

AMENDED IN ASSEMBLY OCTOBER 7, 2010

SENATE BILL

No. 853

Introduced by Committee on Budget and Fiscal Review

January 11, 2010

An act relating to the Budget Act of 2010. An act to amend Section 56.30 of the Civil Code, to amend Section 854.1 of the Government Code, to amend Sections 1324.20, 1324.21, 1324.22, 1324.23, 1324.27, 1324.28, 1324.30, 1567.50, 120917, 130251, 130500, 130507, 130509, and 130543 of, to amend and repeal Section 1324.29 of, and to add Sections 1356.2, 1417.5, 120971, 130250.1, 130251.15, 130252, 130253, and 130254 to, the Health and Safety Code, to amend Sections 12693.21 and 12693.26 of, and to add Section 12693.23 to, the Insurance Code, to amend Sections 12009, 12204, 12207, 12242, 12251, 12253, 12254, 12257, 12258, 12260, 12301, 12302, 12303, 12304, 12305, 12307, 12412, 12413, 12421, 12422, 12423, 12427, 12428, 12429, 12431, 12433, 12434, 12491, 12493, 12494, 12601, 12602, 12631, 12632, 12636, 12636.5, 12679, 12681, 12801, 12951, 12977, 12983, 12984, and 13108 of, and to amend, add, and repeal Section 12201 of, the Revenue and Taxation Code, to amend Sections 4474.2, 4474.3, 4474.4, 4474.5, 4474.8, 4684.50, 4684.53, 4684.55, 4684.58, 4684.60, 4684.63, 4684.65, 4684.70, 4684.75, 5370.2, 10022, 14005.11, 14089, 14089.05, 14089.4, 14091.3, 14126.023, 14126.027, 14126.033, 14132, 14154, 14165.4, 14301.1, and 14301.11 of, to amend the heading of Article 3.5 (commencing with Section 4684.50) of Chapter 6 of Division 4.5 of, to add Sections 4101.5, 4646.55, 4701.1, 4791, 5813.6, 14105.08, 14105.28, 14105.281, 14105.456, 14126.022, 14132.925, 14167.351, and 14183.6 to, to repeal Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9 of, to repeal and amend Section 14005.25 of, and to repeal and add Section 4684.74 of, the Welfare and Institutions Code, and to amend Section 10 of Chapter 13 of the Third

Extraordinary Session of the Statutes of 2009, relating to health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 853, as amended, Committee on Budget and Fiscal Review.
~~Budget Act of 2010-Health.~~

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

Pursuant to a federal waiver, the Medi-Cal program administers a program known as the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program, under which comprehensive clinical family planning services, as defined, are provided to any person who has a family income at or below 200% of the federal poverty level and who is eligible to receive those services pursuant to the terms of the waiver. Existing law requires the program to be operated only in accordance with the waiver and certain statutes and regulations and subject to the terms, conditions, and duration of the waiver.

This bill would rename the program as the Family PACT Program. The bill would provide that in addition to being operated in accordance with the waiver, the program may be operated in accordance with a state plan amendment adopted pursuant to federal law, as specified, known as the Family PACT successor state plan amendment and would make conforming changes. The bill would expand the definition of comprehensive clinical family planning services to include services, drugs, devices, and supplies deemed by the federal Centers for Medicare and Medicaid Services to be appropriate for the Family PACT Program. The bill would permit the Director of Health Care Services to implement the state plan amendment retroactively to July 1, 2010.

Existing law authorizes the Director of Health Care Services to limit the rates of payment for health care services provided under the Medi-Cal program.

This bill would require the director to reduce rates applicable to radiology services so that they do not exceed 80% of the lowest maximum allowance established under the federal Medicare program for the same or similar services with dates of service on or after October

1, 2010. This bill would require the director to implement these provisions only to the extent that the director determines that the rates will comply with applicable federal Medicaid requirements and that federal financial participation is available.

This bill would require the department to develop and implement a payment methodology based on diagnosis-related groups, subject to federal approval, that reflects the costs and staffing levels associated with quality of care for patients in all general acute care hospitals, with certain exceptions, in state and out of state, as specified. The bill would provide that the diagnosis-related group-based payments apply to all claims, except as specified. The bill would require the department to submit to the Legislature annual status reports, commencing on April 1, 2011, and ending on April 1, 2014, on the implementation of the above-described provisions.

This bill would require, in order to enable the department to develop and implement the above-mentioned payment methodology, the Director of Health Care Services, subject to federal approval, to freeze rates applicable to inpatient hospital services, as specified. It would permit the department to modify this rate-freeze in order to comply with federal Medicaid requirements. The bill would require the department, within 90 days of the above-described provisions becoming effective, to develop and provide to all hospitals the methodology that will be utilized to implement the rate freeze for noncontract hospitals.

Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans.

Existing law, until January 1, 2011, requires the State Department of Health Care Services, subject to any necessary federal approval, to take all appropriate steps to amend the Medicaid state plan, to implement a requirement that any hospital that does not have in effect a contract with a Medi-Cal managed health care plan that establishes payment amounts for services furnished to a beneficiary enrolled in that plan shall accept, as payment in full, prescribed payment amounts.

This bill would extend the duration of these provisions until January 1, 2012.

Under existing law, the California Medical Assistance Commission is authorized to negotiate contracts with managed health care plans and other entities in clearly defined geographic areas for the provision of Medi-Cal services, with these contracts being binding upon the department.

This bill would, instead, provide that the department, rather than the commission, has the exclusive authority to negotiate these contracts, and would make conforming changes. It would provide that contracts or contract amendments negotiated pursuant to the bill are public records for purposes of the California Public Records Act.

Existing law specifies the procedures by which the State Department of Health Care Services determines prospective capitation rates to health plans participating in the Medi-Cal managed care program, and permits the department to utilize a county and health plan specific rate methodology to develop Medi-Cal managed care capitation rates for contracts between the department and case management plans, county health systems, and a geographic managed care pilot project.

This bill would provide that, prior to October 1, 2011, the risk-adjusted countywide capitation rate shall comprise no more than 20% of the total capitation rate paid to each Medi-Cal managed care plan.

Existing law imposes various taxes, including a tax at a specified rate on the gross premiums of an insurer, as defined, and, until January 1, 2011, on the total operating revenue, as specified, of a Medi-Cal managed care plan, as defined. Existing law provides that the tax on Medi-Cal managed care plans would have no force or effect if any of specified conditions apply.

This bill would extend the imposition of the tax on the total operating revenue of Medi-Cal managed care plans until July 1, 2011, and make other conforming changes.

Existing law continuously appropriates the proceeds from the tax on Medi-Cal managed care plans (1) to the department for purposes of the Medi-Cal program in an amount equal to 38.41% of the proceeds from the tax and (2) to the Managed Risk Medical Insurance Board for purposes of the Healthy Families Program in an amount equal to 61.59% of the proceeds from the tax.

This bill, from July 1, 2010, to June 1, 2011, inclusive, would, instead, continuously appropriate (1) a percentage of the revenues from the tax on Medi-Cal managed care plans equal to the difference between 100% and the applicable federal medical assistance percentage (FMAP) to the department for purposes of the Medi-Cal program and (2) the remaining revenues to the Managed Risk Medical Insurance Board for purposes of the Healthy Families Program. The bill would make an appropriation by extending the continuous appropriation.

Existing law requires every return required to be filed with the State Insurance Commissioner pursuant to provisions governing taxes on the gross premiums of insurers and, until January 1, 2011, on the total operating revenue of Medi-Cal managed care plans, to be signed by the insurer or an executive officer of the insurer and to be made under oath or contain a written declaration that it is made under penalty of perjury.

This bill would, instead, require every return required to be filed with the State Insurance Commissioner pursuant to provisions governing taxes on the total operating revenue of Medi-Cal managed care plans until July 1, 2011. By expanding the crime of perjury, this bill would impose a state-mandated local program.

Existing law requires the department to impose a uniform quality assurance fee on each skilled nursing facility, with certain exceptions, in accordance with a prescribed formula. The formula is based on the determination of the projected net revenues of skilled nursing facilities. The fee will cease to be assessed and collected on and after July 31, 2011, and these provisions will be repealed on January 1, 2012.

This bill would provide that, beginning in the 2010–11 rate year, specified multilevel facilities will no longer be exempt from the quality assurance fee. However, the bill would provide that a multilevel facility shall not be required to pay the quality assurance fee until changes to the quality assurance fee and the rate methodology enacted in the 2010 portion of the 2009–10 Regular Session of the Legislature are approved by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services has increased the Medi-Cal rates and the increased rates are paid to facilities.

This bill would also extend the assessment and collection of the uniform quality assurance fee through July 31, 2012. The bill provides for the collection of all quality assurance fees and penalties, including interest, that have been assessed, even after the quality assurance fee ceases to be assessed and would modify the remedies for collection of these fees. The bill would extend the repeal date for these provisions until January 1, 2013.

This bill would require the State Department of Public Health, in consultation with stakeholders, to develop recommendations, as prescribed, to address the findings published in a specified report and would require the State Department of Public Health to provide the recommendations to the fiscal and policy committees of the Legislature no later than March 1, 2011.

Existing law, the Medi-Cal Long-Term Reimbursement Act, requires the department to implement a facility-specific reimbursement ratesetting system for certain freestanding skilled nursing facilities. Reimbursement rates for these facilities are funded by a combination of federal funds and moneys collected pursuant to the above-described uniform quality assurance fee. Existing law provides that this rate methodology shall cease to be implemented on July 1, 2011, with these provisions to be repealed on January 1, 2012.

This bill would extend the implementation date of the freestanding skilled nursing facility rate reimbursement provisions through July 31, 2012, would make various conforming changes in these provisions, and would extend the repeal date for all of these provisions until January 1, 2013. It would also modify, for the 2010–11 and 2011–12 rate years, the facility reimbursement formula to be used under these provisions.

This bill would also require the department, by August 1, 2011, to develop the Skilled Nursing Facility Quality and Accountability Supplemental Payment System, as specified, subject to federal approval and the availability of federal, state, or other funds. The bill would provide that the system shall be utilized for providing supplemental payments to skilled nursing facilities that improve the quality and accountability of care rendered to residents and penalizing those facilities that do not meet measurable standards, in accordance with prescribed requirements. The bill would provide specific methodologies to be used in calculating the supplemental payments to be made and the penalties to be imposed.

The bill would create in the State Treasury the Skilled Nursing Facility Quality and Accountability Special Fund and continuously appropriate the moneys in the fund, without regard to fiscal year, to the department to make the above-described supplemental payments. The bill would provide that, upon appropriation of the Legislature, the moneys in the fund may also be used to cover administrative costs incurred by the State Department of Public Health and the State Department of Health Care Services, for positions and contract funding to implement the above-described provisions, and to provide funding assistance for Long-Term Care Ombudsman program activities.

This bill would appropriate, for the 2010–11 fiscal year, \$1.9 million from the Skilled Nursing Quality and Accountability Special Fund to the California Department of Aging to fund Long-Term Care Ombudsman program activities.

This bill would create in the Special Deposit Fund, the Skilled Nursing Facility Minimum Staffing Penalty Account, and would require the State Department of Public Health to deposit penalty payments collected into the account. This bill would require the State Department of Public Health to transfer, on a monthly basis, moneys in the Skilled Nursing Facility Minimum Staffing Penalty Account to the Skilled Nursing Quality and Accountability Special Fund.

The bill would make the above-described supplemental payment provisions subject to federal approval and would provide that in the event of a final judicial determination that these provisions are unlawful, they shall become inoperative.

Existing law, subject to federal approval, imposes, as a condition of participation in state-funded health insurance programs other than the Medi-Cal program, a quality assurance fee, as specified, on certain general acute care hospitals through and including December 31, 2010. Existing law creates the Hospital Quality Assurance Revenue Fund in the State Treasury and requires that the money collected from the quality assurance fee be deposited into the fund. Existing law provides that the moneys in the fund shall, upon appropriation by the Legislature, be available only for certain purposes, including health care coverage for children.

This bill would provide that it is the intent of the Legislature that the moneys in the fund for health care coverage for children be used to expand and enhance health services for children when the health of the economy and state budget are strong enough to allow for program expansions, and strong enough to ensure that the funds supplement, rather than supplant, existing funding for children's health services during the time that the above-described provisions are in effect.

Existing law requires the department to establish and maintain a plan, known as the County Administrative Cost Control Plan, for the purpose of effectively controlling costs related to the county administration of the determination of eligibility for benefits under the Medi-Cal program within the amounts annually appropriated for that administration.

