

Assembly Bill No. 5

Passed the Assembly July 23, 2009

Chief Clerk of the Assembly

Passed the Senate July 23, 2009

Secretary of the Senate

This bill was received by the Governor this _____ day
of _____, 2009, at _____ o'clock ____M.

Private Secretary of the Governor

CHAPTER _____

An act to add Section 293 to the Financial Code, to amend Sections 1250, 1265.5, 1266, 1275.3, 1324.20, 1326, 1337, 1418, 1567.50, 104820, 105250, 116565, 125175, 130500, 130507, 130509, and 130543 of, to amend and repeal Section 125165 of, and to add Sections 125155.1, 125157, and 125166 to, the Health and Safety Code, to amend Section 12739 of the Insurance Code, and to amend Sections 4107, 4684.60, 4684.74, 4684.75, 7502.5, 14005.40, 14007.9, 14011.2, 14087.9, 14105.191, 14105.436, 14105.45, 14110.55, 14126.033, 14132, 14132.951, 14166.20, 14166.225, 14166.23, 14166.245, 14495.10, and 14526.1 of, to add Sections 5783, 14005.50, 14013.5, 14105.455, 14105.46, 14132.20, 14132.952, 14166.115, 14522.4, 14525.1, 14526.2, and 14550.6 to, and to repeal Section 14522.3, 14526.1, and 14550.5 of, the Welfare and Institutions Code, relating to health, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 5, Evans. Health.

Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health, including an intermediate care facility/developmentally disabled-nursing. Violation of these provisions is a misdemeanor.

This bill would create as a new category of health facility for, and require the department to license and regulate, intermediate care facility/developmentally disabled-continuous nursing (ICF/DD-CN) facilities, as defined. This bill would require facilities providing continuous skilled nursing services to persons with developmental disabilities pursuant to the above-described provisions to apply for licensure as an ICF/DD-CN within 90 days after licensing regulations become effective. This bill would make other conforming changes. By creating a new crime, this bill would impose a state-mandated local program.

Existing law, until January 1, 2010, authorizes the State Department of Social Services and the State Department of Developmental Services, to jointly establish and administer a pilot project for licensing and regulating Adult Residential Facilities

for Persons with Special Health Care Needs (ARFPSHN), to the extent that funds are appropriated for this purpose in the annual Budget Act. Under existing law, a licensed ARFPSHN may provide 24-hour services to up to 5 adults with developmental disabilities who have special health care and intensive support needs.

This bill would extend the pilot project until January 1, 2011, and would make other conforming changes. This bill would impose a state-mandated local program by changing the definition of crimes provided for under the California Community Care Facilities Act.

Existing law authorizes local sponsors, as defined, to offer community dental disease prevention programs to schoolchildren in preschool through 6th grade, and in classes for individuals with exceptional needs. Existing law requires the program to include educational programs focused on the development of personal practices by pupils, as specified, and preventative services. Existing law requires any acts performed or services provided pursuant to the program that constitute the practice of dentistry to be performed or provided by a licensed dentist.

Existing law provides that it is the intent of the Legislature that the above-described program shall be funded according to customary budget procedures.

This bill would, instead, require that the above-described program be funded according to customary budget procedures and that it only be implemented upon appropriation of funds by the Legislature.

Existing law requires the State Department of Public Health to implement and administer a program to meet the requirements of the federal Residential Lead-Based Paint Hazard Reduction Act of 1992. The department is required to establish fees for the accreditation of training providers, the certification of individuals, and the licensing of entities engaged in lead-related occupations.

This bill would, effective July 1, 2010, require the collected fees to be deposited in the Lead-Related Construction Fund, which would be established by the bill. These moneys would be available to the department upon appropriation by the Legislature for purposes of the program, and would be available for borrowing in accordance with prescribed provisions.

Existing law establishes the Occupational Lead Poisoning Prevention Account, into which fees are paid by employers in

prescribed industries that have documented evidence of potential poisoning. Moneys in this account are expended for purposes of the Lead Poisoning Prevention Program, which is conducted by the State Department of Public Health in accordance with prescribed requirements.

This bill would provide that of the funds appropriated from this account in the Budget Act of 2009, \$500,000 would be used for purposes of administration of the residential lead-based paint program during the 2009–10 fiscal year. It would express the intent of the Legislature that funds shall be repaid to the account upon a determination by the Department of Finance that sufficient moneys are available in the Lead-Related Construction Fund.

Existing law, the Calderon-Sher Safe Drinking Water Act of 1996, requires the State Department of Public Health to adopt regulations covering water testing, the monitoring of contaminants, the frequency and method of sampling and testing, the reporting of results, and other matters as may be necessary to determine and ensure the quality of domestic water supplies. Existing law defines “public water system” to mean a system for the provision of water for human consumption through pipes or other constructed conveyances that has 15 or more service connections or regularly serves at least 25 individuals daily at least 60 days out of the year.

Existing law requires public water systems serving 1,000 or more service connections and public water systems that treat water on behalf of one or more water systems, as specified, to reimburse the department for the actual cost incurred by the department in conducting its required activities relating to public water systems, as provided. Existing law further requires public water systems serving less than 1,000 service connections to pay an annual drinking water operating fee to the department for costs incurred by the department in conducting its required activities relating to public water systems, as provided. Existing law contains limitations on maximum fee amounts that may be imposed on public water systems under these provisions.

This bill would, instead, require these water systems to pay specified fees per service connection, subject to prescribed minimum amounts. This bill would authorize the department to increase the fees, as specified, subject to approval by the Legislature.

Existing law requires the State Department of Health Care Services to establish and administer the Genetically Handicapped Persons Program (GHPP) for the provision of health services to genetically handicapped persons.

This bill would provide that a person who is found eligible for GHPP services whose employer-sponsored health coverage is later terminated or a person who applies for GHPP services whose employer-sponsored health coverage was terminated during the 6-month period prior to the date he or she applies for services shall be ineligible for GHPP services, unless certain exceptions apply. The bill would require an applicant for GHPP services to certify, at the time of application, under penalty of perjury, that he or she was not covered by employer-sponsored health coverage during the 6-month period prior to the date of his or her application or, if he or she was covered by employer-sponsored health coverage, attest to why one of the exceptions to ineligibility applies and provide documentation from the employer-sponsored health coverage that supports his or her attestation. Because the bill would require representations in the statement by the applicant to be made under penalty of perjury, thus changing the definition of a crime, it would impose a state-mandated local program by expanding the crime of perjury.

This bill would also provide that persons who have been found eligible for GHPP services whose employer-sponsored health coverage is thereafter terminated to notify the GHPP within 45 days of the effective date of the termination of their employer-sponsored health coverage and, when applicable, provide the program with the same certification required of applicants for GHPP services.

This bill would authorize the director, on a case-by-case basis, to waive determinations of ineligibility made pursuant to the above-described provisions, or reduce certain time periods as set forth above, if the director determines that the determination of ineligibility or the time periods will result in undue hardship.

This bill would authorize the department to require a client under the GHPP to apply to enroll or otherwise participate in any other state or federal program or other contractual or legal entitlement that would provide services to the client that would otherwise be reimbursed under the GHPP.

This bill would authorize the department, when it determines it to be cost effective, to pay for 3rd-party health coverage for persons eligible for GHPP services in certain circumstances.

Existing law requires the department to determine and establish an enrollment fee for GHPP services that shall be a sliding scale based upon family size and income.

The bill would, with certain exceptions, commencing July 1, 2009, instead, base the annual enrollment fee on the client's or, if the client is a minor, the client's parents' or legal guardians' combined adjusted gross income as reported on the relevant state or federal income tax forms for the previous tax year. The bill would require the enrollment fee to be 1½% of adjusted gross income when the reported adjusted gross income was between 200% and 299%, inclusive, of the federal poverty level and to be 3% of adjusted gross income when the reported adjusted gross income was equal to or greater than 300% of the federal poverty level.

The bill would also provide that in the event the annual enrollment fee determined pursuant to the above provisions exceeds the cost of care incurred during the applicable year, the department shall reduce the enrollment fee by refund or credit to an amount equal to the cost of care. The bill would also make conforming changes.

Existing law establishes the California Discount Prescription Drug Program, which is administered by the State Department of Health Care Services. Existing law requires, on August 1, 2010, the department to determine whether pharmaceutical manufacturer participation in the program has been sufficient to meet certain benchmarks. It also requires the department, on and after that date, to reassess program outcomes, at least once every year, consistent with the benchmarks.

This bill would provide that the California Discount Prescription Drug Program become operative on or after July 1, 2010, and would extend the above-described deadlines to August 1, 2013.

Existing law creates the California Major Risk Medical Insurance Program (MRMIP), which is administered by the Managed Risk Medical Insurance Board, to arrange for major risk medical coverage for eligible residents of the state who are unable to secure adequate private health care coverage. Existing law creates the continuously appropriated Major Risk Medical Insurance Fund

within the MRMIP where revenue, including \$18,000,000 from the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund is deposited annually for the operation of the program.

This bill would, instead, for the 2009–10 fiscal year, prohibit the Controller from depositing any amount into the Major Risk Medical Insurance Fund from the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund.

Existing law establishes the State Department of Developmental Services and sets forth its duties and responsibilities, including, but not limited to, administration and oversight of the state developmental centers and programs relating to persons with developmental disabilities. Existing law, the Lanterman Developmental Disabilities Services Act, requires the department to allocate funds to private nonprofit regional centers for the provision of community services and support for persons with developmental disabilities and their families.

Existing law provides that the State Department of Mental Health shall house no more than 1,336 patients at Patton State Hospital. However, until September 2009, up to 1,530 patients may be housed at the hospital.

This bill would extend the date that 1,530 patients may be housed at the hospital to September 2012.

Existing law prohibits the total number of developmental center residents in the secure treatment facility at Porterville Developmental Center from exceeding 297.

This bill would include residents receiving services in the center’s transition treatment program for purposes of this limit.

Existing law establishes the federal Medicaid program, administered by each state, California’s version of which is the Medi-Cal program. The Medi-Cal program, administered by the State Department of Health Care Services, provides basic health care services to qualified low-income persons.

Existing federal and state law contain requirements relating to the establishment of United States citizenship or national status for purposes of establishing Medi-Cal eligibility. Existing Medi-Cal provisions implementing these requirements specify that, except as prescribed, no Medi-Cal services shall be available to any person who fails to comply with these documentation requirements.

This bill would, to the extent that federal financial participation is available and all agreements with the federal government have been obtained, permit the department to exercise a prescribed federal option relating to health care benefits for children.

This bill would require the department, pursuant to, and only to the extent required by, federal law and subject to the provisions described below, to implement an asset verification program for the purpose of determining or redetermining the eligibility of an applicant for, or recipient of, Medi-Cal benefits on the basis of being aged, blind, or disabled.

This bill would require any applicant or recipient described above, and any other person whose resources are required by law to be disclosed to determine the eligibility of the applicant or recipient, to provide authorization for the department to obtain from any financial institution, as defined, any financial record, as defined, held by the institution with respect to the applicant or recipient, and any other person, as applicable, whenever the department determines the record is needed in connection with a determination with respect to eligibility for, or the amount or extent of, medical assistance. The bill would provide that the obtaining of financial records by the department, or its designee, shall be at no cost to the applicant, recipient, or any other person whose resources are required to be disclosed. The bill would authorize the department to determine that an applicant or recipient is ineligible for medical assistance if the applicant or recipient, or any other person, as applicable, refuses to provide, or revokes, any authorization made pursuant to the above-described provisions. The bill would require the department to provide the applicant or recipient with notice of the asset verification requirement prior to the applicant or recipient being required to provide authorization.

This bill would require an officer of a financial institution, as defined, to furnish the department or its designee with information in the possession of the bank or company regarding the assets of any person who is applying for, or is receiving assistance or benefits from, the department and has provided authorization pursuant to the above-described provisions.

Existing law allows the California Medical Assistance Commission to negotiate exclusive contracts with any county that seeks to provide, or arrange for the provision of, Medi-Cal health care services. The system of services provided by or through a

county pursuant to these provisions is known as a county-organized health system. Existing law permits a combination of counties to contract with the department pursuant to these provisions for the provision of services on a regional basis.

This bill would delete the regional basis limitation.

Existing law requires the reimbursement to Medi-Cal pharmacy providers for legend and nonlegend drugs, as defined, to consist of the estimated acquisition cost of the drug, as defined, plus a professional fee for dispensing.

Existing law requires the department to establish a list of maximum allowable ingredient costs (MAIC) for generically equivalent drugs for purposes of establishing the acquisition cost for legend and nonlegend drugs, as provided. Existing law requires the department to update the list of, and establish new, MAICs, and to 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.

This bill would require the department to establish an MAIC only when 3 or more generically equivalent drugs are available for purchase and dispensing by retail pharmacies in California.

This bill would provide that if average manufacturer's prices are unavailable, the department shall establish the MAIC, either (1) based on the volume weighted average, as defined, of the wholesaler acquisition costs, as defined, 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 or (2) pursuant to a contract with a vendor for the purpose of surveying drug price information, collecting data, and calculating a proposed MAIC.

This bill would require the department to establish a process for providers to seek a change to a specific MAIC when the providers believe the MAIC does not reflect current available market prices.

Under existing law, the State Department of Mental Health is required to implement managed mental health care for Medi-Cal recipients through fee-for-service or capitated contracts with counties, counties acting jointly, qualified individuals or organizations, or nongovernmental entities. The State Department

of Mental Health is responsible for assuming specified program oversight authority formerly provided by the State Department of Health Care Services, including, but not limited to, oversight of certain utilization controls.

This bill would, if federal approval is obtained, authorize public agencies that meet certain conditions to, in addition to reimbursement or other payments that the agency would otherwise receive for Medi-Cal specialty mental health services, receive supplemental Medi-Cal reimbursement equal to the amount of federal financial participation received as a result of claims submitted by the State Department of Health Care Services for certain expenditures related to specialty mental health services that are allowable expenditures under federal law.

Existing law authorizes the State Department of Social Services to enter into contracts with manufacturers of single source and multiple source drugs on a bid or nonbid basis and to maintain a list of contract drugs for purposes of the Medi-Cal program. Existing law prescribes conditions under which certain drugs for use in the treatment of acquired immunodeficiency syndrome (AIDS) or an AIDS-related condition or cancer are deemed approved for addition to the Medi-Cal list of contract drugs or considered a Medi-Cal benefit.

Existing law requires, commencing July 1, 2002, all pharmaceutical manufacturers to provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal laws, for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to the above-described provisions related to drugs used to treat AIDS and cancer and reimbursed through the Medi-Cal outpatient fee-for-service drug program. Existing law requires the state rebate to be negotiated as necessary between the department and pharmaceutical manufacturers.

This bill would, commencing July 1, 2009, and until January 1, 2010, require pharmaceutical manufacturers to provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, for certain drug products used to treat AIDS and cancer that have been added to the Medi-Cal list of contract drugs, as specified.

Existing federal law requires the United States Secretary of Health and Human Services to enter into an agreement with each

manufacturer of covered drugs that are not subject to a rebate under an agreement between the state Medicaid program and the manufacturer under which the amount required to be paid to the manufacturer for covered drugs, with certain exceptions, purchased by a covered entity, as defined, does not exceed an amount equal to the average manufacturer price for the drug under the federal Medicaid program in the preceding calendar quarter, reduced by the rebate received pursuant to the Medicaid agreement.

This bill would provide that a covered entity shall dispense only the above-described drugs to Medi-Cal beneficiaries. This bill provides that if a covered entity is unable to purchase the above-described drugs, the covered entity may dispense a drug purchased at regular drug wholesale rates to a Medi-Cal beneficiary, but that it is required to maintain documentation of their inability to obtain the drugs.

Existing law requires the reimbursement to Medi-Cal pharmacy providers for legend and nonlegend drugs, as defined, to consist of the estimated acquisition cost of the drug, as defined, plus a professional fee for dispensing.

This bill would require pharmacy providers to submit their usual and customary charge, as defined, when billing the Medi-Cal program for prescribed drugs. The bill would require that payment to pharmacy providers be the lower of the pharmacy's usual and customary charge or the above-described reimbursement rate for legend and nonlegend drugs.

Existing law, as long as prescribed conditions are met, provides for the imposition of a uniform quality assurance fee on skilled nursing facilities, subject to prescribed exemptions, to be administered by the Director of Health Care Services and deposited in the State Treasury to be available to enhance federal financial participation in the Medi-Cal program or to provide additional reimbursement to, and support facility quality improvement efforts in, licensed skilled nursing facilities. Existing law provides that the 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. Existing law defines "net revenue" to mean gross resident revenue for routine nursing services and ancillary services provided to all residents by a skilled nursing facility, less Medicare revenue for routine and ancillary services, including Medicare revenue for services provided to residents covered under

a Medicare managed care plan, less payer discounts and applicable contractual allowances as permitted under federal law and regulation.

This bill would, for the 2009–10 and 2010–11 rate years, and subject to federal approval, also include within the definition of “net revenue” Medicare revenue for routine and ancillary services and Medicare revenue for services provided to residents covered under a Medicare managed care plan.

Existing law, the Medi-Cal Long-Term Reimbursement Act, requires the department to implement a cost-based reimbursement rate methodology for freestanding skilled nursing facilities, excluding skilled nursing facilities that are a distinct part of a facility that is licensed as a general acute care hospital. Reimbursement rates for these facilities are funded by a combination of federal funds and moneys collected pursuant to the above-described uniform quality assurance fees. Existing law provides that this rate methodology shall cease to be implemented on July 31, 2011, with these provisions to be repealed on January 1, 2012. Existing law provides, for the 2009–10 and 2010–11 rate years, that the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of the above-described provisions shall not exceed 5% of the weighted average Medi-Cal reimbursement rate for the prior fiscal year.

This bill would, instead, provide that for the 2009–10 and 2010–11 rate years, the weighted average Medi-Cal reimbursement rate required for purposes of the above-described provisions shall not be increased with respect to the weighted average Medi-Cal reimbursement rate for the 2008–09 rate year.

Existing law requires the director to reduce provider payments for certain classes of health facilities for dates of service on and after March 1, 2009, by 5% for Medi-Cal fee-for-service benefits.

This bill would prohibit Medi-Cal reimbursement rates applicable to specified classes of providers for services rendered during the 2009–10 rate year and each rate year thereafter from exceeding the reimbursement rates that were applicable to those classes of facilities in the 2008–09 rate year, with certain exceptions.

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, 2010.

This bill would instead, repeal the pilot program if and when the federal Centers for Medicare and Medicaid Services approve a federal waiver or approve a Medicaid State Plan amendment to make the pilot program a permanent program. The bill would set forth provisions for the permanent program that are similar to the provisions of the pilot program and would make these permanent program provisions operative upon the date federal approval is obtained. The bill would make other conforming changes.

Existing law provides for the State Supplementary Program for the Aged, Blind, and Disabled (SSP), which requires the State Department of Social Services to contract with the United States Secretary of Health and Human Services to make payments to SSP recipients to supplement supplemental security income (SSI) payments made available pursuant to the federal Social Security Act.

Under existing law, benefit payments under the SSP program are calculated by establishing the maximum level of nonexempt income and federal (SSI) and state (SSP) benefits for each category of eligible recipient. The state SSP payment is the amount, when added to the nonexempt income and SSI benefits available to the recipient, which would be required to provide the maximum benefit payment.

Existing law authorizes the State Department of Health Care Services, to the extent that federal financial participation is available, to exercise options under federal law to implement a program to provide Medi-Cal benefits for designated aged, blind, and disabled persons who meet specified income standards.

This bill would require the State Department of Health Care Services, to the extent that federal financial participation is available, to exercise an option under federal law to extend full-scope Medi-Cal benefits to individuals who are ineligible to receive those benefits under certain aid programs, including SSI/SSP, as a result of a specified July 1, 2009, reduction in SSI/SSP maximum aid payments. This bill would identify the applicable income and resource standards and methodologies to be utilized for its purposes, and would require an income disregard to be applied, as specified, to adjust the applicable income standard to that which was in place on May 1, 2009.

This bill would authorize the department to implement these revised Medi-Cal eligibility provisions through all-county letters

or similar instructions, and would cease implementation of these provisions when SSI/SSP program payment levels increase beyond those in effect on May 1, 2009. The bill would require the department to seek any approvals from the federal Centers for Medicare and Medicaid Services necessary to implement these provisions.

Existing law provides for the county-administered In-Home Supportive Services (IHSS) program, under which qualified aged, blind, and disabled persons are provided with services in order to permit them to remain in their own homes and avoid institutionalization. Existing law permits services to be provided under the IHSS program either through the employment of individual providers, a contract between the county and an entity for the provision of services, the creation by the county of a public authority, or a contract between the county and a nonprofit consortium. Under existing law, personal care services provided to an individual who is eligible for Medi-Cal benefits as a categorically needy person are a Medi-Cal covered benefit. Personal care services are also a covered benefit under the IHSS program.

