that beneficiary or eligible applicant.

(C) Each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, he or she shall be assigned to, and enrolled in, a health care plan.

(4) At the time the beneficiary or eligible applicant selects a health care plan, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider or clinic contracting with the selected health care plan.

(5) Commencing with the implementation of a geographic managed care project in a designated county, a Medi-Cal or CalWORKs beneficiary who does not make a choice of health care plans in accordance with paragraph (2), shall be assigned to and enrolled in an appropriate health care plan providing service within the area in which the beneficiary resides.

(6) If a beneficiary or eligible applicant does not choose a primary care provider or clinic, or does not select any primary care provider who is available, the health care plan selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.

(7) Any Medi-Cal or CalWORKs beneficiary dissatisfied with the primary care provider or health care plan shall be allowed to select or be assigned to another primary care provider within the same health care plan. In addition, the beneficiary shall be allowed to select or be assigned to another health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides in accordance with Section 1903(m)(2)(F)(ii) of the Social Security Act.

(8) The department or its contractor shall notify a health care plan when it has been selected by or assigned to a beneficiary. The health care plan that has been selected or assigned by a beneficiary shall notify the primary care provider that has been selected or assigned. The health care plan shall also notify the beneficiary of the health care plan and primary care provider selected or assigned.

(9) This section shall be implemented in a manner consistent with any federal waiver that is required to be obtained by the department to implement this section.

(f) A participating county may include within the plan or plans providing coverage pursuant to this section, employees of county government,

and others who reside in the geographic area and who depend upon county funds for all or part of their health care costs.

(g) The negotiator and the department shall establish pilot projects to test the cost-effectiveness of delivering benefits as defined in subdivisions (a) to (f), inclusive.

(h) The California Medical Assistance Commission shall evaluate the cost-effectiveness of these pilot projects after one year of implementation. Pursuant to this evaluation the commission may either terminate or retain the existing pilot projects.

(i) Funds may be provided to prospective contractors to assist in the design, development, and installation of appropriate programs. The award of these funds shall be based on criteria established by the department.

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

SEC. 60. Section 14091.21 of the Welfare and Institutions Code is amended to read:

14091.21. (a) Nursing facility services necessary for the treatment of illness or injury are covered subject to the provisions of this section:

(b) Nursing facility services are covered only after prior authorization has been obtained from the designated Medi-Cal consultant for the field office area in which the nursing facility is located. The authorization request shall be initiated by the facility and shall be signed by the attending physician. Nursing facility services may be authorized either for a distinct-part nursing facility (a facility that is a distinct part of an acute care hospital), or for a freestanding nursing facility (a facility that is not part of an acute care hospital).

(1) Distinct-part nursing facility care at the distinct-part nursing facility reimbursement rate for any Medi-Cal patient determined to need long-term nursing care shall be authorized when any one of the following conditions is met:

(A) There is no freestanding nursing facility within 15 miles, which shall be defined as 30 minutes at 30 miles per hour, from the established residential address of that patient prior to admission to nursing care and the distinct-part nursing facility is within a shorter actual travel time than the closest freestanding nursing facility able and willing to admit the patient.

(B) There is a freestanding nursing facility within 15 miles, as defined in subparagraph (A) from the established residential address of the patient before admission to nursing care, but after reasonable placement efforts, no such facility is able and willing to accept the patient, and the distinct-part nursing facility is within a shorter travel time than the closest freestanding nursing facility able and willing to admit the patient, within the 25-day placement period.

(C) There is no freestanding nursing facility within 30 minutes actual travel time from the established residential address of the immediate family member, such as the spouse, parent, child, or sibling of the patient, who certifies that he or she is the family member who will be most frequently visiting and helping with the personal needs of the patient, or if there is such a freestanding nursing facility, there is none able and willing, after reasonable placement efforts, to accept the patient, and the distinct-part nursing facility is within a shorter travel time than the closest freestanding nursing facility. In this case, the distinct-part nursing facility shall submit with the treatment authorization request a signed statement from the immediate family member certifying that he or she is the person who will be most frequently visiting and seeing to the personal needs of the patient. The signed statement of the family member shall contain an explanation of the relationship to the patient, the residential address used in calculating the distance to the distinct-part nursing facility, and the mode of transportation to be used. A copy of this certification shall be kept in the patient's file at the distinct-part nursing facility.

(D) The immediate family member who will be most frequently visiting and seeing to the personal needs of the patient cannot, because of established health reasons, travel to a freestanding nursing facility that is able and willing to admit the patient and that is within 30 minutes actual travel time, but he or she is able to travel to the distinct-part nursing facility. The certification so stating, and signed by that family member, shall be submitted with the treatment authorization request. A copy of this certification shall be kept in the patient's file at the distinct-part nursing facility.

(E) The patient has a spouse residing in the same distinct-part nursing facility.

(F) The patient is currently, as of the time approval is sought, residing in the distinct-part nursing facility and has been continuously residing in that facility for at least 120 consecutive days, and payment has been made or approved during the 120 consecutive days by Medicare, other health insurance, or by Medi-Cal at a distinct-part nursing facility rate. For patients who have met this requirement and are later hospitalized, a treatment authorization request at the distinct-part nursing facility rate shall be reinstated if the patient returns to the same distinct-part nursing facility during the seven-day bed-hold period specified in Section 1599.79 of the Health and Safety Code. Otherwise, to reside in a distinct-part nursing facility, the patient shall meet one of the conditions set forth unless the patient's attending physician documents in the medical record that discharge to a freestanding nursing facility would cause physical or psychological harm to the patient.

(2) "Actual travel time" means the amount of time it would usually take the immediate family member to travel between two specific points by means of whatever transport would be available to him or her, taking into account actual road and weather conditions.

(3) "Reasonable placement efforts" means that during the 25-day time period beginning with the date that approval for the Medi-Cal distinct-

part nursing facility rate is first sought, the facility shall do all of the following:

(A) Contact on a daily basis, not including Saturdays, Sundays, or holidays, Medi-Cal-certified freestanding nursing facilities within the applicable mileage or travel time, to determine whether each such freestanding nursing facility is able and willing to admit the patient. In meeting this requirement, facilities shall contact only those freestanding nursing facilities that they, in good faith, believe may be able and willing to admit this patient, taking into account previous contacts. Further attempts at placement calls will be waived by the department. Freestanding nursing facilities within the applicable mileage or travel time are those within the appropriate travel time plus any freestanding nursing facility within a shorter actual travel time than the distinct-part nursing facility from the appropriate residential address such as the patient's or the immediate family member's.

(B) Document that the facility contacted a person responsible for admission decisions during each required contact, the date and time of each contact with a freestanding nursing facility, the name and title of each person contacted, the reason given for the freestanding nursing facility not being able or willing to admit the patient on the day contacted, and the date, if any, when the freestanding nursing facility would be able and willing to accept the patient. Contacts may be made by telephone or facsimile transmission.

(C) Submit the documentation specified in subparagraph (B) to the Medi-Cal field office at the conclusion of the 25-day placement effort period.

(4) Upon submission of documentation that reasonable placement efforts requirement were met, the distinct-part nursing facility rate or acute administrative days shall be approved as follows:

(A) Hospitals seeking to place a patient into their own distinct-part nursing facilities shall be approved for acute administrative days for a patient determined to need long-term nursing facility care, who remains in an acute care bed during the placement period. If a contacted freestanding nursing facility was able and willing to admit the patient during the 25-day period, the hospital's treatment authorization request shall be subsequently authorized for approval of acute administrative days until the date that the freestanding nursing facility is able to accept the patient.

At the completion of the reasonable placement effort period, if no freestanding nursing facility is able and willing to take the patient, the hospital's treatment authorization request shall be authorized for approval for acute administrative days for days of care during the reasonable placement period. The hospital, in order to comply with this subparagraph, shall complete the 25-day placement period if there is a freestanding nursing facility within the applicable mileage or travel time willing to take the patient, but due to occupancy, is unable to accept transfer on the days it was contacted. If, however, there is a freestanding nursing facility within the applicable mileage or travel time, but the freestanding nursing

facility is not able or willing to admit the patient at the time of the placement effort or in the future, the length of placement time required shall vary and may be shorter than 25 days. If documentation establishes that no freestanding nursing facility within the applicable mileage or travel time, is, or will ever be, able or willing to admit the patient, further placement efforts shall not be required. The distinct-part nursing facility rate of reimbursement shall be approved upon the patient's admission to the distinct-part nursing facility if reasonable placement efforts requirement has been met and no freestanding nursing facility within the applicable mileage or travel time standard was able and willing to accept the patient.

(B) When a patient is either admitted to a distinct-part nursing facility from an acute hospital, nonacute facility, or community setting, or was a distinct-part nursing facility resident whose care has been, but is no longer being, paid by another payment source, a treatment authorization request shall be approved at the distinct-part nursing facility rate for a patient who has been admitted and determined to need long-term nursing facility placement when the reasonable placement efforts requirement has been met. If a contacted freestanding nursing facility is able and willing to admit the patient during the 25-day period, the distinct-part nursing facility treatment authorization request shall be subsequently authorized for approval at the distinct-part nursing facility rate until the date that the freestanding nursing facility is able to accept the patient. If the basis on which the final distinct-part nursing facility approval is sought is the lack of any freestanding nursing facility able and willing to take the patient after reasonable placement efforts, this approval shall not be given until after the completion of the reasonable placement period, but may be given for days of care during that period. The criteria for shortening the reasonable placement period to less than 25 days shall apply. Notwithstanding the general requirement that skilled nursing care must receive prior authorization, when a distinct-part nursing facility admits a patient during the time it is making reasonable placement efforts, authorization of the distinct-part nursing facility rate may be given postadmission.

However, no days of care shall be authorized for any period prior to the receipt of the treatment authorization request from the facility, unless retroactive authorization may be given.

(C) When a patient spends some of the placement period in the hospital and some of that time in a distinct-part nursing facility, acute administrative days shall be authorized for the hospital days and the distinct-part nursing facility rate for the distinct-part nursing facility days, subject to the provisions of this paragraph.

(5) Reasonable placement efforts, as defined in paragraph (3), shall be conducted for all patients in need of long-term nursing care who are seeking admission to a distinct-part nursing facility pursuant to paragraph (1) of subdivision (a) of Section 51335 of Title 22 of the California Code of Regulations. Patients requiring nursing care for postsurgical rehabilitative or therapy services shall not be subject to the reasonable placement

efforts required for admission to a distinct-part nursing facility but they shall be subject to all other Medi-Cal criteria for these admissions. A patient, who is a resident of a distinct-part nursing facility and who has been hospitalized for more than the seven-day bed-hold period, may be readmitted to the distinct-part nursing facility without meeting the reasonable placement efforts requirement for admission, if the attending physician documents that discharge to a freestanding nursing facility will result in physical or psychological harm.

(6) If a distinct-part nursing facility desires of its own volition to admit a patient needing nursing care at the freestanding nursing facility rate, the department shall approve a treatment authorization request submitted for approval at that rate. Distinct-part nursing facilities shall be enrolled in the Medi-Cal program as a freestanding nursing facility provider for that purpose, in addition to being otherwise enrolled in the Medi-Cal program. A distinct-part nursing facility objecting to the freestanding nursing facility rate in any other circumstance, such as when it has not accepted the rate of its own volition, shall not be deemed to have waived its rights to administrative appeal and further review.

(7) With respect to acute care hospitals that are licensed for distinct-part nursing beds, and determined by the State Department of Health Services to provide special services to a unique population, the department shall enact and enforce no regulation, field office instruction, or preadmission screening criteria that restricts a Medi-Cal beneficiary's freedom to seek admission to a nursing facility or unit that is a distinct part of an acute care hospital on terms or conditions different from those governing admission to a long-term care facility.

(c) The department may waive the requirements of this section if it can be demonstrated that both of the following apply:

(1) Access to care is compromised for a specific patient population.

(2) The facility can demonstrate an increase in acute administrative days that are attributable to unsuccessful placement efforts.

SEC. 61. Section 14100.95 of the Welfare and Institutions Code is amended to read:

14100.95. (a) The department shall enter into demonstration contracts with manufacturers of medical supplies for four items of its own selection of medical supplies existing on the pharmacy claims processing system, for the purpose of establishing rebates or other cost-saving mechanisms and demonstrating cost savings in the purchase of these medical supplies. The department shall maintain a list of the supplies for which contracts have been executed.

(b) Nothing in this section shall prevent a small retail business from continuing to supply medical supplies for use by Medi-Cal beneficiaries.

(c) In establishing these demonstration contracts, the department shall preserve reasonable access to these supplies by beneficiaries. To ensure that the health needs of Medi-Cal beneficiaries are met, the department shall evaluate products and execute contracts pursuant to subdivision (c) of Section 14105.47.

(d) The department shall report the outcomes of these demonstration contracts to the Legislature no later than January 1, 2009.