This bill would require the plan to delineate processes for determining county administration base costs and funding for caseload changes, cost-of-living adjustments, and program and other changes. The bill would require the department and county welfare departments to develop procedures to ensure the data clarity, consistency, and reliability of information contained in the county budget survey

documents utilized under the plan that is submitted by counties to the department, including the format of the budget survey documents and use of the documents for the development of determining county administration costs. By requiring county welfare departments to develop the above-described procedures, this bill would impose a state-mandated local program. The bill would require any changes developed pursuant to the above-described provisions to be incorporated within the state's annual budget process by not later than the 2011–12 fiscal year.

Under existing law, the Legislature finds and declares that linking appropriate funding for county Medi-Cal administrative operations, including annual cost-of-doing-business adjustments, with performance standards will give counties the incentive to meet the performance standards and enable them to continue to do the work they do on behalf of the state. Existing law provides that it is the intent of the Legislature to provide appropriate funding to the counties for a cost-of-doing-business adjustment, except for the 2008–09 and 2009–10 fiscal years.

This bill would additionally provide that it is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2010–11 fiscal year.

Existing law requires the State Department of Health Care Services, to the extent required by federal law, for Medi-Cal recipients who are qualified Medicare beneficiaries, to pay the Medicare premiums, deductibles, and coinsurance for elderly and disabled persons whose income does not exceed the federal poverty level or 200% of a specified Supplemental Security Income program standard. For beneficiaries with a share of cost at or below \$500 who do not qualify for assistance because their income exceeds the above-described income requirements and they are not eligible for any other federally funded assistance for the payment of their Medicare Part B premium, existing law requires the State Department of Health Care Services to pay the beneficiary's Medicare Part B premium on a monthly basis regardless of whether the beneficiary's share of cost has been met.

This bill would delete the requirement that the State Department of Health Care Services pay the beneficiary's Medicare Part B premium on a monthly basis regardless of whether the beneficiary's share of cost has been met for the above-described beneficiaries with a share of cost at or below \$500.

Existing law, until July 1, 2012, requires the department, subject to the availability of federal financial participation, to exercise a federal option to expand continuous eligibility to children 19 years of age and younger for 6 months, after which date the continuous eligibility period shall be from the date of a determination of eligibility to the earlier of either the end of a 12-month period following the eligibility determination or the date the child exceeds 19 years of age.

Existing law provides that the provisions limiting continuous eligibility to 6 months shall be inoperative from March 27, 2009, until the date the Director of Health Care Services executes a declaration specifying that increased federal financial participation is no longer available pursuant to the federal American Recovery and Reinvestment Act of 2009 (ARRA). Existing law provides that during period in which the provisions limiting continuous eligibility to 6 months are inoperative, the continuous eligibility period shall be from the date of a determination of eligibility to the earlier of either the end of a 12-month period following the eligibility determination or the date the child exceeds 19 years of age.

This bill would delete the above-described provisions in effect until July 1, 2012. This bill would delete the delayed operative date of July 1, 2012, for the above-described provisions that provide that the continuous eligibility period shall be from the date of a determination of eligibility to the earlier of either the end of a 12-month period following the eligibility determination or the date the child exceeds 19 years of age, thereby making those provisions operative on the date this bill becomes effective.

Existing law requires reimbursement to Medi-Cal pharmacy providers of 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, commencing January 1, 2011, and subject to federal approval, would permit the department to reimburse Medi-Cal providers for physician-administered drugs, as defined, using either the Healthcare Common Procedure Coding System code rate or the National Drug Code rate, as specified, except that the reimbursement rate shall not be less than the Medicare reimbursement rate.

This bill would provide that nonlegend acetaminophen-containing products, with the exception of children's Tylenol, selected by the department are not covered benefits.

Existing law authorizes the State Department of Health Care Services to enter into nonexclusive contracts with entities to provide fiscal intermediary services in order to administer and disburse funds available for Medi-Cal services to health care providers in accordance with the provisions of the contract and any schedule of charges or formula for determining payments established pursuant to the contract.

This bill would require the department to provide the appropriate fiscal and policy committees of the Legislature, the Legislative Analyst's Office, the Office of the State Chief Information Officer (OCIO), and the Bureau of State Audits (BSA) with quarterly reports on the transition and takeover process efforts of the Medi-Cal fiscal intermediary contract, as specified, including copies of any oversight reports developed by contractors of the department for the California Medicaid Management Information System (CA-MMIS) project and any subsequent responses from the department. The bill would provide that the reports be provided within 30 days of the close of each quarter, commencing July 1, 2010, and continuing through the life of the contract.

Upon request from the Chair of the Joint Legislative Budget Committee (JLBC), this bill would require the department to provide updates on the Implementation Advanced Planning Document provided to the federal Centers for Medicare and Medicaid Services pertaining to the CA-MMIS project. This bill would require the CA-MMIS project to be subject to reviews and recommendations of the OCIO and would require the OCIO to submit a copy of those reviews and recommendations to the JLBC. The bill would require the BSA to review the appropriate project documents and quarterly reports and make recommendations about the new system implementation project, as necessary, and would require the BSA to submit a copy of any reviews and recommendations to the JLBC. This bill would authorize the Chair of the JLBC to request an audit of the progress of the transition, development, and implementation of the CA-MMIS.

Existing law provides that a person with private health care coverage is not entitled to receive health care items or services furnished or paid for by a publicly funded health care program, as defined, if covered by that private health care coverage. Existing law entitles a publicly funded health care program that furnishes or pays for designated services to be subrogated to the rights that person has against the carrier of the coverage, to the extent of the health care items provided or services rendered. Under existing law, an entity providing private health care

coverage, as defined, is required to respond to inquiries of, and agree not to deny claims submitted by, the state, in connection with the provision of a health care item or service, as specified. Existing law requires a claim for payment to be made within 3 years after provision of the relevant health care item or service.

This bill would extend the above requirements imposed upon an entity providing private health care coverage to include inquiries and claims submitted by providers, as defined.

Under existing law, the State Department of Developmental Services contracts with the regional centers to provide services and supports to persons with developmental disabilities. The services and supports to be provided to a regional center consumer are contained in an individual program plan (IPP), developed in accordance with prescribed requirements. Under existing law, Medi-Cal benefits include intermediate care facility services for persons with developmental disabilities.

This bill, effective July 1, 2007, would require certain types of licensed intermediate care facilities for persons with developmental disabilities (ICF-DDs), as specified, to be responsible for providing day treatment and transportation services that are selected and authorized through an IPP, as specified, for each beneficiary receiving those services who resides in that licensed ICF-DD.

The bill would require the regional centers to arrange the day treatment and transportation services and would require the licensed ICF-DDs to reimburse the regional center for the full costs of making disbursements to day treatment and transportation service providers.

This bill would require the State Department of Developmental Services to be responsible for reimbursing a licensed ICF-DD for the costs of reimbursing the regional center for the full cost of making disbursements for day treatment and transportation services, plus a coordination fee which will include an administrative fee and reimbursement for increased costs associated with the quality assurance fee. This bill, effective July 1, 2007, would authorize the State Department of Developmental Services to make a supplemental payment to an enrolled Medi-Cal provider that is a licensed ICF-DD for day treatment and transportation services provided to Medi-Cal beneficiaries residing in the ICF-DDs.

This bill would require the State Department of Developmental Services to amend the regional center contracts for the 2007–08 fiscal year to extend the contract liquidation period until June 30, 2011.

This bill would require the State Department of Health Care Services to request approval from the federal Centers for Medicare and Medicaid Services for the implementation of the above-described provisions. The bill would provide that if after seeking federal approval, federal approval is not obtained or federal financial participation is no longer available, the above-described provisions shall not be implemented or shall become inoperative.

This bill would provide that due to a change in the availability of federal funding that addresses the ability of California to capture additional federal financial participation for day treatment and transportation services provided to a Medi-Cal beneficiary residing in a licensed ICF-DD, certain funds appropriated in the Budget Act of 2007 shall be available for liquidation until June 30, 2011, which would extend the term for which existing appropriation is available, thereby making an appropriation.

Existing law requires that, as a condition of participation in the Medi-Cal program, there be imposed a quality assurance fee each state fiscal year upon the entire gross receipts, as defined, of a designated intermediate care facilities, as defined. Existing law requires that the fee be placed in the General Fund and allocated to intermediate care facilities to support their quality improvement efforts, and distributed to each facility based on the number of Medi-Cal patients at the eligible facility. Existing law requires the department to seek federal approval for the implementation of the fee.

This bill would provide that upon approval of the above-described state plan amendment authorizing reimbursement for day treatment and transportation services provided on or after July 1, 2007, the reimbursement payments made by the State Department of Developmental Services to the ICF-DDs shall be subject to the above-described quality assurance fee.

Existing law requires regional centers, in order to implement changes in the level of funding for regional center purchase of services, from February 1, 2009, to June 30, 2011, inclusive, to reduce certain payments for services delivered on or after February 1, 2009, by 3%, except as specified.

This bill would, instead, require regional centers to reduce the payments for those services by 3% from February 1, 2009, to June 30, 2010, inclusive, and by 4.25% from July 1, 2010, to June 30, 2011, inclusive.

This bill would, between July 1, 2010, and June 30, 2011, subject to certain conditions, permit a regional center, for providers who are subject to the 4.25% payment reduction, with certain exceptions, to temporarily modify personnel requirements, functions, or qualifications, or staff training requirements.

This bill would, from July 1, 2010, to June 30, 2011, inclusive, suspend prescribed annual review and reporting requirements that are imposed on providers whose payment is reduced by 4.25% pursuant to the above-described provisions.

Existing law establishes various state developmental centers, including the Agnews Developmental Center and the Lanterman Developmental Center, for the care of developmentally disabled persons. Existing law contains various provisions concerning the closure of the Agnews Developmental Center, including a provision authorizing the State Department of Developmental Services to operate any facility, provide its employees to assist in the operation of any facility, or provide other necessary services and supports if, in the discretion of the department, it determines that the activity will assist in meeting the goal of an orderly closure of Agnews Developmental Center.

This bill would extend many of the above-described provisions concerning the closure of the Agnews Developmental Center to the Lanterman Developmental Center. This bill would provide that for the Lanterman Developmental Center, the use of department employees is in effect for up to 2 years following the transfer of the last resident of the Lanterman Developmental Center, as specified. Additionally, this bill would require the State Department of Developmental Services to prepare a report on the use of the department's employees in providing services in the community to assist in the orderly closures of Agnews Developmental Center and Lanterman Developmental Center. The bill would require the report to be submitted with the Governor's proposed budget for the 2012–13 fiscal year to the fiscal committees of both houses of the Legislature and annually thereafter.

Existing law requires a service agency, which is defined as a developmental center or regional center that receives state funds to provide services to persons with developmental disabilities, to provide adequate notice, as defined, to an applicant for, or recipient of, services from the service agency, and to the applicant's or recipient's authorized representative, if any, prior to the agency making a decision without the mutual consent of the service recipient or authorized representative

to reduce, terminate, or change services set forth in an IPP or prior to a recipient being determined to be no longer eligible for agency services.

This bill would require the notice to inform the recipient and authorized representative of whether or not the individual is eligible for an exemption or exception to the action the service agency proposes to take, as specified, and the specific law supporting the exemption or exception.

Existing law, until January 1, 2011, 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. Existing law authorizes the State Department of Social Services to, subject to certain conditions, license an ARFPSHN to provide 24-hour services to up to 5 adults with developmental disabilities who have special health care and intensive support needs, as defined.

This bill would indefinitely extend the duration of the above-described program and would make 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 provides that an ARFPSHN may be established in a facility financed pursuant to certain provisions under which the State Department of Developmental Services approves a regional center proposal to provide for housing for persons eligible for regional center services.

This bill would, instead, provide that an ARFPSHN may only be established in a facility approved by the State Department of Developmental Services to provide for housing for persons eligible for regional center services or through an approved regional center community placement plan, as specified. However, this bill would provide that the State Department of Developmental Services shall only approve the development of ARFPSHNs that are directly associated with the orderly closure of the Lanterman Developmental Center.

Existing law prohibits a regional center from paying a rate to any ARFPSHN for any consumer that exceeds the average annual cost of serving a consumer at Agnews Developmental Center, as determined by the State Department of Developmental Services.

This bill would, instead, prohibit a regional center from paying a rate to any ARFPSHN for any consumer that exceeds the rate in the

State Department of Developmental Services approved community placement plan for that facility unless the regional center demonstrates that a higher rate is necessary to protect a consumer's health and safety and the department has granted prior written authorization.