Existing law provides for the payment of a supplementary benefit under the IHSS program to any eligible aged, blind, or disabled person who is receiving Medi-Cal personal care services and who would otherwise be deemed a categorically needy recipient under the IHSS program. Existing law extends application of this provision to any aged, blind, or disabled person who is receiving Medi-Cal benefits and eligible for services under a federal waiver program known as the IHSS Plus waiver, and who would otherwise be deemed a categorically needy recipient under the IHSS program.

This bill would require the State Department of Health Care Services to seek approval of the IHSS Plus option, an amendment to the Medicaid state plan to provide self-directed personal assistance services under the state plan, to the extent that federal financial participation is available, in order to provide IHSS services as a Medi-Cal benefit. The bill would require these services to be rendered under the administrative direction of the State Department of Social Services, as specified.

This bill would exclude residents of designated health and care facilities from receiving the services provided pursuant to the bill. It would authorize the State Department of Health Care Services

to implement the IHSS Plus option provisions through all-county letters or similar instructions, and to adopt emergency regulations.

This bill would require the Director of Health Care Services to notify the Legislature of any modifications to IHSS benefits, eligibility, and operational requirements necessary for the state plan amendment to become effective.

Existing law, the Medi-Cal Hospital/Uninsured Care Demonstration Project Act authorizes the director to, pursuant to a federal waiver, use modified funding methodologies to maximize the use of federal funds to resolve Medi-Cal reimbursement inequities experienced by public and private disproportionate share hospitals. The demonstration project provides for specified stabilization funding to be provided for prescribed purposes.

This bill would, notwithstanding those provisions, require that for each of the 2008–09 and 2009–10 fiscal years, the amount available for these purposes shall be reduced by prescribed amounts which sum shall be retained in, or transferred to, the General Fund. This bill would authorize the department to increase federal claiming from the safety net care pool for state-funded programs if necessary to achieve prescribed savings.

It would also, for the 2009–10 fiscal years, make a prescribed reduction from allocations to distressed hospitals, as defined, and would transfer the amount of this transfer to the General Fund.

The bill would require a 10% reduction in disproportionate share hospital replacement payments to private hospitals for the 2009–10 fiscal year and would require the department to seek any necessary federal approvals to implement this requirement.

Under existing law, the State Department of Mental Health is required to implement managed mental health care for Medi-Cal recipients through fee-for-service or capitated contracts with counties, counties acting jointly, qualified individuals or organizations, or nongovernmental entities. The State Department of Mental Health is responsible for assuming specified program oversight authority, including, but not limited to, oversight of certain utilization controls.

This bill would, if federal approval is obtained, authorize public agencies that meet certain conditions to, in addition to reimbursement or other payments that the agency would otherwise receive for Medi-Cal specialty mental health services, receive supplemental Medi-Cal reimbursement equal to the amount of

federal financial participation received as a result of claims submitted by the State Department of Health Care Services for certain expenditures related to specialty mental health services that are allowable expenditures under federal law.

Under existing law, one of the benefits provided for under the Medi-Cal program is adult day health care services. Existing law contains eligibility criteria for these services, and requires that adult day health care center provide core services, as defined.

This bill would provide that, commencing 30 days after the effective date of the bill, adult day health care is covered for a maximum of three days per week, until the date that the Director of Health Care Services executes a declaration specifying that provisions described below relating to adult day health care services, are operative, at which time these services are covered for a maximum of 5 days per week.

Under existing law, treatment authorization requests may be granted for adult day health care services for up to 6 months.

Under existing law, one of the eligibility criteria applicable to adult day health care services is that the Medi-Cal beneficiary requires assistance and supervision in performing prescribed activities.

This bill, subject to federal approval, would permit treatment authorization requests for a period of up to 12 months, would modify eligibility criteria to require, with certain exceptions, that the beneficiary need substantial human assistance in performing the prescribed activities, and would modify certain elements of the core services, with all of these provisions to be operative upon the execution of a declaration by the director that all necessary methods and procedures necessary to implement the treatment authorization request provisions have been met.

This bill would require the State Department of Mental Health, by no later than March 1, 2011, to provide the legislative budget and policy committees with an analysis of selected county and subcontractor costs for the 2009–10 fiscal year that are not wholly reimbursed by the schedule of maximum allowances rates, as specified.

This bill would require the California Health and Human Services Agency to develop an action plan regarding coordination of core programmatic functions between the State Department of Mental Health and the State Department of Health Care Services.

Under existing law, for certain hospitals that receive Medi-Cal reimbursement from the State Department of Health Care Services and that are not under contract with the department pursuant to specified existing law, interim payments and cost report settlements for inpatient hospital services provided on and after July 1, 2008, are reduced by 10%, as specified. Existing law revises the amount of these payments, beginning on October 1, 2008, pursuant to a specified formula. Existing law exempts certain small and rural hospitals and certain open health facility planning areas from this revised formula. Existing law, for purposes of interim payments, specifically provides that open health facility planning areas with 3 or more hospitals with licensed general acute care beds are not exempt from this revised formula. Existing law, for purposes of the cost report settlements, specifically provides that open health facility planning areas with more than 3 hospitals with licensed general acute care beds are not exempt from this revised formula.

This bill would revise both of the above provisions to prohibit a state-owned or state-operated hospital from being included in determining the number of hospitals in an open health facility planning area.

This bill would revise the cost report settlement provision by requiring that an open health facility planning area have 3 or more specified hospitals, instead of more than 3 specified hospitals.

This bill would revise the exemption for small and rural hospitals, as specified.

The bill would require the state Department of Health Care Services to provide the Legislature with a quarterly update regarding the implementation of the federal American Recovery and Reinvestment Act of 2009, as specified. It would also require the department to provide, in a timely manner, the applicable fiscal and policy committees of the Legislature with copies of all federal audits and their findings that pertain to the Medi-Cal program.

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

This bill would provide that no reimbursement is required by this act for a specified reason.

The California Constitution authorizes the Governor to declare a fiscal emergency and to call the Legislature into special session

for that purpose. The Governor issued a proclamation declaring a fiscal emergency, and calling a special session for this purpose, on July 1, 2009.

This bill would state that it addresses the fiscal emergency declared by the Governor by proclamation issued on July 1, 2009, pursuant to the California Constitution.

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

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

SECTION 1. Section 293 is added to the Financial Code, to read:

293. (a) An officer of a financial institution, within the meaning of Section 1101(1) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3401(1)), shall furnish the State Department of Health Care Services or its designee with information in the possession of the bank or company regarding the assets of any person who is applying for, or is receiving assistance or benefits from, the State Department of Health Care Services and has provided authorization pursuant to Section 14013.5 of the Welfare and Institutions Code.

(b) The obtaining of financial records by the State Department of Health Care Services, or its designee, pursuant to this section shall be subject to the cost reimbursement requirements of Section 1115(a) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3415(a)) and shall be at no cost to the applicant, recipient, or any other person, as defined in paragraph (3) of subdivision (c) of Section 14013.5 of the Welfare and Institutions Code.

(c) An authorization obtained by the State Department of Health Care Services, or its designee, under Section 14013.5 of the Welfare and Institutions Code shall be considered as meeting the requirements of Section 1103(a) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3403(a)) and, notwithstanding Section 1104(a) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3404(a)), need not be furnished to the financial institution.

(d) The certification requirements of Section 1103(b) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec.

3403(b)) shall not apply to requests by the State Department of Health Care Services, or its designee, pursuant to an authorization provided under Section 14013.5 of the Welfare and Institutions Code.

(e) A request by the State Department of Health Care Services, or its designee, pursuant to an authorization provided under Section 14013.5 of the Welfare and Institutions Code shall be deemed to meet the requirements of Section 1104(a)(3) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3404(a)(3)) and of Section 1102 of the act (12 U.S.C. Sec. 3402), relating to a reasonable description of financial records.

SEC. 2. Section 1250 of the Health and Safety Code is amended to read:

1250. As used in this chapter, “health facility” means any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or longer, and includes the following types:

(a) “General acute care hospital” means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. A general acute care hospital may include more than one physical plant maintained and operated on separate premises as provided in Section 1250.8. A general acute care hospital that exclusively provides acute medical rehabilitation center services, including at least physical therapy, occupational therapy, and speech therapy, may provide for the required surgical and anesthesia services through a contract with another acute care hospital. In addition, a general acute care hospital that, on July 1, 1983, provided required surgical and anesthesia services through a contract or agreement with another acute care hospital may continue to provide these surgical and anesthesia services through a contract or agreement with an acute care hospital. The general acute care hospital operated by the State Department of Developmental Services at Agnews Developmental

Center may, until June 30, 2007, provide surgery and anesthesia services through a contract or agreement with another acute care hospital. Notwithstanding the requirements of this subdivision, a general acute care hospital operated by the Department of Corrections and Rehabilitation or the Department of Veterans Affairs may provide surgery and anesthesia services during normal weekday working hours, and not provide these services during other hours of the weekday or on weekends or holidays, if the general acute care hospital otherwise meets the requirements of this section.

A “general acute care hospital” includes a “rural general acute care hospital.” However, a “rural general acute care hospital” shall not be required by the department to provide surgery and anesthesia services. A “rural general acute care hospital” shall meet either of the following conditions:

(1) The hospital meets criteria for designation within peer group six or eight, as defined in the report entitled Hospital Peer Grouping for Efficiency Comparison, dated December 20, 1982.

(2) The hospital meets the criteria for designation within peer group five or seven, as defined in the report entitled Hospital Peer Grouping for Efficiency Comparison, dated December 20, 1982, and has no more than 76 acute care beds and is located in a census dwelling place of 15,000 or less population according to the 1980 federal census.

(b) “Acute psychiatric hospital” means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for mentally disordered, incompetent, or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services.

(c) “Skilled nursing facility” means a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis.

(d) “Intermediate care facility” means a health facility that provides inpatient care to ambulatory or nonambulatory patients who have recurring need for skilled nursing supervision and need

supportive care, but who do not require availability of continuous skilled nursing care.

(e) “Intermediate care facility/developmentally disabled habilitative” means a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer persons with developmental disabilities who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.

(f) “Special hospital” means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical or dental staff that provides inpatient or outpatient care in dentistry or maternity.

(g) “Intermediate care facility/developmentally disabled” means a facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to persons with developmental disabilities whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.

(h) “Intermediate care facility/developmentally disabled-nursing” means a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for persons with developmental disabilities who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons with developmental disabilities or who demonstrate significant developmental delay that may lead to a developmental disability if not treated.

(i) (1) “Congregate living health facility” means a residential home with a capacity, except as provided in paragraph (4), of no more than 12 beds, that provides inpatient care, including the following basic services: medical supervision, 24-hour skilled nursing and supportive care, pharmacy, dietary, social, recreational, and at least one type of service specified in paragraph (2). The primary need of congregate living health facility residents shall be for availability of skilled nursing care on a recurring, intermittent, extended, or continuous basis. This care is generally

less intense than that provided in general acute care hospitals but more intense than that provided in skilled nursing facilities.

(2) Congregate living health facilities shall provide one of the following services:

(A) Services for persons who are mentally alert, persons with physical disabilities, who may be ventilator dependent.

(B) Services for persons who have a diagnosis of terminal illness, a diagnosis of a life-threatening illness, or both. Terminal illness means the individual has a life expectancy of six months or less as stated in writing by his or her attending physician and surgeon. A “life-threatening illness” means the individual has an illness that can lead to a possibility of a termination of life within five years or less as stated in writing by his or her attending physician and surgeon.

(C) Services for persons who are catastrophically and severely disabled. A person who is catastrophically and severely disabled means a person whose origin of disability was acquired through trauma or nondegenerative neurologic illness, for whom it has been determined that active rehabilitation would be beneficial and to whom these services are being provided. Services offered by a congregate living health facility to a person who is catastrophically disabled shall include, but not be limited to, speech, physical, and occupational therapy.

(3) A congregate living health facility license shall specify which of the types of persons described in paragraph (2) to whom a facility is licensed to provide services.

(4) (A) A facility operated by a city and county for the purposes of delivering services under this section may have a capacity of 59 beds.

(B) A congregate living health facility not operated by a city and county servicing persons who are terminally ill, persons who have been diagnosed with a life-threatening illness, or both, that is located in a county with a population of 500,000 or more persons may have not more than 25 beds for the purpose of serving persons who are terminally ill.

(C) A congregate living health facility not operated by a city and county serving persons who are catastrophically and severely disabled, as defined in subparagraph (C) of paragraph (2) that is located in a county of 500,000 or more persons may have not more

than 12 beds for the purpose of serving persons who are catastrophically and severely disabled.

(5) A congregate living health facility shall have a noninstitutional, homelike environment.

(j) (1) “Correctional treatment center” means a health facility operated by the Department of Corrections and Rehabilitation, the Department of Corrections and Rehabilitation, Division of Juvenile Facilities, or a county, city, or city and county law enforcement agency that, as determined by the state department, provides inpatient health services to that portion of the inmate population who do not require a general acute care level of basic services. This definition shall not apply to those areas of a law enforcement facility that houses inmates or wards that may be receiving outpatient services and are housed separately for reasons of improved access to health care, security, and protection. The health services provided by a correctional treatment center shall include, but are not limited to, all of the following basic services: physician and surgeon, psychiatrist, psychologist, nursing, pharmacy, and dietary. A correctional treatment center may provide the following services: laboratory, radiology, perinatal, and any other services approved by the state department.

(2) Outpatient surgical care with anesthesia may be provided, if the correctional treatment center meets the same requirements as a surgical clinic licensed pursuant to Section 1204, with the exception of the requirement that patients remain less than 24 hours.

(3) Correctional treatment centers shall maintain written service agreements with general acute care hospitals to provide for those inmate physical health needs that cannot be met by the correctional treatment center.

(4) Physician and surgeon services shall be readily available in a correctional treatment center on a 24-hour basis.

(5) It is not the intent of the Legislature to have a correctional treatment center supplant the general acute care hospitals at the California Medical Facility, the California Men’s Colony, and the California Institution for Men. This subdivision shall not be construed to prohibit the Department of Corrections and Rehabilitation from obtaining a correctional treatment center license at these sites.

(k) “Nursing facility” means a health facility licensed pursuant to this chapter that is certified to participate as a provider of care either as a skilled nursing facility in the federal Medicare Program under Title XVIII of the federal Social Security Act or as a nursing facility in the federal Medicaid Program under Title XIX of the federal Social Security Act, or as both.

(l) Regulations defining a correctional treatment center described in subdivision (j) that is operated by a county, city, or city and county, the Department of Corrections and Rehabilitation, or the Department of Corrections and Rehabilitation, Division of Juvenile Facilities, shall not become effective prior to, or if effective, shall be inoperative until January 1, 1996, and until that time these correctional facilities are exempt from any licensing requirements.

(m) “Intermediate care facility/developmentally disabled-continuous nursing (ICF/DD-CN)” means a home-like facility with a capacity of four to eight, inclusive, beds that provides 24-hour personal care, developmental services, and nursing supervision for persons with developmental disabilities who have continuous needs for skilled nursing care and have been certified by a physician and surgeon as warranting continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated. ICF/DD-CN facilities shall be subject to licensure under this chapter upon adoption of licensing regulations in accordance with Section 1275.3. A facility providing continuous skilled nursing services to persons with developmental disabilities pursuant to Section 14132.20 or 14995.10 of the Welfare and Institutions Code shall apply for licensure under this subdivision within 90 days after the regulations become effective, and may continue to operate pursuant to those sections until its licensure application is either approved or denied.

SEC. 3. Section 1265.5 of the Health and Safety Code is amended to read:

1265.5. (a) (1) Prior to the initial licensure or renewal of a license of any person or persons to operate or manage an intermediate care facility/developmentally disabled habilitative, an intermediate care facility/developmentally disabled-nursing, an intermediate care facility/developmentally disabled-continuous nursing, or an intermediate care facility/developmentally disabled,

other than an intermediate care facility/developmentally disabled operated by the state, that secures criminal record clearances for its employees through a method other than as specified in this section or upon the hiring of direct care staff by any of these facilities, the department shall secure from the Department of Justice criminal offender record information to determine whether the applicant, facility administrator or manager, any direct care staff, or any other adult living in the same location, has ever been convicted of a crime other than a minor traffic violation.

(2) (A) The criminal record clearance shall require the applicant to submit electronic fingerprint images and related information of the facility administrator or manager, and any direct care staff, or any other adult living in the same location, to the Department of Justice. Applicants shall be responsible for any cost associated with capturing or transmitting the fingerprint images and related information.

(B) The criminal record clearance shall be completed prior to direct staff contact with residents of the facility. A criminal record clearance shall be complete when the department has obtained the person's criminal record information from the Department of Justice and has determined that he or she is not disqualified from engaging in the activity for which clearance is required.

(3) (A) The Licensing and Certification Program shall issue an All Facilities Letter (AFL) to facility licensees when it determines that both of the following criteria have been met for a period of 30 days:

(i) The program receives, within three business days, 95 percent of its total responses indicating no evidence of recorded criminal information from the Department of Justice.

(ii) The program processes 95 percent of its total responses requiring disqualification in accordance with subdivision (b), with notices mailed to the facility no later than 45 days after the date that the criminal offender record information report is received from the Department of Justice.

(B) After the AFL is issued, facilities shall not allow newly hired facility administrators, managers, direct care staff, or any other adult living in the same location to have direct contact with clients or residents of the facility prior to completion of the criminal record clearance. A criminal record clearance shall be complete when the department has obtained the person's criminal offender

record information search response from the Department of Justice and has determined that the person is not disqualified from engaging in the activity for which clearance is required.

(C) An applicant or certificate holder who may be disqualified on the basis of a criminal conviction shall provide the department with a certified copy of the judgment of each conviction. In addition, the individual may, during a period of two years after the department receives the criminal record report, provide the department with evidence of good character and rehabilitation in accordance with subdivision (c). Upon receipt of a new application for certification of the individual, the department may receive and consider the evidence during the two-year period without requiring additional fingerprint imaging to clear the individual.

(D) The department's Licensing and Certification Program shall explore and implement methods for maximizing its efficiency in processing criminal record clearances within the requirements of law, including a streamlined clearance process for persons that have been disqualified on the basis of criminal convictions that do not require automatic denial pursuant to subdivision (b).

(4) An applicant and any other person specified in this subdivision, as part of the background clearance process, shall provide information as to whether or not the person has any prior criminal convictions, has had any arrests within the past 12-month period, or has any active arrests, and shall certify that, to the best of his or her knowledge, the information provided is true. This requirement is not intended to duplicate existing requirements for individuals who are required to submit fingerprint images as part of a criminal background clearance process. Every applicant shall provide information on any prior administrative action taken against him or her by any federal, state, or local governmental agency and shall certify that, to the best of his or her knowledge, the information provided is true. An applicant or other person required to provide information pursuant to this section that knowingly or willfully makes false statements, representations, or omissions may be subject to administrative action, including, but not limited to, denial of his or her application or exemption or revocation of any exemption previously granted.

(b) (1) The application for licensure or renewal shall be denied if the criminal record indicates that the person seeking initial licensure or renewal of a license referred to in subdivision (a) has

been convicted of a violation or attempted violation of any one or more of the following Penal Code provisions: Section 187, subdivision (a) of Section 192, Section 203, 205, 206, 207, 209, 210, 210.5, 211, 220, 222, 243.4, 245, 261, 262, or 264.1, Sections 265 to 267, inclusive, Section 273a, 273d, 273.5, or 285, subdivisions (c), (d), (f), and (g) of Section 286, Section 288, subdivisions (c), (d), (f), and (g) of Section 288a, Section 288.5, 289, 289.5, 368, 451, 459, 470, 475, 484, or 484b, Sections 484d to 484j, inclusive, or Section 487, 488, 496, 503, 518, or 666, unless any of the following applies:

(A) The person was convicted of a felony and has obtained a certificate of rehabilitation under Chapter 3.5 (commencing with Section 4852.01) of Title 6 of Part 3 of the Penal Code and the information or accusation against the person has been dismissed pursuant to Section 1203.4 of the Penal Code with regard to that felony.

(B) The person was convicted of a misdemeanor and the information or accusation against the person has been dismissed pursuant to Section 1203.4 or 1203.4a of the Penal Code.

(C) The person was convicted of a felony or a misdemeanor, but has previously disclosed the fact of each conviction to the department and the department has made a determination in accordance with law that the conviction does not disqualify the person.

(2) The application for licensure or renewal shall be denied if the criminal record of the person includes a conviction in another state for an offense that, if committed or attempted in this state, would have been punishable as one or more of the offenses set forth in paragraph (1), unless evidence of rehabilitation comparable to the dismissal of a misdemeanor or a certificate of rehabilitation as set forth in subparagraph (A) or (B) of paragraph (1) is provided to the department.

(c) If the criminal record of a person described in subdivision (a) indicates any conviction other than a minor traffic violation or other than a conviction listed in subdivision (b), the department may deny the application for licensure or renewal. In determining whether or not to deny the application for licensure or renewal pursuant to this subdivision, the department shall take into consideration the following factors as evidence of good character and rehabilitation:

(1) The nature and seriousness of the offense under consideration and its relationship to their employment duties and responsibilities.

(2) Activities since conviction, including employment or participation in therapy or education, that would indicate changed behavior.