SEC. 62. Section 14105.2 of the Welfare and Institutions Code is amended to read:

14105.2. (a) The allowable markup payable for the dispensing of medical supplies by assistive device and sickroom supply dealers and pharmacies shall not exceed 23 percent of the estimated acquisition cost of the item dispensed, as defined by the department.

(b) Payment for diabetic testing supplies shall not exceed the estimated acquisition cost of the item dispensed, as defined by the department, plus a fee equal to the maximum professional fee component used in the payment for legend generic drug types.

(c) In determining the estimated acquisition costs of products pursuant to this section, the department shall consider provider related costs of the product that include, but are not limited to, shipping, handling, storage, and delivery.

SEC. 63. Section 14105.3 of the Welfare and Institutions Code is amended to read:

14105.3. (a) The department is considered to be the purchaser, but not the dispenser or distributor, of prescribed drugs under the Medi-Cal program for the purpose of enabling the department to obtain from manufacturers of prescribed drugs the most favorable price for those drugs furnished by one or more manufacturers, based upon the large quantity of the drugs purchased under the Medi-Cal program, and to enable the department, notwithstanding any other provision of state law, to obtain from the manufacturers discounts, rebates, or refunds based on the quantities purchased under the program, insofar as may be permissible under federal law. Nothing in this section shall interfere with usual and customary distribution practices in the drug industry.

(b) The department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis with manufacturers, distributors, dispensers, or suppliers of appliances, durable medical equipment, medical supplies, and other product-type health care services and with laboratories for clinical laboratory services for the purpose of obtaining the most favorable prices to the state and to assure adequate quality of the product or service. This subdivision shall not apply to pharmacies licensed pursuant to Section 4080 of the Business and Professions Code.

(c) Notwithstanding subdivision (b), the department may not enter into a contract with a clinical laboratory unless the clinical laboratory operates in conformity with Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code and the regulations adopted thereunder, and Section 263a of Title 42 of the United States Code and the regulations adopted thereunder.

(d) The department shall contract with manufacturers of single-source drugs on a negotiated basis, and with manufacturers of multisource drugs on a bid or negotiated basis.

(e) In order to ensure and improve access by Medi-Cal beneficiaries to both hearing aid appliances and provider services, and to ensure that the state obtains the most favorable prices, the department, by June 30, 2008, shall enter into exclusive or nonexclusive contracts, on a bid or negotiated basis, for purchasing hearing aid appliances.

(f) In carrying out contracting activity for this or any section associated with the Medi-Cal list of contract drugs, notwithstanding Section 19130 of the Government Code, the department may contract, either directly or through the fiscal intermediary, for pharmacy consultant staff necessary to accomplish the contracting process or treatment authorization request reviews. The fiscal intermediary contract, including any contract amendment, system change pursuant to a change order, and project or systems development notice shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Chapter 7 (commencing with Section 11700) of Part 1 of Division 3 of Title 2 of the Government Code, and any policies, procedures, or regulations authorized by these provisions.

(g) In order to achieve maximum cost savings the Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Therefore contracts under this section shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(h) For purposes of implementing the contracting provisions specified in this section, the department shall do all of the following:

(1) Ensure adequate access for Medi-Cal patients to quality laboratory testing services in the geographic regions of the state where contracting occurs.

(2) Consult with the statewide association of clinical laboratories and other appropriate stakeholders on the implementation of the contracting provisions specified in this section to ensure maximum access for Medi-Cal patients consistent with the savings targets projected by the 2002–03 Budget Conference Committee for clinical laboratory services provided under the Medi-Cal program.

(3) Consider which types of laboratories are appropriate for implementing the contracting provisions specified in this section, including independent laboratories, outreach laboratory programs of hospital based laboratories, clinic laboratories, physician office laboratories, and group practice laboratories.

SEC. 64. Section 14105.45 of the Welfare and Institutions Code is amended to read:

14105.45. (a) For purposes of this section, the following definitions shall apply:

(1) “Average manufacturers price” means the price reported to the department by the Centers for Medicare and Medicaid Services pursuant to Section 1927 of the Social Security Act (42 U.S.C. Sec. 1396r-8). In the event an average manufacturer’s price is not available, the department shall use the direct price as the average manufacturer’s price.

(2) "Average wholesale price" means the price for a drug product listed in the department's primary price reference source.

(3) "Direct price" means the price for a drug product purchased by a pharmacy directly from a drug manufacturer listed in the department's primary reference source.

(4) "Estimated acquisition cost" means the department's best estimate of the price generally and currently paid by providers for a drug product sold by a particular manufacturer or principal labeler in a standard package.

(5) "Federal upper limit" means the maximum per unit reimbursement when established by the Centers for Medicare and Medicaid Services and published by the department in Medi-Cal pharmacy provider bulletins and manuals.

(6) "Generically equivalent drugs" means drug products with the same active chemical ingredients of the same strength, quantity, and dosage form, and of the same generic drug name, as determined by the United States Adopted Names (USAN) and accepted by the federal Food and Drug Administration (FDA), as those drug products having the same chemical ingredients.

(7) "Legend drug" means any drug whose labeling states "Caution: Federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(8) "Maximum allowable ingredient cost" (MAIC) means the maximum amount the department will reimburse Medi-Cal pharmacy providers for generically equivalent drugs.

(9) "Innovator multiple source drug," "noninnovator multiple source drug," and "single source drug" have the same meaning as those terms are defined in Section 1396r-8(k)(7) of Title 42 of the United States Code.

(10) "Nonlegend drug" means any drug whose labeling does not contain the statement referenced in paragraph (7).

(11) "Selling price" means the price used in the establishment of the estimated acquisition cost. The department shall base the selling price on the average manufacturer's price plus a percent markup determined by the department to be necessary for the selling price to represent the average purchase price paid by retail pharmacies in California. The selling price shall not be considered confidential and shall be subject to disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(b) (1) Reimbursement to Medi-Cal pharmacy providers for legend and nonlegend drugs shall consist of the estimated acquisition cost of the drug plus a professional fee for dispensing. The professional fee shall be seven dollars and twenty-five cents ($7.25) per dispensed prescription. The professional fee for legend drugs dispensed to a beneficiary residing in a skilled nursing facility or intermediate care facility shall be eight dollars ($8) per dispensed prescription. For purposes of this paragraph "skilled nursing facility" and "intermediate care facility" shall have the same meaning as defined in Division 5 (commencing with Section 70001) of Title 22 of the California Code of Regulations.

(2) The department shall establish the estimated acquisition cost of legend and nonlegend drugs as follows:

(A) For single source and innovator multiple source drugs, the estimated acquisition cost shall be equal to the lowest of the average wholesale price minus 17 percent, the selling price, the federal upper limit, or the MAIC.

(B) For noninnovator multiple source drugs, the estimated acquisition cost shall be equal to the lowest of the average wholesale price minus 17 percent, the selling price, the federal upper limit, or the MAIC.

(3) For purposes of paragraph (2), the department shall establish a list of MAICs for generically equivalent drugs, which shall be published in pharmacy provider bulletins and manuals. The department shall update the list of MAICs and establish additional MAICs in accordance with all of the following:

(A) The department shall base the MAIC on the mean of the average manufacturer's price of drugs generically equivalent to the particular innovator drug plus a percent markup determined by the department to be necessary for the MAIC to represent the average purchase price paid by retail pharmacies in California.

(B) The department shall update MAICs at least every three months and notify Medi-Cal providers at least 30 days prior to the effective date of a MAIC.

(c) The department shall update the Medi-Cal claims processing system to reflect the selling price of drugs not later than 30 days after receiving the average manufacturer's price.

(d) In order to maintain beneficiary access to prescription drug services, no later than 30 days after the department initially implements selling price as a component of estimated acquisition cost, pursuant to paragraph (2) of subdivision (b), the department shall make a one-time adjustment to the dispensing fees paid to pharmacy providers in accordance with paragraph (1) of subdivision (b). This change shall only be made if selling price results in a lower aggregate drug reimbursement. Any increase in dispensing fee made pursuant to this subdivision shall not exceed the aggregate savings associated with the implementation of selling price. At least 30-days prior to implementing the dispensing fee increase, the department shall issue a copy of the department's request for federal approval pursuant to subdivision (e), to the chairperson in each house that considers appropriations and the Chairperson of the Joint Legislative Budget Committee, or whatever lesser time the Chairperson of the Joint Legislative Budget Committee or his or her designee may determine.

(e) The director shall implement this section in a manner that is consistent with federal Medicaid law and regulations. The director shall seek any necessary federal approvals for the implementation of this section. This section shall be implemented only to the extent that federal approval is obtained.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in this section by means of a provider

bulletin or notice, policy letter, or other similar instructions, without taking regulatory action.

(g) The department shall issue a Medi-Cal pharmacy reimbursement fact sheet to the chairperson of the committee in each house of the Legislature that considers appropriations no later than March 1, 2008. The reimbursement fact sheet shall contain, but not be limited to, available data and information regarding the change in reimbursement due to the federal Deficit Reduction Act of 2005 implementation of average manufacturer's price based federal upper limits, the implementation of selling price, change in the average wholesale price reported to the department by the primary price reference source, change in pharmacy dispensing fees, prescription drug volume trends, and the number of active Medi-Cal pharmacy providers. The fact sheet shall also contain general information and definitions regarding drug pricing terminology and a description of pharmacy claims processing in Medi-Cal.

SEC. 65. Section 14105.47 of the Welfare and Institutions Code is amended to read:

14105.47. (a) (1) The department shall establish a list of medical supplies. The list shall specify utilization controls to be applied to each medical supply product.

(2) The utilization controls specified shall include, but not be limited to, those provided by regulation of the department.

(3) The department shall notify providers at least 30 days prior to the effective date of a change in utilization controls.

(b) (1) The department shall establish a list of maximum allowable product costs (MAPCS) for medical supplies, which shall be published in provider bulletins.

(2) The department shall update existing MAPCS and establish additional MAPCS in accordance with all of the following:

(A) In establishing the MAPCS, the director shall assure that eligible persons shall receive medical supply products that are available to the public generally, without discrimination or segregation based purely on economic disability.

(B) All related medical supply products within each particular medical supply type available for retail distribution shall be reviewed by the department in consultation with representatives from the California Association of Medical Product Suppliers and the California Pharmacists Association.

(C) The department shall base MAPCS on the mean of the wholesale selling price of related medical supply products that are available in California. For purposes of this section, "wholesale selling price" means the price, including discounts and rebates, paid by a provider to a wholesaler, distributor, or manufacturer for a medical supply product.

(D) In establishing the MAPCS, the department shall consider the provider related costs of the product that include, but are not limited to, shipping, handling, storage, and delivery.

(E) The department shall notify Medi-Cal providers at least 30 days prior to the effective date of MAPCS.

(c) (1) In establishing the list of medical supplies, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis with manufacturers, distributors, dispensers, or suppliers of medical supplies pursuant to Sections 14100.95 and 14105.3.

(2) To ensure that the health needs of Medi-Cal beneficiaries are met, the department shall, when evaluating a decision to execute a contract, and when evaluating medical supplies for retention on, addition to, or deletion from, the list of medical supplies, consider all of the following criteria:

(A) The safety of the product.

(B) The effectiveness of the product.

(C) The essential need for the product.

(D) The potential for misuse of the product.

(E) The immediate or long-term cost effectiveness of the product.

(3) The deficiency of a product when measured by one of the criteria specified in paragraph (2) may be sufficient to support a decision that the product should be deleted from, should not be added to, or should not be retained on, the list of medical supplies. However, the superiority of a product under one criterion may be sufficient to warrant the addition or retention of the product, notwithstanding a deficiency in another criterion.

(4) In the evaluation of the effectiveness of a product, the department may require the manufacturer, distributor, dispenser, or supplier to submit its products to testing by an independent laboratory. For the purposes of this section, "independent laboratory" means an analytical laboratory that is not a subsidiary of, affiliated with, or on retainer for, the manufacturer, distributor, dispenser, or supplier. The department shall only utilize this paragraph involving products where there is a demonstrated experience of a significant variation in performance among the products subject to this particular contracting process.

(d) Notwithstanding the provisions of 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.

SEC. 66. Section 14105.475 is added to the Welfare and Institutions Code, to read:

14105.475. (a) In maintaining the lists of medical supplies, incontinence medical supplies, and enteral nutrition products, the department may perform a review of, and contract for, various products in a specific product category.

(b) The department shall notify each manufacturer of products in the categories selected pursuant to Sections 14100.95, 14105.47, 14105.8, and Sections 14125 to 14125.9, inclusive.

(c) If, within 30 days of notification, a manufacturer does not enter into negotiations for a contract pursuant to those sections, the department may

delete the products from their respective lists, or refuse to consider for addition, products of that manufacturer in the selected product categories.

(d) If, after 270 days from the initial notification, a contract is not executed for a product currently on the list of medical supplies, incontinence medical supplies, or enteral nutrition products, the department may delete the product from its respective list.