Under existing law, the State Department of Mental Health operates and maintains state institutions for the mentally disordered.

This bill would allow the State Department of Mental Health to contract with providers of health care services and health care network providers for the provision of emergency health care services, as specified. The bill would also specify maximum rates of payment for services received from health care providers either under contract, or that do not contract, with the department.

Existing law requires the State Department of Mental Health to contract with a single nonprofit agency, as specified, for the provision of mental health patients' rights and advocacy services on a multiyear basis for a contract term of up to 3 years.

This bill would, instead, require the State Department of Mental Health to contract on a multiyear basis for a contract term of up to 5 years.

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

Existing law requires the Director of Mental Health, at the time of the release of the January 10 budget plan and the May Revision, to submit information to the Legislature regarding the expenditure of Proposition 63 funding for each state department and each major program category.

This bill would require the information submitted to the Legislature to include a complete listing of state support expenditures for the current year and for the budget year by the State Department of Mental Health, including the number of state positions and any contract funds.

Existing law, the federal Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires state child health plans to provide certain disenrollment rights and to establish sanctions against managed care organizations, as specified. The act also, among other things, requires state child health plans to convert to the Medicaid prospective payment system for services provided by federally qualified health centers and rural health clinics.

Existing law creates the Healthy Families Program, administered by the Managed Risk Medical Insurance Board (MRMIB), to arrange for the provision of health, vision, and dental benefits to children less than 19 years of age who meet certain criteria, including having a limited household income. Existing law requires MRMIB to negotiate separate contracts with participating health, dental, and vision plans for specified benefit packages.

This bill would, on and after January 1, 2011, authorize MRMIB to impose sanctions on participating health, dental, and vision plans by applying a specified Medicaid managed care provision imposed under CHIPRA. The bill would, on and after January 1, 2011, also authorize MRMIB to enter into contracts with entities other than participating health, dental, or vision plans in order to provide or pay benefits to Healthy Families Program subscribers for certain purposes, including ensuring that Healthy Families Program subscribers have adequate access to benefits. The bill would exempt any interagency agreement entered into pursuant to these provisions, and any contract or contract amendment necessary to implement that agreement, from competitive bidding laws and review or approval of the Department of General Services. The bill would authorize MRMIB to adopt emergency regulations for purposes of implementing these requirements or any other provision of CHIPRA not addressed by those requirements.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires health care service plans to pay specified assessments each fiscal year as a reimbursement of their share of the costs and expenses reasonably incurred in the administration of the act.

This bill would authorize the Director of the Department of Managed Health Care, by notice to all licensed health care service plans on or before October 15, 2010, to require health care service plans to pay an additional assessment, which is separate and independent of the above-described assessment, to provide the department with sufficient revenues to support costs and expenses of the department, as specified, for the 2010–11 fiscal year. The bill would require the additional assessment to be paid in full by December 1, 2010. By expanding the definition of a crime, this bill would impose a state-mandated local program.

Existing law limits the amount of the assessments paid by health care service plans.

This bill would, on and after July 1, 2011, and until August 31, 2015, authorize the director to raise the assessment limit to incorporate annual expenditure levels as set forth by the above-described provisions relating to the additional assessment.

Existing law, the Confidentiality of Medical Information Act, prohibits a health care provider, a contractor, or a health care service plan from disclosing medical information, as defined, regarding a patient of the provider or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as specified.

This bill would also exempt certain medical information and records disclosed to, and their use by, MRMIB, as specified.

Existing law requires the department to submit an application to the federal Centers for Medicare and Medicaid Services for a waiver or demonstration project that would implement specified objectives.

This bill would require the State Department of Health Care Services to enter into an interagency agreement with the Department of Managed Health Care to have the Department of Managed Health Care, on behalf of the State Department of Health Care Services, conduct financial audits, medical surveys, and a review of the provider networks of the managed care health plans participating in the above-described demonstration project.

Existing law establishes the California Discount Prescription Drug Program, which is administered by the State Department of Health Care Services. Existing law provides that the program shall become operative on or after July 1, 2010.

This bill would require the program to be implemented only if, and to the extent that, a Budget Act or other statute that is enacted on or before February 1, 2015, includes or makes an appropriation to implement the program.

Existing law requires, on August 1, 2013, 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 August 10, 2013, to reassess program outcomes, at least once every year, consistent with the benchmarks.

This bill would, if the program is implemented, extend the above-described requirement dates to August 1, 2017.

Existing law establishes the Office of Health Information Integrity within the California Health and Human Services Agency to ensure the

enforcement of state law mandating confidentiality of medical information and to impose administrative fines for the unauthorized use of medical information. Existing law authorizes the California Health and Human Services Agency, or one of the departments under its jurisdiction, to apply for federal funds made available through the federal American Recovery and Reinvestment Act of 2009 (ARRA) for health information technology and exchange, and establishes the California Health Information Technology and Exchange Fund for these purposes. Existing law provides that if the agency or one of the departments under its jurisdiction, elects not to submit an application for federal funds, the Governor shall designate a qualified nonprofit entity to be the state-designated entity for the purposes of establishing health information exchange.

This bill would, if the agency or one of its departments applies for federal funds, authorize the agency or department to later choose to subgrant, in whole or in part, portions of the federal grant to a qualified nonprofit entity, which would be designated as the state governance entity, for the purposes of establishing health information exchange.

This bill would specify the duties of the agency, the state-designated entity, or state governance entity in performing these functions, and would modify the membership of the initial governing board of the entity. The bill would require the agency to develop a detailed implementation plan and to submit it to the Legislature by November 1, 2010. The bill would, commencing October 1, 2010, require the agency to report, by October 1 and April 1 of each year, to the Legislature regarding expenditures and the status of health information technology and exchange activities funded through the fund.

This bill would specify that the agency, state-designated entity, or state governance entity shall establish and begin providing health information exchange services no later than January 1, 2012.

This bill would provide that all deliverables, as defined in the scope of work originated or prepared by the state-designated entity or state governance entity, as specified, shall, upon delivery and acceptance by the agency, become the exclusive property of the state, and may be copyrighted by the state under the oversight of the agency, as prescribed.

This bill would require the agency to require the state-designated entity or state governance entity to develop specified policies and procedures to provide the public with transparency of the actions of the entity.

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

This bill would require the State Department of Health Care Services and the State Department of Public Health, in the event state expenditures for the ADAP are identified by California to be used for a certified public expenditure for the purpose of obtaining federal financial participation under the Medi-Cal program for any purpose, to ensure the integrity of the ADAP in meeting its maintenance of effort requirements to receive federal funds and to obtain all ADAP drug rebates to support the ADAP.

Existing law establishes the Office of AIDS in the State Department of Public Health. Existing law authorizes HIV counselors trained by the Office of AIDS and working in an HIV counseling and testing site funded by the State Department of Public Health through a local health jurisdiction, or its agents, to perform skin punctures for purposes of withdrawing blood for HIV test purposes.

This bill would additionally authorize HIV counselors to perform skin punctures for purposes of withdrawing blood for HIV test purposes if the HIV counselor is working at an HIV counseling and testing site that utilizes HIV counseling staff who are trained by the Office of AIDS, or its agents, and has a quality assurance plan approved by the local health department, as specified, and staff who comply with certain quality assurance requirements required by regulation. The bill would authorize the Office of AIDS, or its agents, to charge a fee for training HIV counselors. The bill would authorize the local health department to charge a fee for the quality assurance plan approval.

Existing law, the California Special Supplemental Food Program for Women, Infants, and Children (WIC), authorizes establishment of a statewide program, administered by the State Department of Public Health, for providing nutritional food supplements to low-income pregnant women, low-income postpartum and lactating women, and

low-income infants and children under 5 years of age, who have been determined to be at nutritional risk. The program, which implements a program authorized under existing federal law, provides for the redemption of nutrition coupons by recipients at any authorized retail food vendor.

This bill would, by no later than January 10 and May 14 of each year, require the State Department of Public Health to provide the fiscal committees of the Legislature with an estimate package for WIC that shall include all significant assumptions underlying the estimate for the WIC program's current-year and budget-year proposals and concise information identifying applicable estimate components necessary to support the estimate.

Existing law requires the State Department of Public Health to provide breast cancer and cervical cancer screening services under a federal grant made under the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program to eligible low-income individuals. Funding for these services is provided by a combination of federal and state moneys. The above-described provisions are collectively known as the Every Woman Counts program.

This bill would, by no later than January 10 and May 14 of each year, require the State Department of Public Health to provide the fiscal committees of the Legislature with an estimate package for the Every Woman Counts program that includes all significant assumptions underlying the estimate for this program, including current-year and budget-year proposals, and that contains concise information identifying applicable estimate components necessary to support the estimate.

This bill would require the State Department of Public Health to provide the fiscal and appropriate policy committees of the Legislature with quarterly updates on caseload, estimated expenditures, and related program monitoring data for the Every Woman Counts program by no later than the 15th day of the month following the end of each quarter of the fiscal year.

Existing law establishes specified licensing and certification program fees for various health facilities, and contains provisions relating to methodologies for adjustment of those fees. Existing law requires the State Department of Public Health to annually prepare a report of all costs for activities of the Licensing and Certification Program. Existing law requires the report to include, among other things, recommendations for Licensing and Certification Program fees in accordance with specified criteria.

This bill would, by no later than January 10 and May 14 of each year, require the State Department of Public Health to provide the fiscal committees of the Legislature with an estimate package for the Licensing and Certification Program that includes all significant assumptions underlying the estimate for this program, including current-year and budget-year proposals, and that contains concise information identifying applicable estimate components, as specified.

This bill would, no later than January 20 of each year, require the State Department of Public Health to provide a vacancy report, effective as of December 1 of the previous calendar year, to the Joint Legislative Budget Committee and the chairs of the fiscal committees of both houses of the Legislature that identifies both filled and vacant positions within the department by center, division, branch, and classification.

This bill would require the State Department of Health Care Services to seek support from one or more foundations to support and develop a study or studies of the California Children's Services (CCS) Program, to be provided to interested stakeholders and the fiscal and appropriate policy committees of the Legislature by May 2011. It would express the intent of the Legislature concerning the purposes to which the study or studies are to be used.

This bill would require the State Department of Health Care Services to provide the fiscal and appropriate policy committees of the Legislature with semiannual updates containing certain information regarding all of California's Medicaid waivers to be provided in March and October of each year.

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

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

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

This bill would express the intent of the Legislature to enact statutory changes relating to the Budget Act of 2010.

Vote: ~~majority~~^{2/3}. Appropriation: ~~no~~^{yes}. Fiscal committee: ~~no~~^{yes}. State-mandated local program: ~~no~~^{yes}.

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

1 SECTION 1. Section 56.30 of the Civil Code is amended to
2 read:

3 56.30. The disclosure and use of the following medical
4 information shall not be subject to the limitations of this part:

5 (a) (Mental health and developmental disabilities) Information
6 and records obtained in the course of providing services under
7 Division 4 (commencing with Section 4000), Division 4.1
8 (commencing with Section 4400), Division 4.5 (commencing with
9 Section 4500), Division 5 (commencing with Section 5000),
10 Division 6 (commencing with Section 6000), or Division 7
11 (commencing with Section 7100) of the Welfare and Institutions
12 Code.

13 (b) (Public social services) Information and records that are
14 subject to Sections 10850, 14124.1, and 14124.2 of the Welfare
15 and Institutions Code.

16 (c) (State health services, communicable diseases, developmental
17 disabilities) Information and records maintained pursuant to former
18 Chapter 2 (commencing with Section 200) of Part 1 of Division 1
19 of the Health and Safety Code and pursuant to the Communicable
20 Disease Prevention and Control Act (subdivision (a) of Section
21 27 of the Health and Safety Code).

22 (d) (Licensing and statistics) Information and records maintained
23 pursuant to Division 2 (commencing with Section 1200) and Part
24 1 (commencing with Section 102100) of Division 102 of the Health
25 and Safety Code; pursuant to Chapter 3 (commencing with Section
26 1200) of Division 2 of the Business and Professions Code; and
27 pursuant to Section 8608, 8817, or 8909 of the Family Code.

28 (e) (Medical survey, workers' safety) Information and records
29 acquired and maintained or disclosed pursuant to Sections 1380
30 and 1382 of the Health and Safety Code and pursuant to Division
31 5 (commencing with Section 6300) of the Labor Code.