(3) The time that has elapsed since the commission of the conduct or offense referred to in paragraph (1) or (2) and the number of offenses.

(4) The extent to which the person has complied with any terms of parole, probation, restitution, or any other sanction lawfully imposed against the person.

(5) Any rehabilitation evidence, including character references, submitted by the person.

(6) Employment history and current employer recommendations.

(7) Circumstances surrounding the commission of the offense that would demonstrate the unlikelihood of repetition.

(8) The granting by the Governor of a full and unconditional pardon.

(9) A certificate of rehabilitation from a superior court.

(d) Nothing in this section shall be construed to require a criminal record check of a person receiving services in an intermediate care facility/developmentally disabled habilitative, intermediate care facility/developmentally disabled-nursing, intermediate care facility/developmentally disabled-continuous nursing, or intermediate care facility/developmentally disabled.

(e) For purposes of this section, “direct care staff” means all facility staff who are trained and experienced in the care of persons with developmental disabilities and who directly provide program and nursing services to clients. Administrative and licensed personnel shall be considered direct care staff when directly providing program and nursing services to clients. Persons employed as consultants and acting as direct care staff shall be subject to the same requirements for a criminal record clearance as other direct care staff. However, the employing facility shall not be required to pay any costs associated with that criminal record clearance.

(f) Upon the employment of any person specified in subdivision (a), and prior to any contact with clients or residents, the facility shall ensure that electronic fingerprint images are submitted to the

Department of Justice for the purpose of obtaining a criminal record check.

(g) The department shall develop procedures to ensure that any licensee, direct care staff, or certificate holder for whom a criminal record has been obtained pursuant to this section or Section 1338.5 or 1736 shall not be required to obtain multiple criminal record clearances.

(h) In addition to the persons who are not required to obtain multiple criminal record clearances pursuant to subdivision (g), a person shall not be required to obtain a separate criminal record clearance if the person meets all of the following criteria:

(1) The person is employed as a consultant and acts as direct care staff.

(2) The person is a registered nurse, licensed vocational nurse, physical therapist, occupational therapist, or speech-language pathologist.

(3) The person has obtained a criminal record clearance as a prerequisite to holding a license or certificate to provide direct care services.

(4) The person has a license or certificate to provide direct care service that is in good standing with the appropriate licensing or certification board.

(5) The person is providing time-limited specialized clinical care or services.

(6) The person is not left alone with the client.

(i) If, at any time, the department determines that it does not meet the standards specified in clauses (i) and (ii) of subparagraph (A) of paragraph (3) of subdivision (a), for a period of 90 consecutive days, the requirements in paragraph (3) of subdivision (a) shall be suspended until the department determines that it has met those standards for a period of 90 consecutive days.

(j) During any period of time in which paragraph (3) of subdivision (a) is inoperative, facilities may allow newly hired facility administrators, managers, direct care staff, or any other adult living in the same location to have direct contact with clients or residents of the facility after those persons have submitted live-scan fingerprint images to the Department of Justice, and the department shall issue an AFL advising of this change in the statutory requirement.

(k) Notwithstanding any other provision of law, the department is authorized to provide an individual with a copy of his or her state or federal level criminal offender record information search response as provided to that department by the Department of Justice if the department has denied a criminal background clearance based on this information and the individual makes a written request to the department for a copy specifying an address to which it is to be sent. The state or federal level criminal offender record information search response shall not be modified or altered from its form or content as provided by the Department of Justice and shall be provided to the address specified by the individual in his or her written request. The department shall retain a copy of the individual's written request and the response and date provided.

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) (1) 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

(2) In the first year of licensure for intermediate care facility/developmentally disabled-continuous nursing (ICF/DD-CN) facilities, the licensure fee for those facilities shall be equivalent to the licensure fee for intermediate care facility/developmentally disabled-nursing facilities during the same year. Thereafter, the licensure fee for ICF/DD-CN facilities shall be established pursuant to subdivisions (c) and (d).

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

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

(1) The department shall prepare a report of all costs for activities of the Licensing and Certification Program. At a minimum, this report shall include a narrative of all baseline

adjustments and their calculations, a description of how each category of facility was calculated, descriptions of assumptions used in any calculations, and shall recommend Licensing and Certification Program fees in accordance with the following:

(A) Projected workload and costs shall be grouped for each fee category, including workload costs for facility categories that have been established by statute and for which licensing regulations and procedures are under development.

(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 1275.3 of the Health and Safety Code is amended to read:

1275.3. (a) The State Department of Public Health and the State Department of Developmental Services shall jointly develop and implement licensing regulations appropriate for intermediate care facilities/developmentally disabled-nursing and intermediate care facility/developmentally disabled-continuous nursing.

(b) The regulations adopted pursuant to subdivision (a) shall ensure that residents of intermediate care facilities/developmentally disabled-nursing and intermediate care facility/developmentally disabled-continuous nursing receive appropriate medical and nursing services, and developmental program services in a normalized, least restrictive physical and programmatic environment appropriate to individual resident need.

In addition, the regulations shall do all of the following:

(1) Include provisions for the completion of a clinical and developmental assessment of placement needs, including medical and other needs, and the degree to which they are being met, of clients placed in an intermediate care facility/developmentally disabled-nursing and intermediate care facility/developmentally disabled-continuous nursing and for the monitoring of these needs at regular intervals.

(2) Provide for maximum utilization of generic community resources by clients residing in a facility.

(3) Require the State Department of Developmental Services to review and approve an applicant's program plan as part of the licensing and certification process.

(4) Require that the physician providing the certification that placement in the intermediate care facility/developmentally disabled-nursing or intermediate care facility/developmentally

disabled-continuous nursing is needed, consult with the physician who was the physician of record at the time the person’s proposed placement is being considered by the interdisciplinary team.

(c) Regulations developed pursuant to this section shall include licensing fee schedules appropriate to facilities which will encourage their development.

(d) Nothing in this section supersedes the authority of the State Fire Marshal pursuant to Sections 13113, 13113.5, 13143, and 13143.6 to the extent that these sections are applicable to community care facilities.

SEC. 6. Section 1324.20 of the Health and Safety Code is amended to read:

1324.20. For purposes of this article, the following definitions shall apply:

(a) “Continuing care retirement community” means a provider of a continuum of services, including independent living services, assisted living services as defined in paragraph (5) of subdivision (a) of Section 1771, and skilled nursing care, on a single campus, that is subject to Section 1791, or a provider of such a continuum of services on a single campus that has not received a Letter of Exemption pursuant to subdivision (b) of Section 1771.3.

(b) “Exempt facility” means a skilled nursing facility that is part of a continuing care retirement community, a skilled nursing facility operated by the state or another public entity, a unit that provides pediatric subacute services in a skilled nursing facility, a skilled nursing facility that is certified by the State Department of Mental Health for a special treatment program and is an institution for mental disease as defined in Section 1396d(i) of Title 42 of the United States Code, or a skilled nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital.

(c) (1) “Net revenue” means gross resident revenue for routine nursing services and ancillary services provided to all residents by a skilled nursing facility, less Medicare revenue for routine and ancillary services, including Medicare revenue for services provided to residents covered under a Medicare managed care plan, less payer discounts and applicable contractual allowances as permitted under federal law and regulation.

(2) Notwithstanding paragraph (1), for the 2009–10 and 2010–11 rate years, “net revenue” means gross resident revenue for routine

nursing services and ancillary services provided to all residents by a skilled nursing facility, including Medicare revenue for routine and ancillary services and Medicare revenue for services provided to residents covered under a Medicare managed care plan, less payer discounts and applicable contractual allowances as permitted under federal law and regulation. To implement this paragraph, the department shall request federal approval pursuant to Section 1324.27.

(3) “Net revenue” does not mean charitable contributions and bad debt.

(d) “Payer discounts and contractual allowances” means the difference between the facility’s resident charges for routine or ancillary services and the actual amount paid.

(e) “Skilled nursing facility” means a licensed facility as defined in subdivision (c) of Section 1250.

SEC. 7. Section 1326 of the Health and Safety Code is amended to read:

1326. As used in this article, “long-term health care facility” means any skilled nursing facility, intermediate care facility, intermediate care facility/developmentally disabled, intermediate care facility/developmentally disabled habilitative, intermediate care facility/developmentally disabled-nursing, intermediate care facility/developmentally disabled-continuous nursing, or congregate living health facility licensed pursuant to this chapter.

SEC. 8. Section 1337 of the Health and Safety Code is amended to read:

1337. (a) The Legislature finds that the quality of patient care in skilled nursing and intermediate care facilities is dependent upon the competence of the personnel who staff its facilities. The Legislature further finds that direct patient care in skilled nursing and intermediate care facilities is currently rendered largely by certified nurse assistants. To assure the availability of trained personnel in skilled nursing and intermediate care facilities, the Legislature intends that all such facilities in this state participate in approved training programs established under this article. This article shall not apply to intermediate care facilities/developmentally disabled habilitative, intermediate care facility/developmentally disabled-nursing, and intermediate care facility/developmentally disabled-continuous nursing which have staff training programs approved by the State Department of

Developmental Services, general acute care hospitals, acute psychiatric hospitals, or special hospitals.

(b) The requirement that certified nurse assistants obtain a criminal record clearance upon certification and biannually thereafter shall apply regardless of the setting in which the certified nurse assistant is employed.

(c) The department shall develop procedures to ensure that certified nurse assistants employed by intermediate care facilities for the developmentally disabled/habilitative and intermediate care facilities for the developmentally disabled/nursing shall not be required to obtain multiple criminal record clearances.

(d) For the purpose of this article:

(1) “Nurse assistant” means any unlicensed aide, assistant, or orderly, who performs nursing services directed at the safety, comfort, personal hygiene, or protection of patients in a skilled nursing or intermediate care facility.

(2) “Approved training program” means a program for the training of nurse assistants that meets the criteria established and approved under this chapter.

(3) “Certified nurse assistant” means any person who holds himself or herself out as a certified nurse assistant and who, for compensation, performs basic patient care services directed at the safety, comfort, personal hygiene, and protection of patients, and is certified as having completed the requirements of this article. These services shall not include any services which may only be performed by a licensed person and otherwise shall be performed under the supervision of a registered nurse, as defined in Section 2725 of the Business and Professions Code, or a licensed vocational nurse, as defined in Section 2859 of the Business and Professions Code.

(4) “State department” means the State Department of Public Health.

SEC. 9. Section 1418 of the Health and Safety Code is amended to read:

1418. As used in this chapter:

(a) “Long-term health care facility” means any facility licensed pursuant to Chapter 2 (commencing with Section 1250) that is any of the following:

(1) Skilled nursing facility.

(2) Intermediate care facility.

- (3) Intermediate care facility/developmentally disabled.
 - (4) Intermediate care facility/developmentally disabled habilitative.
 - (5) Intermediate care facility/developmentally disabled-nursing.
 - (6) Congregate living health facility.
 - (7) Nursing facility.
 - (8) Intermediate care facility/developmentally disabled-continuous nursing.
- (b) “Long-term health care facility” also includes a pediatric day health and respite care facility licensed pursuant to Chapter 8.6 (commencing with Section 1760).
- (c) “Long-term health care facility” does not include a general acute care hospital or an acute psychiatric hospital, except for that distinct part of the hospital that provides skilled nursing facility, intermediate care facility, or pediatric day health and respite care facility services.
- (d) “Licensee” means the holder of a license issued under Chapter 2 (commencing with Section 1250) or Chapter 8.6 (commencing with Section 1760) for a long-term health care facility.

SEC. 10. Section 1567.50 of the Health and Safety Code is amended to read:

1567.50. (a) Notwithstanding that a community care facility means a place that provides nonmedical care under subdivision (a) of Section 1502, pursuant to Article 3.5 (commencing with Section 4684.50) of Chapter 6 of Division 4.5 of the Welfare and Institutions Code, the department shall jointly implement with the State Department of Developmental Services a pilot project to test the effectiveness of providing special health care and intensive support services to adults in homelike community settings.

(b) The State Department of Social Services may license, subject to the following conditions, an Adult Residential Facility for Persons with Special Health Care Needs to provide 24-hour services to up to five adults with developmental disabilities who have special health care and intensive support needs, as defined in subdivisions (f) and (g) of Section 4684.50 of the Welfare and Institutions Code.

(1) The State Department of Developmental Services shall be responsible for granting the certificate of program approval for an Adult Residential Facility for Persons with Special Health Care

Needs (ARFPSHN). The State Department of Social Services shall not issue a license unless the applicant has obtained a certification of program approval from the State Department of Developmental Services.

(2) The State Department of Social Services shall ensure that the ARFPSHN meets the administration requirements under Article 2 (commencing with Section 1520) including, but not limited to, requirements relating to fingerprinting and criminal records under Section 1522.

(3) The State Department of Social Services shall administer employee actions under Article 5.5 (commencing with Section 1558).

(4) The regional center shall monitor and enforce compliance of the program and health and safety requirements, including monitoring and evaluating the quality of care and intensive support services. The State Department of Developmental Services shall ensure that the regional center performs these functions.

(5) The State Department of Developmental Services may decertify any ARFPSHN that does not comply with program requirements. When the State Department of Developmental Services determines that urgent action is necessary to protect clients of the ARFPSHN from physical or mental abuse, abandonment, or any other substantial threat to their health and safety, the State Department of Developmental Services may request the regional center or centers to remove the clients from the ARFPSHN or direct the regional center or centers to obtain alternative services for the consumers within 24 hours.

(6) The State Department of Social Services may initiate proceedings for temporary suspension of the license pursuant to Section 1550.5.

(7) The State Department of Developmental Services, upon its decertification, shall inform the State Department of Social Services of the licensee's decertification, with its recommendation concerning revocation of the license, for which the State Department of Social Services may initiate proceedings pursuant to Section 1550.

(8) The State Department of Developmental Services and the regional centers shall provide the State Department of Social Services all available documentation and evidentiary support necessary for any enforcement proceedings to suspend the license

pursuant to Section 1550.5, to revoke or deny a license pursuant to Section 1551, or to exclude an individual pursuant to Section 1558.

(9) The State Department of Social Services Community Care Licensing Division shall enter into a memorandum of understanding with the State Department of Developmental Services to outline a formal protocol to address shared responsibilities, including monitoring responsibilities, complaint investigations, administrative actions, and closures.

(10) The licensee shall provide documentation that, in addition to the administrator requirements set forth under paragraph (4) of subdivision (a) of Section 4684.63 of the Welfare and Institutions Code, the administrator, prior to employment, has completed a minimum of 35 hours of initial training in the general laws, regulations and policies and procedural standards applicable to facilities licensed by the State Department of Social Services under Article 2 (commencing with Section 1520). Thereafter, the licensee shall provide documentation every two years that the administrator has completed 40 hours of continuing education in the general laws, regulations and policies and procedural standards applicable to adult residential facilities. The training specified in this section shall be provided by a vendor approved by the State Department of Social Services and the cost of the training shall be borne by the administrator or licensee.

(c) The article shall remain in effect only until January 1, 2011, and as of that date is repealed, unless a later enacted statute extends or deletes that date.

(d) This article shall only be implemented to the extent that funds are made available through an appropriation in the annual Budget Act.

SEC. 11. Section 104820 of the Health and Safety Code is amended to read:

104820. The dental disease prevention program established by this article shall be funded according to customary budget procedures and shall only be implemented upon appropriation of funds by the Legislature.

SEC. 12. Section 105250 of the Health and Safety Code is amended to read:

105250. (a) A program is hereby established within the department to meet the requirements of the Residential Lead-Based

Paint Hazard Reduction Act of 1992 (42 U.S.C. Sec. 4851 and following) and Title X of the Housing and Community Development Act of 1992 (P.L. 102-550).

(b) The department shall implement and administer the program. The department shall have powers and authority consistent with the intent of, and shall adopt regulations to establish the program as an authorized state program pursuant to, Title IV, Sections 402 to 404, inclusive, of the Toxic Substances Control Act (15 U.S.C. Sec. 2601 and following).

(c) Regulations regarding accreditation of training providers that are adopted pursuant to subdivision (b) shall include, but not be limited to, provisions governing accreditation of providers of health and safety training to employees who engage in or supervise lead-related construction work as defined in Section 6716 of the Labor Code, and certification of employees who have successfully completed that training. Regulations regarding accreditation of training providers shall, as a condition of accreditation, require providers to offer training that meets the requirements of Section 6717 of the Labor Code. The department shall, not later than August 1, 1994, adopt regulations establishing fees for the accreditation of training providers, the certification of individuals, and the licensing of entities engaged in lead-related occupations. The fees imposed under this subdivision shall be established at levels not exceeding an amount sufficient to cover the costs of administering and enforcing the standards and regulations adopted under this section. The fees established pursuant to this subdivision shall not be imposed on any state or local government or nonprofit training program.

(d) All regulations affecting the training of employees shall be adopted in consultation with the Division of Occupational Safety and Health. The regulations shall include provisions for allocating to the division an appropriate portion of funds to be expended for the program for the division's cost of enforcing compliance with training and certification requirements. The department shall adopt regulations to establish the program on or before August 1, 1994.

(e) The department shall review and amend its training, certification, and accreditation regulations adopted under this section as is necessary to ensure continued eligibility for federal and state funding of lead-hazard reduction activities in the state.

(f) Effective July 1, 2010, all fees collected pursuant to subdivision (c) shall be deposited in the Lead-Related Construction Fund, which is hereby created in the State Treasury. Moneys in the fund shall be expended by the department upon appropriation by the Legislature for the purposes of this chapter. Moneys in the fund are available for cashflow borrowing pursuant to Sections 16310 and 16381 of the Government Code.

(g) Of the amount appropriated in Item 4265-001-0070 of Section 2.00 of the Budget Act of 2009, five hundred thousand dollars (\$500,000) from the Occupational Lead Poisoning Prevention Account shall be used to administer the program in the 2009–10 fiscal year. These funds shall be repaid to the Occupational Lead Poisoning Prevention Account upon a determination by the Department of Finance that sufficient moneys are available in the Lead-Related Construction Fund. No interest shall be paid by the Lead-Related Construction Fund at the time of repayment.

SEC. 13. Section 116565 of the Health and Safety Code is amended to read:

116565. (a) Each public water system serving 1,000 or more service connections and any public water system that treats water on behalf of one or more public water systems for the purpose of rendering it safe for human consumption, shall reimburse the department for actual cost incurred by the department for conducting those activities mandated by this chapter relating to the issuance of domestic water supply permits, inspections, monitoring, surveillance, and water quality evaluation that relate to that specific public water system. The amount of reimbursement shall be sufficient to pay, but in no event shall exceed, the department's actual cost in conducting these activities.

(b) Each public water system serving less than 1,000 service connections shall pay an annual drinking water operating fee to the department as set forth in this subdivision for costs incurred by the department for conducting those activities mandated by this chapter relating to inspections, monitoring, surveillance, and water quality evaluation relating to public water systems. The total amount of fees shall be sufficient to pay, but in no event shall exceed, the department's actual cost in conducting these activities. Notwithstanding adjustment of actual fees collected pursuant to Section 100425 as authorized pursuant to subdivision (d) of Section

106590, the amount that shall be paid annually by a public water system pursuant to this section shall be as follows:

(1) Community water systems, six dollars (\$6) per service connection, but not less than two hundred fifty dollars (\$250) per water system, which may be increased by the department, as provided for in subdivision (f), to ten dollars (\$10) per service connection, but not less than two hundred fifty dollars (\$250) per water system.

(2) Nontransient noncommunity water systems pursuant to subdivision (k) of Section 116275, two dollars (\$2) per person served, but not less than four hundred fifty-six dollars (\$456) per water system, which may be increased by the department, as provided for in subdivision (f), to three dollars (\$3) per person served, but not less than four hundred fifty-six dollars (\$456) per water system.

(3) Transient noncommunity water systems pursuant to subdivision (k) of Section 116275, eight hundred dollars (\$800) per water system, which may be increased by the department, as provided for in subdivision (f), to one thousand three hundred thirty-five dollars (\$1,335) per water system.

(4) Noncommunity water systems exempted pursuant to Section 116282, one hundred two dollars (\$102) per water system.

(c) For purposes of determining the fees provided for in subdivision (a), the department shall maintain a record of its actual costs for pursuing the activities specified in subdivision (a) relative to each system required to pay the fees. The fee charged each system shall reflect the department's actual cost, or in the case of a local primacy agency the local primacy agency's actual cost, of conducting the specified activities.

(d) The department shall submit an invoice for cost reimbursement for the activities specified in subdivision (a) to the public water systems no more than twice a year.

(1) The department shall submit one estimated cost invoice to public water systems serving 1,000 or more service connections and any public water system that treats water on behalf of one or more public water systems for the purpose of rendering it safe for human consumption. This invoice shall include the actual hours expended during the first six months of the fiscal year. The hourly cost rate used to determine the amount of the estimated cost invoice shall be the rate for the previous fiscal year.