(e) If, within 270 days from the initial notification, a contract is executed for a product currently on the list of medical supplies, incontinence medical supplies, or enteral nutrition products, the department shall retain the product on its respective list.

(f) If, within 270 days from the date of the initial notification, a contract is executed for a product not currently on the list of medical supplies, incontinence medical supplies, or enteral nutrition products, the department shall add the product to its respective list.

(g) The department shall terminate all negotiations 270 days after the initial notification.

(h) The department may delete any product from its respective list at the expiration of the contract term or when the contract between the department and the manufacturer of that product is terminated.

(i) In the absence of a contract, the department may deem any product on the list of medical supplies, incontinence medical supplies, or enteral nutrition products, a nonbenefit of the program and delete that product from its respective list.

(j) Deletions made to the lists of medical supplies, incontinence supplies, and enteral nutrition products, shall become effective no sooner than 30 days after publication of the changes in provider bulletins.

(k) (1) A manufacturer of a medical supply, incontinence supply, or enteral nutrition product denied a contract pursuant to this section, or pursuant to Sections 14100.95, 14105.47, 14105.8, and Sections 14125 to 14125.9, inclusive, may file an appeal of that decision with the director within 30 calendar days of the department's written decision.

(2) The director shall issue a final decision on the appeal within 60 calendar days of the postmark date of the appeal.

(*l*) 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 product pursuant to this subdivision. 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 product is available from Medi-Cal.

SEC. 67. Section 14105.8 of the Welfare and Institutions Code is amended to read:

14105.8. (a) The department may enter into contracts with manufacturers of enteral nutrition products that can be used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food, on a bid or nonbid basis. The department shall maintain a list of those products for which contracts have been executed. For those contracts that generate

rebates, those rebates shall be managed through the department's drug rebate accounting system.

(b) (1) To ensure that the health needs of Medi-Cal beneficiaries are met, the department shall, when evaluating a decision to execute a contract, and when evaluating enteral nutrition products for retention on, addition to, or deletion from, the list of enteral nutrition products, consider all of the following criteria:

(A) The safety of the product.

(B) The effectiveness of the product.

(C) The essential need for the product.

(D) The potential for misuse of the product.

(E) The immediate or long-term cost effectiveness of the product.

(2) The deficiency of a product when measured by one of the criteria specified in paragraph (1) may be sufficient to support a decision that the product should be deleted from, should not be added to, or should not be retained on, the list of medical supplies. However, the superiority of a product under one criterion may be sufficient to warrant the addition or retention of the product, notwithstanding a deficiency in another criterion.

(c) In order that Medi-Cal beneficiaries may have access to a comprehensive range of enteral nutrition products pursuant to subdivision (a), the department shall ensure that there is representation on the list of both general use and specialized use enteral nutrition products. The department deems all products designed to meet the normal needs of infants, and all products that are an incomplete source of nutrition, including modular products, and all products intended for use in weight loss, are not benefits of the Medi-Cal program. The department may deem an incomplete product a benefit for patients with diagnoses, including, but not limited to, malabsorption and inborn errors of metabolism, when the product either appropriately lacks only an offending nutrient, or has been shown to not be investigational nor experimental when used as part of a therapeutic regimen to prevent serious disability or death, or when both conditions apply.

(d) 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.

(e) Deletions made to the list of enteral nutrition products shall become effective no sooner than 30 days after publication of the changes in provider bulletins.

(f) Changes made to the list of enteral nutrition products under this or any other section are exempt from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law.

(g) The department may provide beneficiaries continuing care for products deleted from the list of enteral nutrition products. The department shall assess the need for continuing care based on the criteria in subdivision (b) and the potential impact on beneficiary access to appropriate therapy. To be eligible for continuing care status under this subdivision, a beneficiary must be taking the enteral nutrition product when the product is deleted. Additionally, the department shall have received a claim for the enteral nutrition product with a date of service that is within 100 days prior to the date the product was deleted. A beneficiary shall remain eligible for continuing care status provided that a claim is submitted for the enteral nutrition product 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 enteral nutrition product.

(h) The department shall provide individual notice to Medi-Cal beneficiaries at least 60 calendar days prior to the effective date of the deletion of any enteral nutrition product from the list of enteral nutrition products. 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 enteral nutrition product is available from Medi-Cal.

(i) Enteral nutrition products authorized pursuant to subdivision (a) shall be available only through prior authorization. The department may designate those enteral nutrition products that are without a contract as not being a benefit of the Medi-Cal program, except in the case of continuing care as described in subdivision (h) of this section.

(j) 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).

(k) (1) Manufacturers shall calculate and pay interest on late or unpaid rebates.

(2) Interest pursuant to paragraph (1) shall begin accruing 38 calendar days from the date of mailing of the quarterly invoice, including supporting utilization data sent to the manufacturer. Interest shall continue to accrue until the date of mailing of the manufacturer's payment.

(3) Interest rates and calculations pursuant to paragraph (1) shall be identical and shall be equal to the drug rebate interest rates as determined by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations.

(4) If the date of mailing of a state rebate payment is 69 days of more from the date of mailing of the invoice, including supporting utilization data sent to the manufacturer, the interest rate shall be as specified in paragraph (3), however the interest rate shall be increased by 10 percentage points.

(*l*) The department may adopt emergency regulations to implement this section in accordance with the rulemaking provisions of the Administrative

Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 68. Section 14105.85 of the Welfare and Institutions Code is amended to read:

14105.85. (a) Effective July 1, 2002, payment for enteral nutrition products dispensed by a pharmacy provider shall be based on the estimated acquisition cost for that product plus a percentage markup to be determined by the department in consultation with provider representatives from the California Association of Medical Product Suppliers and the California Pharmacists Association. Any changes to the percentage markup may be implemented with 30-day notice to the provider community via a provider bulletin or other specific notification to providers.

(b) In determining the estimated acquisition cost of products pursuant to this section, the department shall consider provider related costs of the products that include, but are not limited to, shipping, handling, storage, and delivery.

SEC. 69. Section 14110 of the Welfare and Institutions Code is amended to read:

14110. No payment for care or services shall be made under Medi-Cal to a medical or health care facility unless it has been certified by the department for participation, and it meets one of the following:

(a) It is licensed by the department.

(b) It is licensed by a comparable agency in another state.

(c) It is exempt from licensure.

(d) It is operated by the Regents of the University of California.

(e) It meets the utilization review plan criteria for certification or is certified as an institutional provider of services under Title XVIII of the Federal Social Security Act and regulations issued thereunder.

Nothing in this section shall preclude payments for care for aged patients in medical facilities or institutions operated or licensed by the department, or the State Department of Mental Health, State Department of Developmental Services, State Department of Social Services, or Department of Rehabilitation.

The department shall certify facilities licensed pursuant to subdivision (e) of Section 1250 of the Health and Safety Code for participation in the program within 30 calendar days of receipt of a complete application or date of licensure, whichever is greater, if the facility meets all the requirements for certification. The department for claims purposes only, shall enroll facilities which meet all certification requirements within 30 calendar days of the date of certification or 60 calendar days of licensure, whichever is greater.

SEC. 70. Section 14124.70 of the Welfare and Institutions Code is amended to read:

14124.70. As used in this article:

(a) "Carrier" includes any insurer as defined in Section 23 of the Insurance Code, including any private company, corporation, mutual association, trust fund, reciprocal or interinsurance exchange authorized under

the laws of this state to insure persons against liability or injuries caused to another, and also any insurer providing benefits under a policy of bodily injury liability insurance covering liability arising out of the ownership, maintenance or use of a motor vehicle which provides uninsured motorist endorsement or coverage, pursuant to Section 11580.2 of the Insurance Code.

(b) "Beneficiary" means any person who has received benefits or will be provided benefits under this chapter because of an injury for which another person or party may be liable. It includes such beneficiary's guardian, conservator or other personal representative, his estate or survivors.

(c) "Reasonable value of benefits" means both of the following:

(1) Except in a case in which services were provided to a beneficiary under a managed care arrangement or contract, "reasonable value of benefits" means the Medi-Cal rate of payment, for the type of services rendered, under the schedule of maximum allowances authorized by Section 14106 or, the Medi-Cal rate of payment, for the type of services rendered, under regulations adopted pursuant to this chapter, including but not limited, to Section 14105.

(2) If services were provided to a beneficiary under a managed care arrangement or contract, "reasonable value of benefits" means the rate of payment to the provider by the plan for the services rendered to the beneficiary, except in cases where the plan pays the provider on a capitated or risk sharing basis, in which case it means the value of the services rendered to the beneficiary calculated by the plan as the usual customary and reasonable charge made to the general public by the provider for similar services.

(d) "Lien" means the director's claim for recovery, from a beneficiary's tort action or claim, of the reasonable value of benefits provided on behalf of the beneficiary.

SEC. 71. Section 14124.76 of the Welfare and Institutions Code is amended to read:

14124.76. (a) No settlement, judgment, or award in any action or claim by a beneficiary to recover damages for injuries, where the director has an interest, shall be deemed final or satisfied without first giving the director notice and a reasonable opportunity to perfect and to satisfy the director's lien. Recovery of the director's lien from an injured beneficiary's action or claim is limited to that portion of a settlement, judgment, or award that represents payment for medical expenses, or medical care, provided on behalf of the beneficiary. All reasonable efforts shall be made to obtain the director's advance agreement to a determination as to what portion of a settlement, judgment, or award that represents payment for medical expenses, or medical care, provided of behalf on the beneficiary. Absent the director's advance agreement as to what portion of a settlement, judgment, or award represents payment for medical expenses, or medical care, provided on behalf of the beneficiary, the matter shall be submitted to a court for decision. Either the director or the beneficiary may seek

resolution of the dispute by filing a motion, which shall be subject to regular law and motion procedures. In determining what portion of a settlement, judgment, or award represents payment for medical expenses, or medical care, provided on behalf of the beneficiary and as to what the appropriate reimbursement amount to the director should be, the court shall be guided by the United States Supreme Court decision in Arkansas Department of Health and Human Services v. Ahlborn (2006) 547 U.S. 268 and other relevant statutory and case law.

(b) If the beneficiary has filed a third-party action or claim, the court where the action or claim was filed shall have jurisdiction over a dispute between the director and the beneficiary regarding the amount of a lien asserted pursuant to this section that is based upon an allocation of damages contained in a settlement or compromise of the third-party action or claim. If no third-party action or claim has been filed, any superior court in California where venue would have been proper had a claim or action been filed shall have jurisdiction over the motion. The motion may be filed as a special motion and treated as an ordinary law and motion proceeding and subject to regular motion fees. The reimbursement determination motion shall be treated as a special proceeding of a civil nature pursuant to Part 3 (commencing with Section 1063) of the Code of Civil Procedure. When no action is pending, the person making the motion shall be required to pay a first appearance fee. When an action is pending, the person making the motion shall pay a regular law and motion fee. Notwithstanding Section 1064 of the Code of Civil Procedure, either the beneficiary or the director may appeal the final findings, decision, or order.

(c) The court shall issue its findings, decision, or order, which shall be considered the final determination of the parties' rights and obligations with respect to the director's lien, unless the settlement is contingent on an acceptable allocation of the settlement proceeds, in which case, the court's findings, decision, or order shall be considered a tentative determination. If the beneficiary does not serve notice of a rejection of the tentative determination, which shall be based solely upon a rejection of the contingent settlement, within 30 days of the notice of entry of the court's tentative determination, subject to further consideration by the court pursuant to subdivision (d), the tentative determination shall become final. Notwithstanding Section 1064 of the Code of Civil Procedure, either the beneficiary or the director may appeal the final findings, decision, or order.

(d) If the beneficiary does not accept the tentative determination, which shall be based solely upon a rejection of the contingent settlement, any party may subsequently seek further consideration of the court's findings upon application to modify the prior findings, decision, or order based on new or different facts or circumstances. The application shall include an affidavit showing what application was made before, when, and to what judge, what order or decision was made, and what new or different facts or circumstances, including a different settlement, are claimed to

exist. Upon further consideration, the court may modify the allocation in the interest of fairness and for good cause.

SEC. 72. Section 14124.78 of the Welfare and Institutions Code is amended to read:

14124.78. Notwithstanding any other provision of law, in no event shall the director recover more than the beneficiary recovers after deducting, from the settlement judgment, or award, attorney's fees and litigation costs paid for by the beneficiary. If the director's recovery is determined under this section, the reductions in subdivision (d) of Section 14124.72 shall not apply.

SEC. 73. Section 14124.785 is added to the Welfare and Institutions Code, to read:

14124.785. The director's recovery is limited to the amount derived from applying Section 14124.72, 14124.76, or 14124.78, whichever is less.

SEC. 74. Section 14124.792 is added to the Welfare and Institutions Code, to read:

14124.792. If any provision of this article, or the application of any provision of this article to any person, firm, corporation, or other entity or to any circumstance or situation, shall be held invalid, the remaining provisions of this article shall not be affected thereby, and shall be given effect.