32 (f) (Industrial accidents) Information and records acquired,
33 maintained, or disclosed pursuant to Division 1 (commencing with
34 Section 50), Division 4 (commencing with Section 3200), Division

1 4.5 (commencing with Section 6100), and Division 4.7
2 (commencing with Section 6200) of the Labor Code.

3 (g) (Law enforcement) Information and records maintained by
4 a health facility which are sought by a law enforcement agency
5 under Chapter 3.5 (commencing with Section 1543) of Title 12 of
6 Part 2 of the Penal Code.

7 (h) (Investigations of employment accident or illness)
8 Information and records sought as part of an investigation of an
9 on-the-job accident or illness pursuant to Division 5 (commencing
10 with Section 6300) of the Labor Code or pursuant to Section
11 105200 of the Health and Safety Code.

12 (i) (Alcohol or drug abuse) Information and records subject to
13 the federal alcohol and drug abuse regulations (Part 2 (commencing
14 with Section 2.1) of subchapter A of Chapter 1 of Title 42 of the
15 Code of Federal Regulations) or to Section 11977 of the Health
16 and Safety Code dealing with narcotic and drug abuse.

17 (j) (Patient discharge data) Nothing in this part shall be construed
18 to limit, expand, or otherwise affect the authority of the California
19 Health Facilities Commission to collect patient discharge
20 information from health facilities.

21 (k) Medical information and records disclosed to, and their use
22 by, the Insurance Commissioner, the Director of the Department
23 of Managed Health Care, the Division of Industrial Accidents, the
24 Workers' Compensation Appeals Board, the Department of
25 Insurance, or the Department of Managed Health Care.

26 *(l) Medical information and records related to services provided*
27 *on and after January 1, 2006, disclosed to, and their use by, the*
28 *Managed Risk Medical Insurance Board to the same extent that*
29 *those records are required to be provided to the board related to*
30 *services provided on and after July 1, 2009, to comply with Section*
31 *403 of the federal Children's Health Insurance Program*
32 *Reauthorization Act of 2009 (Public Law 111-3), applying*
33 *subdivision (c) of Section 1932 of the federal Social Security Act.*

34 SEC. 2. Section 854.1 of the Government Code is amended to
35 read:

36 854.1. (a) It is the intent of the Legislature to ensure continuity
37 of care for clients of Agnews Developmental Center *and*
38 *Lanterman Developmental Center.*

39 (b) In the effort to achieve these goals, it is the intent of the
40 Legislature to seek and implement recommendations that include

1 all of the following services to retain Agnews *and Lanterman* staff
2 as employees:

3 (1) Crisis management teams that provide behavioral, medical,
4 and dental treatment, training, and technical assistance.

5 (2) Specialized services, including adaptive equipment design
6 and fabrication, and medical, dental, psychological, and assessment
7 services.

8 (3) Staff support in community homes to assist individuals with
9 behavioral or psychiatric needs.

10 (c) As used in this chapter, the terms “mental institution” or
11 “medical facility” also include a developmental services facility.
12 For the purposes of this chapter “developmental services facility”
13 means any facility or place where a public employee provides
14 developmental services relating to the closure of Agnews
15 Developmental Center *or Lanterman Developmental Center*.

16 SEC. 3. Section 1324.20 of the Health and Safety Code is
17 amended to read:

18 1324.20. For purposes of this article, the following definitions
19 shall apply:

20 (a) (1) “Continuing care retirement community” means a
21 provider of a continuum of services, including independent living
22 services, assisted living services as defined in paragraph (5) of
23 subdivision (a) of Section 1771, and skilled nursing care, on a
24 single campus, that is subject to Section 1791, or a provider of
25 such a continuum of services on a single campus that has not
26 received a Letter of Exemption pursuant to subdivision ~~(b)~~ (d) of
27 Section 1771.3.

28 (2) *Notwithstanding paragraph (1), beginning with the 2010–11*
29 *rate year and for every rate year thereafter, the term “continuing*
30 *care retirement community” shall have the definition contained*
31 *in paragraph (11) of subdivision (c) of Section 1771.*

32 (b) “Department,” unless otherwise specified, means the State
33 Department of Health Care Services.

34 ~~(b)~~

35 (c) (1) “Exempt facility” means a skilled nursing facility that
36 is part of a continuing care retirement community, a skilled nursing
37 facility operated by the state or another public entity, a unit that
38 provides pediatric subacute services in a skilled nursing facility,
39 a skilled nursing facility that is certified by the State Department
40 of Mental Health for a special treatment program and is an

1 institution for mental disease as defined in Section 1396d(i) of
2 Title 42 of the United States Code, or a skilled nursing facility that
3 is a distinct part of a facility that is licensed as a general acute care
4 hospital.

5 (2) *Notwithstanding paragraph (1), beginning with the 2010–11*
6 *rate year and for every rate year thereafter, the term “exempt*
7 *facility” shall mean a skilled nursing facility that is part of a*
8 *continuing care retirement community, as defined in paragraph*
9 *(2) of subdivision (a), a skilled nursing facility operated by the*
10 *state or another public entity, a unit that provides pediatric*
11 *subacute services in a skilled nursing facility, a skilled nursing*
12 *facility that is certified by the State Department of Mental Health*
13 *for a special treatment program and is an institution for mental*
14 *disease as defined in Section 1396d(i) of Title 42 of the United*
15 *States Code, or a skilled nursing facility that is a distinct part of*
16 *a facility that is licensed as a general acute care hospital.*

17 (3) *Notwithstanding paragraph (1), beginning with the 2010–11*
18 *rate year and every rate year thereafter, a multilevel facility, as*
19 *described in paragraph (1) of subdivision (a), shall not be exempt*
20 *from the quality assurance fee requirements pursuant to this article,*
21 *unless it meets the definition of a continuing care retirement*
22 *community in paragraph (11) of subdivision (c) of Section 1771.*

23 (e)

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

31 (2) ~~Notwithstanding paragraph (1), for the 2009–10 and 2010–11~~
32 ~~to 2011–12, inclusive,~~ rate years, “net revenue” means gross
33 resident revenue for routine nursing services and ancillary services
34 provided to all residents by a skilled nursing facility, including
35 Medicare revenue for routine and ancillary services and Medicare
36 revenue for services provided to residents covered under a
37 Medicare managed care plan, less payer discounts and applicable
38 contractual allowances as permitted under federal law and
39 regulation. To implement this paragraph, the department shall
40 request federal approval pursuant to Section 1324.27.

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

3 ~~(d)~~

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

7 ~~(e)~~

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

10 SEC. 4. Section 1324.21 of the Health and Safety Code is
11 amended to read:

12 1324.21. (a) For facilities licensed under subdivision (c) of
13 Section 1250, there shall be imposed each fiscal year a uniform
14 quality assurance fee per resident day. The uniform quality
15 assurance fee shall be based upon the entire net revenue of all
16 skilled nursing facilities subject to the fee, except an exempt
17 facility, as defined in Section 1324.20, calculated in accordance
18 with subdivision (b).

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

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

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

39 (2) (A) For the rate year 2005–06 and subsequent rate years
40 through and including the ~~2010–11~~ 2009–10 rate year, the net

1 revenue shall be projected for all skilled nursing facilities subject
2 to the uniform quality assurance fee. The projection of net revenue
3 shall be based on the prior rate year's data. Once determined, the
4 aggregate projected net revenue for all facilities shall be multiplied
5 by 6 percent, as determined under the approved methodology, and
6 then divided by the projected total resident days of all providers
7 subject to the fee. The amounts so determined shall be subject to
8 the provisions of subdivision (d).

9 *(B) For the 2010–11 rate year and subsequent rate years, the*
10 *net revenue shall be projected for all skilled nursing facilities*
11 *subject to the uniform quality assurance fee. The projection of net*
12 *revenue shall be based on the prior year's data trended forward,*
13 *using historical increases in net revenues. Once determined, the*
14 *aggregate projected net revenue for all facilities shall be multiplied*
15 *by 6 percent, as determined under the approved methodology, and*
16 *then divided by the projected total resident days of all providers*
17 *subject to the fee. The amounts so determined shall be subject to*
18 *subdivision (d).*

19 (c) The director may assess and collect a nonuniform fee
20 consistent with the methodology approved pursuant to Section
21 1324.27.

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

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

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

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

38 (3) Facilities that have been assessed a fee by the department
39 shall pay the fee assessed within 60 days of the date rates are

1 increased in accordance with paragraph (2) of subdivision (a) of
2 Section 1324.28 and paid to facilities.

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

6 SEC. 5. Section 1324.22 of the Health and Safety Code is
7 amended to read:

8 1324.22. (a) The quality assurance fee, as calculated pursuant
9 to Section 1324.21, shall be paid by the provider to the department
10 for deposit in the State Treasury on a monthly basis on or before
11 the last day of the month following the month for which the fee is
12 imposed, except as provided in subdivision (e) of Section 1324.21.

13 (b) On or before the last day of each calendar quarter, each
14 skilled nursing facility shall file a report with the department, in
15 a prescribed form, showing the facility's total resident days for
16 the preceding quarter and payments made. If it is determined that
17 a lesser amount was paid to the department, the facility shall pay
18 the amount owed in the preceding quarter to the department with
19 the report. Any amount determined to have been paid in excess to
20 the department during the previous quarter shall be credited to the
21 amount owed in the following quarter.

22 (c) On or before August 31 of each year, each skilled nursing
23 facility subject to an assessment pursuant to Section 1324.21 shall
24 report to the department, in a prescribed form, the facility's total
25 resident days and total payments made for the preceding state fiscal
26 year. If it is determined that a lesser amount was paid to the
27 department during the previous year, the facility shall pay the
28 amount owed to the department with the report.

29 (d) (1) A newly licensed skilled nursing facility, ~~as defined by~~
30 ~~the department,~~ facility shall complete all requirements of
31 subdivision (a) for any portion of the year in which it commences
32 operations and of subdivision (b) for any portion of the quarter in
33 which it commences operations.

34 (2) *For purposes of this subdivision, "newly licensed skilled*
35 *nursing facility" means a location that has not been previously*
36 *licensed as a skilled nursing facility.*

37 (e) (1) When a skilled nursing facility fails to pay all or part of
38 the quality assurance fee within 60 days of the date that payment
39 is due, the department may deduct the unpaid assessment and
40 interest owed from any Medi-Cal reimbursement payments to the

1 facility until the full amount is recovered. Any deduction shall be
2 made only after written notice to the facility and may be taken
3 over a period of time taking into account the financial condition
4 of the facility.

5 (2) *In addition to the provisions of paragraph (1), any unpaid*
6 *quality assurance fee assessed by this article shall constitute a*
7 *debt due to the state and may be collected pursuant to Section*
8 *12419.5 of the Government Code.*

9 (f) *Notwithstanding any other provision of law, the department*
10 *shall continue to assess and collect the quality assurance fee,*
11 *including any previously unpaid quality assurance fee, from each*
12 *skilled nursing facility, irrespective of any changes in ownership*
13 *or ownership interest or control or the transfer of any portion of*
14 *the assets of the facility to another owner.*

15 (g) *During the time period in which a temporary manager is*
16 *appointed to a facility pursuant to Section 1325.5 or during which*
17 *a receiver is appointed by a court pursuant to Section 1327, the*
18 *State Department of Public Health shall not be responsible for*
19 *any unpaid quality assurance fee assessed prior to the time period*
20 *of the temporary manager or receiver. Nothing in this subdivision*
21 *shall affect the responsibility of the facility to make all payments*
22 *of unpaid or current quality assurance fees, as required by this*
23 *section and Section 1324.21.*

24 ~~(f) Should~~

25 (h) *If all or any part of the quality assurance fee ~~remain~~ remains*
26 *unpaid, the department may take either or both of the following*
27 *actions:*

28 (1) *Assess a penalty equal to 50 percent of the unpaid fee amount*
29 *for unpaid fees assessed during the 2004–05 to 2009–10, inclusive,*
30 *rate years, and up to 50 percent of the unpaid fee amount for*
31 *unpaid fees assessed during the 2010–11 rate year and any*
32 *subsequent rate year.*

33 (2) (A) *Delay license renewal.*

34 (B) *Beginning with the 2010–11 rate year, the department may*
35 *recommend to the State Department of Public Health that license*
36 *renewal be delayed until the full amount of the quality assurance*
37 *fee, penalties, and interest is recovered.*

38 ~~(g)~~

39 (i) *In accordance with the provisions of the Medicaid ~~state plan~~*
40 *State Plan, the payment of the quality assurance fee shall be*

1 considered as an allowable cost for Medi-Cal reimbursement
2 purposes.