(2) The department shall submit a final invoice to the public water system prior to October 1 following the fiscal year that the costs were incurred. The invoice shall indicate the total hours expended during the fiscal year, the reasons for the expenditure, the hourly cost rate of the department for the fiscal year, the estimated cost invoice, and payments received. The amount of the final invoice shall be determined using the total hours expended during the fiscal year and the actual hourly cost rate of the department for the fiscal year. The payment of the estimated invoice, exclusive of late penalty, if any, shall be credited toward the final invoice amount.

(3) Payment of the invoice issued pursuant to paragraphs (1) and (2) shall be made within 90 days of the date of the invoice. Failure to pay the amount of the invoice within 90 days shall result in a 10-percent late penalty that shall be paid in addition to the invoiced amount.

(e) Any public water system under the jurisdiction of a local primacy agency shall pay the fees specified in this section to the local primacy agency in lieu of the department. This section shall not preclude a local health officer from imposing additional fees pursuant to Section 101325.

(f) The department may increase the fees established in subdivision (b) as follows:

(1) By February 1 of the fiscal year prior to the fiscal year for which fees are proposed to be increased, the department shall publish a list of fees for the following fiscal year and a report showing the calculation of the amount of the fees.

(2) The department shall make the report and the list of fees available to the public by submitting them to the Legislature and posting them on the department's Internet Web site.

(3) The department shall establish the amount of fee increases subject to the approval and appropriation by the Legislature.

SEC. 14. Section 125155.1 is added to the Health and Safety Code, to read:

125155.1. (a) Any person found eligible for services under this article whose employer-sponsored health coverage is later terminated or any person who applied for services provided under this article whose employer-sponsored health coverage was terminated during the six-month period prior to the date he or she applied for services pursuant to this article shall be determined

ineligible for the services, unless the reason his or her employer-sponsored health coverage was terminated was because of one of the following:

(1) The individual for whom the employer-sponsored coverage had been available lost coverage because of one or more of the following reasons:

(A) A loss of employment or a change in employment status.

(B) A change of address to a ZIP Code that is not covered by the employer-sponsored health coverage.

(C) The individual's employer discontinued health benefits to all employees or dependents, or ceased to provide coverage or contributions for the category of employees or dependents applicable to the person or applicant.

(D) The death of, or a legal separation or divorce from, the individual through whom the applicant was covered.

(2) The applicant's employer-sponsored health coverage became unavailable because the services paid for under that coverage attained the lifetime coverage limit.

(3) Coverage was under a COBRA policy and the COBRA coverage period has ended.

(b) A person who applies for services provided pursuant to this article shall certify, at the time of application, under penalty of perjury, that he or she was not covered by employer-sponsored health coverage during the six-month period prior to the date of his or her application or, if he or she was covered by employer-sponsored health coverage, attest to why one of the reasons listed in subdivision (a) is applicable to him or her and provide documentation from the employer-sponsored health coverage that supports his or her attestation.

(c) A person who has been found eligible for services provided pursuant to this article who is covered by employer-sponsored health coverage that is terminated shall notify the Genetically Handicapped Persons Program within 45 days of the effective date of the termination and, when applicable, provide the program with the certification described in subdivision (b).

(d) An applicant or eligible person who fails to comply with subdivisions (b) and (c) shall be ineligible for services pursuant to this article for six months. The department shall provide written notice to all persons found to be ineligible pursuant to this section.

The notice shall provide information on the ability of the person to appeal or seek a waiver of determinations of ineligibility.

(e) The department shall provide a process to appeal decisions of ineligibility based on this section in accordance with the procedures for resolution of complaints and appeals established for applicants and persons eligible for services pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2.

(f) The director, on a case-by-case basis, may waive determinations of ineligibility pursuant to this section, or reduce the time periods set forth in subdivision (a) or subdivision (d), if the director determines that the determination or the time periods will result in undue hardship.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of Genetically Handicapped Persons Program policy letters. Following consultation with a stakeholder workgroup consisting of, but not limited to, provider associations, provider representatives, and consumer groups to ensure stakeholder participation in the implementation of this section, including, but not limited to, any changes deemed necessary by the department and the stakeholder workgroup to update the application for enrollment form and the development of regulations, the department shall, within 18 months from the effective date of this section, 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.

SEC. 15. Section 125157 is added to the Health and Safety Code, to read:

125157. (a) The department may require a client under this article to apply to enroll or otherwise participate in any other state or federal program or other contractual or legal entitlement that would provide services to the client that would otherwise be reimbursed pursuant to this article.

(b) The department may, when it determines that it is cost effective, pay the premium for, or otherwise subsidize the subscriber cost-sharing obligation for, third-party health coverage for a person eligible for services under this article.

(c) The department may, for a person eligible for services under this article, when the person's third-party health coverage would

lapse due to loss of employment, change in health status, lack of sufficient income or financial resources, or any other reason, continue the health coverage by paying the costs of continuation of group coverage pursuant to federal law or converting from a group to individual plan, when the department determines that it is cost effective.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of Genetically Handicapped Persons Program policy letters. Following consultation with a stakeholder workgroup consisting of, but not limited to, provider associations, provider representatives, and consumer groups to ensure stakeholder participation in the implementation of this section, including, but not limited to, any changes deemed necessary by the department and the stakeholder workgroup to update the application for enrollment form and the development of regulations, the department shall, within 18 months from the effective date of this section, 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.

SEC. 16. Section 125165 of the Health and Safety Code is amended to read:

125165. (a) The department shall determine and establish an enrollment fee for the services provided pursuant to this article.

(b) Beginning July 1, 1993, each client eligible for services shall pay an annual enrollment fee to the department, except as provided in subdivision (f).

(c) (1) The annual enrollment fee schedule shall be a sliding scale based upon family size and income and shall be identical to the fee schedule established under Section 123900. The department shall adjust the scale to reflect changes in the federal poverty level. Family size shall be based upon the number of persons living with the applicant who are dependent upon the family income. Family income shall include the total gross income of the applicant and other individuals living with the applicant.

(2) Until July 1, 1995, the annual enrollment fee for eligible participants who use the Genetically Handicapped Persons Program but receive only case management services provided by the program shall be determined by using 50 percent of the amount

specified in the sliding scale. On or before July 1, 1995, the department shall evaluate the revenue enhancement resulting from the use of this reduced enrollment fee schedule for persons who receive only case management services. After July 1, 1995, all eligible participants shall pay the enrollment fee established pursuant to paragraph (1).

(d) Notwithstanding any other subdivision, those persons whose family income exceeds forty thousand dollars (\$40,000) per year and whose cost of care is 20 percent or less of the family's adjusted gross income shall pay either the enrollment fee or the cost of care, whichever is greater. Those persons whose family income exceeds forty thousand dollars (\$40,000) per year and whose cost of care exceeds 20 percent of the family's adjusted gross income shall pay the enrollment fee.

(e) Payment of the enrollment fee is a condition of program participation and is independent of any other outstanding obligations to the program. The department may arrange for periodic payment during the year if it determines a lump-sum payment will be a hardship for the family. The director, on a case-by-case basis, may waive or reduce the amount of an enrollment fee if the director determines payment of the fee will result in undue hardship. Otherwise, failure to pay or arrange for payment of the enrollment fee within 60 days of the due date shall result in disenrollment and ineligibility for coverage of treatment services effective 60 days after the due date of the fee.

(f) The enrollment fee shall not be charged in the following cases:

(1) The client is eligible for the full scope of Medi-Cal benefits, without being required to pay a share of cost, at the time of enrollment fee determination.

(2) The family of the client otherwise eligible to receive services has a gross annual income of less than 200 percent of the federal poverty level.

(g) Upon determination of program eligibility, the department shall enter into an agreement with the applicant or client legally responsible for that applicant for payment of the enrollment fee.

(h) All enrollment fees shall be used in support of the program for services established under this article.

(i) Commencing July 1, 2009, except as provided in subdivision (j), fee determinations and annual redeterminations shall be controlled by Section 125166.

(j) For a client whose eligibility has been determined or redetermined prior to July 1, 2009, the provisions of this section shall continue to control the fee calculation until the client's next annual redetermination.

(k) This section shall become inoperative on July 1, 2010, and, as of January 1, 2011, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2011, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 17. Section 125166 is added to the Health and Safety Code, to read:

125166. (a) Commencing July 1, 2009, except as provided in subdivision (d), each client determined or redetermined by the department to be eligible for services provided pursuant to this article shall pay an annual enrollment fee to the department as set forth in this section.

(b) (1) There shall be an annual enrollment fee based on the client's adjusted gross income or, if the client is a minor, the client's parents' or legal guardians' combined adjusted gross income, as reported on the relevant state or federal income tax forms for the previous tax year. In calculating the enrollment fee where both a state and a federal income tax form has been filed, the higher of the two adjusted gross income amounts shall be used.

(2) For adjusted gross income between 200 and 299 percent of the federal poverty level, the annual enrollment fee shall be 1.5 percent of adjusted gross income.

(3) For adjusted gross income equal to or greater than 300 percent of the federal poverty level, the annual enrollment fee shall be 3 percent of adjusted gross income.

(4) In the event the annual enrollment fee determined pursuant to paragraph (2) or (3) exceeds the cost of care incurred during the applicable year, the department shall reduce the enrollment fee by refund or credit to an amount equal to the cost of care.

(c) (1) Payment of the enrollment fee is a condition of program participation.

(2) The department may arrange for periodic payment of the fee during the year.

(3) The director, on a case-by-case basis, may waive or reduce the amount of an enrollment fee if the director determines payment of the fee will result in undue hardship for the family. Otherwise, failure to pay or arrange for payment of the enrollment fee within 60 days of the due date shall result in disenrollment and ineligibility for coverage of treatment services effective 60 days after the due date of the fee.

(d) The enrollment fee shall not be charged in the following cases:

(1) The client is eligible for the full scope of Medi-Cal benefits, without being required to pay a share of cost, at the time of enrollment fee determination.

(2) The client who is otherwise eligible to receive services has, or if the client is a minor, the client's parents or guardians have, an adjusted gross income of less than 200 percent of the federal poverty level.

(e) All enrollment fees shall be used in support of the program for services provided pursuant to this article.

(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 implement this section by means of Genetically Handicapped Persons Program policy letters. Following consultation with a stakeholder workgroup consisting of, but not limited to, provider associations, provider representatives, and consumers groups to ensure stakeholder participation in the implementation of this section, including, but not limited to, any changes to update the application for enrollment form and the development of regulations, the department shall, within 18 months from the effective date of this section, 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.

SEC. 18. Section 125175 of the Health and Safety Code is amended to read:

125175. The health care benefits and services specified in this article, to the extent that the benefits and services are neither provided under any other federal or state law nor provided nor available under other contractual or legal entitlements of the person, shall be provided to any patient who is a resident of this state and is made eligible by this article. After the patient has utilized the

contractual or legal entitlements, the payment liability under Section 125165 or Section 125166, whichever shall be applicable at the time, shall then be applied to the remaining cost of genetically handicapped person's services.

SEC. 19. Section 130500 of the Health and Safety Code is amended to read:

130500. (a) This division shall be known, and may be cited, as the California Discount Prescription Drug Program.

(b) The provisions of this division shall become operative on or after July 1, 2010.

SEC. 20. Section 130507 of the Health and Safety Code is amended to read:

130507. (a) On August 1, 2013, the department shall determine whether manufacturer participation in the program has been sufficient to meet both of the following benchmarks:

(1) The number and type of drugs available through the program are sufficient to give eligible Californians a formulary comparable to the Medi-Cal list of contract drugs or, if this information is available to the department, a formulary comparable to that provided to CalPERS enrollees.

(2) The volume weighted average discount of single-source prescription drugs offered pursuant to this program is equal to or below any one of the benchmark prices described in subdivision (a) of Section 130506.

(b) On and after August 10, 2013, the department shall reassess program outcomes, at least once every year, consistent with the benchmarks described in subdivision (a).

SEC. 21. Section 130509 of the Health and Safety Code is amended to read:

130509. (a) The department may require prior authorization in the Medi-Cal program for any drug of a manufacturer if the manufacturer fails to agree to a volume weighted average discount for single-source prescription drugs that is equal to or below any one of the benchmark prices described in subdivision (a) of Section 130506 and only to the extent that this requirement does not increase costs to the Medi-Cal program, as determined pursuant to subdivision (c).

(b) If prior authorization is required for a drug pursuant to this section, a Medi-Cal beneficiary shall not be denied the continued use of a drug that is part of a prescribed therapy until that drug is

no longer prescribed for that beneficiary's therapy. The department shall approve or deny requests for prior authorization necessitated by this section as required by state or federal law.

(c) The department, in consultation with the Department of Finance, shall determine the fiscal impact of placing a drug on prior authorization pursuant to this section. In making this determination, the department shall consider all of the following:

(1) The net cost of the drug, including any rebates that would be lost if the drug is placed on prior authorization.

(2) The projected volume of purchases of the drug, before and after the drug is placed on prior authorization, considering the continuity of care provisions set forth in subdivision (b).

(3) The net cost of comparable drugs to which volume would be shifted if a drug is placed on prior authorization, including any additional rebates that would be received.

(4) The projected volume of purchases of comparable drugs, before and after the drug is placed on prior authorization.

(5) Any other factors determined by the department to be relevant to a determination of the fiscal impact of placing a drug on prior authorization.

(d) This section shall be implemented only to the extent permitted under federal law, and in a manner consistent with state and federal laws.

(e) This section may apply to any manufacturer that has not negotiated with the department.

(f) The department shall notify the Speaker of the Assembly and the President pro Tempore of the Senate that the department is requiring prior authorization no later than five days after making this requirement.

(g) (1) Subject to paragraph (2), this section shall become operative on August 1, 2013.

(2) This section shall become operative only if the department determines that participation by manufacturers has been insufficient to meet both of the benchmarks identified in Section 130507.

SEC. 22. Section 130543 of the Health and Safety Code is amended to read:

130543. (a) The director may adopt regulations as are necessary to implement and administer this division.

(b) 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 division, in whole or in part, by means of a provider bulletin or other similar instructions, without taking regulatory action, provided that no bulletin or other similar instructions shall remain in effect after August 1, 2014. It is the intent that regulations adopted pursuant to this section shall be adopted on or before August 1, 2014.

SEC. 23. Section 12739 of the Insurance Code is amended to read:

12739. (a) There is hereby created in the State Treasury a special fund known as the Major Risk Medical Insurance Fund that is, notwithstanding Section 13340 of the Government Code, continuously appropriated to the board for the purposes specified in Sections 10127.15 and 12739.1 and Section 1373.62 of the Health and Safety Code.

(b) After June 30, 1991, the following amounts shall be deposited annually in the Major Risk Medical Insurance Fund:

(1) (A) Eighteen million dollars (\$18,000,000) from the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund.

(B) Notwithstanding subparagraph (A), for the 2009–10 fiscal year, the Controller shall not deposit any amount into the Major Risk Medical Insurance Fund from the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund.

(2) (A) Eleven million dollars (\$11,000,000) from the Physician Services Account in the Cigarette and Tobacco Products Surtax Fund.

(B) Notwithstanding subparagraph (A), for the 2007–08 fiscal year only, the Controller shall reduce the amount deposited into the Major Risk Medical Insurance Fund from the Physician Services Account in the Cigarette and Tobacco Products Surtax Fund to one million dollars (\$1,000,000).

(3) One million dollars (\$1,000,000) from the Unallocated Account in the Cigarette and Tobacco Products Surtax Fund.

SEC. 24. Section 4107 of the Welfare and Institutions Code is amended to read:

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

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

(c) Notwithstanding any other provision of law, the State Department of Mental Health shall house no more than 1,336 patients at Patton State Hospital. However, until September 2012, up to 1,530 patients may be housed at the hospital.

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

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

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

SEC. 25. Section 4684.60 of the Welfare and Institutions Code is amended to read:

4684.60. The vendoring regional center shall, before placing any consumer into an ARFPSHN, ensure that the ARFPSHN has a license issued by the State Department of Social Services for not more than five adults and a contract with the regional center that includes, at a minimum, all of the following:

- (a) The names of the regional center and the licensee.
- (b) The purpose of the pilot project.
- (c) A requirement that the contractor shall comply with all applicable statutes and regulations, including Section 4681.1.
- (d) The effective date and termination date of the contract.
- (e) A requirement that, under no circumstances, shall the contract extend beyond the stated termination date, which shall not be longer than the pilot legislation end date of January 1, 2011.
- (f) The definition of terms.
- (g) A requirement that the execution of any amendment or modification to the contract be in accordance with all applicable federal and state statutes and regulations and be by mutual agreement of both parties.
- (h) A requirement that the licensee and the agents and employees of the licensee, in the performance of the contract, shall act in an independent capacity, and not as officers or employees or agents of the regional center.
- (i) A requirement that the assignment of the contract for consumer services shall not be allowed.
- (j) The rate of payment per consumer.
- (k) Incorporation, by reference, of the ARFPSHN's approved program plan.
- (l) A requirement that the contractor verify, and maintain for the duration of the project, possession of commercial general liability insurance in the amount of at least one million dollars (\$1,000,000) per occurrence.
- (m) Contractor performance criteria.
- (n) An agreement to provide, to the evaluation contractor engaged pursuant to subdivision (a) of Section 4684.74, all information necessary for evaluating the project.

SEC. 26. Section 4684.74 of the Welfare and Institutions Code is amended to read:

4684.74. (a) By July 1, 2006, the State Department of Developmental Services shall contract with an independent agency or organization to evaluate the pilot project and prepare a written

report of its findings. The scope of services for the contractor shall be jointly prepared by the State Department of Developmental Services, the State Department of Social Services, the State Department of Public Health, and the State Department of Health Care Services and, at a minimum, shall address all of the following:

- (1) The number, business status, and location of all the ARFPSHNs.
- (2) The number and characteristics of the consumers served.
- (3) The effectiveness of the pilot project in addressing consumers' health care and intensive support needs.
- (4) The extent of consumers' community integration and satisfaction.
- (5) The consumers' access to, and quality of, community-based health care and dental services.
- (6) The types, amounts, qualifications, and sufficiency of staffing.
- (7) The overall impressions, problems encountered, and satisfaction with the ARFPSHN service model by ARFPSHN employees, regional center participants, state licensing and monitoring personnel, and consumers and families.
- (8) The costs of all direct, indirect, and ancillary services.
- (9) An analysis and summary findings of all ARFPSHN consumer special incident reports and unusual occurrences reported during the evaluation period.
- (10) The recommendations for improving the ARFPSHN service model.
- (11) The cost-effectiveness of the ARFPSHN model of care compared with other existing public and private models of care serving similar consumers.

(b) The contractor's written report shall be submitted to the State Department of Developmental Services, the State Department of Social Services, the State Department of Public Health, and the State Department of Health Care Services. The State Department of Developmental Services shall submit the report to the appropriate fiscal and policy committees of the Legislature by January 1, 2010.

SEC. 27. Section 4684.75 of the Welfare and Institutions Code is amended to read:

4684.75. (a) The State Department of Developmental Services may adopt emergency regulations 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 State Department of Developmental Services is hereby exempted from the requirement that it describe specific facts showing the need for immediate action. A certificate of compliance for these implementing regulations shall be filed within 24 months following the adoption of the first emergency regulations filed pursuant to this section.

(b) This article shall remain in effect only until January 1, 2011, and as of that date is repealed, unless a later enacted statute extends or deletes that date.

(c) This article shall only be implemented to the extent that funds are made available through an appropriation in the annual Budget Act.

SEC. 28. Section 5783 is added to the Welfare and Institutions Code, to read:

5783. (a) Each eligible public agency, as described in subdivision (b), may, in addition to reimbursement or other payments that the agency would otherwise receive for Medi-Cal specialty mental health services, receive supplemental Medi-Cal reimbursement to the extent provided for in this section.

(b) A public agency shall be eligible for supplemental reimbursement only if it is a county, city, city and county, or the University of California and if, consistent with Section 5778, it meets either or both of the following characteristics continuously during a state fiscal year:

(1) Provides, pursuant to the Medi-Cal Specialty Mental Health Services Consolidation Waiver (Number CA.17), as approved by the federal Centers for Medicare and Medicaid Services, specialty mental health services to Medi-Cal beneficiaries in one or more of its publically owned and operated facilities.

(2) Provides or subcontracts for specialty mental health services to Medi-Cal beneficiaries as a mental health plan (MHP) pursuant to this part.

(c) (1) Subject to paragraph (2), an eligible public agency's supplemental reimbursement pursuant to this section shall be equal to the amount of federal financial participation received as a result

of the claims submitted pursuant to paragraph (2) of subdivision (f).

(2) Notwithstanding paragraph (1), in computing an eligible public agency's reimbursement, in no instance shall the expenditures certified pursuant to paragraph (1) of subdivision (e), when combined with the amount received from other sources of payment and with reimbursement from the Medi-Cal program, including expenditures otherwise certified for purposes of claiming federal financial participation, exceed 100 percent of actual, allowable costs, as determined pursuant to California's Medicaid State Plan, for the specialty mental health services to which the expenditure relates. Supplemental payment may be made on an interim basis until the time when actual, allowable costs are finally determined.