SEC. 75. Section 14124.89 of the Welfare and Institutions Code is amended to read:

14124.89. (a) Every health insurer, self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, including health care service plans as defined in subdivision (f) of Section 1345 of the Health and Safety Code, licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall, upon request of the department for any records, or any information contained in records pertaining to an individual or group health insurance policy or plan issued by such insurer or plan against, or pertaining to the medical or dental benefits paid by or claims made against such insurer or plans under a policy or plan, make the requested records or information available upon a certification by the department that the individual is an applicant for or recipient of services under this chapter or is a person who is legally responsible for such an applicant or recipient.

(b) The department shall enter into a cooperative agreement setting forth mutually agreeable procedures for requesting and furnishing appropriate information, not inconsistent with any law pertaining to the confidentiality and privacy of medical records, which procedure shall include such financial arrangements as may be necessary to reimburse insurers or plans for necessary costs incurred in furnishing requested information,

and the time and manner such procedures are to become effective. Reimbursement to insurers or plans complying with the provisions of this section shall be at the same rate of reimbursement used to reimburse the Department of Motor Vehicles for providing information to insurance carriers.

(c) The information required to be made available pursuant to this section shall be limited to information necessary to determine whether health benefits have been or should have been claimed and paid pursuant to a health insurance policy or plan with respect to items of medical care and services received by a particular individual for which Medi-Cal coverage would otherwise be available.

(d) Not later than the date upon which the procedures agreed to pursuant to subdivision (b) become effective, the director shall establish guidelines to assure that information relating to an individual certified to be an applicant for or recipient of medical assistance, furnished to any insurer or plan pursuant to this section, is used only for the purpose of identifying the records or information requested in such manner so as not to violate the confidentiality of an applicant or recipient.

(e) The department shall implement the provisions of this section by January 1, 1983.

SEC. 76. Section 14124.90 of the Welfare and Institutions Code is amended to read:

14124.90. It is the intent of the Legislature to comply with federal law requiring that when a beneficiary has third-party health coverage or insurance, the State Department of Health Services shall be the payer of last resort. In order to assess overlapping or duplicate health coverage, every health insurer, self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, including health care service plans as defined in subdivision (f) of Section 1345 of the Health and Safety Code, licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall maintain a centralized file of the subscribers', policyholders', or enrollees' names, mailing addresses, and social security numbers or date of birth, and where available, for all other covered persons, the names and social security numbers or date of birth. This information shall be made available to the State Department of Health Services upon reasonable request. Notwithstanding Section 20134 of the Government Code, the Board of Administration of the California Public Employees' Retirement System and affiliated systems or contract agencies shall permit data matches with the state department to identify Medi-Cal beneficiaries with third-party health coverage or insurance. A recipient's Medi-Cal identification card shall, where information is available, contain information advising providers of health care services of any third-party health coverage for the recipient.

Providers shall seek reimbursement from available third-party health coverage before billing the Medi-Cal program.

SEC. 77. Section 14124.94 of the Welfare and Institutions Code is amended to read:

14124.94. (a) When the rights of a Medi-Cal beneficiary to health care benefits from an insurer have been assigned to the department, an insurer shall not impose any requirement on the department that is different from any requirement applicable to an agent or any assignee of the covered beneficiary.

(b) The department, in the administration of the Medi-Cal program, may garnish the wages, salary, or other employment income of, and withhold amounts from state tax refunds from, any person to whom both of the following apply:

(1) The person is required by a court or administrative order to provide coverage of the costs of health services to a child who is eligible for medical assistance under the Medi-Cal program.

(2) The person has received payment from a third party for the costs of the health services for the child, but he or she has not used the payments to reimburse, as appropriate, either the other parent or the person having custody of the child, or the provider of the health services, to the extent necessary to reimburse the department for expenditures for those costs under the Medi-Cal program. All claims for current or past due child support shall take priority over claims made by the department for the costs of Medi-Cal services.

(c) For purposes of this section, "insurer" includes every health insurer, self-insured plan, group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, including health care service plans as defined in subdivision (f) of Section 1345 of the Health and Safety Code, licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

SEC. 78. Section 14125 of the Welfare and Institutions Code is amended to read:

14125. (a) The purpose of this article is to establish provider reimbursement rates for incontinence medical supplies covered by the Medi-Cal program. Reimbursement for incontinence medical supplies shall consist of the negotiated contract prices within each product category, plus a markup fee equal to 38 percent of the contract price.

(b) (1) In establishing the list of incontinence medical supplies, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis with manufacturers, distributors, dispensers, or suppliers of incontinence medical supplies.

(2) To ensure that the health needs of Medi-Cal beneficiaries are met, the department shall, when evaluating a decision to execute a contract,

and when evaluating incontinence medical supplies for retention on, addition to, or deletion from, the list of incontinence medical supplies, consider all of the following criteria:

(A) The safety of the product.

(B) The effectiveness of the product.

(C) The essential need for the product.

(D) The potential for misuse of the product.

(E) The immediate or long-term cost-effectiveness of the product.

(3) The deficiency of a product when measured by one of the criteria specified in paragraph (2) may be sufficient to support a decision that the product should be deleted from, should not be added to, or should not be retained on, the list of medical supplies. However, the superiority of a product under one criterion may be sufficient to warrant the addition or retention of the product, notwithstanding a deficiency in another criterion.

(4) In the evaluation of the effectiveness of a product, the department may require the manufacturer, distributor, dispenser, or supplier to submit their products to testing by an independent laboratory. For the purposes of this section, "independent laboratory" means an analytical laboratory that is not a subsidiary of, affiliated with, or on retainer for, the manufacturer, distributor, dispenser, or supplier.

(c) The department may use Healthcare Common Procedure Code System codes or Universal Product Number codes for the processing and payment of incontinence medical supplies.

SEC. 79. Section 14125.2 of the Welfare and Institutions Code is amended to read:

14125.2. (a) (1) To qualify for Medi-Cal coverage a product shall be in general retail distribution, sold to the general public, and comply with any standards for products established by law or regulation. No product that is manufactured, distributed, or otherwise promoted for the exclusive use of beneficiaries of the Medi-Cal program shall be a Medi-Cal benefit.

(2) For purposes of this section, "product" means any product which is in general retail distribution.

(3) For purposes of this subdivision, "general retail distribution" means either of the following:

(A) The product is included in a listing of approved products for purchase either by the federal or state government.

(B) The product is on display and available for purchase by customers for private payment at licensed pharmacies or licensed medical supply dealers within California which are physical locations open to the general public.

(b) In order to qualify as a Medi-Cal provider of incontinence medical supplies, a dealer shall have an established place of business that is readily identifiable as a medical supply business, be open to the general public at regularly established business hours, have incontinence supplies in stock on the premises or in a warehouse under the provider's direct control, and meet all local laws and ordinances regarding business licensing and operations. The department shall establish additional rules and regulations

for participation in the Medi-Cal program as it deems necessary to ensure adequate safeguards to the integrity of the Medi-Cal program.

SEC. 80. Section 14125.8 of the Welfare and Institutions Code is amended to read:

14125.8. (a) In order to more fully identify the owner or owners of companies or corporations that apply to be or currently are providers of incontinence medical supplies, within 30 days of the receipt of a request from the department, or a request to the department from the Department of Justice, the applicant or provider shall provide, as part of the application process or as a condition of continued participation in the Medi-Cal program, the following:

(1) The name of the corporation, the official titles of the applicants, and a list of all the corporate officers.

(2) The California driver's license or California identification card number of the applicants, coowners, corporate officers, and financially interested parties.

(3) The applicant's business permit control number, issued by the State Board of Equalization, for the business location where services are rendered to the public.

(4) A statement of all current sources of capital, identity of all investors, disclosure of all manufacturers, suppliers, and providers currently doing business with the applicant, and disclosure of all entities to whom the applicant has extended a line of credit.

(5) A statement certifying that all information supplied pursuant to this section is accurate.

(b) A Medi-Cal provider of incontinence supplies shall not submit a claim for goods or services to the department prior to the date the goods or services are delivered to the Medi-Cal beneficiary. The date of delivery to a beneficiary shall be the earlier of the date the beneficiary actually received the goods or services, or the date the goods were posted or otherwise dispatched from the provider's premises and control. A claim submitted to the department prior to the date of delivery shall not be paid. Violation of this subdivision shall be grounds for expulsion from the Medi-Cal program.

(c) The department may implement a 180-day moratorium on the enrollment of new providers or new business addresses for incontinence medical supply dealers when the department determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program.

SEC. 81. Section 14126.027 of the Welfare and Institutions Code is amended to read:

14126.027. (a) (1) The Director of Health Services, or his or her designee, shall administer this article.

(2) The regulations and other similar instructions adopted pursuant to this article shall be developed in consultation with representatives of the long-term care industry, organized labor, seniors, and consumers.

(b) (1) The director may adopt regulations as are necessary to implement this article. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe specific facts showing the need for immediate action.

(2) The regulations adopted pursuant to this section may include, but need not be limited to, any regulations necessary for any of the following purposes:

(A) The administration of this article, including the specific analytical process for the proper determination of long-term care rates.

(B) The development of any forms necessary to obtain required cost data and other information from facilities subject to the ratesetting methodology.

(C) To provide details, definitions, formulas, and other requirements.

(c) As an alternative to the adoption of regulations pursuant to subdivision (b), and notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this article, in whole or in part, by means of a provider bulletin or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, 2008. It is the intent that regulations adopted pursuant to subdivision (b) shall be in place on or before July 31, 2008.

SEC. 82. Section 14126.033 of the Welfare and Institutions Code is amended to read:

14126.033. (a) This article, including Section 14126.031, shall be funded as follows:

(1) General Fund moneys appropriated for purposes of this article pursuant to Section 6 of the act adding this section shall be used for increasing rates, except as provided in Section 14126.031, for freestanding skilled nursing facilities, and shall be consistent with the approved methodology required to be submitted to the Centers for Medicare and Medicaid Services pursuant to Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code.

(2) (A) Notwithstanding Section 14126.023, for the 2005–06 rate year, the maximum annual increase in the weighted average Medi-Cal rate required for purposes of this article shall not exceed 8 percent of the weighted average Medi-Cal reimbursement rate for the 2004–05 rate year as adjusted for the change in the cost to the facility to comply with the nursing facility quality assurance fee for the 2005–06 rate year, as required under subdivision (b) of Section 1324.21 of the Health and Safety Code, plus the total projected Medi-Cal cost to the facility of complying with new state or federal mandates.

(B) Beginning with the 2006–07 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for pur-

poses of this article shall not exceed 5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

(C) Beginning with the 2007–08 rate year and continuing through the 2008–09 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not exceed 5.5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

(D) To the extent that new rates are projected to exceed the adjusted limits calculated pursuant to subparagraph (A) or (B), the department shall adjust the increase to each skilled nursing facility's projected rate for the applicable rate year by an equal percentage.

(b) The rate methodology shall cease to be implemented on and after July 31, 2009.

(c) (1) It is the intent of the Legislature that the implementation of this article result in individual access to appropriate long-term care services, quality resident care, decent wages and benefits for nursing home workers, a stable workforce, provider compliance with all applicable state and federal requirements, and administrative efficiency.

(2) Not later than December 1, 2006, the Bureau of State Audits shall conduct an accountability evaluation of the department's progress toward implementing a facility-specific reimbursement system, including a review of data to ensure that the new system is appropriately reimbursing facilities within specified cost categories and a review of the fiscal impact of the new system on the General Fund.

(3) Not later than January 1, 2007, to the extent information is available for the three years immediately preceding the implementation of this article, the department shall provide baseline information in a report to the Legislature on all of the following:

(A) The number and percent of freestanding skilled nursing facilities that complied with minimum staffing requirements.

(B) The staffing levels prior to the implementation of this article.

(C) The staffing retention rates prior to the implementation of this article.

(D) The numbers and percentage of freestanding skilled nursing facilities with findings of immediate jeopardy, substandard quality of care, or actual harm, as determined by the certification survey of each freestanding skilled nursing facility conducted prior to the implementation of this article.

(E) The number of freestanding skilled nursing facilities that received state citations and the number and class of citations issued during calendar year 2004.

(F) The average wage and benefits for employees prior to the implementation of this article.

(4) Not later than January 1, 2009, the department shall provide a report to the Legislature that does both of the following:

(A) Compares the information required in paragraph (2) to that same information two years after the implementation of this article.

(B) Reports on the extent to which residents who had expressed a preference to return to the community, as provided in Section 1418.81 of the Health and Safety Code, were able to return to the community.

(5) The department may contract for the reports required under this subdivision.

(d) This section shall become inoperative on July 31, 2009, and as of January 1, 2010, is repealed, unless a later enacted statute, that is enacted before January 1, 2010, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 83. Section 14132.100 of the Welfare and Institutions Code is amended to read:

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d (a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accord with the definition of "visit" set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1, thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accord with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(F) Any changes in any of the services described in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites.