3 ~~(h)~~

4 (j) The assessment process pursuant to this section shall become
5 operative not later than 60 days from receipt of federal approval
6 of the quality assurance fee, unless extended by the department.
7 The department may assess fees and collect payment in accordance
8 with subdivision (e) of Section 1324.21 in order to provide
9 retroactive payments for any rate increase authorized under this
10 article.

11 (k) *The amendments made to subdivision (d) and the addition*
12 *of subdivision (f) by the act that added this subdivision shall not*
13 *be construed as substantive changes, but are merely clarifying*
14 *existing law.*

15 SEC. 6. Section 1324.23 of the Health and Safety Code is
16 amended to read:

17 1324.23. (a) The Director of Health Care Services, or his or
18 her designee, shall administer this article.

19 (b) The director may adopt regulations as are necessary to
20 implement this article. These regulations may be adopted as
21 emergency regulations in accordance with the rulemaking
22 provisions of the Administrative Procedure Act (Chapter 3.5
23 (commencing with Section 11340) of Part 1 of Division 3 of Title
24 2 of the Government Code). For purposes of this article, the
25 adoption of regulations shall be deemed an emergency and
26 necessary for the immediate preservation of the public peace, health
27 and safety, or general welfare. The regulations shall include, but
28 need not be limited to, any regulations necessary for any of the
29 following purposes:

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

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

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

37 (c) As an alternative to subdivision (b), and notwithstanding
38 the rulemaking provisions of Chapter 3.5 (commencing with
39 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
40 Code, the director may implement this article, in whole or in part,

1 by means of a provider bulletin, or other similar instructions,
2 without taking regulatory action, provided that no such bulletin or
3 other similar instructions shall remain in effect after July 31, ~~2010~~
4 2012. It is the intent of the Legislature that the regulations adopted
5 pursuant to subdivision (b) shall be adopted on or before July 31,
6 ~~2010~~ 2012.

7 SEC. 7. Section 1324.27 of the Health and Safety Code is
8 amended to read:

9 1324.27. (a) (1) The department shall request approval from
10 the federal Centers for Medicare and Medicaid Services for the
11 implementation of this article. In making this request, the
12 department shall seek specific approval from the federal Centers
13 for Medicare and Medicaid Services to exempt facilities identified
14 in subdivision ~~(b)~~ (c) of Section 1324.20, including the submission
15 of a request for waiver of broad-based requirement, waiver of
16 uniform fee requirement, or both, pursuant to paragraphs (1) and
17 (2) of subdivision (e) of Section 433.68 of Title 42 of the Code of
18 Federal Regulations.

19 (2) The director may alter the methodology specified in this
20 article, to the extent necessary to meet the requirements of federal
21 law or regulations or to obtain federal approval. The Director of
22 Health Services may also add new categories of exempt facilities
23 or apply a nonuniform fee to the skilled nursing facilities subject
24 to the fee in order to meet requirements of federal law or
25 regulations. The Director of Health Services may apply a zero fee
26 to one or more exempt categories of facilities, if necessary to obtain
27 federal approval.

28 (3) If after seeking federal approval, federal approval is not
29 obtained, this article shall not be implemented.

30 (b) The department shall make retrospective adjustments, as
31 necessary, to the amounts calculated pursuant to Section 1324.21
32 in order to assure that the aggregate quality assurance fee for any
33 particular state fiscal year does not exceed 6 percent of the
34 aggregate annual net revenue of facilities subject to the fee.

35 SEC. 8. Section 1324.28 of the Health and Safety Code is
36 amended to read:

37 1324.28. (a) This article shall be implemented as long as both
38 of the following conditions are met:

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

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

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

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

14 (2) The Medi-Cal Long Term Care Reimbursement Act, Article
15 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of
16 Division 9 of the Welfare and Institutions Code, as added during
17 the 2003–04 Regular Session by the act adding this section, is
18 enacted and implemented on or before July 31, 2005, or as
19 extended as provided in that article, and remains in effect thereafter.

20 (3) The state has continued its maintenance of effort for the
21 level of state funding of nursing facility reimbursement for ~~rate~~
22 ~~year~~ *the 2005–06 rate year*, and for every subsequent rate year
23 continuing through the ~~2010–11~~ *2011–12* rate year, in an amount
24 not less than the amount that specific facilities would have received
25 under the rate methodology in effect on July 31, 2004, plus
26 Medi-Cal’s projected proportional costs for new state or federal
27 mandates, not including the quality assurance fee.

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

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

37 (d) Notwithstanding subdivisions (a), (b), and (c), in the event
38 of a final judicial determination made by any state or federal court
39 that is not appealed, or by a court of appellate jurisdiction that is
40 not further appealed, in any action by any party, or a final

1 determination by the administrator of the federal Centers for
2 Medicare and Medicaid Services, that federal financial participation
3 is not available with respect to any payment made under the
4 methodology implemented pursuant to this article because the
5 methodology is invalid, unlawful, or contrary to any provision of
6 federal law or regulations, or of state law, this section shall become
7 inoperative.

8 SEC. 9. Section 1324.29 of the Health and Safety Code is
9 amended to read:

10 1324.29. (a) The quality assurance fee shall cease to be
11 assessed ~~and collected on or~~ after July 31, ~~2011~~ 2012.

12 (b) *Notwithstanding subdivision (a) and Section 1324.30, the*
13 *department's authority and obligation to collect all quality*
14 *assurance fees and penalties, including interest, shall continue in*
15 *effect and shall not cease until the date that all amounts are paid*
16 *or recovered in full.*

17 (c) *This section shall remain operative until the date that all*
18 *fees and penalties, including interest, have been recovered pursuant*
19 *to subdivision (b), and as of that date is repealed.*

20 SEC. 10. Section 1324.30 of the Health and Safety Code is
21 amended to read:

22 1324.30. This article shall become inoperative ~~on~~ after July
23 31, ~~2011~~ 2012, and, as of January 1, ~~2012~~ 2013, is repealed, unless
24 a later enacted statute, that becomes operative on or before January
25 1, ~~2012~~ 2013, deletes or extends the dates on which it becomes
26 inoperative and is repealed.

27 SEC. 11. Section 1356.2 is added to the Health and Safety
28 Code, to read:

29 1356.2. The director, by notice to all licensed health care
30 service plans on or before October 15, 2010, may require health
31 care service plans to pay an additional assessment to provide the
32 department with sufficient revenues to support costs and expenses
33 of the department as set forth in subdivision (b) of Section 1341.4
34 and Section 1356 for the 2010–11 fiscal year. The assessment paid
35 pursuant to this section shall be separate and independent of the
36 assessment imposed pursuant to subdivision (b) of Section 1356
37 and shall not be aggregated with the assessment imposed pursuant
38 to subdivision (b) of Section 1356 for the purposes of limitation
39 or otherwise. The assessment paid pursuant to this section shall
40 not be subject to the limitations imposed on assessments pursuant

1 to Section 1356.1. In imposing an assessment pursuant to this
2 section, the director shall levy on each health care service plan an
3 amount determined by the director using the categories of plans
4 in the schedules set forth in subdivision (b) of Section 1356. The
5 assessments imposed pursuant to this section shall be paid in full
6 by December 1, 2010. On and after July 1, 2011, and until August
7 31, 2015, the director may raise the assessment limit described in
8 subdivision (b) of Section 1356 to incorporate the annual
9 expenditure levels set forth in this section.

10 SEC. 12. Section 1417.5 is added to the Health and Safety
11 Code, to read:

12 1417.5. (a) The department, in consultation with stakeholders,
13 shall develop recommendations to address the findings published
14 in the June 2010 report entitled, “Department of Public Health: It
15 Reported Inaccurate Financial Information and Can Likely Increase
16 Revenues for the State and Federal Health Facilities Citation
17 Penalties Accounts” (Report 2010-108). The recommendations
18 shall address, but not be limited to, all of the following:

19 (1) Streamlining the citation appeal process, including the
20 citation review conference process.

21 (2) Increasing citation penalty amounts, including late penalty
22 fees, and annually adjusting penalty amounts to reflect an inflation
23 indicator, such as the California Consumer Price Index.

24 (3) Revising state law to enable the department to recommend
25 that the federal Centers for Medicare and Medicaid Services impose
26 a federal civil money penalty when the department’s Licensing
27 and Certification Division determines that a facility is out of
28 compliance with both state and federal requirements.

29 (4) Authorizing the department to collect citation penalty
30 amounts upon appeal of the citation and allowing the department
31 to place those funds into a special interest bearing account.

32 (b) The department shall provide the recommendations to the
33 fiscal and policy committees of the Legislature no later than March
34 1, 2011.

35 SEC. 13. Section 1567.50 of the Health and Safety Code is
36 amended to read:

37 1567.50. (a) Notwithstanding that a community care facility
38 means a place that provides nonmedical care under subdivision
39 (a) of Section 1502, pursuant to Article 3.5 (commencing with
40 Section 4684.50) of Chapter 6 of Division 4.5 of the Welfare and

1 Institutions Code, the department shall jointly implement with the
2 State Department of Developmental Services a ~~pilot project to test~~
3 ~~the effectiveness of providing~~ *licensing program to provide* special
4 health care and intensive support services to adults in homelike
5 community settings.

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

13 (1) The State Department of Developmental Services shall be
14 responsible for granting the certificate of program approval for an
15 Adult Residential Facility for Persons with Special Health Care
16 Needs (ARFPSHN). The State Department of Social Services shall
17 not issue a license unless the applicant has obtained a certification
18 of program approval from the State Department of Developmental
19 Services.

20 (2) The State Department of Social Services shall ensure that
21 the ARFPSHN meets the administration requirements under Article
22 2 (commencing with Section 1520) including, but not limited to,
23 requirements relating to fingerprinting and criminal records under
24 Section 1522.

25 (3) The State Department of Social Services shall administer
26 employee actions under Article 5.5 (commencing with Section
27 1558).

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

33 (5) The State Department of Developmental Services may
34 decertify any ARFPSHN that does not comply with program
35 requirements. When the State Department of Developmental
36 Services determines that urgent action is necessary to protect clients
37 of the ARFPSHN from physical or mental abuse, abandonment,
38 or any other substantial threat to their health and safety, the State
39 Department of Developmental Services may request the regional
40 center or centers to remove the clients from the ARFPSHN or

1 direct the regional center or centers to obtain alternative services
2 for the consumers within 24 hours.

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

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

12 (8) The State Department of Developmental Services and the
13 regional centers shall provide the State Department of Social
14 Services all available documentation and evidentiary support
15 necessary for any enforcement proceedings to suspend the license
16 pursuant to Section 1550.5, to revoke or deny a license pursuant
17 to Section 1551, or to exclude an individual pursuant to Section
18 1558.

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

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

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

4 ~~(d)~~

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

8 SEC. 14. Section 120917 of the Health and Safety Code is
9 amended to read:

10 120917. (a) ~~An HIV counselor who is trained by the Office~~
11 ~~of AIDS and working in an HIV counseling and testing site funded~~
12 ~~by the department through a local health jurisdiction, or its agents,~~
13 *meets the requirements of subdivision (e)* may do all of the
14 following:

15 (1) Perform any HIV test that is classified as waived under the
16 federal Clinical Laboratory Improvement Act (CLIA) (42 U.S.C.
17 Sec. 263a and following) if all of the following conditions exist:

18 (A) The performance of the HIV test meets the requirements of
19 CLIA and, subject to subparagraph (B), Chapter 3 (commencing
20 with Section 1200) of Division 2 of the Business and Professions
21 Code.

22 (B) Notwithstanding Section 1246 of the Business and
23 Professions Code, an HIV counselor may perform skin punctures
24 for the purpose of withdrawing blood for HIV testing, upon specific
25 authorization from a licensed physician and surgeon, provided that
26 the person meets both of the following requirements:

27 (i) He or she works under the direction of a licensed physician
28 and surgeon.

29 (ii) He or she has been trained in both rapid HIV test proficiency
30 for skin puncture blood tests and oral swab tests and in universal
31 infection control precautions, consistent with best infection control
32 practices established by the Division of Occupational Safety and
33 Health in the Department of Industrial Relations and the federal
34 Centers for Disease Control and Prevention.