(3) The supplemental Medi-Cal reimbursement provided by this section shall be distributed under a payment methodology based on specialty mental health services provided to Medi-Cal patients by each eligible public agency, on a per-visit basis, a per-procedure basis, a time basis, in one or more lump sums, or on any other federally permissible basis. The State Department of Health Care Services shall seek approval from the federal Centers for Medicare and Medicaid Services for the payment methodology to be utilized, and shall not make any payment pursuant to this section prior to obtaining that federal approval.

(d) (1) It is the intent of the Legislature in enacting this section to provide the supplemental reimbursement described in this section without any expenditure from the General Fund. The department or the State Department of Health Care Services may require an eligible public agency, as a condition of receiving supplemental reimbursement pursuant to this section, to enter into, and maintain, an agreement with the department for the purposes of implementing this section and reimbursing the department and the State Department of Health Care Services for the costs of administering this section.

(2) Expenditures submitted to the department and to the State Department of Health Care Services for purposes of claiming federal financial participation under this section shall have been paid only with funds from the public agencies described in subdivision (b) and certified to the state as provided in subdivision (e).

(e) An eligible public agency shall do all of the following:

(1) Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for the specialty mental health services are eligible for federal financial participation.

(2) Provide evidence supporting the certification as specified by the department or by the State Department of Health Care Services.

(3) Submit data as specified by the department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.

(4) Keep, maintain, and have readily retrievable, any records specified by the department or by the State Department of Health Care Services to fully disclose reimbursement amounts to which the eligible public agency is entitled, and any other records required by the federal Centers for Medicare and Medicaid Services.

(f) (1) The State Department of Health Care Services shall promptly seek any necessary federal approvals for the implementation of this section. If necessary to obtain federal approval, the program shall be limited to those costs that the federal Centers for Medicare and Medicaid Services determines to be allowable expenditures under Title XIX of the federal Social Security Act (Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code). If federal approval is not obtained for implementation of this section, this section shall not be implemented.

(2) The State Department of Health Care Services shall submit claims for federal financial participation for the expenditures described in subdivision (e) related to specialty mental health services that are allowable expenditures under federal law.

(3) The State Department of Health Care Services shall, on an annual basis, submit any necessary materials to the federal Centers for Medicare and Medicaid Services to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

(4) The department shall collaborate with the State Department of Health Care Services to ensure that the department's policies, procedures, data, and other relevant materials are available to the State Department of Health Care Services as may be required for

the implementation and administration of this section and for the claiming of federal financial participation.

(g) (1) The director may adopt regulations as are necessary to implement this section. The adoption, amendment, repeal, or readoption of a regulation authorized by this subdivision shall be 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) As an alternative to the adoption of regulations pursuant to paragraph (1), 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 and administer this article, in whole or in part, by means of provider bulletins or similar instructions, without taking regulatory action, provided that no bulletin or similar instruction shall remain in effect after June 30, 2011. It is the intent that regulations adopted pursuant to paragraph (1) shall be in place on or before June 30, 2011.

SEC. 29. Section 7502.5 of the Welfare and Institutions Code is amended to read:

7502.5. The total number of developmental center residents in the secure treatment facility at Porterville Developmental Center, including those residents receiving services in the Porterville Development Center transition treatment program, shall not exceed 297.

SEC. 30. Section 14005.40 of the Welfare and Institutions Code is amended to read:

14005.40. (a) To the extent federal financial participation is available, the department shall exercise its option under Section 1902(a)(10)(A)(ii)(X) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(X)), to implement a program for aged and disabled persons as described in Section 1902(m) of the federal Social Security Act (42 U.S.C. Sec. 1396a(m)(1)).

(b) To the extent federal financial participation is available, the blind shall be included within the definition of disabled for the purposes of the program established in this section.

(c) An individual shall satisfy the financial eligibility requirement of this program if all of the following conditions are met:

(1) Countable income, as determined in accordance with Section 1902(m) of the federal Social Security Act (42 U.S.C. Sec. 1396a(m)), does not exceed an income standard equal to 100 percent of the applicable federal poverty level, plus two hundred thirty dollars (\$230) for an individual or, in the case of a couple, three hundred ten dollars (\$310), provided that the income standard so determined shall not be less than the SSI/SSP payment level for a disabled individual or, in the case of a couple, the SSI/SSP payment level for a disabled couple.

(2) (A) For the purposes of calculating countable income under this section, an income exemption shall be applied as necessary to adjust the SSI/SSP payment level as used in this section so that it is the same as the SSI/SSP payment level that was in place on May 1, 2009.

(B) This additional income exemption shall cease to be implemented when the SSI/SSP payment levels increase beyond those in effect on May 1, 2009.

(C) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this paragraph by means of an all-county letter or similar instruction without taking regulatory action.

(3) Countable resources, as determined in accordance with Section 1902(m) of the federal Social Security Act (42 U.S.C. Sec. 1396a(m)), do not exceed the maximum levels established in that section.

(d) The financial eligibility requirements provided in subdivision (c) may be adjusted upwards to reflect the cost of living in California, contingent upon appropriation in the annual Budget Act.

(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 implement this section by means of all-county letters or similar instructions, and without taking regulatory action. 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.

(f) For purposes of calculating income under this section during any calendar year, increases in social security benefit payments under Title II of the federal Social Security Act (42 U.S.C. Sec.

401 et seq.) arising from cost-of-living adjustments shall be disregarded commencing in the month that these social security benefit payments are increased by the cost-of-living adjustment through the month before the month in which a change in the federal poverty level requires the department to modify the income standard described in subdivision (c).

(g) (1) For purposes of this section the following definitions apply:

(A) “SSI” means the federal Supplemental Security Income program established under Title XVI of the federal Social Security Act.

(B) “Income standard” means the applicable income standard including the augmentations specified in paragraph (1) of subdivision (c).

(C) The board and care “personal care services” or “PCS” deduction refers to an income disregard that is applied to a resident in a licensed community care facility in lieu of the board and care deduction (equal to the amount by which the basic board and care rate exceeds the income standard in subparagraph (B), of paragraph (1) of subdivision (g)) when the PCS deduction is greater than the board and care deduction.

(2) (A) For purposes of this section, the SSI recipient retention amount is the amount by which the SSI maximum payment amount to an individual residing in a licensed community care facility exceeds the maximum amount that the state allows community care facilities to charge a resident who is an SSI recipient.

(B) For the purposes of this section, the personal and incidental needs deduction for an individual residing in a licensed community care facility is either of the following:

(i) If the board and care deduction is applicable to the individual, the amount, not to exceed the amount by which the SSI recipient retention amount exceeds twenty dollars (\$20), nor to be less than zero, by which the sum of the amount which the individual pays to his or her licensed community care facility and the SSI recipient retention amount exceed the sum of the individual’s income standard, the individual’s board and care deduction, and twenty dollars (\$20).

(ii) If the PCS deduction specified in paragraph (1) of subdivision (g) is applicable to the individual, an amount, not to exceed the amount by which the SSI recipient retention amount

exceeds twenty dollars (\$20), nor to be less than zero, by which the sum of the amount which the individual pays to his or her community care facility and the SSI recipient retention amount exceed the sum of the individual's income standard, the individual's PCS deduction and twenty dollars (\$20).

(3) In determining the countable income under this section of an individual residing in a licensed community care facility, the individual shall have deducted from his or her income the amount specified in subparagraph (B) of paragraph (2).

(h) No later than one month after the effective date of subdivision (g), the department shall submit to the federal medicaid administrator a state plan amendment seeking approval of the income deduction specified in paragraph (3) of subdivision (g), and of federal financial participation for the costs resulting from that income deduction.

(i) The deduction prescribed by paragraph (3) of subdivision (g) shall be applied no later than the first day of the fourth month after the month in which the department receives approval for the federal financial participation specified in subdivision (h). Until approval for federal financial participation is received, there shall be no deduction under paragraph (3) of subdivision (g).

SEC. 31. Section 14005.50 is added to the Welfare and Institutions Code, to read:

14005.50. (a) To the extent that federal financial participation is available, the department shall exercise the option made available under Section 1902(a)(10)(A)(ii)(I) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(I)) to extend full-scope Medi-Cal benefits to individuals who are ineligible for full-scope Medi-Cal benefits under a program listed in subdivision (c) as a result of the July 1, 2009, reduction in the SSI/SSP program maximum aid payments pursuant to Section 12200.019, or any subsequent reductions in maximum aid payments.

(b) The programs authorized under this section shall utilize the income and resource standards and methodologies of the SSI/SSP program and in addition an income disregard shall be applied as necessary to adjust the income standard to that which was in place for the affected program on May 1, 2009.

(c) (1) The SSI/SSP program under Title XVI of the federal Social Security Act.

(2) The Pickle program under the Pickle Amendment to Title XIX of the federal Social Security Act (Public Law 94-566).

(3) The Disabled Adult Child program under Section 1634 of the federal Social Security Act (42 U.S.C. Sec. 1383c).

(4) The Disabled Widow or Widower program under Section 1634 of the federal Social Security Act (42 U.S.C. Sec. 1383c).

(d) Notwithstanding subdivision (b), for the purposes of this section, for blind individuals who meet the criteria for blindness as set forth in Section 1614(a)(2) of the federal Social Security Act (42 U.S.C. Sec. 1382c(a)(2)), but who have not been determined to be disabled in accordance with Section 1614(a)(3) of that Act (42 U.S.C. Sec. 1382c(a)(3)), the income and resource standards and methodologies applied in determining eligibility under this section shall be identical to that of the Aged and Disabled Federal Poverty Level program under Section 14005.40.

(e) The department shall implement an expedited application process to determine the Medi-Cal eligibility under this section for individuals who, based on excess income, are denied eligibility for the SSI/SSP program by the Social Security Administration. The department shall use its best efforts to identify these individuals from information provided by the Social Security Administration. The department shall also allow these individuals to self-identify by producing a copy of the notice of action that they received from the Social Security Administration informing them that their application for eligibility for the SSI/SSP program was denied based on excess income.

(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 implement this section by means of an all-county letter or similar instruction without taking regulatory action.

(g) This section shall cease to be implemented when the SSI/SSP program payment levels increase beyond those in effect on May 1, 2009.

(h) Nothing in this section shall be read as entitling any individual to Medi-Cal benefits before his or her Medi-Cal eligibility determination has been completed.

(i) This section shall not change the procedures for redetermining a beneficiary's eligibility for Medi-Cal benefits.

(j) The department shall seek any approvals from the federal Centers for Medicare and Medicaid Services necessary to obtain federal financial participation and to expeditiously implement this section.

SEC. 32. Section 14007.9 of the Welfare and Institutions Code is amended to read:

14007.9. (a) The department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XIII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII)). In order to be eligible for benefits under this section, an individual shall be required to meet all of the following requirements:

(1) His or her net countable income is less than 250 percent of the federal poverty level for one person or, if the deeming of spousal income applies to the individual, his or her net countable income is less than 250 percent of the federal poverty level for two persons.

(2) He or she is disabled under Title II of the Social Security Act (Subch. 2 (commencing with Sec. 401), Ch. 7, Title 42 U.S.C.), Title XVI of the Social Security Act (Subch. 16 (commencing with Sec. 1381), Ch. 7, Title 42, U.S.C.), or Section 1902(v) of the Social Security Act (42 U.S.C. Sec. 1396a(v)). An individual shall be determined to be eligible under this section without regard to his or her ability to engage in, or actual engagement in, substantial gainful activity, as defined in Section 223(d)(4) of the Social Security Act (42 U.S.C. Sec. 423(d)(4)).

(3) Except as otherwise provided in this section, his or her net nonexempt resources, which shall be determined in accordance with the methodology used under Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), are not in excess of the limits provided for under those provisions.

(b) (1) Countable income shall be determined under Section 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), except that the individual's disability income, including all federal and state disability benefits and private disability insurance, shall be exempted. Resources excluded under Section 1613 of the federal Social Security Act (42 U.S.C. Sec. 1382b) shall be disregarded.

(2) Resources in the form of employer or individual retirement arrangements authorized under the Internal Revenue Code shall be exempted as authorized by Section 1902(r) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)).

(3) (A) For the purposes of calculating countable income under this section, an income exemption shall be applied as necessary to adjust the income standard so that it is the same as the income standard that was in place on May 1, 2009.

(B) This additional income exemption shall cease to be implemented when the SSI/SSP program payment levels increase beyond those in effect on May 1, 2009.

(C) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this paragraph by means of an all-county letter or similar instruction without taking regulatory action.

(c) Medi-Cal benefits provided under this chapter pursuant to this section shall be available in the same amount, duration, and scope as those benefits are available for persons who are eligible for Medi-Cal benefits as categorically needy persons and as specified in Section 14007.5.

(d) Individuals eligible for Medi-Cal benefits under this section shall be subject to the payment of premiums determined under this subdivision. The department shall establish sliding-scale premiums that are based on countable income, with a minimum premium of twenty dollars (\$20) per month and a maximum premium of two hundred fifty dollars (\$250) per month, and shall, by regulations, annually adjust the premiums. Prior to adjustment of any premiums pursuant to this subdivision, the department shall submit a report of proposed premium adjustments to the appropriate committees of the Legislature as part of the annual budget act process.

(e) The department shall adopt regulations specifying the process for discontinuance of eligibility under this section for nonpayment of premiums for more than two months by a beneficiary.

(f) In order to implement the collection of premiums under this section, the department may develop and execute a contract with a public or private entity to collect premiums, or may amend any existing or future premium-collection contract that it has executed. Notwithstanding any other provision of law, any contract developed and executed or amended pursuant to this subdivision is exempt from the approval of the Director of General Services and from the Public Contract Code.

(g) 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 department shall implement, without taking any regulatory action, this section by means of an all-county letter or similar instruction. 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.

(h) Notwithstanding any other provision of law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation is available pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(i) Subject to subdivision (h), this section shall be implemented commencing April 1, 2000.

SEC. 33. Section 14011.2 of the Welfare and Institutions Code, as amended by Section 61 of Chapter 74 of the Statutes of 2006, is amended to read:

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

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

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

(d) Every applicant or beneficiary or, in the case of a child, by the child's caretaker relative or legal guardian on his or her behalf shall declare, under penalty of perjury, that he or she is, or is not any of the following:

- (1) A citizen of the United States.
- (2) A national of the United States.
- (3) An alien who has satisfactory immigration status.

(e) (1) Notwithstanding Section 50301.1 of Title 22 of the California Code of Regulations, an individual who declares to be a citizen or national of the United States in accordance with Section 1903(i)(22) of the federal Social Security Act (42 U.S.C. Sec. 1396b(i)(22)) shall present satisfactory documentary evidence of citizenship or nationality in compliance with Section 1903(x) (42 U.S.C. Sec. 1396b(x) of the federal Social Security Act). Except as otherwise provided in Section 14007.2 and in paragraph (7), no services shall be available under this chapter for an individual who fails to comply with the documentation requirements of this section.

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

- (i) During the initial application process for applicants.
- (ii) During the redetermination process for existing beneficiaries.

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

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

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

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

or other failure to provide the required documentation, and relying on other information that may be available electronically.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) To the extent federal financial participation is available, and only to the extent any necessary federal approvals have been obtained, the department may, in its discretion, elect the option referenced in Section 1396a(a)(46)(B)(ii) of Title 42 of the United States Code to satisfy the requirements of paragraph (1). This paragraph shall become operative on January 1, 2010, or when all necessary agreements with the Commissioner of Social Security are in place, whichever is later. The department may implement this paragraph earlier than January 1, 2010, only to the extent allowed by federal law or guidance.

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

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

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

(B) The termination of Medi-Cal benefits under this paragraph shall occur without the necessity of further review or determination by the department. This shall not affect an individual's right to a

hearing with respect to the denial of the application or termination of eligibility resulting from the annual eligibility redetermination.

(9) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this subdivision by means of an all county letter or similar instruction without taking regulatory action. Within three years from the date that this subdivision becomes effective, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

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

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

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

SEC. 34. Section 14013.5 is added to the Welfare and Institutions Code, to read:

14013.5. (a) Pursuant to, and only to the extent required by, Section 1940 of the federal Social Security Act (42 U.S.C. Sec. 1396w) and subject to the provisions of this section, the department shall implement an asset verification program for the purpose of determining or redetermining the eligibility of an applicant for, or recipient of, Medi-Cal benefits on the basis of being aged, blind, or disabled.

(b) (1) Any applicant or recipient described in subdivision (a), and any other person whose resources are required by law to be disclosed to determine the eligibility of the applicant or recipient, shall provide authorization for the department to obtain from any financial institution any financial record held by the institution with respect to the applicant or recipient, and any other person, as applicable, whenever the department determines the record is

needed in connection with a determination with respect to the eligibility for, or the amount or extent of, the medical assistance.

(2) The department's obtaining of financial records pursuant to this section shall be subject to the cost reimbursement requirements of Section 1115(a) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3415(a)) and shall be at no cost to the applicant, recipient, or any other person.

(3) An authorization under this subdivision shall not be required for any applicant or recipient whose assets have been verified by the federal Social Security Administration.

(4) An authorization under this subdivision shall only be required for those applicants and recipients as required by federal law and federal guidance.

(c) As used in this section:

(1) "Financial institution" has the same meaning as defined in Section 1101(1) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3401(1)).

(2) "Financial record" has the same meaning as defined in Section 1101(2) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3401(2)).

(3) "Any other person" shall mean the spouse of an applicant or recipient, a parent of an unemancipated minor, or any other person whose resources are required by federal law to be disclosed to determine the eligibility of the applicant or recipient.

(d) An authorization provided to the department under subdivision (b) shall remain effective until the earlier of:

(1) The rendering of a final adverse decision on the applicant's application for medical assistance.

(2) The cessation of the recipient's eligibility for the medical assistance.

(3) The express revocation by the applicant or recipient, or other required person, as applicable, of the authorization, in a written notification to the department.

(e) (1) An authorization obtained by the department under subdivision (b) shall be considered as meeting the requirements of Section 1103(a) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3403(a)) and, notwithstanding Section 1104(a) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3404(a)), need not be furnished to the financial institution.

(2) The certification requirements of Section 1103(b) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3403(b)) shall not apply to requests by the department or its designee pursuant to an authorization provided under subdivision (b).

(3) A request by the department or its designee pursuant to an authorization provided under subdivision (b) shall be deemed to meet the requirements of Section 1104(a)(3) of the federal Right to Financial Privacy Act of 1978 (12 U.S.C. Sec. 3404(a)(3)) and of Section 1102 of the act (12 U.S.C. Sec. 3402), relating to a reasonable description of financial records.

(f) If an applicant for, or recipient of, medical assistance, or other required person, as applicable, refuses to provide, or revokes, any authorization made by the applicant or recipient, or other required person, as applicable, for the department to obtain from any financial institution any financial record, the department may, on that basis, determine that the applicant or recipient is ineligible for medical assistance.

(g) The department shall provide the applicant or recipient with notice of the asset verification requirement of this section, including privacy protections and the duration and scope of the authorization, prior to the applicant or recipient being requested to provide the authorization required by subdivision (b).

(h) The department shall, in coordination with the counties and advocates, develop criteria regarding how and when the authorization required under subdivision (b) will be required, how and when verification will be required, what standards will be used, and the content of the notice to the applicants and recipients described in subdivision (g) concerning the authorization.

(i) 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 department shall implement, without taking any regulatory action, this section by means of an all-county letter or similar instruction. 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.

(j) To implement this section, the department may contract with public or private entities that shall be subject to the same requirements and limitations on use and disclosure of information

as would apply if the department were to implement this section directly. In order to demonstrate good faith efforts to meet federal implementation requirements of Section 1940 of the federal Social Security Act (42 U.S.C. Sec. 1396w) and to avoid any withholding of federal financial participation, 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 Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part. Contracts under this section shall be exempt from the requirements of Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of the Government Code.

SEC. 35. Section 14087.9 of the Welfare and Institutions Code is amended to read:

14087.9. A combination of counties may contract with the department pursuant to this article for the provision of services.

SEC. 36. Section 14105.191 of the Welfare and Institutions Code is amended to read:

14105.191. (a) Notwithstanding any other provision of law, in order to implement changes in the level of funding for health care services, the director shall reduce provider payments, as specified in this section.

(b) (1) Except as otherwise provided in this section, payments shall be reduced by 1 percent for Medi-Cal fee-for-service benefits for dates of service on and after March 1, 2009.

(2) Except as provided in subdivision (d), for dates of service on and after March 1, 2009, payments to the following classes of providers shall be reduced by 5 percent for Medi-Cal fee-for-service benefits:

(A) Intermediate care facilities, excluding those facilities identified in paragraph (5) of subdivision (d). For purposes of this section, “intermediate care facility” has the same meaning as defined in Section 51118 of Title 22 of the California Code of Regulations.

(B) Skilled nursing facilities that are distinct parts of general acute care hospitals. For purposes of this section, “distinct part” has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(C) Rural swing-bed facilities.

(D) Subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this subparagraph, “subacute care unit” has the same meaning as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(E) Pediatric subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this subparagraph, “pediatric subacute care unit” has the same meaning as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(F) Adult day health care centers.