(G) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in subdivisions (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

(I) Any changes in the scope of a project approved by the federal Health Resources and Service Administration (HRSA).

(3) No change in costs shall, in and of itself, be considered a scope-of-service change unless all of the following apply:

(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of services defined in subdivisions (a) and (b), as applicable.

(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section 413) of Subchapter B of Chapter 4 of Title 42 of the Code of Federal Regulations, or its successor.

(C) The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75 percent threshold shall be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

(4) An FQHC or RHC may submit requests for scope-of-service changes once per fiscal year, only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(5) An FQHC or RHC shall submit a scope-of-service rate change request within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit

rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a scope-of-service rate change request within 90 days of the beginning of the following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change shall be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to "fiscal year" shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision (*l*). These supplemental payments shall be determined separately from the scope-of-service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include all of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant (two hundred thousand dollars ($200,000) or 1 percent of a facility's total costs, whichever is less).

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this section, "physician" shall be interpreted in a manner consistent with the Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a medical doctor, osteopath, podiatrist, dentist, optometrist, and chiropractor. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal services practitioner, as defined in Section 51179.1 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a four-hour day of attendance at an adult day health care center, and any other provider identified in the state plan's definition of an FQHC or RHC visit.

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity (as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code), the Medicare program, or the Child Health and Disability Prevention (CHDP) program, the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) An entity that first qualifies as an FQHC or RHC in the year 2001 or later, a newly licensed facility at a new location added to an existing FQHC or RHC, and any entity that is an existing FQHC or RHC that is relocated to a new site shall each have its reimbursement rate established in accordance with one of the following methods, as selected by the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that

is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(2) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously submitted an annual utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs.

(3) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis until it is informed of its enrollment as an FQHC or RHC, and the department shall reconcile the difference between the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

(j) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, or in a mobile unit as defined by paragraph (2) of subdivision (b) of Section 1765.105 of the Health and Safety Code, shall be billed by and reimbursed at the same rate as the FQHC or RHC establish-

ing the intermittent clinic site or the mobile unit, subject to the right of the FQHC or RHC to request a scope-of-service adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes. An FQHC or RHC that reverses its election under this subdivision shall revert to its prior rate, subject to an increase to account for all MEI increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable scope-of-services adjustments as provided in subdivision (e).

(*l*) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, scope-of-service changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under all other provisions of law of this state.

(m) The department shall, by no later than March 30, 2004, promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

(n) The department shall implement this section only to the extent that federal financial participation is obtained.

SEC. 84. Section 14134.5 of the Welfare and Institutions Code is amended to read:

14134.5. All of the following provisions apply to the provision of services pursuant to subdivision (u) of Section 14132:

(a) "Comprehensive perinatal provider" means any general practice physician, family practice physician, obstetrician-gynecologist, pediatrician, certified nurse midwife, a group, any of whose members is one of the above-named physicians, or any preferred provider organization or clinic enrolled in the Medi-Cal program and certified pursuant to the standards of this section.

(b) "Perinatal" means the period from the establishment of pregnancy to one month following delivery.

(c) "Comprehensive perinatal services" shall include, but not be limited to, the provision of the combination of services developed through the Department of Health Services Obstetrical Access Pilot Program.

(d) The comprehensive perinatal provider shall schedule visits with appropriate providers and shall track the patient to verify whether services have been received. As part of the reimbursement for coordinating these services, the comprehensive perinatal provider shall ensure the provision of the following services either through the provider's own service or through subcontracts or referrals to other providers:

(1) A psychosocial assessment and when appropriate referrals to counseling.

(2) Nutrition assessments and when appropriate referral to counseling on food supplement programs, vitamins and breast-feeding.

(3) Health, childbirth, and parenting education.

(e) Except where existing law prohibits the employment of physicians, a health care provider may employ or contract with all of the following medical and other practitioners for the purpose of providing the comprehensive services delineated in this section:

(1) Physicians, including a general practitioner, a family practice physician, a pediatrician, or an obstetrician-gynecologist.

(2) Certified nurse midwives.

(3) Nurses.

(4) Nurse practitioners.

(5) Physician assistants.

(6) Social workers.

(7) Health and childbirth educators.

(8) Registered dietitians.

The department shall adopt regulations which define the qualifications of any of these practitioners who are not currently included under the regulations adopted pursuant to this chapter. Providers shall, as feasible, utilize staffing patterns which reflect the linguistic and cultural features of the populations they serve.

(f) The California Medical Assistance Program and the Maternal and Child Health Branch of the State Department of Health Services in consultation with the California Conference of Local Health Officers shall establish standards for health care providers and for services rendered pursuant to this subdivision.

(g) The department shall assist local health departments to establish a community perinatal program whose responsibilities may include certifying and monitoring providers of comprehensive perinatal services. The department shall provide the local health departments with technical assistance for the purpose of implementing the community perinatal program. The department shall, to the extent feasible, and to the extent funding for administrative costs is available, utilize local health departments in the administration of the perinatal program. If these funds are not available, the department shall use alternative means to implement the community perinatal program.

(h) It is the intent of the Legislature that the department shall establish a method for reimbursement of comprehensive perinatal providers which shall include a fee for coordinating services and which shall be sufficient to cover reasonable costs for the provision of comprehensive perinatal services. The department may utilize fees for service, capitated fees, or global fees to reimburse providers. However, if capitated or global fees are established, the department shall set minimum standards for the provision of services including, but not limited to, the number of prenatal visits and the amount and type of psychosocial, nutritional, and educational services patients shall receive.

Notwithstanding the type of reimbursement system, the comprehensive perinatal provider shall not be financially at risk for the provision of inpatient services. The provision of inpatient services which are not related to perinatal care shall not be subject to the provisions of this section. Inpatient services related to services pursuant to this subdivision shall be reimbursed, in accordance with Section 14081, 14086, 14087, or 14087.2, whichever is applicable.

(i) The department shall develop systems for monitoring and oversight of the comprehensive perinatal services provided in this section. The monitoring shall include, but shall not be limited to, collection of information using the perinatal data form.

(j) Participation for services provided pursuant to this section shall be voluntary. The department shall adopt patient rights safeguards for recipients of the comprehensive perinatal services.

SEC. 86. Section 14166.4 of the Welfare and Institutions Code is amended to read:

14166.4. (a) Notwithstanding Article 2.6 (commencing with Section 14081), and any other provision of law, fee-for-service payments to the designated public hospitals for inpatient services to Medi-Cal beneficiaries shall be governed by this section. Each of the designated public hospitals shall receive as payment for inpatient hospital services provided to Medi-Cal beneficiaries during any project year, the hospital's allowable costs incurred in providing those services, multiplied by the federal medical assistance percentage. These costs shall be determined, certified, and claimed in accordance with Sections 14166.8 and 14166.9. All Medicaid federal financial participation received by the state for the certified public expenditures of the hospital, or the governmental entity with which the hospital is affiliated, for inpatient hospital services rendered to Medi-Cal beneficiaries shall be paid to the hospital.

(b) With respect to each project year, each of the designated public hospitals shall receive an interim payment for each day of inpatient hospital services rendered to Medi-Cal beneficiaries based upon claims filed by the hospital in accordance with the claiming process set forth in Division 3 (commencing with Section 50000) of Title 22 of the California Code of Regulations. The interim per diem payment amount shall be based on estimated costs, which shall be derived from statistical data from the following sources and which shall be multiplied by the federal medical assistance percentage:

(1) For allowable costs reflected in the Medicare cost report, the cost report most recently audited by the hospital's Medicare fiscal intermediary adjusted by a trend factor to reflect increased costs, as approved by the federal Centers for Medicare and Medicaid Services for the demonstration project.

(2) For allowable costs not reflected in the Medicare cost report, each hospital shall provide hospital-specific cost data requested by the department. The department shall adjust the data by a trend factor as necessary to reflect project year allowable costs.

(c) Until the department commences making payments pursuant to subdivision (b), the department may continue to make fee-for-service, per diem payments to the designated public hospitals, pursuant to the selective provider contracting program in accordance with Article 2.6 (commencing with Section 14081), for services rendered on and after July 1, 2005, for a period of 120 days following the award of this demonstration. Per diem payments shall be adjusted retroactively to the amounts determined under the payment methodology prescribed in this article.

(d) No later than April 1 following the end of the project year, the department shall undertake an interim reconciliation of payments made pursuant to subdivisions (a) to (c), inclusive, based on Medicare and other cost and statistical data submitted by the hospital for the project year and shall adjust payments to the hospital accordingly.

(e) (1) The designated public hospitals shall receive supplemental reimbursement for the costs incurred for physician and nonphysician practitioner services provided to Medi-Cal beneficiaries who are patients of the hospital, to the extent that those services are not claimed as inpatient hospital services by the hospital and the costs of those services are not otherwise recognized under subdivision (a).

(2) Expenditures made by the designated public hospital, or a governmental entity with which it is affiliated, for the services identified in paragraph (1) shall be reduced by any payments received pursuant to Article 7 (commencing with Section 51501) of Title 22 of the California Code of Regulations. The remainder shall be certified by the appropriate public official and claimed by the department in accordance with Sections 14166.8 and 14166.9. These expenditures may include any of the following:

(A) Compensation to physicians or nonphysician practitioners pursuant to contracts with the designated public hospital.

(B) Salaries and related costs for employed physicians and nonphysician practitioners.

(C) The costs of interns, residents, and related teaching physician and supervision costs.

(D) Administrative costs associated with the services described in subparagraphs (A) to (C), inclusive, including billing costs.

(3) Designated public hospitals shall receive federal funding based on the expenditures identified and certified in paragraph (2). All federal financial participation received by the department for the certified public expenditures identified in paragraph (2) shall be paid to the designated public hospital, or a governmental entity with which it is affiliated.

(4) To the extent that the supplemental reimbursement received under this subdivision relates to services provided to hospital inpatients, the reimbursement shall be applied in determining whether the designated public hospital has received full baseline payments for purposes of paragraph (1) of subdivision (b) of Section 14166.21.

(5) Supplemental reimbursement under this subdivision may be distributed as part of the interim payments under subdivision (b), on a per-visit basis, on a per-procedure basis, or on any other federally permissible basis.

(6) The department shall submit for federal approval, by September 30, 2005, a proposed amendment to the Medi-Cal state plan to implement this subdivision, retroactive to July 1, 2005, to the extent permitted by the federal Centers for Medicare and Medicaid Services. If necessary to obtain federal approval, the department may limit the application of this subdivision to costs determined allowable by the federal Centers for Medicare and Medicaid Services. If federal approval is not obtained, this subdivision shall not be implemented.

SEC. 87. Section 14199.2 of the Welfare and Institutions Code is amended to read:

14199.2. (a) The pilot program provided for under this article shall provide the necessary information to assess the effectiveness of pharmacist care in improving health outcomes for HIV/AIDS patients. If the department determines that the pilot program has shown that HIV/AIDS-related medication therapy management service is effective at improving the health outcomes of HIV/AIDS patients and is cost effective, then the department may seek federal authorization, through a state plan amendment or Medicaid waiver application, to receive federal financial participation for this service.

(b) The department shall implement an HIV/AIDS-related medication therapy management service pilot project in no more than 10 pharmacies.

(c) The selection of the pharmacy providers shall be based on all of the following:

(1) Percentage of HIV/AIDS patients serviced by the pharmacy. More than 90 percent of the total patients serviced by the pharmacy in the months of May, June, and July 2004, must have been HIV/AIDS patients.

(2) Ability of the pharmacy to immediately provide specialized services. The provider shall be required to establish specialized services with capability to implement all statutorily mandated services on the implementation date of the project. The pharmacy shall provide all the services listed in subdivision (e).

(3) All specialized services shall be rendered by a qualified pharmacist or other health care provider operating within his or her scope of practice. The department shall develop, in consultation with pharmacy providers, the appropriate professional qualifications needed by the pharmacists rendering services, including any continuing education requirements.

(d) The department shall select the first pharmacies that apply and meet the criteria specified in subdivision (c) for the pilot program.

(e) Pharmacies that participate in this pilot program shall provide the following services:

(1) Patient-specific and individualized services provided directly by a pharmacist to the patient, or in limited circumstances, the patient's caregiver. These services are distinct from generalized patient education and

information activities already required by law and provided for in the professional fee for dispensing.

(2) Face-to-face interaction between the patient or caregiver and the pharmacist during delivery of medication therapy management services. When barriers to face-to-face communication exist, patients shall have equitable access to appropriate alternative delivery methods.

(3) Pharmacists and other qualified health care providers to identify patients who should receive medication therapy management services.

(f) The department shall consult with the pilot program pharmacies to establish appropriate outcome measures and the required timeframes for reporting those measures, which in no case shall be less than annually. The department shall retain the ability to require additional outcome measures during the course of the project.

(g) The medication therapy management services shall be based on the individual patient's needs and may include, but are not limited to, the following:

(1) Performing or obtaining necessary assessments of the patient's health status.