35 (C) The person performing the HIV test meets the requirements
36 for the performance of waived laboratory testing pursuant to
37 subdivision (a) of Section 1206.5 of the Business and Professions
38 Code. For purposes of this subdivision and subdivision (a) of
39 Section 1206.5 of the Business and Professions Code, an HIV
40 counselor ~~trained by the Office of AIDS~~ *who meets the*

1 *requirements of subdivision (e)* shall be “other health care
2 personnel providing direct patient care” as referred to in paragraph
3 (12) of subdivision (a) of Section 1206.5 of the Business and
4 Professions Code.

5 (D) The patient is informed that the preliminary result of the
6 test is indicative of the likelihood of HIV infection and that the
7 result must be confirmed by an additional more specific test, or,
8 if approved by the federal Centers for Disease Control and
9 Prevention for that purpose, a second different rapid HIV test.
10 Nothing in this subdivision shall be construed to allow an HIV
11 counselor ~~trained by the Office of AIDS~~ to perform any HIV test
12 that is not classified as waived under the CLIA.

13 (2) Notwithstanding Sections 1246.5 and 2053 of the Business
14 and Professions Code, order and report HIV test results from tests
15 performed pursuant to paragraph (1) to patients without
16 authorization from a licensed health care professional or his or her
17 authorized representative. Patients with indeterminate or positive
18 test results from tests performed pursuant to paragraph (1) shall
19 be referred to a licensed health care provider whose scope of
20 practice includes the authority to refer patients for laboratory
21 testing for further evaluation.

22 (b) An HIV counselor who has been certified pursuant to
23 subdivision (b) of Section 120871 prior to September 1, 2009, and
24 who will administer rapid HIV skin puncture tests shall obtain
25 training required by clause (ii) of subparagraph (B) of paragraph
26 (1) of subdivision (a) prior to September 1, 2011. The HIV
27 counselor shall not, unless also certified as a limited phlebotomist
28 technician, perform a skin puncture pursuant to this section until
29 he or she has completed the training required by that clause.

30 (c) An HIV counselor who meets the requirements of this section
31 with respect to performing any HIV test that is classified as waived
32 under the CLIA may not perform any other test unless that person
33 meets the statutory and regulatory requirements for performing
34 that other test.

35 (d) This section shall not be construed to certify an HIV
36 counselor as a phlebotomy technician or a limited phlebotomy
37 technician, or to fulfill any requirements for certification as a
38 phlebotomy technician or a limited phlebotomy technician, unless
39 the HIV counselor has otherwise satisfied the certification

1 requirements imposed pursuant to Section 1246 of the Business
2 and Professions Code.

3 *(e) (1) An HIV counselor shall meet one of the following*
4 *criteria:*

5 *(A) Is trained by the Office of AIDS and working in an HIV*
6 *counseling and testing site funded by the department through a*
7 *local health jurisdiction, or its agents.*

8 *(B) Is working in an HIV counseling and testing site that meets*
9 *both of the following criteria:*

10 *(i) Utilizes HIV counseling staff who are trained by the Office*
11 *of AIDS or its agents.*

12 *(ii) Has a quality assurance plan approved by the local health*
13 *department in the jurisdiction where the site is located and has*
14 *HIV counseling and testing staff who comply with the quality*
15 *assurance requirements specified in Section 1230 of Article 1 of*
16 *Group 9 of Subchapter 1 of Chapter 2 of Division 1 of Title 17 of*
17 *the California Code of Regulations.*

18 *(2) (A) The Office of AIDS or its agents may charge a fee for*
19 *training HIV counseling staff.*

20 *(B) The local health department may charge a fee for the quality*
21 *assurance plan approval.*

22 SEC. 15. Section 120971 is added to the Health and Safety
23 Code, to read:

24 120971. (a) In the event state expenditures for the AIDS Drug
25 Assistance Program (ADAP) are identified by California to be
26 used as a certified public expenditure for the purpose of obtaining
27 federal financial participation under the Medi-Cal program for any
28 purposes, including federal demonstration waivers, the State
29 Department of Health Care Services and the State Department of
30 Public Health shall ensure the integrity of the ADAP in meeting
31 its maintenance of effort requirements to receive federal funds and
32 to obtain all ADAP drug rebates to support the ADAP.

33 (b) The State Department of Health Care Services and the State
34 Department of Public Health shall keep the appropriate policy and
35 fiscal committees of the Legislature informed of any potential
36 concerns that may arise in the event that state expenditures for the
37 ADAP are used as a certified public expenditure as described in
38 subdivision (a).

39 SEC. 16. Section 130250.1 is added to the Health and Safety
40 Code, to read:

1 130250.1. (a) This division shall be known, and may be cited,
2 as the California Health Information Technology Act.

3 (b) Any duties under the act are subject to the availability of
4 sufficient funding to carry out the duties. The provisions of this
5 act shall only be implemented to the extent permitted by federal
6 law.

7 SEC. 17. Section 130251 of the Health and Safety Code is
8 amended to read:

9 130251. (a) The California Health and Human Services Agency
10 or one of the departments under its jurisdiction may apply for
11 federal funds made available through the federal American
12 Recovery and Reinvestment Act of 2009 (Public Law 111-5) for
13 health information technology and exchange. *If the California*
14 *Health and Human Services Agency or one of the departments*
15 *under its jurisdiction submits an application pursuant to this*
16 *subdivision, and later chooses to subgrant, in whole or in part, a*
17 *portion of the federal grant to a qualified nonprofit entity for the*
18 *purposes of establishing health information exchange, that entity*
19 *shall be designated as the state governance entity.*

20 (b) In the event that the California Health and Human Services
21 Agency or one of the departments under its jurisdiction elects not
22 to submit an application described in subdivision (a), the Governor
23 shall designate a qualified nonprofit entity to be the
24 state-designated entity for the purposes of health information
25 exchange, pursuant to the requirements set forth in ~~ARRA~~ *the*
26 *federal American Reinvestment and Recovery Act of 2009.*

27 (c) *In addition to existing requirements applicable to nonprofit*
28 *entities, the state governance entity may be held to additional*
29 *requirements under federal and state law, and directives from the*
30 *California Health and Human Services Agency.*

31 (e)

32 (d) The agency or state-designated entity shall execute tasks
33 related to accessing federal stimulus funds made available through
34 ARRA, and facilitate and expand the use and disclosure of health
35 information electronically among organizations according to
36 nationally recognized standards and implementation specifications
37 while protecting, to the greatest extent possible, individual privacy
38 and the confidentiality of electronic medical records.

39 (d)

1 (e) The agency or state-designated entity shall develop a plan
2 *strategic and operational plans* to ensure that health information
3 exchange capabilities are available, adopted, and utilized statewide
4 so that patients do not experience disparities in access to the
5 benefits of this technology by age, race, ethnicity, language,
6 income, insurance status, geography, or otherwise.

7 ~~(e)~~

8 (f) The agency or, state-designated entity, or state governance
9 entity shall create a plan for a self-sustaining funding mechanism
10 that does not include use of General Fund moneys that shall cover
11 all reasonable costs of the administration of health information
12 exchange when federal ARRA funds expire or are exhausted. A
13 *detailed business plan and sustainability model shall be submitted*
14 *to the Governor and the Legislature by April 1, 2011. The plan*
15 *may include a combination of approaches to create viable revenue*
16 *streams, and shall take into account the needs of safety net*
17 *institutions and providers.*

18 ~~(f)~~

19 (g) The state-designated entity or state governance entity shall
20 continually meet any conditions for being so designated as
21 determined by the Secretary of California Health and Human
22 Services. Failure to comply with this subdivision may result in the
23 applicable entity losing its ~~designation~~ *contract for state*
24 *designation or subgrant agreement.*

25 ~~(g)~~

26 (h) As a condition of receiving the ~~state designation~~ *contract*
27 *for state designation or subgrant agreement*, the state-designated
28 entity or state governance entity shall comply with all of the
29 following requirements:

30 (1) It shall be subject to oversight by the California Health and
31 Human Services Agency.

32 (2) (A) It shall be governed by a *an initial* board with a diverse
33 composition from multiple types of organizations from multiple
34 regions throughout the state. The *initial* governing board shall
35 include, at a minimum, all of the following:

36 (i) The Secretary of California Health and Human Services or
37 or his or her designee.

38 (ii) The Chair of the Senate Committee on Health or his or her
39 designee.

- 1 (iii) The Chair of the Assembly Committee on Health ~~on~~ or his
 2 or her designee.
- 3 (iv) *One administrator from a state department under the*
 4 *jurisdiction of the California Health and Human Services Agency*
 5 *responsible for a statewide health program.*
- 6 ~~(iv)~~
- 7 (v) At least two consumer representatives, one of whom shall
 8 have expertise in privacy and security of health information.
- 9 (vi) *One licensed physician and surgeon, representing a solo*
 10 *or small group practice.*
- 11 (vii) *One licensed physician and surgeon, representing a medical*
 12 *group or independent practice association.*
- 13 (viii) *One representative from a safety net clinic.*
- 14 (ix) *Two representatives of hospitals, one of whom shall*
 15 *represent a public hospital.*
- 16 (x) *Two representatives of health plans or health insurers, one*
 17 *of whom shall represent a publicly run health plan or insurer.*
- 18 (xi) *One local public health officer.*
- 19 (xii) *Two representatives of health information exchange*
 20 *organizations, one from northern California, and one from*
 21 *southern California.*
- 22 (xiii) *One representative of the medical informatics industry or*
 23 *who has experience in medical informatics.*
- 24 (xiv) *One representative of an employer who provides employees*
 25 *with health care coverage, or a group purchaser of health care*
 26 *coverage.*
- 27 (xv) *One representative from labor.*
- 28 (xvi) *The chief executive officer of the nonprofit entity.*
- 29 (xvii) *Two at-large cochairs of the nonprofit entity.*
- 30 (B) The majority of the board shall be comprised of
 31 ~~nongovernmental~~ *nongovernmental* employees.
- 32 (3) If the governing board convenes workgroups or
 33 subcommittees, the workgroups or subcommittees shall be
 34 comprised of representatives from multiple types of organizations
 35 from multiple regions throughout the state, and meetings of any
 36 workgroup or subcommittee shall be held in an open, public, and
 37 transparent way.
- 38 (4) ~~The~~ *The state-designated entity or state governance entity* shall
 39 have nondiscrimination and conflict-of-interest policies that

1 demonstrate a commitment to open, fair, and nondiscriminatory
2 participation by stakeholders.

3 ~~(h)~~

4 ~~(i) The state-designated entity shall report to the California~~
5 ~~Health and Human Services Agency and the Legislature on its~~
6 ~~progress and activities at least annually, in consultation with the~~
7 ~~initial governing board, may modify the composition of the initial~~
8 ~~governing board. If a modification is made to the composition of~~
9 ~~the initial governing board pursuant to this subdivision, the agency~~
10 ~~shall inform the Legislature of, and the reason for, the change~~
11 ~~implemented.~~

12 ~~(j) Upon the completion of the initial one-year term of the two~~
13 ~~at-large cochairs of the state-designated entity or state governance~~
14 ~~entity, the board shall select a chair or two cochairs from its~~
15 ~~membership.~~

16 SEC. 18. Section 130251.15 is added to the Health and Safety
17 Code, to read:

18 130251.15. (a) All deliverables, as defined in the scope of
19 work originated or prepared by the state-designated entity or state
20 governance entity pursuant to its applicable contract, including
21 papers, reports, charts, and other documentation, but not including
22 the applicable entity's administrative communications and records
23 relating to the contract, shall, upon delivery and acceptance by the
24 California Health and Human Services Agency, become the
25 exclusive property of the state, and may be copyrighted by the
26 state under the oversight of the agency.

27 (b) If any material funded pursuant to the contract may be
28 copyrighted, the agency reserves the right to copyright the material,
29 and the entity agrees not to copyright the material without prior
30 written approval from the Secretary of California Health and
31 Human Services. The secretary shall consent to, or give a reason
32 for the denial to, the entity in writing within 60 days of receipt of
33 the request.

34 (c) If the material is copyrighted with the consent of the agency,
35 the agency reserves a royalty-free, nonexclusive, and irrevocable
36 license to reproduce, prepare derivative works, publish, distribute,
37 and use the materials, in whole or in part, and to authorize others
38 to do so, provided written credit is given to the author.

39 (d) All inventions, discoveries, or improvements of the
40 techniques, programs, or materials developed pursuant to the

1 contract shall be the property of the agency. The agency agrees to
2 grant a royalty-free, nonexclusive license for any invention,
3 discovery, or improvement to the entity and further agrees that the
4 entity may sublicense additional persons on the same royalty-free
5 basis subject to the approval of the agency.