(3) Except as provided in subdivision (d), for dates of service on and after March 1, 2009, Medi-Cal fee-for-service payments to pharmacies shall be reduced by 5 percent.

(4) Except as provided in subdivision (d), payments shall be reduced by 1 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after March 1, 2009.

(5) For managed health care plans that contract with the department pursuant to this chapter, Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590), payments shall be reduced by the actuarial equivalent amount of the payment reductions specified in this subdivision pursuant to contract amendments or change orders effective on July 1, 2008, or thereafter.

(c) Notwithstanding any other provision of this section, payments to hospitals that are not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) for inpatient hospital services provided to Medi-Cal beneficiaries and that are subject to Section 14166.245 shall be governed by that section.

(d) To the extent applicable, the services, facilities, and payments listed in this subdivision shall be exempt from the payment reductions specified in subdivision (b):

(1) Acute hospital inpatient services that are paid under contracts pursuant to Article 2.6 (commencing with Section 14081).

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver pursuant to subsection (a) of Section 1115 of the federal Social Security Act (42 U.S.C. Sec. 1315(a)).

(3) Rural health clinic services.

(4) Skilled nursing facilities licensed pursuant to subdivision (c) of Section 1250 of the Health and Safety Code other than those specified in paragraph (2) of subdivision (b).

(5) Intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, or facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14495.10.

(6) Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services.

(7) Hospice services.

(8) Contract services, as designated by the director pursuant to subdivision (g).

(9) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations.

(10) Services pursuant to local assistance contracts and interagency agreements to the extent the funding is not included in the funds appropriated to the department in the annual Budget Act.

(11) Payments to Medi-Cal managed care plans pursuant to Section 4474.5 for services to consumers transitioning from Agnews Developmental Center into the Counties of Alameda, San Mateo, and Santa Clara pursuant to the Plan for the Closure of Agnews Developmental Center.

(12) Breast and cervical cancer treatment provided pursuant to Section 14007.71 and as described in paragraph (3) of subdivision (a) of Section 14105.18 or Article 1.5 (commencing with Section 104160) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code.

(13) The Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program pursuant to Section 14105.18.

(14) Small and rural hospitals, as defined in Section 124840 of the Health and Safety Code.

(e) Subject to the exemptions listed in subdivision (d), the payment reductions required by paragraph (1) of subdivision (b) shall apply to the benefits rendered by any provider who may be

authorized to bill for provision of the benefit, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse midwives, nurse anesthetists, and organized outpatient clinics.

(f) (1) Notwithstanding any other provision of law, Medi-Cal reimbursement rates applicable to the classes of providers identified in paragraph (2) of subdivision (b), for services rendered during the 2009–10 rate year and each rate year thereafter, shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008–09 rate year.

(2) In addition to the classes of providers described in paragraph (1), Medi-Cal reimbursement rates applicable to the following classes of facilities for services rendered during the 2009–10 rate year, and each rate year thereafter, shall not exceed the reimbursement rates that were applicable to those facilities and services in the 2008–09 rate year:

(A) Facilities identified in paragraph (5) of subdivision (d).

(B) Freestanding pediatric subacute care units, as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(3) Paragraphs (1) and (2) shall not apply to providers that are paid pursuant to Article 3.8 (commencing with Section 14126), or to services, facilities, and payments specified in subdivision (d), with the exception of facilities described in paragraph (5) of subdivision (d).

(4) The limitation set forth in this subdivision shall be applied only after the reductions in paragraph (2) of subdivision (b) have been made.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer this section by means of provider bulletins, or similar instructions, without taking regulatory action.

(h) The reductions and limitations described in this section shall apply only to payments for benefits when the General Fund share of the payment is paid with funds directly appropriated to the department in the annual Budget Act, and shall not apply to payments for benefits paid with funds appropriated to other departments or agencies.

(i) The department shall promptly seek any necessary federal approvals for the implementation of this section. To the extent that

federal financial participation is not available with respect to any payment that is reduced or limited pursuant to this section, the director may elect not to implement that reduction or limitation.

SEC. 37. Section 14105.436 of the Welfare and Institutions Code is amended to read:

14105.436. (a) Effective July 1, 2002, all pharmaceutical manufacturers shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 and reimbursed through the Medi-Cal outpatient fee-for-service drug program. The state rebate shall be negotiated as necessary between the department and the pharmaceutical manufacturer. The negotiations shall take into account offers such as rebates, discounts, disease management programs, and other cost savings offerings and shall be retroactive to July 1, 2002.

(b) The department may use existing administrative mechanisms for any drug for which the department does not obtain a rebate pursuant to subdivision (a). The department may only use those mechanisms in the event that, by February 1, 2003, the manufacturer refuses to provide the additional rebate. This subdivision shall become inoperative on January 1, 2010.

(c) For purposes of this section, “Medi-Cal utilization data” means the data used by the department to reimburse providers under all programs that qualify for federal drug rebates pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8) or that otherwise qualify for federal funds under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) pursuant to the Medicaid state plan or waivers. Medi-Cal utilization data excludes data from covered entities identified in Section 256b(a)(4) of Title 42 of the United States Code in accordance with Sections 256b(a)(5)(A) and 1396r-8(a)(5)(C) of Title 42 of the United States Code, and those capitated plans that include a prescription drug benefit in the capitated rate and that have negotiated contracts for rebates or discounts with manufacturers.

(d) Effective July 1, 2009, all pharmaceutical manufacturers shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, equal to an amount not less than 10 percent of the average manufacturer price

based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2.

(e) Pharmaceutical manufacturers shall, by January 1, 2010, enter into a supplemental rebate agreement for the rebate required in subdivision (d) for drug products added to the Medi-Cal list of contract drugs on or before December 31, 2009.

(f) Effective January 1, 2010, all pharmaceutical manufacturers who have not entered into a supplemental rebate agreement pursuant to subdivisions (d) and (e), shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, equal to an amount not less than 20 percent of the average manufacturer price based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 prior to January 1, 2010. If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement by March 1, 2010, the manufacturer's drug product shall be made available only through an approved treatment authorization request pursuant to subdivision (h).

(g) For a drug product added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 on or after January 1, 2010, a pharmaceutical manufacturer shall provide to the department a state rebate pursuant to subdivision (d). If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement within 60 days after the addition of the drug to the Medi-Cal list of contract drugs, the manufacturer shall provide to the department a state rebate equal to not less than 20 percent of the average manufacturers price based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2. If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement within 120 days after the addition of the drug to the Medi-Cal list of contract drugs, the pharmaceutical manufacturer's drug product shall be made available only through an approved treatment authorization request pursuant to subdivision (h). For supplemental rebate agreements executed more than 120 days after the addition of the drug product to the Medi-Cal list of contract drugs, the state rebate shall equal an amount not less than 20 percent of the average manufacturers price based on Medi-Cal

utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2.

(h) Notwithstanding any other provision of law, drug products added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 of manufacturers who do not execute an agreement to pay additional rebates pursuant to this section, shall be available only through an approved treatment authorization request.

(i) For drug products added on or before December 31, 2009, a beneficiary may obtain a drug product that requires a treatment authorization request pursuant to subdivision (h) if the beneficiary qualifies for continuing care status. To be eligible for continuing care status, a beneficiary must be taking the drug product and the department must have record of a reimbursed claim for the drug product with a date of service that is within 100 days prior to the date the drug product was placed on treatment authorization request status. A beneficiary may remain eligible for continuing care status, provided that a claim is submitted for the drug 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 drug product.

(j) Changes made to the Medi-Cal list of contract drugs under this section shall be 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.

SEC. 38. 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 as the average wholesale price 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).

(12) “Volume weighted average” means the aggregated average volume for generically equivalent drugs, weighted by each drug’s percentage of the total volume in the Medi-Cal fee-for-service program during the previous six months. For purposes of this paragraph, volume is based on the standard billing unit used for the generically equivalent drugs.

(13) “Wholesaler acquisition cost” means the price for a drug product listed as the wholesaler acquisition cost in the department’s primary price reference source.

(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 establish a MAIC only when three or more generically equivalent drugs are available for purchase and dispensing by retail pharmacies in California. 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) If average manufacturer prices are unavailable, the department shall establish the MAIC in either of the following ways:

(i) Based on the volume weighted average of wholesaler acquisition costs 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.

(ii) Pursuant to a contract with a vendor for the purpose of surveying drug price information, collecting data, and calculating a proposed MAIC.

(C) The department may enter into contracts with a vendor for the purpose of this section on a bid or nonbid basis. 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.

(D) 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.

(E) The department shall establish a process for providers to seek a change to a specific MAIC when the providers believe the MAIC does not reflect current available market prices. If the department determines a MAIC change is warranted, the department may update a specific MAIC prior to notifying providers.

(F) In determining the average purchase price, the department shall consider the provider-related costs of the products that include, but are not limited to, shipping, handling, storage, and delivery. Costs of the provider that are included in the costs of the dispensing shall not be used to determine the average purchase price.

(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. 39. Section 14105.455 is added to the Welfare and Institutions Code, to read:

14105.455. (a) Pharmacy providers shall submit their usual and customary charge when billing the Medi-Cal program for prescribed drugs.

(b) “Usual and customary charge” means the lower of the following:

(1) The lowest price reimbursed to the pharmacy by other third-party payers in California, excluding Medi-Cal managed care plans and Medicare Part D prescription drug plans.

(2) The lowest price routinely offered to any segment of the general public.

(c) Donations or discounts provided to a charitable organization are not considered usual and customary charges.

(d) Pharmacy providers shall keep and maintain records of their usual and customary charges for a period of three years from the date the service was rendered.

(e) Payment to pharmacy providers shall be the lower of the pharmacy’s usual and customary charge or the reimbursement rate pursuant to subdivision (b) of Section 14105.45.

(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.

SEC. 40. Section 14105.46 is added to the Welfare and Institutions Code, to read:

14105.46. (a) For purposes of this section:

(1) “Covered entity” means a provider defined as a covered entity in Section 256b of Title 42 of the United States Code.

(2) “340B” means the discount drug purchasing program described in Section 256b of Title 42 of the United States Code.

(b) A covered entity shall dispense only 340B drugs to Medi-Cal beneficiaries.

(c) If a covered entity is unable to purchase a specific 340B drug, the covered entity may dispense a drug purchased at regular drug wholesale rates to a Medi-Cal beneficiary. If a covered entity dispenses a drug purchased at regular drug wholesale rates pursuant to this subdivision, the covered entity is required to maintain documentation of their inability to obtain the 340B drug.

(d) A covered entity shall bill an amount not to exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with Section 256b of Title 42 of the United States Code plus the professional fee pursuant to Section 14105.45 or the dispensing fee pursuant to Section 14132.01.

(e) A covered entity shall identify a 340B drug on the claim submitted to the Medi-Cal program for reimbursement.

(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.

SEC. 41. Section 14110.55 of the Welfare and Institutions Code is amended to read:

14110.55. For the purposes of the pilot program established under Section 14495.10, or, if Section 14495.10 is repealed and replaced by Section 14132.20, then under the program implemented pursuant to Section 14132.20, the department shall develop a reimbursement rate for continuous skilled nursing care services provided by a participating health facility to developmentally disabled individuals who meet the federal waiver eligibility criteria or Medi-Cal State Plan amendment criteria. The reimbursement rate shall be determined in accordance with a methodology that shall be developed by the department. The department may elect to establish individual patient-specific rates.

SEC. 42. 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 federal 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 purposes 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) For the 2009–10 and 2010–11 rate years, the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not be increased with respect to the weighted average Medi-Cal reimbursement rate for the 2008–09 rate year, as adjusted for the projected cost of complying with new state or federal mandates.

(E) To the extent that new rates are projected to exceed the adjusted limits calculated pursuant to subparagraphs (A) to (D), inclusive, as applicable, the department shall adjust 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, 2011.

(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, 2011, and as of January 1, 2012, is repealed, unless a later enacted statute, that is enacted before January 1, 2012, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 43. Section 14132 of the Welfare and Institutions Code is amended to read:

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

(a) Outpatient services are covered as follows:

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

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

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

(d) (1) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(2) Purchase of drugs used to treat erectile dysfunction or any off-label uses of those drugs are covered only to the extent that federal financial participation is available.

(3) (A) To the extent required by federal law, the purchase of outpatient prescribed drugs, for which the prescription is executed by a prescriber in written, nonelectronic form on or after April 1,

2008, is covered only when executed on a tamper resistant prescription form. The implementation of this paragraph shall conform to the guidance issued by the federal Centers of Medicare and Medicaid Services but shall not conflict with state statutes on the characteristics of tamper resistant prescriptions for controlled substances, including Section 11162.1 of the Health and Safety Code. The department shall provide providers and beneficiaries with as much flexibility in implementing these rules as allowed by the federal government. The department shall notify and consult with appropriate stakeholders in implementing, interpreting, or making specific this paragraph.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instructions without taking regulatory action.

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

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

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the

director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.

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

(A) Periodontal treatment is not a benefit.

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

(C) Laboratory processed crowns are not a benefit.

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

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

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

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

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

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

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

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

custom-made orthopedic shoes are covered, subject to utilization controls.

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

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

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

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

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

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

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

(p) (1) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(2) Commencing 30 days after the effective date of the act that added this paragraph, and notwithstanding the number of days previously approved through a treatment authorization request, adult day health care is covered for a maximum of three days per week.

(3) As provided in accordance with paragraph (4), adult day health care is covered for a maximum of five days per week.

(4) As of the date that the director makes the declaration described in subdivision (g) of Section 14525.1, paragraph (2) shall become inoperative and paragraph (3) shall become operative.

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

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

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

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

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

(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be

provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, “in-home medical care service” includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

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

- (1) Level of care and cost of care evaluations.
- (2) Expenses, directly attributable to home care activities, for materials.
- (3) Physician fees for home visits.
- (4) Expenses directly attributable to home care activities for shelter and modification to shelter.
- (5) Expenses directly attributable to additional costs of special diets, including tube feeding.
- (6) Medically related personal services.
- (7) Home nursing education.
- (8) Emergency maintenance repair.
- (9) Home health agency personnel benefits which permit coverage of care during periods when regular personnel are on vacation or using sick leave.
- (10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.
- (11) Emergency and nonemergency medical transportation.
- (12) Medical supplies.
- (13) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.
- (14) Utility use directly attributable to the requirements of home care activities which are in addition to normal utility use.
- (15) Special drugs and medications.
- (16) Home health agency supervision of visiting staff which is medically necessary, but not included in the home health agency rate.
- (17) Therapy services.
- (18) Household appliances and household utensil costs directly attributable to home care activities.
- (19) Modification of medical equipment for home use.
- (20) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

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

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

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

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

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

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

(w) Hospice service which is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be

available only to the extent that no additional net program costs are incurred.

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

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

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

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

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

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

(2) The department shall seek a waiver for a program to provide comprehensive clinical family planning services as described in

paragraph (8). The program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. The services shall be provided under the program only if the waiver is approved by the federal Centers for Medicare and Medicaid Services in accordance with Section 1396n of Title 42 of the United States Code and only to the extent that federal financial participation is available for the services.

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

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

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

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

considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

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

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

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration approved contraceptive drugs, devices, and

supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

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

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

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

(D) A comprehensive health history, updated at the next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

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

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

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

SEC. 44. Section 14132.20 is added to the Welfare and Institutions Code, to read:

14132.20. (a) The department shall establish a program to provide continuous skilled nursing care to persons with developmental disabilities as a benefit of the Medi-Cal program, when those services are provided in accordance with an approved federal waiver or Medi-Cal State Plan amendment 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 facility participating in the program. Continuous skilled nursing care shall include a minimum of eight hours per day provided by or under the direct supervision of a registered nurse. Each facility providing continuous skilled nursing care in the program shall have a minimum of one registered nurse or one licensed vocational nurse awake and in the facility at all times when a consumer is present.

(b) The department shall submit to the federal Centers for Medicare and Medicaid Services, a request, developed in consultation with the State Department of Public Health, the State Department of Developmental Services, and the Association of Regional Center Agencies, to provide continuous skilled nursing care services under a federal waiver pursuant to Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)) or pursuant to a Medi-Cal State Plan amendment.

(c) (1) The program shall provide continuous skilled nursing care to persons with developmental disabilities in the least restrictive home-like setting.

(2) Participation in the program shall be restricted to facilities that meet all eligibility requirements. The facilities shall be approved by the department, in consultation with the State Department of Public Health, the State Department of Developmental Services, and the appropriate regional center agencies, and shall meet the requirements of subdivision (f).

(d) Under the program established by this section, a person with developmental disabilities shall be eligible to receive continuous skilled nursing care if all of the following conditions are met:

(1) The person with developmental disabilities meets the criteria specified in the federal waiver or the Medi-Cal State Plan amendment.

(2) The person with developmental disabilities resides in a facility that meets the provider participation criteria as specified in the federal waiver or the Medi-Cal State Plan amendment.

(3) The continuous skilled nursing care services are provided in accordance with the federal waiver or the Medi-Cal State Plan amendment.

(e) The services provided to persons with developmental disabilities under the program, pursuant to Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)), shall not result in costs that exceed the fiscal limit established in the federal waiver.

(f) A facility seeking to participate in the program shall provide care for persons with developmental disabilities who require the availability of continuous skilled nursing care in accordance with the terms of the federal waiver or the Medi-Cal State Plan amendment. During participation in the program, the facility shall comply with all the terms and conditions of the federal waiver or the Medi-Cal State Plan amendment.

(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 not become operative unless and until the federal Centers for Medicare and Medicaid Services approve a federal waiver pursuant to Section 1915(c) of the Social Security Act (42 U.S.C. Sec. 1396n(c)) or approve a Medi-Cal State Plan amendment to implement the program authorized by this section. If the federal Centers for Medicare and Medicaid Services provide the aforementioned approval, the Director of Health Care Services shall execute a declaration stating that this approval has been granted. The director shall retain the declaration and this section shall become operative on the date that the director executes a declaration pursuant to this subdivision.

SEC. 45. Section 14132.951 of the Welfare and Institutions Code is amended to read:

14132.951. (a) It is the intent of the Legislature that the State Department of Health Services seek approval of a Medicaid waiver under the federal Social Security Act in order that the services

available under Article 7 (commencing with Section 12300) of Chapter 3, known as the In-Home Supportive Services program, may be provided as a Medi-Cal benefit under this chapter, to the extent federal financial participation is available. The waiver shall be known as the “IHSS Plus waiver.”

(b) To the extent feasible, the IHSS Plus waiver described in subdivision (a) shall incorporate the eligibility requirements, benefits, and operational requirements of the In-Home Supportive Services program. The director shall have discretion to modify eligibility requirements, benefits, and operational requirements as needed to secure approval of the Medicaid waiver.

(c) Upon implementation of the IHSS Plus waiver, and to the extent federal financial participation is available, the services available through the In-Home Supportive Services program shall be furnished as benefits of the Medi-Cal program through the IHSS Plus waiver to persons who meet the eligibility requirements of the IHSS Plus waiver. The benefits shall be limited by the terms and conditions of the IHSS Plus waiver and by the availability of federal financial participation.

(d) Upon implementation of the IHSS Plus waiver:

(1) A person who is eligible for the IHSS Plus waiver shall no longer be eligible to receive services under the In-Home Supportive Services program to the extent those services are available through the IHSS Plus waiver.

(2) A person shall not be eligible to receive services pursuant to the IHSS Plus waiver to the extent those services are available pursuant to Section 14132.95.

(e) Services provided pursuant to this section shall be rendered, under the administrative direction of the State Department of Social Services, in the manner authorized in Article 7 (commencing with Section 12300) of Chapter 3, for the In-Home Supportive Services program.

(f) Services shall not be provided to residents of facilities licensed by the department, and shall not be provided to residents of a community care facility or a residential care facility for the elderly licensed by the State Department of Social Services.

(g) To the extent permitted by federal law, reimbursement rates for services shall be equal to the rates in each county for the same mode of services in the In-Home Supportive Services program

pursuant to Article 7 (commencing with Section 12300) of Chapter 3.

(h) (1) Notwithstanding 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 department may implement the provisions of this section through all-county welfare director letters or similar publications. Actions taken to implement, interpret, or make specific this section shall not be subject to the Administrative Procedure Act or to the review and approval of the Office of Administrative Law. Upon request of the department, the Office of Administrative Law shall publish the regulations in the California Code of Regulations. All county welfare director letters or similar publications authorized pursuant to this section shall remain in effect for no more than 18 months.

(2) The department may also adopt emergency regulations implementing the provisions of this section. The adoption of regulations implementing this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. Any emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and shall remain in effect for no more than 18 months by which time final regulations shall be adopted. The department shall seek input from the entities listed in Section 12305.72 when developing the regulations, all county welfare director letters, or similar publications.

(i) In the event of a conflict between the terms of the IHSS Plus waiver and any provision of this part or any regulation, all-county welfare directors letters or similar publications adopted for the purpose of implementing this part, the terms of the waiver shall control to the extent that the services are covered by the waiver. If the department determines that a conflict exists, the department shall issue updated instructions to counties for the purposes of implementing necessary program changes. The department shall post a copy of, or a link to, the instructions on its Web site.