(2) Formulating a medication treatment plan.

(3) Selecting, initiating, modifying, or administering medication therapy.

(4) Monitoring and evaluating the patient's response to therapy, including safety and effectiveness.

(5) Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events.

(6) Documenting the care delivered and communicating essential information to the patient's other primary care providers.

(7) Providing verbal education and training, beyond what is already required by law, that is designed to enhance patient understanding and appropriate use of the patient's medications.

(8) Providing information, support services, and resources, such as compliance packaging, designed to enhance patient adherence to his or her therapeutic regimens.

(9) Coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

(10) Home delivery of medications.

(h) Participants in this pilot program shall be paid an additional dispensing fee of nine dollars and fifty cents ($9.50) per prescription for services rendered after September 1, 2004.

(i) Notwithstanding any other provision of law, the department shall not make any payments for services listed in subdivision (g) that were rendered during any time period in which subdivision (b) of Section 14105.45 has been enjoined by a court order or is otherwise not in effect.

(j) Pilot project contracts under this section may be executed on a noncompetitive bid basis and shall be exempt from the requirements of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(k) Pharmacies shall maintain a sufficient quantity of HIV/AIDS medication in their inventories.

(*l*) Pharmacies shall purchase HIV medications from state licensed wholesalers.

SEC. 88. Section 14199.3 of the Welfare and Institutions Code is amended to read:

14199.3. This article shall remain in effect only until June 30, 2008, and as of that date is repealed, unless a later enacted statute that becomes effective on or before June 30, 2008, deletes or extends that date.

SEC. 89. Section 14262 of the Welfare and Institutions Code is amended to read:

14262. (a) "Actuarial methods" mean any reasonable and adequate method of computing or determining prospective per capita rates of payment which is based upon various assumptions, including "experience data," to determine the expected cost and expected frequency of utilization (by aid category, age and sex) for each component or grouping of services and other requirements for which the rate or rates will serve as compensation or reimbursement. Initially, expected cost and utilization information shall be developed from recent experience data and then projected over the period for which the per capita rates are to be effective. Such a projection shall be adjusted to take into consideration various actuarial factors, including inflation and requirements, if any, which exceed the program or basis from which the experience data is derived.

(b) "Experience data" mean cost and utilization data from the Medi-Cal fee-for-service or prepaid health plan programs. Such data shall be sufficient in quantity and extent to provide credibility.

(c) "Actuarial equivalence" means the actual per capita costs for Medi-Cal beneficiaries adjusted by age, sex, aid category, and other appropriate factors so as to be comparable with the costs of prepaid health plan enrollees.

(d) "Actuary" or "consulting actuary" means a person who has engaged in the practice of actuarial science and has demonstrated, by training and experience, actuarial competence to the director.

(e) This section shall become inoperative on August 1, 2007, and as of January 1, 2008, is repealed.

SEC. 90. Section 14301.1 is added to the Welfare and Institutions Code, to read:

14301.1. (a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health plan and county specific rates. The department shall utilize a county and model specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

(1) Health plan specific encounter and claims data.

(2) Supplemental utilization and cost data submitted by the health plans.

(3) Fee-for-service data for the underlying county of operation or other appropriate counties as deemed necessary by the department.

(4) Department of Managed Health Care financial statement data specific to Medi-Cal operations.

(5) Other demographic factors, such as age, gender, or diagnostic-based risk adjustments, as the department deems appropriate.

(b) To the extent that the department is unable to obtain sufficient actual plan data, it may substitute plan model, similar plan, or county specific fee-for-service data.

(c) The department shall develop rates that include administrative costs, and may apply different administrative costs with respect to separate aid code groups.

(d) The department shall develop rates that shall include, but are not limited to, assumptions for underwriting, return on investment, risk, contingencies, changes in policy, and a detailed review of health plan financial statements to validate and reconcile costs for use in developing rates.

(e) The department may develop rates that pay plans based on performance incentives, including quality indicators, access to care, and data submission.

(f) The department may develop and adopt condition-specific payment rates for health conditions, including, but not limited to, childbirth delivery.

(g) Prior to finalizing Medi-Cal managed care capitation rates, the department shall provide health plans with information on how the rates were developed, including rate sheets for that specific health plan, and provide the plans with the opportunity to provide additional supplemental information.

(h) For the purposes of developing capitation rates through implementation of this ratesetting methodology, Medi-Cal managed care health plans shall provide the department with financial and utilization data in a form and substance as deemed necessary by the department to establish rates. This data shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act.

(i) The department shall report, upon request, to the fiscal and policy committees of the respective houses of the Legislature regarding implementation of this section.

SEC. 91. Section 14464.5 of the Welfare and Institutions Code is amended to read:

14464.5. (a) For purposes of this article, the following definitions apply:

(1) “Capitation payment” means the monthly amount paid by the state to a designated Medi-Cal managed care plan in exchange for contracted

health care services procured by means of the Medi-Cal managed care contracts described in paragraph (3).

(2) "Capitation rate" means the per member per month rate used to calculate the capitation payments.

(3) "Medi-Cal managed care plan" means any Medi-Cal managed care plan contracting with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.9 (commencing with Section 14088), Article 2.91 (commencing with Section 14089), and Section 14087.51 of Chapter 7, or pursuant to this chapter, and that is also an organization that meets the criteria in Section 1396b(w)(7)(A)(viii) of Title 42 of the United States Code.

(4) "Total operating revenue" means non-Medicare amounts received by a managed care plan for the coverage or providing of all health care services, including amounts received in exchange for health care procured by means of a Medi-Cal managed care contract as described in paragraph (3). Total operating revenue does not include amounts received by a managed care plan pursuant to a subcontract with a Medi-Cal managed care plan to provide health care services to Medi-Cal beneficiaries.

(b) The department shall impose, on an annual basis, a quality improvement fee no earlier than January 1, 2005. The quality improvement fee shall be paid to the state monthly and shall be up to 6 percent of each Medi-Cal managed care plan's total operating revenue. The quality improvement fee shall be subject to all of the following provisions:

(1) The quality improvement fee shall be paid monthly to the state and is due within 15 calendar days following the close of each month and shall be calculated on the prior month's total operating revenue as defined in paragraph (4) of subdivision (a).

(2) The quality improvement fee shall be deposited in the General Fund.

(3) If the Medi-Cal managed care plan does not timely pay the quality improvement fee, or any part thereof, the department may offset the amount of the fee that is unpaid against any amounts due from the state to the Medi-Cal managed care plan. Notwithstanding any such offset, the methodology for determining the fee as set forth in this subdivision shall be followed.

(4) The department shall make retrospective adjustments as necessary to the amounts calculated pursuant to this subdivision in order to assure that the Medi-Cal managed care plan's aggregate quality improvement fee for any particular state fiscal year does not exceed 6 percent of the total operating revenue for the Medi-Cal managed care plan for that year.

(5) If, on account of delay in the adoption of the annual Budget Act, or for any other reason, a Medi-Cal managed care plan is not paid by the department for a period in excess of 30 days, the payment date for the fee specified in paragraph (1) shall be extended until 45 days following the date that regular payments are resumed to the plans.

(6) On or before August 31 of each year, each Medi-Cal managed care plan subject to the quality improvement fee shall report to the department,

in a prescribed form, the plan's total operating revenue as defined in paragraph (4) of subdivision (a) for the preceding state fiscal year.

(7) Any fee imposed pursuant to this section shall not be considered to be an administrative cost for purposes of Section 1378 of the Health and Safety Code, Section 14087.101, 14087.103, or 14087.105, or any regulation adopted pursuant to those sections.

(c) (1) The department shall implement this section in a manner that complies with federal requirements. If the department is unable to comply with the federal requirements for federal matching funds under this section, the quality improvement fee shall not be assessed or collected.

(2) The director may alter the methodology specified in this section for calculating the quality improvement fee to the extent necessary to meet the requirement of federal law or regulations.

(3) If, after implementation of this section, federal disapproval of the quality improvement fee program as described in this section occurs, any fees paid by the plans to the department in any period for which such disapproval is effective shall be refunded to the plans.

(d) In addition to the Medi-Cal capitation rates that a Medi-Cal managed care plan would otherwise receive for providing services to Medical beneficiaries, the capitation rates shall be increased in an amount determined by the department, subject to the following requirements:

(1) The additional Medi-Cal reimbursement provided by this section shall be distributed under a capitation payment methodology or on any other federally permissible basis.

(2) The additional Medi-Cal reimbursement provided by this section shall not supplant the payments otherwise due to any Medi-Cal managed care plan in the absence of such an additional reimbursement.

(3) Additional reimbursement provided by this section to any particular Medi-Cal managed care plan shall not cause the total reimbursement paid to that plan to exceed any applicable limit on payments as established pursuant to federal law and regulations.

(e) The director, or his or her designee, shall administer this section.

(f) The director may adopt regulations as are necessary to implement this section. These regulations shall be adopted as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). For purposes of this section, 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. The regulations shall include, but not be limited to, any regulations necessary for either of the following purposes:

(1) The administration of this section, including the proper imposition and collection of the quality improvement fees.

(2) The development of any forms necessary to calculate, notify, collect, and distribute the quality improvement fees.

(g) As an alternative to subdivision (f), and notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2

of the Government Code, the director may implement this section by means of a provider bulletin, contract amendment, policy letter, or other similar instructions, without taking regulatory action.

(h) To the extent permitted by federal law, any limitation on rates to the Medi-Cal managed care plan based on Medi-Cal fee-for-service costs shall be increased to include any capitation rate increase related to the quality improvement fee in subdivision (b).

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

SEC. 92. Section 14495.10 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 93. Section 14499.5 of the Welfare and Institutions Code is amended to read:

14499.5. (a) (1) In carrying out the intent of this article, the director shall contract for the operation of one local pilot program. Special consideration shall be given to approving a program contracted through county government in Santa Barbara County.

(2) Notwithstanding the limitations contained in Section 14490, the director may enter into, or extend, contracts with the local pilot program in Santa Barbara County pursuant to paragraph (1) for periods that do not exceed three years.

(b) The establishment of a pilot program pursuant to this section shall be contingent upon the availability of state and federal funding. The program shall include the following components:

(1) Local authority for administration, fiscal management, and delivery of services, but not including eligibility determination.

(2) Physician case management.

(3) Cost containment through provider incentives and other means.

(c) The program for the pilot project shall include a plan and budget for delivery of services, administration, and evaluation. During the first year of the pilot program, the amount of the state contract shall equal 95 percent of total projected Medi-Cal expenditures for delivery of services and for administration based on fee-for-service conditions in the program county. During the remaining years of the pilot project Medi-Cal expenditures in the program county shall be no more than 100 percent of total projected expenditures for delivery of services and for administration based on any combination of the following paragraphs:

(1) Relevant prior fee-for-service Medi-Cal experience in the program county.

(2) The fee-for-service Medi-Cal experience in comparable counties or groups of counties.

(3) Medi-Cal experience of the pilot project in the program county if, as determined by the department, the scope, level, and duration of, and expenditures for, any services used in setting the rates under this paragraph would be comparable to fee-for-service conditions were they to exist in the program county and would be more actuarially reliable for use in ratesetting than data available for use in applying paragraph (1) or (2).

The projected total expenditure shall be determined annually according to an acceptable actuarial process. The data elements used by the department shall be shared with the proposed contractor.

(d) The director shall accept or reject the proposal within 30 days after the date of receipt. If a decision is made to reject the proposal, the director shall set forth the reasons for this decision in writing. Upon approval of the proposal, a contract shall be written within 60 days. After signature by the local contractor, the State Department of Health Care Services and the Department of General Services shall execute the contract within 60 days.

(e) The director shall seek the necessary state and federal waivers to enable operation of the program. If the federal waivers for delivery of services under this plan are not granted, the department is under no obligation to contract for implementation of the program.

(f) For purposes of Section 1343 of the Health and Safety Code, the Santa Barbara Regional Health Authority shall be considered to be a county-operated pilot program contracting with the State Department of Health Care Services pursuant to this article, and notwithstanding any other provision of law, during the period that this contract is in effect, the contractor shall be exempt from the provisions of the Knox-Keene Health Care Service Plan Act of 1975, Chapter 2.2 (commencing with Section

1340) of Division 2 of the Health and Safety Code, relative to the services provided to Medi-Cal beneficiaries under the terms and provisions of the pilot program.

(g) Dental services may be included within the services provided in this pilot program.

(h) Any federal demonstration funding for this pilot program shall be made available to the county within 60 days upon notification of the award without the state retaining any portion not previously specified in the grant application as submitted.

(i) (1) (A) The department may negotiate exclusive contracts and rates with the Santa Barbara Regional Health Authority in the implementation of this section.

(B) Contracts entered into under this article may be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(C) The department shall enter into contracts pursuant to this article, and shall be bound by the terms and conditions related to the rates negotiated by the negotiator.

(2) The department shall implement this subdivision to the extent that the following apply:

(A) Its implementation does not revise the status of the pilot program as a federal demonstration project.