6 (e) Nothing in this section shall be construed to limit the
7 intellectual property and copyright authority of the federal
8 government.

9 SEC. 19. Section 130252 is added to the Health and Safety
10 Code, to read:

11 130252. (a) Subject to available funding, the California Health
12 and Human Services Agency shall be responsible for ensuring that
13 all federal grant deliverables are met. The agency shall coordinate
14 electronic health activities in the state and work with stakeholders,
15 state departments, and the Legislature to support policy needs for
16 health information technology and health information exchange
17 in California.

18 (b) In the event that a state governance entity is established, all
19 of the following conditions shall be met:

20 (1) The agency shall be responsible for ensuring that all
21 deliverables established in the strategic and operational plans
22 established pursuant to subdivision (e) of Section 130251, and as
23 required by the federal grant, are met.

24 (2) Any grant issued by the agency to the state governance entity
25 for health information exchange shall be deliverables based. All
26 deliverables shall be subject to approval and acceptance by the
27 agency.

28 (c) The agency, state-designated entity, or the state governance
29 entity shall establish and begin providing health information
30 exchange services by January 1, 2012.

31 (d) The state-designated entity or state governance entity shall
32 ensure that an effective model for health information exchange
33 governance and accountability is in place. In order to avoid any
34 real or apparent conflict of interest, the state-designated entity or
35 state governance entity shall ensure organizational and functional
36 separation exists between the governance functions of the entity
37 and its operational functions, specifically between operating entities
38 that are or may be involved in building and maintaining the health
39 information exchange. The agency shall conduct periodic internal
40 reviews at least once after an entity has received the designation,

1 and periodically as necessary, to ensure this separation is
2 maintained, and that the state-designated entity or state governance
3 entity operates in a manner that ensures organizational integrity
4 and accountability.

5 (e) The state-designated entity or state governance entity shall
6 provide a process for public comment and input, which may include
7 integrating public workgroups convened by the agency during the
8 operational planning process into its organizational structure.

9 (f) The state-designated entity or state governance entity, in
10 consultation with the Office of Health Information Integrity, shall
11 develop detailed standards and policies to be included in all
12 contracts with health care entities that are participants of the
13 state-designated entity's or governance entity's health information
14 exchange for health information exchange services provided by
15 the applicable entity. The state-designated entity or state
16 governance entity shall also work with the Office of Health
17 Information Integrity to ensure standardization of privacy and
18 security policies for health information exchange statewide. The
19 state-designated entity or state governance entity shall develop
20 operational policies based on privacy and security guidelines
21 developed by the state, and create a uniform set of privacy and
22 security rules to be used by other entities participating in health
23 information exchanges established by the state-designated entity
24 or state governance entity for health information exchange or a
25 contract made by the applicable entity for health information
26 exchange.

27 (g) The agency shall develop a detailed implementation plan
28 that meets all requirements, deliverables, and goals specified in
29 the strategic and operational plans established pursuant to
30 subdivision (e) of Section 130251. The implementation plan shall
31 be submitted to the Legislature by November 1, 2010. The
32 implementation plan shall include, but need not be limited to, all
33 of the following:

- 34 (1) A detailed work plan and communications plan.
- 35 (2) A model that defines the technical architecture for services
36 recommended in the operational plan.
- 37 (3) A description of specific core services enabled or provided
38 by the health information exchange and timeframes for the rollout
39 of those services.

1 (4) A determination of how to most effectively engage
2 stakeholders throughout the state.

3 (5) A description of specific deliverables and timeframes to
4 ensure that statewide health information exchange is achieved
5 pursuant to the state strategic and operational plans.

6 (6) Detailed information on internal infrastructure that ensures
7 the state governance entity for health information exchange meets
8 legal and regulatory criteria needed, including, but not limited to,
9 a comprehensive staffing plan.

10 (h) Any contract for state designation or subgrant agreement
11 pursuant to this section shall be made through an open and
12 competitive process as required by federal law.

13 (i) The state designated entity or state governance entity shall
14 comply with applicable provisions of the federal Health
15 Information Technology for Economic and Clinical Health Act
16 (HITECH Act; Public Law 111-5), the federal Public Health
17 Service Act (42 U.S.C. Sec. 300x-26), and applicable federal
18 policies, guidance, and requirements. These provisions shall
19 include, but are not limited to, the requirement that funds be used
20 to conduct activities to facilitate and expand the electronic
21 movement and use of health information among organizations
22 according to nationally recognized standards in effect on December
23 31, 2010.

24 SEC. 20. Section 130253 is added to the Health and Safety
25 Code, to read:

26 130253. (a) To provide the public with transparency of the
27 actions by the state-designated entity or state governance entity,
28 the California Health and Human Services Agency shall require
29 the state-designated entity or state governance entity to develop
30 policies and procedures that include, but are not limited to, all of
31 the following areas:

32 (1) Conflicts of interest. The policies and procedures shall be
33 consistent with federal law and modeled on the Political Reform
34 Act of 1974 (Title 9 (commencing with Section 81000) of the
35 Government Code).

36 (2) Public access to meetings.

37 (A) (i) The state-designated entity or state governance entity
38 shall hold board and workgroup meetings open to the public,
39 including the entity's annual meeting.

1 (ii) The state-designated entity or state governance entity may
2 hold additional meetings as it determines are necessary or
3 appropriate. Subject to subparagraph (B), these meetings shall also
4 be open to the public.

5 (B) The state governance entity may conduct closed sessions
6 when it meets to consider or discuss confidential matters, including,
7 but not limited to, those concerning the appointment, employment,
8 performance, compensation, or dismissal of the entity's officers
9 and employees.

10 (C) The state-designated entity shall award grants and contracts
11 in public meetings consistent with federal requirements for an open
12 and competitive process, and shall adopt all governance, technical,
13 and policy standards in public meetings.

14 (3) Contracts.

15 (A) The Public Contract Code shall not apply to contracts issued
16 by the state governance entity. This subparagraph shall not be
17 construed to modify existing law regarding the application of the
18 Public Contract Code.

19 (B) For contracts entered into by the state governance entity,
20 policies shall be governed by applicable federal regulations,
21 policies specified by the Office of the National Coordinator for
22 Health Information Technology, including, but not limited to,
23 provisions required by the federal State Health Information
24 Exchange Cooperative Agreement Program and any additional
25 requirements as specified by the agency.

26 (b) The policies and procedures developed pursuant to this
27 section are exempt from the Administrative Procedure Act (Chapter
28 3.5 (commencing with Section 11340) of Part 1 of Division 3 of
29 Title 2 of the Government Code).

30 SEC. 21. Section 130254 is added to the Health and Safety
31 Code, to read:

32 130254. Notwithstanding Section 10231.5 of the Government
33 Code, commencing October 1, 2010, the California Health and
34 Human Services Agency shall report, by October 1 and April 1 of
35 each year, to the Legislature regarding the expenditures made from
36 the California Health Information Technology and Exchange Fund,
37 and the status of health information technology and exchange
38 activities funded through the fund. The report shall be in
39 compliance with Section 9795 of the Government Code. This
40 report shall include, at a minimum, all of the following:

1 (a) The agency's evaluation of the extent to which the state
2 governance entity for health information exchange has completed
3 each deliverable outlined in grant agreements or contracts between
4 the state and the entity, and the extent to which deliverables were
5 completed within the timelines specified in the grant agreements
6 or contracts.

7 (b) A detailed update on hiring and expenditures on staff hired
8 through this fund, including, but not limited to, staff hired by the
9 state governance entity for health information exchange.

10 (c) The status and amounts of grants and contracts awarded by
11 the state governance entity for health information exchange,
12 including, but not limited to, descriptions and deliverables.

13 SEC. 22. Section 130500 of the Health and Safety Code is
14 amended to read:

15 130500. (a) This division shall be known, and may be cited,
16 as the California Discount Prescription Drug Program.

17 (b) ~~The provisions of this~~ This division shall become operative
18 ~~on or~~ and after July 1, 2010.

19 (c) *The California Discount Prescription Drug Program shall*
20 *be implemented only if, and to the extent that, a Budget Act or*
21 *other statute that is enacted on or before February 1, 2015,*
22 *includes or makes an appropriation of moneys to the department*
23 *to implement this program.*

24 (d) *Notwithstanding any other provision of this division, if the*
25 *California Discount Prescription Drug Program is not*
26 *implemented pursuant to subdivision (c), this division shall become*
27 *inoperative on February 1, 2015, and as of January 1, 2016, is*
28 *repealed, unless a later enacted statute, that is enacted before*
29 *January 1, 2016, deletes or extends the dates on which it becomes*
30 *inoperative and is repealed.*

31 SEC. 23. Section 130507 of the Health and Safety Code is
32 amended to read:

33 130507. (a) On August 1, ~~2013~~ 2017, the department shall
34 determine whether manufacturer participation in the program has
35 been sufficient to meet both of the following benchmarks:

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

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

5 (b) On and after August 10, 2013 1, 2017, the department shall
6 reassess program outcomes, at least once every year, consistent
7 with the benchmarks described in subdivision (a).

8 SEC. 24. Section 130509 of the Health and Safety Code is
9 amended to read:

10 130509. (a) The department may require prior authorization
11 in the Medi-Cal program for any drug of a manufacturer if the
12 manufacturer fails to agree to a volume weighted average discount
13 for single-source prescription drugs that is equal to or below any
14 one of the benchmark prices described in subdivision (a) of Section
15 130506 and only to the extent that this requirement does not
16 increase costs to the Medi-Cal program, as determined pursuant
17 to subdivision (c).

18 (b) If prior authorization is required for a drug pursuant to this
19 section, a Medi-Cal beneficiary shall not be denied the continued
20 use of a drug that is part of a prescribed therapy until that drug is
21 no longer prescribed for that beneficiary's therapy. The department
22 shall approve or deny requests for prior authorization necessitated
23 by this section as required by state or federal law.

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

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

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

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

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

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

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

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

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

10 (g) (1) Subject to paragraph (2), this section shall ~~become~~
 11 ~~operative~~ *be implemented on and after August 1, 2013 2017.*

12 (2) This section shall ~~become operative~~ *be implemented* only if
 13 the department determines that participation by manufacturers has
 14 been insufficient to meet both of the benchmarks identified in
 15 Section 130507.

16 SEC. 25. Section 130543 of the Health and Safety Code is
 17 amended to read:

18 130543. (a) The director may adopt regulations as are
 19 necessary to implement and administer this division.

20 (b) Notwithstanding Chapter 3.5 (commencing with Section
 21 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
 22 the director may implement this division, in whole or in part, by
 23 means of a provider bulletin or other similar instructions, without
 24 taking regulatory action, provided that no bulletin or other similar
 25 instructions shall remain in effect after August 1, ~~2014~~ 2015. It is
 26 the intent that regulations adopted pursuant to this section shall be
 27 adopted on or before August 1, ~~2014~~ 2015.

28 SEC. 26. Section 12693.21 of the Insurance Code is amended
 29 to read:

30 12693.21. The board may do all of the following consistent
 31 with the standards in this part:

32 (a) Determine eligibility criteria for the program.

33 (b) Determine the participation requirements of applicants,
 34 subscribers, purchasing credit members, and participating health,
 35 dental, and vision plans.

36 (c) Determine when subscribers' coverage begins and the extent
 37 and scope of coverage.

38 (d) Determine family contribution amount schedules and collect
 39 the contributions.