(j) (1) Notwithstanding subdivision (b) or any other provision of this section, the department shall not waive or modify the

provisions of Section 12301.2, 12301.6, 12302.25, 12306.1, or 12309.

(2) Upon receipt of the IHSS Plus waiver, the director shall report to the Legislature on any modifications in benefits or eligibility and operational requirements of the In-Home Supportive Services program required for receipt of the waiver.

SEC. 46. Section 14132.952 is added to the Welfare and Institutions Code, to read:

14132.952. (a) The department shall seek approval of an amendment to the Medicaid state plan pursuant to Section 1396n(j) of Title 42 of the United States Code to provide self-directed personal assistance services under the state plan in order that the services available under Article 7 (commencing with Section 12300) of Chapter 3, known as the In-Home Supportive Services (IHSS) program, may be provided as a Medi-Cal benefit under this chapter, to the extent that federal financial participation is available. This program shall be known as the “IHSS Plus option.”

(b) To the extent feasible, the IHSS Plus option shall incorporate the eligibility requirements, benefits, and operational requirements of the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3. The director shall have the discretion to modify these eligibility requirements, benefits, and operational requirements to the extent necessary to secure federal approval of the Medicaid state plan amendment.

(c) The services available through the IHSS Plus waiver pursuant to Section 14132.951 shall be furnished as benefits under the IHSS Plus option to the extent that federal financial participation is available to persons who meet the eligibility requirements of the IHSS Plus option. Upon implementation of the IHSS Plus option, a person who is eligible for services under the IHSS Plus option shall no longer be eligible to receive services under Section 14132.951.

(d) Upon implementation of the IHSS Plus option:

(1) A person who is eligible for the IHSS Plus option shall not be eligible to receive services under the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3 to the extent those services are available through the IHSS Plus option.

(2) A person shall not be eligible to receive services pursuant to the IHSS Plus option to the extent those services are available pursuant to Section 14132.95.

(e) Services provided pursuant to this section shall be rendered, under the administrative direction of the State Department of Social Services, in the manner authorized in Article 7 (commencing with Section 12300) of Chapter 3, for the In-Home Supportive Services program.

(f) Services shall not be provided to residents of facilities licensed by the State Department of Public Health, and shall not be provided to residents of a community care facility or a residential care facility for the elderly licensed by the State Department of Social Services.

(g) To the extent permitted by federal law, reimbursement rates for services under the IHSS Plus option shall be equal to the rates in each county for the same mode of services in the In-Home Supportive Services program pursuant to Article 7 (commencing with Section 12300) of Chapter 3.

(h) (1) Notwithstanding 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 department may implement the provisions of this section through all-county welfare director letters or similar publications. Actions taken to implement, interpret, or make specific this section shall not be subject to the Administrative Procedure Act or to the review and approval of the Office of Administrative Law. Upon request of the department, the Office of Administrative Law shall publish the regulations in the California Code of Regulations. All county welfare director letters or similar publications authorized pursuant to this section shall remain in effect for no more than 18 months.

(2) The department may also adopt emergency regulations implementing the provisions of this section. The adoption of regulations implementing this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The emergency regulations authorized by this section shall be exempt from review and approval by the Office of Administrative Law. Any emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and shall remain in effect for no more than 18 months by which

time final regulations shall be adopted. The department shall seek input from the entities listed in Section 12305.72 when developing the regulations, all-county welfare director letters, or similar publications.

(i) (1) Notwithstanding subdivision (b) or any other provision of this section, the department shall not waive or modify the provisions of Section 12301.2, 12301.6, 12302.25, 12306.1, or 12309.

(2) Upon the federal Centers for Medicare and Medicaid Services' approval of the Medicaid state plan amendment known as the "IHSS Plus option," the director shall notify the Legislature of any modifications in benefits or eligibility and operational requirements of the In-Home Supportive Services program required for that Medicaid state plan amendment to become effective.

SEC. 46.5. Section 14166.115 is added to the Welfare and Institutions Code, to read:

14166.115. (a) Due to the state budget deficit and in order to implement changes in the level of funding for health care services, the department shall reduce disproportionate share hospital replacement payments to private hospitals made pursuant to Section 14166.11 as specified in this section.

(b) Disproportionate share hospital replacement payments to private hospitals pursuant to Section 14166.11 shall be reduced by 10 percent. The reductions shall be applied to all disproportionate share hospital replacement payments to private hospitals made for the 2009–10 fiscal year, including, but not limited to, interim payments, tentative adjusted monthly payments, data corrected payments, and the final adjusted payment.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer this section by means of provider bulletins, or similar instructions, without taking regulatory action.

(d) The reductions described in this section shall apply only to payments for services when the General Fund share of the payment is paid with funds appropriated to the department in the annual Budget Act.

(e) The department shall promptly seek any necessary federal approvals for the implementation of this section.

SEC. 47. Section 14166.20 of the Welfare and Institutions Code is amended to read:

14166.20. (a) With respect to each project year, the total amount of stabilization funding shall be the sum of the following:

(1) (A) Federal Medicaid funds available in the Health Care Support Fund, established pursuant to Section 14166.21, reduced by the amount necessary to meet the baseline funding amount, or the adjusted baseline funding amount, as appropriate, for project years after the 2005–06 project year for each designated public hospital, project year private DSH hospitals in the aggregate, and nondesignated public hospitals in the aggregate as determined in Sections 14166.5, 14166.13, and 14166.18, respectively, taking into account all other payments to each hospital under this article. This amount shall be not less than zero.

(B) For purposes of subparagraph (A), federal Medicaid funds available in the Health Care Support Fund shall not include health care coverage initiative amounts identified under paragraph (2) of subdivision (e) of Section 14166.9.

(2) The state general funds that were made available due to the receipt of federal funding for previously state-funded programs through the safety net care pool and any federal Medicaid hospital reimbursements resulting from these expenditures, unless otherwise recognized under paragraph (1), to the extent those funds are in excess of the amount necessary to meet the baseline funding amount, or the adjusted baseline funding amount, as appropriate, for project years after the 2005–06 project year for each designated public hospital, for project year private DSH hospitals in the aggregate, and for nondesignated public hospitals in the aggregate, as determined in Sections 14166.5, 14166.13, and 14166.18, respectively.

(3) To the extent not included in paragraph (1) or (2), the amount of the increase in state General Fund expenditures for Medi-Cal inpatient hospital services for the project year for project year private DSH hospitals and nondesignated public hospitals, including amounts expended in accordance with paragraph (1) of subdivision (c) of Section 14166.23, that exceeds the expenditure amount for the same purpose and the same hospitals necessary to provide the aggregate baseline funding amounts applicable to the project determined pursuant to Sections 14166.13 and 14166.18,

and any direct grants to designated public hospitals for services under the demonstration project.

(4) To the extent not included in paragraph (2), federal Medicaid funds received by the state as a result of the General Fund expenditures described in paragraph (3).

(5) The federal Medicaid funds received by the state as a result of federal financial participation with respect to Medi-Cal payments for inpatient hospital services made to project year private DSH hospitals and to nondesignated public hospitals for services rendered during the project year, the state share of which was derived from intergovernmental transfers or certified public expenditures of any public entity that does not own or operate a public hospital.

(6) Federal safety net care pool funds claimed and received for inpatient hospital services rendered under the health care coverage initiative identified under paragraph (3) of subdivision (e) of Section 14166.9.

(b) With respect to the 2005–06, 2006–07, and subsequent project years, the stabilization funding determined under subdivision (a) shall be allocated as follows:

(1) Eight million dollars (\$8,000,000) shall be paid to San Mateo Medical Center. All or a portion of this amount may be paid as disproportionate share hospital payments in addition to the hospital's allocation that would otherwise be determined under Section 14166.6. The amount provided for in this paragraph shall be disregarded in the application of the limitations described in paragraph (3) of subdivision (a) of Section 14166.6, and in paragraph (1) of subdivision (a) of Section 14166.7.

(2) (A) Ninety-six million two hundred twenty-eight thousand dollars (\$96,228,000) shall be allocated to designated public hospitals to be paid in accordance with Section 14166.75.

(B) Forty-two million two hundred twenty-eight thousand dollars (\$42,228,000) shall be allocated to private DSH hospitals to be paid in accordance with Section 14166.14.

(C) Five hundred forty-four thousand dollars (\$544,000) shall be allocated to nondesignated public hospitals to be paid in accordance with Section 14166.17.

(D) In the event that stabilization funding is less than one hundred forty-seven million dollars (\$147,000,000), the amounts allocated to designated public hospitals, private DSH hospitals,

and nondesignated public hospitals under this paragraph shall be reduced proportionately.

(3) (A) An amount equal to the lesser of 10 percent of the total amount determined under subdivision (a) or twenty-three million five hundred thousand dollars (\$23,500,000), but at least fifteen million three hundred thousand dollars (\$15,300,000), shall be made available for additional payments to distressed hospitals that participate in the selective provider contracting program under Article 2.6 (commencing with Section 14081), including designated public hospitals, in amounts to be determined by the California Medical Assistance Commission. The additional payments to designated public hospitals shall be negotiated by the California Medical Assistance Commission, but shall be paid by the department in the form of a direct grant rather than as Medi-Cal payments.

(B) Notwithstanding subparagraph (A) and solely for the 2006–07 fiscal year, if the amount that otherwise would be made available for additional payments to distressed hospitals under subparagraph (A) is equal to or greater than eighteen million three hundred thousand dollars (\$18,300,000), that amount shall be reduced by eighteen million three hundred thousand dollars (\$18,300,000) and the state’s obligation to make these payments shall be reduced by this amount. In the event the amount that otherwise would be made available under subparagraph (A) is less than eighteen million three hundred thousand dollars (\$18,300,000), but greater than or equal to the minimum amount of fifteen million three hundred thousand dollars (\$15,300,000), then the amount available under this paragraph shall be zero and the state’s obligation to make these payments shall be zero.

(C) Notwithstanding subparagraph (A) and solely for the 2008–09 and 2009–10 fiscal years, the amount to be made available shall be reduced by fifteen million three hundred thousand dollars (\$15,300,000) in each of the two years. The funds generated from this reduction shall be retained in the General Fund.

(4) An amount equal to 0.64 percent of the total amount determined under subdivision (a), to nondesignated public hospitals to be paid in accordance with Section 14166.19.

(5) The amount remaining after subtracting the amount determined in paragraphs (1) and (2), subparagraph (A) of paragraph (3), and paragraph (4), without taking into account

subparagraphs (B) and (C) of paragraph (3), shall be allocated as follows:

(A) Sixty percent to designated public hospitals to be paid in accordance with Section 14166.75.

(B) Forty percent to project year private DSH hospitals to be paid in accordance with Section 14166.14.

(c) By April 1 of the year following the project year for which the payment is made, and after taking into account final amounts otherwise paid or payable to hospitals under this article, the director shall calculate in accordance with subdivision (a), allocate in accordance with subdivision (b), and pay to hospitals in accordance with Sections 14166.75, 14166.14, and 14166.19, as applicable, the stabilization funding.

(d) For purposes of determining amounts paid or payable to hospitals under subdivision (c), the department shall apply the following:

(1) In determining amounts paid or payable to designated public hospitals that are based on allowable costs incurred by the hospital, or the governmental entity with which it is affiliated, the following shall apply:

(A) If the final payment amount is based on the hospital's Medicare cost report, the department shall rely on the cost report filed with the Medicare fiscal intermediary for the project year for which the calculation is made, reduced by a percentage that represents the average percentage change from total reported costs to final costs for the three most recent cost reporting periods for which final determinations have been made, taking into account all administrative and judicial appeals. Protested amounts shall not be considered in determining the average percentage change unless the same or similar costs are included in the project year cost report.

(B) If the final payment amount is based on costs not included in subparagraph (A), the reported costs as of the date the determination is made under subdivision (c), shall be reduced by 10 percent.

(C) In addition to adjustments required in subparagraphs (A) and (B), the department shall adjust amounts paid or payable to designated public hospitals by any applicable deferrals or disallowances identified by the federal Centers for Medicare and Medicaid Services as of the date the determination is made under

subdivision (c) not otherwise reflected in subparagraphs (A) and (B).

(2) Amounts paid or payable to project year private DSH hospitals and nondesignated public hospitals shall be determined by the most recently available Medi-Cal paid claims data increased by a percentage to reflect an estimate of amounts remaining unpaid.

(e) The department shall consult with hospital representatives regarding the appropriate calculation of stabilization funding before stabilization funds are paid to hospitals. The calculation may be comprised of multiple steps involving interim computations and assumptions as may be necessary to determine the total amount of stabilization funding under subdivision (a) and the allocations under subdivision (b). No later than 30 days after this consultation, the department shall establish a final determination of stabilization funding that shall not be modified for any reason other than mathematical errors or mathematical omissions on the part of the department.

(f) The department shall distribute 75 percent of the estimated stabilization funding on an interim basis throughout the project year.

(g) The allocation and payment of stabilization funding shall not reduce the amount otherwise paid or payable to a hospital under this article or any other provision of law, unless the reduction is required by the demonstration project's Special Terms and Conditions or by federal law.

(h) It is the intent of the Legislature that the amendments made to Sections 14166.12 and to this section by the act that added this subdivision in the 2007–08 Regular Session shall not be construed to amend or otherwise alter the ongoing structure of the department's Medicaid Demonstration Project and Waiver approved by the federal Centers for Medicare and Medicaid Services to begin on September 1, 2005.

SEC. 48. Section 14166.225 of the Welfare and Institutions Code is amended to read:

14166.225. (a) In order to implement changes in the level of funding for health care services, the director shall reduce safety net care pool payments as specified in this section.

(b) Notwithstanding the provisions of this article, safety net care pool payments made to the designated public hospitals and the South Los Angeles Medical Services Preservation Fund, for

services rendered on or after July 1, 2009, through and including June 30, 2010, shall be reduced by 10 percent, but in no event shall the total amount of the reduction exceed fifty-four million two-hundred thousand dollars (\$54,200,000).

(c) (1) Notwithstanding Section 14166.22 and any other provision of this article, the department shall increase federal claiming from the safety net care pool for the state-funded programs listed in subdivision (a) of Section 14166.22 above the amount necessary to maintain stabilization funding to private hospitals, nondesignated public hospitals, and distressed hospitals pursuant to Section 14166.20, by an amount equivalent to the reduction made pursuant to subdivision (b), but only to the extent that the state-only funded programs have sufficient costs available for the claiming of federal funds from the safety net care pool.

(2) If necessary to reach the full amount of the reduction set forth in subdivision (b), the department may increase federal claiming from the safety net care pool for the state-funded programs listed in subdivision (a) of Section 14166.22 for fiscal years prior to the 2009–10 fiscal year, but only to the extent that the state-only funded programs have sufficient costs available in fiscal years prior to the 2009–10 fiscal year that were not previously the basis for claiming federal funds.

(d) The General Fund savings generated pursuant to subdivision (c) shall be made available to the General Fund and shall not be subject to the provisions of subdivisions (b) and (d) of Section 14166.22.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of a provider bulletin, or other similar instruction, without taking regulatory action.

SEC. 49. Section 14166.23 of the Welfare and Institutions Code is amended to read:

14166.23. (a) For purposes of this section, “distressed hospitals” are hospitals that participate in selective providers contracting under Article 2.6 (commencing with Section 14081) and that meet all of the following requirements, as determined by the California Medical Assistance Commission in its discretion:

(1) The hospital serves a substantial volume of Medi-Cal patients measured either as a percentage of the hospital’s overall volume

or by the total volume of Medi-Cal services furnished by the hospital.

(2) The hospital is a critical component of the Medi-Cal program's health care delivery system, such that the Medi-Cal health care delivery system would be significantly disrupted if the hospital reduced its Medi-Cal services or no longer participated in the Medi-Cal program.

(3) The hospital is facing a significant financial hardship that may impair its ability to continue its range of services for the Medi-Cal program.

(b) The Distressed Hospital Fund is hereby created in the State Treasury.

(c) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department for the purposes specified in this section.

(d) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) The amounts transferred to the fund pursuant to subdivision (e).

(2) Any additional amounts appropriated to the fund by the Legislature.

(3) Any interest that accrues on amounts in the fund.

(e) The following amounts shall be transferred to the fund from the prior supplemental funds at the beginning of each project year.

(1) Twenty percent of the amount in the prior supplemental funds on the effective date of this article, less any and all payments for services rendered prior to July 1, 2005, but paid after July 1, 2005.

(2) Interest that accrued on the prior supplemental funds during the prior project year.

(3) Notwithstanding paragraph (1), solely for the 2009–10 fiscal year, the amount of funds transferred shall be reduced by six million one hundred and ninety-one thousand dollars (\$6,191,000). The funds generated from this reduction shall be transferred to the General Fund.

(f) No distributions, payments, transfers, or disbursements shall be made from the prior supplemental funds except as set forth in this section.

(g) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section.

(h) Except as otherwise provided in subdivision (j), moneys shall be applied to obtain federal financial participation to the extent available in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section. Distributions from the fund shall be supplemental to any other Medi-Cal reimbursement received by the hospitals, including amounts that hospitals receive under the selective provider contracting program, and shall not affect provider rates paid under the selective provider contracting program.

(i) Subject to subdivision (j), all amounts that are in the fund shall be available for negotiation by the California Medical Assistance Commission, along with corresponding federal financial participation, for additional payments to distressed hospitals. These amounts shall be paid under contracts entered into by the department and negotiated by the California Medical Assistance Commission pursuant to Article 2.6 (commencing with Section 14081), provided that any amounts payable to a designated public hospital shall be paid in the form of a direct grant of state general funds pursuant to a contract negotiated by the California Medical Assistance Commission. The commission shall not consider the lack of federal financial participation in direct grants to designated public hospitals in determining which hospital may receive funding under this section.

(j) After April 1, 2007, and each April 1 thereafter, in the event that funding under this article is insufficient to meet the adjusted aggregate baseline funding amounts for a particular project year, as determined in subdivision (d) of Section 14166.5, and in Sections 14166.13 and 14166.18, funds under this section shall first be available for use under contracts negotiated by the California Medical Assistance Commission for hospitals contracting under the selective provider contracting program under Article 2.6 (commencing with Section 14081) in an effort to address the insufficiency, to the extent funds under this section are available on or after April 1 for the particular project year.

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

SEC. 50. Section 14166.245 of the Welfare and Institutions Code, as amended by Section 57 of Chapter 758 of the Statutes of 2008, is amended to read:

14166.245. (a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California.

(b) (1) Notwithstanding any other provision of law, except as provided in Article 2.93 (commencing with Section 14091.3), for hospitals that receive Medi-Cal reimbursement from the State Department of Health Care Services and that are not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9, the amounts paid as interim payments for inpatient hospital services provided on and after July 1, 2008, shall be reduced by 10 percent.

(2) (A) Beginning on October 1, 2008, amounts paid that are calculated pursuant to paragraph (1) shall not exceed the applicable regional average per diem contract rate for tertiary hospitals and for all other hospitals established as specified in subparagraph (C), reduced by 5 percent, multiplied by the number of Medi-Cal covered inpatient days for which the interim payment is being made.

(B) This paragraph shall not apply to small and rural hospitals specified in Section 124840 of the Health and Safety Code, or to hospitals in open health facility planning areas that were open health facility planning areas on October 1, 2008, unless either of the following apply:

(i) The open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area as determined by the California Medical Assistance Commission.

(ii) The open health facility planning area has three or more hospitals with licensed general acute care beds. State-owned or operated hospitals shall not be included in determining whether this clause shall apply.

(C) (i) For purposes of this subdivision and subdivision (c), the average regional per diem contract rates shall be derived from unweighted average contract per diem rates that are publicly available on June 1 of each year, trended forward based on the trends in the California Medical Assistance Commission's Annual Report to the Legislature. For tertiary hospitals, and for all other hospitals, the regional average per diem contract rates shall be

based on the geographic regions in the California Medical Assistance Commission's Annual Report to the Legislature. The applicable average regional per diem contract rates for tertiary hospitals and for all other hospitals shall be published by the department on or before October 1, 2008, and these rates shall be updated annually for each state fiscal year and shall become effective each July 1, thereafter. Supplemental payments shall not be included in this calculation.

(ii) For purposes of clause (i), both the federal and nonfederal share of the designated public hospital cost-based rates shall be included in the determination of the average contract rates by multiplying the hospital's interim rate, established pursuant to Section 14166.4 and that is in effect on June 1 of each year, by two.

(iii) For the purposes of this section, a tertiary hospital is a children's hospital specified in Section 10727, or a hospital that has been designated as a Level I or Level II trauma center by the Emergency Medical Services Authority established pursuant to Section 1797.1 of the Health and Safety Code.

(D) For purposes of this section, the terms "open health facility planning area" and "closed health facility planning area" shall have the same meaning and be applied in the same manner as used by the California Medical Assistance Commission in the implementation of the hospital contracting program authorized in Article 2.6 (commencing with Section 14081).