(B) Existing federal waivers apply to the pilot program as revised by this subdivision, or the federal government extends the applicability of the existing federal waivers or authorizes additional federal waivers for the implementation of the program.

(3) The implementation of this subdivision shall not affect the pilot program's having met any of the requirements of Part 3.5 (commencing with Section 1175) of Division 1 of the Health and Safety Code and this division applicable to the pilot program with respect to the negotiations of contracts and rates by the department.

SEC. 94. Section 16809 of the Welfare and Institutions Code 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 governing board shall have responsibilities for specified health services to county residents certified eligible for those services by the county.

(2) The board of supervisors of a county that has contracted with the governing board pursuant to paragraph (1) may also contract with the governing board for the delivery of health care and health-related services to county residents other than under the County Medical Services Program by adopting a resolution to that effect. The governing board shall have responsibilities for the delivery of specified health services to county

residents as agreed upon by the governing board and the county. Participation by a county pursuant to this paragraph shall be voluntary, and funds shall be provided solely by the county.

(b) The governing board may contract with the department or any other person or entity to administer the County Medical Services Program.

(1) If the 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 as determined by the governing board.

(B) Provisions for payment of expenses of the 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.

(E) Provisions for the department to administer the County Medical Services Program pursuant to regulations adopted by the governing board or as otherwise determined by the governing board.

(F) Provisions requiring that the governing board reimburse the state costs of providing administrative support to the County Medical Services Program in accordance with amounts determined between the governing board and the department.

(2) If the governing board does not contract with the department for administration of the County Medical Services Program, the governing board may contract with the department for specified services to assist in the administration of that program. Any contract with the department under this paragraph shall require that the governing board reimburse the state costs of providing administrative support.

(3) The department shall not be liable for any costs related to decisions of the governing board that are in excess of those set forth in the contract between the department and the governing board.

(c) Each county intending to participate in the County Medical Services Program pursuant to this section shall submit to the governing board 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.

(d) A county participating in the County Medical Services Program pursuant to this section, or a county contracting with the governing board pursuant to paragraph (2) or (3) of subdivision (a), or participating in a pilot project or contracting with the governing board for an alternative product pursuant to Section 16809.4, shall not be relieved of its indigent health care obligation under Section 17000.

(e) (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 (n).

(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, unless otherwise determined by the governing board.

(f) Moneys in the program account shall be used by the governing board, or by the department if the department contracts with the governing board for this purpose, to pay for health care services provided to the persons meeting the eligibility criteria established pursuant to subdivision (j) and to pay the governing board expenses and program administrative costs. In addition, moneys in this account may be used to reimburse the department for state costs pursuant to subparagraph (F) of paragraph (1) of subdivision (b).

(g) (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, notwithstanding Section 16305.7 of the Government Code.

(B) All interest deposited pursuant to subparagraph (A) shall be available to reimburse program-covered services, governing board expenses, and program administrative costs.

(h) The governing board shall establish a reserve account for the purpose of depositing funds for the payment of claims and unexpected contingencies. Funds in the reserve account in excess of the amounts the governing board determines necessary for these purposes shall be available for expenditures in years when program expenditures exceed program funds, and to augment the rates, benefits, or eligibility criteria under the program.

(i) (1) Counties shall pay participation fees as established by the 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 governing board.

(3) Payments made pursuant to this subdivision shall be deposited in the program account, unless otherwise directed by the governing board.

(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) 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, 2006–07, and 2007–08 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, 2006–07, and 2007–08 fiscal years.

(B) For the 1999–2000, 2000–01, 2001–02, 2002–03, 2003–04, 2004–05, 2005–06, 2006–07, and 2007–08 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, 2006–07, and 2007–08 fiscal years.

(C) (i) The governing board shall establish uniform eligibility criteria and benefits among all counties participating in the County Medical Services Program listed in paragraph (2). For counties that are not listed in paragraph (2) and that elect to participate pursuant to paragraph (1) of subdivision (a), the eligibility criteria and benefit structure may vary from those of counties participating pursuant to paragraph (2) of subdivision (a).

(ii) Notwithstanding clause (i), the governing board may establish and maintain pilot projects to identify or test alternative approaches for determining eligibility or for providing or paying for benefits under the County Medical Services Program, and may develop and implement alternative products with varying levels of eligibility criteria and benefits outside of the County Medical Services Program.

(2) For the 1991–92 fiscal year, and each year thereafter, 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
Lake	1,022,963
Lassen	687,113
Madera	2,882,147
Marin	7,725,909
Mariposa	435,062
Mendocino	1,654,999
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 subparagraph (A) plus the amount determined pursuant to subparagraph (B), minus the amount specified by the governing board as participation fees.

(A)

Jurisdiction	Amount
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 governing board before a county is permitted to participate in the County Medical Services Program.

(4) The specific amounts and method of apportioning risk to each participating county may be adjusted by the 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 may be pursued.

(n) 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.

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

SEC. 95. Section 24005 of the Welfare and Institutions Code is amended to read:

24005. (a) This section shall apply to the Family Planning Access Care and Treatment Waiver program identified in subdivision (aa) of Section 14132 and this program.

(b) Only licensed medical personnel with family planning skills, knowledge, and competency may provide the full range of family planning medical services covered in this program.

(c) Medi-Cal enrolled providers, as determined by the department, shall be eligible to provide family planning services under the program when these services are within their scope of practice and licensure. Those clinical providers electing to participate in the program and approved by the department shall provide the full scope of family planning education, counseling, and medical services specified for the program, either directly or by referral, consistent with standards of care issued by the department.

(d) The department shall require providers to enter into clinical agreements with the department to ensure compliance with standards and requirements to maintain the fiscal integrity of the program. Provider applicants, providers, and persons with an ownership or control interest, as defined in federal medicaid regulations, shall be required to submit to the department their social security numbers to the full extent allowed under federal law. All state and federal statutes and regulations pertaining to the audit or examination of Medi-Cal providers shall apply to this program.

(e) Clinical provider agreements shall be signed by the provider under penalty of perjury. The department may screen applicants at the initial application and at any reapplication pursuant to requirements developed by the department to determine provider suitability for the program.

(f) The department may complete a background check on clinical provider applicants for the purpose of verifying the accuracy of information provided to the department for purposes of enrolling in the program and in order to prevent fraud and abuse. The background check may include, but not be limited to, unannounced onsite inspection prior to enrollment, review of business records, and data searches. If discrepancies are found to exist during the preenrollment period, the department may conduct additional inspections prior to enrollment. Failure to remediate significant discrepancies as prescribed by the director may result in denial of the application for enrollment. Providers that do not provide services consistent with the standards of care or that do not comply with the department's rules related to the fiscal integrity of the program may be disenrolled as a provider from the program at the sole discretion of the department.

(g) The department shall not enroll any applicant who, within the previous 10 years:

(1) Has been convicted of any felony or misdemeanor that involves fraud or abuse in any government program, that relates to neglect or abuse of a patient in connection with the delivery of a health care item or service, or that is in connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse.

(2) Has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program.

(h) In addition, the department may deny enrollment to any applicant that, at the time of application, is under investigation by the department or any local, state, or federal government law enforcement agency for fraud or abuse. The department shall not deny enrollment to an otherwise qualified applicant whose felony or misdemeanor charges did not result in a conviction solely on the basis of the prior charges. If it is discovered that a provider is under investigation by the department or any local, state, or federal government law enforcement agency for fraud or abuse, that provider shall be subject to immediate disenrollment from the program.

(i) (1) The program shall disenroll as a program provider any individual who, or any entity that, has a license, certificate, or other approval to provide health care, which is revoked or suspended by a federal, California, or other state's licensing, certification, or other approval authority, has otherwise lost that license, certificate, or approval, or has surrendered that license, certificate, or approval while a disciplinary hearing on the license, certificate, or approval was pending. The disenrollment shall be effective on the date the license, certificate, or approval is revoked, lost, or surrendered.

(2) A provider shall be subject to disenrollment if the provider submits claims for payment for the services, goods, supplies, or merchandise provided, directly or indirectly, to a program beneficiary, by an individual or entity that has been previously suspended, excluded, or otherwise made ineligible to receive, directly or indirectly, reimbursement from the pro-

gram or from the Medi-Cal program and the individual has previously been listed on either the Suspended and Ineligible Provider List, which is published by the department, to identify suspended and otherwise ineligible providers or any list published by the federal Office of the Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and medicaid programs, to identify suspended, excluded, or otherwise ineligible providers.

(3) The department shall deactivate, immediately and without prior notice, the provider numbers used by a provider to obtain reimbursement from the program when warrants or documents mailed to a provider's mailing address, its pay to address, or its service address, if any, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the program for one year. Prior to taking this action, the department shall use due diligence in attempting to contact the provider at its last known telephone number and to ascertain if the return by the United States Postal Service is by mistake and shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in regulation.

(4) For purposes of this subdivision:

(A) "Mailing address" means the address that the provider has identified to the department in its application for enrollment as the address at which it wishes to receive general program correspondence.

(B) "Pay to address" means the address that the provider has identified to the department in its application for enrollment as the address at which it wishes to receive warrants.

(C) "Service address" means the address that the provider has identified to the department in its application for enrollment as the address at which the provider will provide services to program beneficiaries.

(j) Subject to Article 4 (commencing with Section 19130) of Chapter 5 of Division 5 of Title 2 of the Government Code, the department may enter into contracts to secure consultant services or information technology including, but not limited to, software, data, or analytical techniques or methodologies for the purpose of fraud or abuse detection and prevention. Contracts under this section shall be exempt from the Public Contract Code.

(k) Enrolled providers shall attend specific orientation approved by the department in comprehensive family planning services. Enrolled providers who insert IUDs or contraceptive implants shall have received prior clinical training specific to these procedures.

(*l*) Upon receipt of reliable evidence that would be admissible under the administrative adjudication provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, of fraud or willful misrepresentation by a provider under the pro-

gram or commencement of a suspension under Section 14123, the department may do any of the following:

(1) Collect any State-Only Family Planning program or Family Planning Access Care and Treatment Waiver program overpayment identified through an audit or examination, or any portion thereof from any provider. Notwithstanding Section 100171 of the Health and Safety Code, a provider may appeal the collection of overpayments under this section pursuant to procedures established in Article 5.3 (commencing with Section 14170) of Part 3 of Division 9. Overpayments collected under this section shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings, if the findings are against the provider. Overpayments shall be returned to a provider with interest if findings are in favor of the provider.

(2) Withhold payment for any goods or services, or any portion thereof, from any State-Only Family Planning program or Family Planning Access Care and Treatment Waiver program provider. The department shall notify the provider within five days of any withholding of payment under this section. The notice shall do all of the following:

(A) State that payments are being withheld in accordance with this paragraph and that the withholding is for a temporary period and will not continue after it is determined that the evidence of fraud or willful misrepresentation is insufficient or when legal proceedings relating to the alleged fraud or willful misrepresentation are completed.

(B) Cite the circumstances under which the withholding of the payments will be terminated.

(C) Specify, when appropriate, the type or types of claimed payments being withheld.

(D) Inform the provider of the right to submit written evidence that is evidence that would be admissible under the administrative adjudication provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, for consideration by the department.

(3) Notwithstanding Section 100171 of the Health and Safety Code, a provider may appeal a withholding of payment under this section pursuant to Section 14043.65. Payments withheld under this section shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings.

(m) As used in this section:

(1) “Abuse” means either of the following:

(A) Practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the medicaid program, the Medicare program, the Medi-Cal program, including the Family Planning Access Care and Treatment Waiver program, identified in subdivision (aa) of Section 14132, another state’s medicaid program, or the State-Only Family Planning program, or other health care programs operated, or financed in whole or in part, by the federal government or any state or local agency in this state or any other state.

(B) Practices that are inconsistent with sound medical practices and result in reimbursement, by any of the programs referred to in subparagraph (A) or other health care programs operated, or financed in whole or in part, by the federal government or any state or local agency in this state or any other state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

(2) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(3) "Provider" means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of any partnership, group, association, corporation, institution, or entity, that provides services, goods, supplies, or merchandise, directly or indirectly, to a beneficiary and that has been enrolled in the program.

(4) "Convicted" means any of the following:

(A) A judgment of conviction has been entered against an individual or entity by a federal, state, or local court, regardless of whether there is a post-trial motion or an appeal pending or the judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed.

(B) A federal, state, or local court has made a finding of guilt against an individual or entity.

(C) A federal, state, or local court has accepted a plea of guilty or nolo contendere by an individual or entity.

(D) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgment of conviction has been withheld.

(5) "Professionally recognized standards of health care" means statewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is an issue, recognize as applying to those peers practicing or providing care within a state. When the United States Department of Health and Human Services has declared a treatment modality not to be safe and effective, practitioners that employ that treatment modality shall be deemed not to meet professionally recognized standards of health care. This definition shall not be construed to mean that all other treatments meet professionally recognized standards of care.