(c) (1) Notwithstanding any other provision of law, for hospitals that receive Medi-Cal reimbursement from the State Department of Health Care Services and that are not under contract with the State Department of Health Care Services, pursuant to Article 2.6 (commencing with Section 14081), the reimbursement amount paid by the department for inpatient services provided to Medi-Cal recipients for dates of service on and after July 1, 2008, shall not exceed the amount determined pursuant to paragraph (3).

(2) For purposes of this subdivision, the reimbursement for inpatient services includes the amounts paid for all categories of inpatient services allowable by Medi-Cal. The reimbursement includes the amounts paid for routine services, together with all related ancillary services.

(3) When calculating a hospital's cost report settlement for a hospital's fiscal period that includes any dates of service on and

after July 1, 2008, the settlement for dates of service on and after July 1, 2008, shall be limited to the lesser of the following:

(A) Ninety percent of the hospital's audited allowable cost per day for those services multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year on or after July 1, 2008.

(B) Beginning for dates of service on and after October 1, 2008, the applicable average regional per diem contract rate established as specified in subparagraph (A) of paragraph (2) of subdivision (b), reduced by 5 percent, multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year, or portion thereof. This subparagraph shall not apply to small and rural hospitals specified in Section 124840 of the Health and Safety Code, or to hospitals in open health facility planning areas that were open health facility planning areas on July 1, 2008, unless either of the following apply:

(i) The open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area as determined by the California Medical Assistance Commission.

(ii) The open health facility planning area has three or more hospitals with licensed general acute care beds. State-owned or operated hospitals shall not be included in determining whether this clause shall apply.

(d) Except as provided in Article 2.93 (commencing with Section 14091.3), hospitals that participate in the Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081) and designated public hospitals under Section 14166.1, except Los Angeles County Martin Luther King, Jr./Charles R. Drew Medical Center and Tuolumne General Hospital, shall be exempt from the limitations required by this section.

(e) 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 and administer this section by means of provider bulletins, or other similar instructions, without taking regulatory action.

(f) The director shall promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan.

(g) (1) Notwithstanding any other provision of this section, small and rural hospitals, as defined in Section 124840 of the Health and Safety Code, shall be exempt from the payment reductions set forth in this section for dates of service on and after November 1, 2008, through and including June 30, 2009. On and after July 1, 2009, small and rural hospitals as defined in this paragraph shall be subject to the reductions set forth in paragraph (1) of subdivision (b) and subparagraph (A) of paragraph (3) of subdivision (c), but shall be exempt from the provisions of subparagraph (A) of paragraph (2) of subdivision (b) and subparagraph (B) of paragraph (3) of subdivision (c).

(2) Notwithstanding any other provision of this section, hospitals that are certified by Medicare as Medical Critical Access Providers or as Rural Referral Centers shall be exempt from the payment reductions set forth in this section for dates of service on and after July 1, 2009.

(h) For hospitals that are subject to clauses (i) and (ii) of subparagraph (B) of paragraph (2) of subdivision (b) and that choose to contract pursuant to Article 2.6 (commencing with Section 14081), the California Medical Assistance Commission shall negotiate rates taking into account factors specified in Section 14083.

(i) (1) In January 2010 and in January 2011, the department and the California Medical Assistance Commission shall submit a written report to the policy and fiscal committees of the Legislature on the implementation and impact of the changes made by this section, including, but not limited to, the impact of those changes on the number of hospitals that are contract and noncontract, patient access, and cost savings to the state.

(2) On or before January 1, 2012, the department, in consultation with the California Medical Assistance Commission, shall report on the implementation of this section. The report shall include, but not be limited to, information and analyses addressing patient access, capacity and needs within the health facility planning area, reimbursement of hospital costs, changes in the number of open and closed health facility planning areas, the impact of this section on the extent of hospital contracting, and fiscal impact on the state.

(j) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.

SEC. 51. 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 (42 U.S.C. Sec. 1396n(c)) 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 be repealed if and when the federal Centers for Medicare and Medicaid Services approve a federal waiver

pursuant to Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)) or approve a state plan amendment to make this pilot program a permanent program. If the federal Centers for Medicare and Medicaid Services provide that approval, the Director of Health Care Services shall execute a declaration stating that this approval has been granted. The director shall retain the declaration and this section shall be repealed on the date that the director executes a declaration pursuant to this subdivision.

SEC. 52. Section 14522.4 is added to the Welfare and Institutions Code, to read:

14522.4. (a) The following definitions shall apply for the purposes of this chapter:

(1) “Activities of daily living (ADL)” means activities performed by the participant for essential living purposes, including bathing, dressing, self-feeding, toileting, ambulation, and transferring.

(2) “Instrumental activities of daily living (IADL)” means functions or tasks of independent living limited to hygiene and medication management.

(3) “Personal health care provider” means the participant’s personal physician, physician’s assistant, or nurse practitioner, operating within his or her scope of practice.

(4) “Care coordination” means the process of obtaining information from, or providing information to, the participant, the participant’s family, the participant’s personal health care provider, or social services agencies to facilitate the delivery of services designed to meet the needs of the participant, as identified by one or more members of the multidisciplinary team.

(5) “Facilitated participation” means an interaction to support a participant’s involvement in a group or individual activity, whether or not the participant takes active part in the activity itself.

(6) “Group work” means a social work service in which a variety of therapeutic methods are applied within a small group setting to promote participants’ self-expression and positive adaptation to their environment.

(7) “Professional nursing” means services provided by a registered nurse or licensed vocational nurse functioning within his or her scope of practice.

(8) “Psychosocial” means a participant’s psychological status in relation to the participant’s social and physical environment.

(9) “Assistance” means verbal or physical prompting or aid, including cueing, supervision, stand-by assistance, or hands-on support to complete the task correctly.

(10) “Substantial human assistance” means direct, hands-on assistance provided by a qualified caregiver, which entails physically helping the participant perform the essential elements of the ADLs and IADLs. It entails more than cueing, supervision, or stand-by assistance to perform the ADLs and IADLs. It also includes the performance of the entire ADL or IADL for participants totally dependent on human assistance.

(11) (a) “Cognitive impairment” means the loss or deterioration of intellectual capacity characterized by impairments in short- or long-term memory, language, concentration and attention, orientation to people, place, or time, visual-spatial abilities or executive functions, or both, including, but not limited to, judgment, reasoning, or the ability to inhibit behaviors that interfere with social, occupational, or everyday functioning due to conditions, including, but not limited to, mild cognitive impairment, Alzheimer’s disease or other form of dementia, or brain injury.

(b) Upon the date of execution of the declaration described under subdivision (g) of Section 14525.1, this section shall become operative and Section 14522.3 shall become inoperative and on that date is repealed.

SEC. 53. Section 14525.1 is added to the Welfare and Institutions Code, to read:

14525.1. (a) Except as provided in subdivisions (b) and (c), any adult eligible for benefits under Chapter 7 (commencing with Section 14000) shall be eligible for adult day health care services if that person meets all of the following criteria:

(1) The person is 18 years of age or older and has one or more chronic or postacute medical, cognitive, or mental health conditions, and a physician, nurse practitioner, or other health care provider has, within his or her scope of practice, requested adult day health care services for the person.

(2) The person has two or more functional impairments involving ambulation, bathing, dressing, self-feeding, toileting, transferring, medication management, and hygiene.

(3) (A) Except as provided under subparagraph (B), the person requires substantial human assistance in performing these activities.

(B) The persons described in subdivisions (b) and (c) shall only require assistance in performing these activities.

(4) The person requires ongoing or intermittent protective supervision, assessment, or intervention by a skilled health or mental health professional to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive, or mental health condition.

(5) The person requires adult day health care services, as defined in Section 14550, that are individualized and planned, including, when necessary, the coordination of formal and informal services outside of the adult day health care program to support the individual and his or her family or caregiver in the living arrangement of his or her choice and to avoid or delay the use of institutional services, including, but not limited to, hospital emergency department services, inpatient acute care hospital services, inpatient mental health services, or placement in a nursing facility or a nursing or intermediate care facility for the developmentally disabled providing continuous nursing care.

(6) The person meets the skilled nursing facility level of care set forth in Section 51124 of Title 22 of the California Code of Regulations.

(b) A resident of an intermediate care facility for the developmentally disabled-habilitative shall be eligible for adult day health care services if that resident meets the criteria set forth in paragraphs (1) to (5), inclusive, of subdivision (a) and has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through adult day health care, placement to a more costly institutional level of care would be likely to occur.

(c) Persons having chronic mental illness or moderate to severe Alzheimer's disease or other cognitive impairments shall be eligible for adult day health care services if they meet the criteria established in paragraphs (1) to (5), inclusive, of subdivision (a).

(d) This section shall only be implemented to the extent permitted by federal law.

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

(f) Prior to implementing this section, the department shall meet and confer with provider representatives, including, but not limited to, adult day health care, home- and community-based services, and nursing facilities for the purpose of presenting and discussing information and evidence to assist the department as it determines the methods and procedures necessary to implement this section.

(g) Upon the determination of the director that all necessary methods and procedures described in subdivision (f) have been ascertained and are sufficient to implement the purposes of this section, the director shall execute and retain a declaration indicating that this determination has been made. Subdivisions (a) to (e), inclusive, shall be inoperative, until the date of execution of the declaration. Upon the date of execution of such a declaration, subdivisions (a) to (e), inclusive of this section shall become operative and Section 14525 shall become inoperative.

SEC. 54. Section 14526.1 of the Welfare and Institutions Code is amended to read:

14526.1. (a) Initial and subsequent treatment authorization requests may be granted for up to six calendar months.

(b) Treatment authorization requests shall be initiated by the adult day health care center, and shall include all of the following:

(1) The signature page of the history and physical form that shall serve to document the request for adult day health care services. A complete history and physical form, including a request for adult day health care services signed by the participant's personal health care provider, shall be maintained in the participant's health record. This history and physical form shall be developed by the department and published in the inpatient/outpatient provider manual. The department shall develop this form jointly with the statewide association representing adult day health care providers.

(2) The participant's individual plan of care, pursuant to Section 54211 of Title 22 of the California Code of Regulations.

(c) Every six months, the adult day health care center shall initiate a request for an updated history and physical form from the participant's personal health care provider using a standard update form that shall be maintained in the participant's health record. This update form shall be developed by the department for that use and shall be published in the inpatient/outpatient provider

manual. The department shall develop this form jointly with the statewide association representing adult day health care providers.

(d) Except for participants residing in an intermediate care facility/developmentally disabled-habilitative, authorization or reauthorization of an adult day health care treatment authorization request shall be granted only if the participant meets all of the following medical necessity criteria:

(1) The participant has one or more chronic or post acute medical, cognitive, or mental health conditions that are identified by the participant's personal health care provider as requiring one or more of the following, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization, or other institutionalization:

(A) Monitoring.

(B) Treatment.

(C) Intervention.

(2) The participant has a condition or conditions resulting in both of the following:

(A) Limitations in the performance of two or more activities of daily living or instrumental activities of daily living, as those terms are defined in Section 14522.3, or one or more from each category.

(B) A need for assistance or supervision in performing the activities identified in subparagraph (A) as related to the condition or conditions specified in paragraph (1) of subdivision (d). That assistance or supervision shall be in addition to any other nonadult day health care support the participant is currently receiving in his or her place of residence.

(3) The participant's network of non-adult day health care center supports is insufficient to maintain the individual in the community, demonstrated by at least one of the following:

(A) The participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.

(B) The participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant.

(C) The participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant.

(4) A high potential exists for the deterioration of the participant's medical, cognitive, or mental health condition or

conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if adult day health care services are not provided.

(5) The participant's condition or conditions require adult day health care services specified in subdivisions (a) to (d), inclusive, of Section 14550.5, on each day of attendance, that are individualized and designed to maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization.

(e) When determining whether a provider has demonstrated that a participant meets the medical necessity criteria, the department may enter an adult day health care center and review participants' medical records and observe participants receiving care identified in the individual plan of care in addition to reviewing the information provided on or with the TAR.

(f) Reauthorization of an adult day health care treatment authorization request shall be granted when the criteria specified in subdivision (d) or (f), as appropriate, have been met and the participant's condition would likely deteriorate if the adult day health care services were denied.

(g) For individuals residing in an intermediate care facility/developmentally disabled-habilitative, authorization or reauthorization of an adult day health care treatment authorization request shall be granted only if the resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through adult day health care, placement to a more costly institutional level of care would be likely to occur.

(h) Subdivision (e) shall become operative commencing on the first day of the month following 30 days after the effective date of the act adding this subdivision.

SEC. 55. Section 14526.2 is added to the Welfare and Institutions Code, to read:

14526.2. (a) Initial and subsequent treatment authorization requests may be granted for up to six calendar months, initial and subsequent treatment authorization requests may, at the discretion of the department, be granted for up to 12 calendar months.

(b) Treatment authorization requests shall be initiated by the adult day health care center, and shall include all of the following:

(1) A complete history and physical form, including a request for adult day health care services signed by the participant's

personal health care provider shall be obtained annually. A copy of the history and physical form shall be submitted with an initial treatment authorization request and maintained in the participant's health record. This history and physical form shall be developed by the department and published in the inpatient/outpatient provider manual.

(2) The participant's individual plan of care, pursuant to Section 54211 of Title 22 of the California Code of Regulations.

(c) Whenever a subsequent treatment authorization request is submitted, the adult day health care center shall obtain and submit an updated history and physical form from the participant's personal health care provider using a standard update form that shall be maintained in the participant's health record. This update form shall be developed by the department for that use and shall be published in the inpatient/outpatient provider manual.

(d) Authorization or reauthorization of an adult day health care treatment authorization request shall be granted only if the participant meets all of the following medical necessity criteria:

(1) The participant has one or more chronic or post acute medical, cognitive, or mental health conditions that are identified by the participant's personal health care provider as requiring one or more of the following, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization, or other institutionalization:

- (A) Assessment and monitoring.
- (B) Treatment.
- (C) Intervention.

(2) The participant has a condition or conditions resulting in both of the following:

(A) Two or more functional impairments involving ambulation, bathing, dressing, self-feeding, toileting, transferring, medication management, and hygiene.

(B) As set forth in subparagraph (A) and (B) of paragraph (3) of subdivision (a) of Section 14525.1, the need for assistance or substantial human assistance in performing the activities identified in subparagraph (A) as related to the condition or conditions specified in paragraph (1). That assistance or substantial human assistance shall be in addition to any other nonadult day health care support the participant is currently receiving in his or her place of residence.

(3) Except for participants residing in an intermediate care facility/developmentally disabled-habilitative, the participant's network of nonadult day health care center supports is insufficient to maintain the individual in the community, demonstrated by at least one of the following:

(A) The participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.

(B) The participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant.

(4) A high potential exists for the deterioration of the participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if adult day health care services are not provided.

(5) The participant's condition or conditions require adult day health care services specified in subdivisions (a) to (d), inclusive, of Section 14550.6, on each day of attendance, that are individualized and designed to maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization.

(e) When determining whether a provider has demonstrated that a participant meets the medical necessity criteria, the department may enter an adult day health care center and review participants' medical records and observe participants receiving care identified in the individual plan of care in addition to reviewing the information provided on or with the TAR.

(f) Reauthorization of an adult day health care treatment authorization request shall be granted when the criteria specified in subdivision (d) or (g), as appropriate, have been met and the participant's condition would likely deteriorate if the adult day health care services were denied.

(g) For individuals residing in an intermediate care facility/developmentally disabled-habilitative, authorization or reauthorization of an adult day health care treatment authorization request shall be granted only if the resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through adult day health care, placement to a more costly institutional level of care would be likely to occur.

(h) This section shall only be implemented to the extent permitted by federal law.

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

(j) Upon the date of execution of the declaration described under subdivision (g) of Section 14525.1, this section shall become operative and Section 14526.1 shall become inoperative and on that date is repealed.

SEC. 56. Section 14550.6 is added to the Welfare and Institutions Code, to read:

14550.6. Adult day health care centers shall offer, and provide directly on the premises, in accordance with the participant's individual plan of care, and subject to authorization pursuant to Section 14526.2, the following core services to each participant during each day of the participant's attendance at the center:

(a) One or more of the following professional nursing services:

(1) Assessment and monitoring of the participant's general health status and changes in his or her condition, risk factors, and the participant's specific medical, cognitive, or mental health condition or conditions upon which admission to the adult day health care center was based.

(2) Monitoring and assessment of the participant's medication regimen, administration and recording of the participant's prescribed medications, and intervention, as needed, based upon professional assessment of the participant's reactions to his or her medications.

(3) Oral or written communication with the participant's personal health care provider, other qualified health care or social service provider, or the participant's family or other caregiver, regarding changes in the participant's condition, signs, or symptoms.

(4) Provision of skilled nursing care and intervention, within scope of practice, to participants, as needed, based upon an assessment of the participant, his or her ability to provide self-care while at the adult day health care center, and any health care provider orders.

(b) Personal care services or social services, or both, needed to address the person's individual needs for benefits as required by Section 14525.1, as follows:

(1) Protective group supervision and interventions to ensure participant safety and to minimize the risk of injury, accident, inappropriate behavior, or wandering.

(2) Assessment, and monitoring of the participant's psychosocial status provided by the adult day health care center social worker or social worker assistant.

(3) Group work to address psychosocial issues.

(c) At least one of the following therapeutic activities provided by the adult day health care center activity coordinator or other trained adult day health care center personnel:

(1) Group or individual activities to enhance the social, physical, or cognitive functioning of the participant.

(2) Facilitated participation in group or individual activities for those participants whose frailty or cognitive functioning level precludes them from active participation in scheduled activities.

(d) One meal per day of attendance, in accordance with Section 54331 of Title 22 of the California Code of Regulations, unless the participant declines the meal or medical contraindications exist, as documented in the participant's health record, that prohibit the ingestion of the meal.

(e) This section shall only be implemented to the extent permitted by federal law.

(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 implement the provisions of this section by means of all-county letters, provider bulletins, or similar instructions without taking further regulatory action.

(g) Upon the date of execution of the declaration described under subdivision (g) of Section 14525.1, this section shall become operative and Section 14550.5 shall become inoperative and on that date is repealed.

SEC. 57. By no later than March 1, 2011, the State Department of Mental Health shall provide the legislative budget and policy committees with an analysis of selected county and subcontractor costs for the 2009–10 fiscal year that are not wholly reimbursed by the schedule of maximum allowances rates. The analysis shall be based on cost data from a limited sampling of counties and their

subcontractors in no more than three large urban counties, two mid-sized counties, and two rural counties.

By October 31, 2009, the department shall determine, in consultation with the county mental health plans and their subcontractors, the seven participating counties and participating subcontractors. In making this selection, the department shall determine that the counties' and subcontractors' data are sufficient to ensure a concise cost comparison based on the limited sample of county-delivered services and the limited sample of subcontractor-delivered services in each of the seven counties.

The selected counties and the selected subcontractors shall report their 2009–10 cost data to the department by October 31, 2010. The selected counties and selected subcontractors may use available sources of financial information, such as the interim 2009–10 cost reports, to meet this requirement so long as the data are submitted to the department by October 31, 2010.

SEC. 58. The State Department of Health Care Services shall provide the Legislature with a quarterly update, including key fiscal data provided to the federal Centers for Medicare and Medicaid Services, regarding the implementation of the federal American Recovery and Reinvestment Act of 2009 (ARRA) as it pertains to California's Medi-Cal program, including all waiver programs. This quarterly update shall be provided to the fiscal and policy committees of the Legislature within 14 working days of the close of the quarter, that commences July 1, 2009. The first quarterly update to be received by the Legislature in July 2009, shall reflect key issues and fiscal data as it pertains to the federal ARRA retroactive claiming from October 1, 2008, to June 30, 2009.

SEC. 59. Due to continued concerns regarding coordination of core programmatic functions between the State Department of Mental Health and the State Department of Health Care Services as they pertain to: (a) the reimbursement of county mental health plans and providers for services provided under Medi-Cal; (b) activities for the development and maintenance of the state's Medicaid waiver for the operation of mental health care services; (c) implementation of the state's Short-Doyle II data system; and (d) implementation of audit recommendations from the Office of State Evaluation and Audits (OSEA), and the federal Centers for Medicare and Medicaid Services (CMS), the California Health

and Human Services Agency or a successor entity, shall develop an action plan.

The purpose of this action plan is to address the need to have a coordinated approach between these two departments in order to produce tangible outcomes for addressing core functions as outlined. This action plan shall be provided to the Legislature no later than February 1, 2010.

SEC. 60. The State Department of Health Care Services shall provide the applicable fiscal and policy committees of the Legislature with copies of all federal audits and their findings that pertain to any component of the Medi-Cal Program, including program components administered by other state departments. This information shall be provided in a timely manner to the Legislature and preferably within seven working days of receipt of a final determination by the federal Centers for Medicare and Medicaid Services (CMS) or other applicable federal departments or agencies.

SEC. 61. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 62. This act addresses the fiscal emergency declared by the Governor by proclamation on July 1, 2009, pursuant to subdivision (f) of Section 10 of Article IV of the California Constitution.

SEC. 63. 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 changes necessary for implementation of the Budget Act of 2009, it is necessary that this act take effect immediately.

Approved _____, 2009

Governor