(6) "Unnecessary or substandard items or services" means those that are either of the following:

(A) Substantially in excess of the provider's usual charges or costs for the items or services.

(B) Furnished, or caused to be furnished, to patients, whether or not covered by Medicare, medicaid, or any of the state health care programs to which the definitions of applicant and provider apply, and which are

substantially in excess of the patient's needs, or of a quality that fails to meet professionally recognized standards of health care. The department's determination that the items or services furnished were excessive or of unacceptable quality shall be made on the basis of information, including sanction reports, from the following sources:

(i) The professional review organization for the area served by the individual or entity.

(ii) State or local licensing or certification authorities.

(iii) Fiscal agents or contractors, or private insurance companies.

(iv) State or local professional societies.

(v) Any other sources deemed appropriate by the department.

(7) "Enrolled or enrollment in the program" means authorized under any and all processes by the department or its agents or contractors to receive, directly or indirectly, reimbursement for the provision of services, goods, supplies, or merchandise to a program beneficiary.

(n) In lieu of, or in addition to, the imposition of any other sanctions available, including the imposition of a civil penalty under Sections 14123.2 or 14171.6, the program may impose on providers any or all of the penalties pursuant to Section 14123.25, in accordance with the provisions of that section. In addition, program providers shall be subject to the penalties contained in Section 14107.

(o) (1) Notwithstanding any other provision of law, every primary supplier of pharmaceuticals, medical equipment, or supplies shall maintain accounting records to demonstrate the manufacture, assembly, purchase, or acquisition and subsequent sale, of any pharmaceuticals, medical equipment, or supplies, to providers. Accounting records shall include, but not be limited to, inventory records, general ledgers, financial statements, purchase and sales journals, and invoices, prescription records, bills of lading, and delivery records.

(2) For purposes of this subdivision, the term "primary supplier" means any manufacturer, principal labeler, assembler, wholesaler, or retailer.

(3) Accounting records maintained pursuant to paragraph (1) shall be subject to audit or examination by the department or its agents. The audit or examination may include, but is not limited to, verification of what was claimed by the provider. These accounting records shall be maintained for three years from the date of sale or the date of service.

(p) Each provider of health care services rendered to any program beneficiary shall keep and maintain records of each service rendered, the beneficiary to whom rendered, the date, and such additional information as the department may by regulation require. Records required to be kept and maintained pursuant to this subdivision shall be retained by the provider for a period of three years from the date the service was rendered.

(q) A program provider applicant or a program provider shall furnish information or copies of records and documentation requested by the department. Failure to comply with the department's request shall be grounds for denial of the application or automatic disenrollment of the provider.

(r) A program provider may assign signature authority for transmission of claims to a billing agent subject to Sections 14040, 14040.1, and 14040.5.

(s) Moneys payable or rights existing under this division shall be subject to any claim, lien, or offset of the State of California, and any claim of the United States of America made pursuant to federal statute, but shall not otherwise be subject to enforcement of a money judgment or other legal process, and no transfer or assignment, at law or in equity, of any right of a provider of health care to any payment shall be enforceable against the state, a fiscal intermediary, or carrier.

SEC. 96. (a) Of the funds appropriated in Item 4265-111-0001 of Section 2.00 of the Budget Act of 2007 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 2007–08 fiscal year from the following accounts:

(1) Twenty million two hundred twenty-seven thousand dollars ($20,227,000) from the Hospital Services Account.

(2) Four million five hundred seventy-six thousand dollars ($4,576,000) from the Physician Services Account.

(b) The funds specified in subdivision (a) shall be allocated proportionately as follows:

(1) Twenty-two million three hundred twenty-four thousand dollars ($22,324,000) shall be administered and allocated for distribution through the California Healthcare for Indigents Program (CHIP), Chapter 5 (commencing with Section 16940) of Part 4.7 of Division 9 of the Welfare and Institutions Code.

(2) Two million four hundred seventy-nine thousand dollars ($2,479,000) shall be administered and allocated through the Rural Health Services Program, Chapter 4 (commencing with Section 16930) of Part 4.7 of Division 9 of the Welfare and Institutions Code.

(c) (1) Funds allocated pursuant to this section from the Physician Services Account and the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund shall be used only for the reimbursement of physicians for losses incurred in providing uncompensated emergency services in general acute care hospitals providing basic, comprehensive, or standby emergency services, as defined in Section 16953 of the Welfare and Institutions Code. Funds shall be transferred to the Physician Services Account in the county Emergency Medical Services Fund established pursuant to Sections 16951 and 16952 of the Welfare and Institutions Code, and shall be paid only to physicians who directly provide emergency medical services to patients, based on claims submitted or a subsequent reconciliation of claims. Payments shall be made as provided in Sections 16951 to 16959, inclusive, of the Welfare and Institutions Code, and payments shall be made on an equitable basis, without preference to any particular physician or group of physicians.

(2) If a county has an Emergency Medical Services Fund Advisory Committee that includes both emergency physicians and emergency de-

partment on-call back-up panel physicians, and if the committee unanimously approves, the administrator of the Emergency Medical Services Fund may create a special fee schedule and claims submission criteria for reimbursement for services rendered to uninsured trauma patients, provided that no more than 15 percent of the tobacco tax revenues allocated to the county's Emergency Medical Services Fund is distributed through this special fee schedule, that all physicians who render trauma services are entitled to submit claims for reimbursement under this special fee schedule, and that no physician's claim may be reimbursed at greater than 50 percent of losses under the special fee schedule.

SEC. 97. The State Department of Mental Health, in direct collaboration with the State Department of Health Care Services as the state's lead Medicaid entity, shall provide the fiscal and policy committees of the Legislature with specified work products as contained in the State Department of Mental Health workplan. The purpose of the workplan is to significantly improve the management of fiscal systems as they pertain to the Medi-Cal program, including the Early, Periodic Screening and Diagnosis and Treatment Program, Mental Health Managed Care, and Short/Doyle Medi-Cal services. The work products to be provided and their delivery dates include, at a minimum, the following:

(a) Accounting and Administrative Control Review recommendations (October 2007).

(b) A detailed implementation plan to implement Accounting and Administrative Control Review recommendations (March 2008).

(c) An action plan to address reforms regarding Mental Health Managed Care and Short/Doyle services (March 2008).

SEC. 98. The State Department of Mental Health, in direct collaboration with the State Department of Health Care Services as the state's lead Medicaid entity, shall provide the fiscal and policy committees of the Legislature, by no later than March 1, 2008, with a policy analysis of the San Mateo Pharmacy and Laboratory Services Project. At a minimum this policy analysis shall do the following:

(a) Articulate best practices learned from the pilot and whether these best practices could be replicated statewide.

(b) Offer suggestions to improve the project.

(c) Clarify the project's relationship to other local and statewide efforts related to pharmaceutical usage and purchasing, such as those conducted through the Health Plan of San Mateo and the CalMEND project, as well as others.

SEC. 99. The State Department of Mental Health shall provide the fiscal and policy committees of the Legislature, by no later than September 1, 2007, with their action plan to implement fiscal reforms regarding the San Mateo Pharmacy and Laboratory Services Project. This action plan shall respond to issues identified by the Office of State Audits and Evaluations, as well as any other applicable concerns identified by the department, stakeholders, and control agencies.

SEC. 100. (a) The State Department of Health Care Services shall issue an All County Welfare Directors Letter and a Medi-Cal Provider Bulletin regarding the Conlan v. Shewry Beneficiary Reimbursement process no later than October 1, 2007, which shall include, at a minimum, all of the following information:

(1) Persons eligible for Medi-Cal on or after June 27, 1997, are eligible for reimbursement of health care services paid out-of-pocket for Medi-Cal covered services during any of the following periods of time:

(A) The three months before an application for Medi-Cal was filed (retroactivity period).

(B) The time between when a Medi-Cal application was filed and was approved (evaluation period).

(C) After being approved for Medi-Cal (postapproval period).

(2) Payments made to a Medi-Cal provider are eligible for reimbursement, including improper copayments, improper share-of-cost amounts, or the cost of covered medical, mental health, IHSS, drug and alcohol or dental services. Payments made to a Medi-Cal provider are ineligible for reimbursement if the payments were for valid copayments or share of cost.

(3) Payments made to non-Medi-Cal providers are eligible for reimbursement if the services were received at either of the following times:

(A) On or before February 2, 2006, and the Medi-Cal eligible person had applied but not received a Medi-Cal card.

(B) During the 90-day retroactivity period prior to the person filing a Medi-Cal application.

(4) Medi-Cal beneficiaries are entitled to reimbursement of the full amount paid minus permissible cost-sharing amounts, not limited to the Medi-Cal rate, if reimbursement is made by the provider or by the State Department of Health Care Services when it has the ability to initiate a recoupment action against a provider. If the Medi-Cal provider has not made full reimbursement, the department shall initiate recoupment from the Medi-Cal provider if appropriate.

(5) Providers who reimburse a Medi-Cal beneficiary may submit claims for payment to the State Department of Health Care Services for those services provided notwithstanding the billing timeliness limitations for claims submissions, (pursuant to Title 42 Code of Federal Regulations, Section 447.45(d)(1) and California Code of Regulations, Title 22 of Division 3 of Sections 51000.8(a) and 51008.5) even if more than 12 months has elapsed since the service was provided. Claims for services that were provided from June 27, 1997, through November 16, 2006, inclusive, shall be submitted to the department by November 16, 2007, or within 90 days after issuance of the Medi-Cal card, whichever is longer. Claims for services provided on or after November 16, 2006, shall be received by the department within one calendar year after the date the service was rendered or within 90 days after issuance of the Medi-Cal card, whichever is longer.

(6) Medi-Cal providers shall either reimburse the beneficiary who requests payment or request a state hearing to contest the request for payment within 30 days of receipt of the letter from the State Department of Health Care Services. The time period for reimbursement may be extended upon a showing of good cause to the department. The reimbursement and recoupment process shall be stayed pending the outcome of the state hearing.

(b) The State Department of Health Care Services shall seek input from consumer advocates and provider representatives in developing the All County Welfare Directors Letter and the Provider Bulletin.

(c) The State Department of Health Care Services shall prominently post on its Web site information on the Conlan v. Shewry Reimbursement Process, including, at a minimum, the Conlan Implementation Plan that was approved by the superior court.

(d) Nothing in this section shall be construed to expand the legal duties of the State Department of Health Care Services under the Conlan v. Shewry Revised Implementation Plan that was approved by the San Francisco Superior Court on November 17, 2006.

SEC. 101. The adoption and readoption of regulations by the Managed Risk Medical Insurance Board pursuant to Section 12693.981 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. The board is hereby exempted from the requirements that it describe specific facts showing the need for immediate action and shall be exempt 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. 102. The Division of Licensing and Certification in the State Department of Public Health may temporarily revise rate structures within individual types of health facilities listed in Section 1266 of the Health and Safety Code during the 2007–08 fiscal year, provided that any revisions are revenue-neutral and do not shift costs between provider groups.

SEC. 102.3. The California Medical Assistance Commission (CMAC) and the State Department of Health Care Services shall report to the Legislature, through budget subcommittee hearings to be convened in 2008, regarding changes implemented in the 2007-08 fiscal year regarding Medi-Cal Managed Care reimbursement rates negotiated under the Geographic Managed Care model with respect to changes made pursuant to Section 14301.1 of the Welfare and Institutions Code concerning the use of health plan specific encounter and claims data, and the application of actuarial methods.

SEC. 102.5. (a) (1) The State Department of Developmental Services shall develop a plan of options for consideration by the Administration and the Legislature to better control regional center costs of operating

and providing state-supported services. The options shall provide program efficiencies while protecting clients.

(2) The plan developed pursuant to paragraph (1) should include a wide range of options, with an analysis of advantages and disadvantages of each.

(b) The department shall submit the plan developed pursuant to subdivision (a) to the Joint Legislative Budget Committee and the fiscal and policy committees of the Legislature no later than October 1, 2007.

SEC. 102.7. (a) (1) The State Department of Mental Health shall develop a plan for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program for consideration by the Administration and the Legislature. The plan shall include all of the following:

(A) Proposals for a statutory framework for the program.

(B) Options for reforms that would control program costs.

(C) Proposals to address the recommendations of the Department of Finance, Office of State Audits and Evaluation.

(2) In developing the plan, the department shall provide program efficiencies while protecting clients, and shall consult with the counties and consider the role of the counties in providing services under the program.

(3) The department shall submit the plan developed pursuant to this subdivision to the Joint Legislative Budget Committee and the fiscal and policy committees of the Legislature no later than March 1, 2008.

(b) The State Department of Mental Health shall work with the Legislature to develop an appropriate administrative structure for the EPSDT Program for implementation in the 2008–09 fiscal year, including enacting legislation to codify the administrative structure of the EPSDT Program.

SEC. 103. 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. 104. 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 2007 at the earliest possible time, it is necessary that this act take effect immediately.

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