- 1 (e) Determine who may be a family contribution sponsor and
2 provide a mechanism for sponsorship.
- 3 (f) Provide or make available subsidized coverage through
4 participating health, dental, and vision plans, in a purchasing pool,
5 which may include the use of a purchasing credit mechanism,
6 through supplemental coverage, or through coordination with other
7 state programs.
- 8 (g) Provide for the processing of applications, the enrollment
9 of subscribers, and the distribution of purchasing credits.
- 10 (h) Determine and approve the benefit designs and copayments
11 required by health, dental, or vision plans participating in the
12 purchasing pool component program.
- 13 (i) Approve those health plans eligible to receive purchasing
14 credits.
- 15 (j) Enter into contracts.
- 16 (k) Sue and be sued.
- 17 (l) Employ necessary staff.
- 18 (m) Authorize expenditures from the fund to pay program
19 expenses that exceed subscriber contributions, and to administer
20 the program as necessary.
- 21 (n) Maintain enrollment and expenditures to ensure that
22 expenditures do not exceed amounts available in the Healthy
23 Families Fund and if sufficient funds are not available to cover
24 the estimated cost of program expenditures, the board shall institute
25 appropriate measures to limit enrollment.
- 26 (o) Issue rules and regulations, as necessary. Until January 1,
27 2000, any rules and regulations issued pursuant to this subdivision
28 may be adopted as emergency regulations in accordance with the
29 Administrative Procedure Act (Chapter 3.5 (commencing with
30 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
31 Code). The adoption of these regulations shall be deemed an
32 emergency and necessary for the immediate preservation of the
33 public peace, health, and safety or general welfare. The regulations
34 shall become effective immediately upon filing with the Secretary
35 of State.
- 36 (p) Exercise all powers reasonably necessary to carry out the
37 powers and responsibilities expressly granted or imposed by this
38 part.
- 39 (q) *Notwithstanding any other provision of law, on and after*
40 *January 1, 2011, impose any sanction on, and provide notice and*

1 *a hearing to, participating health, dental, and vision plans*
2 *consistent with Section 403 of the federal Children's Health*
3 *Insurance Program Reauthorization Act of 2009 (Public Law*
4 *111-3) by applying subsection (e) of Section 1932 of the federal*
5 *Social Security Act.*

6 SEC. 27. Section 12693.23 is added to the Insurance Code, to
7 read:

8 12693.23. Until July 1, 2012, the adoption and readoption of
9 regulations to implement subdivision (q) of Section 12693.21,
10 subdivision (b) of Section 12693.26, or subdivision (l) of Section
11 56.30 of the Civil Code, or any provision of the federal Children's
12 Health Insurance Program Reauthorization Act of 2009 (Public
13 Law 111-3) not addressed by those sections, shall be deemed to
14 be an emergency and necessary for the immediate preservation of
15 the public peace, health and safety, or general welfare for purposes
16 of Sections 11346.1 and 11349.6 of the Government Code, and
17 the board is hereby exempted from the requirement that it describe
18 facts showing the need for immediate action and from review by
19 the Office of Administrative Law.

20 SEC. 28. Section 12693.26 of the Insurance Code is amended
21 to read:

22 12693.26. (a) The board shall establish a purchasing pool for
23 coverage of program subscribers to enable applicants without
24 access to affordable and comprehensive employer-sponsored
25 dependent coverage to provide their eligible children with health,
26 dental, and vision benefits. The board shall negotiate separate
27 contracts with participating health, dental, and vision plans for
28 each of the benefit packages described in Chapters 5 (commencing
29 with Section 12693.60), 6 (commencing with Section 12693.63),
30 and 7 (commencing with Section 12693.65).

31 (b) *Notwithstanding any other provision of law, on and after*
32 *January 1, 2011, the board may negotiate contracts with entities*
33 *that are not participating health, dental, or vision plans, including,*
34 *but not limited to, interagency agreements with the State*
35 *Department of Health Care Services, to provide or pay for benefits*
36 *to subscribers under this part, if necessary for any of the following*
37 *purposes:*

38 (1) *To comply with Section 403 of the federal Children's Health*
39 *Insurance Program Reauthorization Act of 2009 (Public Law*

1 *111-3) by applying paragraph (4) of subsection (a) of Section 1932*
2 *of the federal Social Security Act.*

3 *(2) To comply with Section 503 of the federal Children’s Health*
4 *Insurance Program Reauthorization Act of 2009 (Public Law*
5 *111-3) by applying subsection (bb) of Section 1902 of the federal*
6 *Social Security Act.*

7 *(3) To ensure that subscribers have adequate access to benefits*
8 *under this part.*

9 *(c) Any interagency agreement entered into by a state agency*
10 *with the board pursuant to subdivision (b), and any other contract*
11 *or contract amendment necessary to implement that agreement,*
12 *shall be exempt from any provision of law relating to competitive*
13 *bidding and from the review or approval of any division of the*
14 *Department of General Services in the same manner as contracts*
15 *entered into by the board are exempt pursuant to Section 12693.54.*

16 SEC. 29. Section 12009 of the Revenue and Taxation Code is
17 amended to read:

18 12009. (a) “Medi-Cal managed care plan” or “plan” means
19 any individual, organization, or entity, other than an insurer as
20 described in Section 12003 or a dental managed care plan as
21 described in Section 14087.46 of the Welfare and Institutions
22 Code, that enters into a contract with the State Department of
23 Health Care Services pursuant to Article 2.7 (commencing with
24 Section 14087.3), Article 2.8 (commencing with Section 14087.5),
25 Article 2.81 (commencing with Section 14087.96), Article 2.9
26 (commencing with Section 14088), or Article 2.91 (commencing
27 with Section 14089) of Chapter 7 of, or pursuant to Article 1
28 (commencing with Section 14200) or Article 7 (commencing with
29 Section 14490) of Chapter 8 of, Part 3 of Division 9 of the Welfare
30 and Institutions Code.

31 ~~(b) This section shall remain in effect only until January 1, 2011,~~
32 ~~and as of that date is repealed.~~

33 *(b) This section shall become inoperative on July 1, 2011, and,*
34 *as of January 1, 2012, is repealed, unless a later enacted statute,*
35 *that becomes operative on or before January 1, 2012, deletes or*
36 *extends the dates on which it becomes inoperative and is repealed.*

37 SEC. 30. Section 12201 of the Revenue and Taxation Code,
38 as amended by Section 5 of Chapter 157 of the Statutes of 2009,
39 is amended to read:

1 12201. (a) Every insurer and Medi-Cal managed care plan
 2 doing business in this state shall annually pay to the state a tax on
 3 the bases, at the rates, and subject to the deductions from the tax
 4 hereinafter specified. For purposes of the tax imposed by this
 5 chapter, “insurer” shall be deemed to include a home protection
 6 company as defined in Section 12740 of the Insurance Code.

7 (b) Notwithstanding Section 13340 of the Government Code,
 8 the revenues derived from the imposition of the tax by this chapter
 9 on Medi-Cal managed care plans are hereby continuously
 10 appropriated as follows:

11 (1) To the State Department of Health Care Services for
 12 purposes of the Medi-Cal program in an amount equal to 38.41
 13 percent of the total revenues derived from the imposition of the
 14 tax by this chapter on Medi-Cal managed care plans.

15 (2) To the Managed Risk Medical Insurance Board for purposes
 16 of the Healthy Families Program in an amount equal to 61.59
 17 percent of the total revenues derived from the imposition of the
 18 tax by this chapter on Medi-Cal managed care plans.

19 (c) For purposes of imposing the tax on Medi-Cal managed care
 20 plans during the 2009 calendar year, the tax shall be based on total
 21 revenue for the period of January 1, 2009, to December 31, 2009,
 22 inclusive.

23 (d) The Insurance Commissioner shall report the amount of
 24 revenue derived from the tax imposed on Medi-Cal managed care
 25 plans pursuant to this section to the California Health and Human
 26 Services Agency, the Joint Legislative Budget Committee, and the
 27 Department of Finance.

28 ~~(e) This section shall remain in effect only until January 1, 2011,~~
 29 ~~and as of that date is repealed.~~

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

34 SEC. 31. Section 12201 is added to the Revenue and Taxation
 35 Code, to read:

36 12201. (a) Every insurer and Medi-Cal managed care plan
 37 doing business in this state shall annually pay to the state a tax on
 38 the bases, at the rates, and subject to the deductions from the tax
 39 hereinafter specified. For purposes of the tax imposed by this

1 chapter, “insurer” shall be deemed to include a home protection
2 company as defined in Section 12740 of the Insurance Code.

3 (b) Notwithstanding Section 13340 of the Government Code,
4 the revenues derived from the imposition of the tax by this chapter
5 on Medi-Cal managed care plans are hereby continuously
6 appropriated as follows:

7 (1) A percentage of the revenues derived from the imposition
8 of the tax by this chapter on Medi-Cal managed care plans equal
9 to the difference between 100 percent and the applicable federal
10 medical assistance percentage (FMAP) to the department for
11 purposes of the Medi-Cal program.

12 (2) After deducting the revenues appropriated pursuant to
13 paragraph (1), any remaining revenue to the Managed Risk Medical
14 Insurance Board for purposes of the Healthy Families Program.

15 (c) The Insurance Commissioner shall report the amount of
16 revenue derived from the tax imposed on Medi-Cal managed care
17 plans pursuant to this section to the California Health and Human
18 Services Agency, the Joint Legislative Budget Committee, and the
19 Department of Finance.

20 (d) This section shall become operative on July 1, 2010.

21 (e) This section shall become inoperative on July 1, 2011, and,
22 as of January 1, 2012, is repealed, unless a later enacted statute,
23 that becomes operative on or before January 1, 2012, deletes or
24 extends the dates on which it becomes inoperative and is repealed.

25 SEC. 32. Section 12201 of the Revenue and Taxation Code,
26 as added by Section 6 of Chapter 157 of the Statutes of 2009, is
27 amended to read:

28 12201. (a) Every insurer doing business in this state shall
29 annually pay to the state a tax on the bases, at the rates, and subject
30 to the deductions from the tax hereinafter specified. For purposes
31 of the tax imposed by this chapter, “insurer” shall be deemed to
32 include a home protection company as defined in Section 12740
33 of the Insurance Code.

34 (b) This section shall become operative on ~~January~~ July 1, 2011.

35 SEC. 33. Section 12204 of the Revenue and Taxation Code,
36 as amended by Section 7 of Chapter 157 of the Statutes of 2009,
37 is amended to read:

38 12204. (a) The tax imposed on insurers by this chapter is in
39 lieu of all other taxes and licenses, state, county, and municipal,
40 upon those insurers and their property, except:

1 (1) Taxes upon their real estate.

2 (2) Any retaliatory exactions imposed by paragraph (3) of
3 subdivision (f) of Section 28 of Article XIII of the Constitution.

4 (3) The tax on ocean marine insurance.

5 (4) Motor vehicle and other vehicle registration license fees and
6 any other tax or license fee imposed by the state upon vehicles,
7 motor vehicles or the operation thereof.

8 (5) That each corporate or other attorney in fact of a reciprocal
9 or interinsurance exchange shall be subject to all taxes imposed
10 upon corporations or others doing business in the state, other than
11 taxes on income derived from its principal business as attorney in
12 fact.

13 (b) This section shall not apply to any Medi-Cal managed care
14 plan and to any tax imposed on that plan by this chapter.

15 ~~(e) This section shall remain in effect only until January 1, 2011,~~
16 ~~and as of that date is repealed.~~

17 *(c) This section shall become inoperative on July 1, 2011, and,*
18 *as of January 1, 2012, is repealed, unless a later enacted statute,*
19 *that becomes operative on or before January 1, 2012, deletes or*
20 *extends the dates on which it becomes inoperative and is repealed.*

21 SEC. 34. Section 12204 of the Revenue and Taxation Code,
22 as added by Section 8 of Chapter 157 of the Statutes of 2009, is
23 amended to read:

24 12204. (a) The tax imposed on insurers by this chapter is in
25 lieu of all other taxes and licenses, state, county, and municipal,
26 upon those insurers and their property, except:

27 (1) Taxes upon their real estate.

28 (2) Any retaliatory exactions imposed by paragraph (3) of
29 subdivision (f) of Section 28 of Article XIII of the California
30 Constitution.

31 (3) The tax on ocean marine insurance.

32 (4) Motor vehicle and other vehicle registration license fees and
33 any other tax or license fee imposed by the state upon vehicles,
34 motor vehicles or the operation thereof.

35 (5) That each corporate or other attorney in fact of a reciprocal
36 or interinsurance exchange shall be subject to all taxes imposed
37 upon corporations or others doing business in the state, other than
38 taxes on income derived from its principal business as attorney in
39 fact.

40 (b) This section shall become operative on ~~January~~ July 1, 2011.

1 SEC. 35. Section 12207 of the Revenue and Taxation Code is
2 amended to read:

3 12207. (a) Notwithstanding any other provision of this part,
4 no credit shall be allowed under Section 12206, 12208, or 12209
5 against the tax imposed on Medi-Cal managed care plans pursuant
6 to Section 12201.

7 ~~(b) This section shall remain in effect only until January 1, 2011,~~
8 ~~and as of that date is repealed.~~

9 *(b) This section shall become inoperative on July 1, 2011, and,*
10 *as of January 1, 2012, is repealed, unless a later enacted statute,*
11 *that becomes operative on or before January 1, 2012, deletes or*
12 *extends the dates on which it becomes inoperative and is repealed.*

13 SEC. 36. Section 12242 of the Revenue and Taxation Code is
14 amended to read:

15 12242. ~~This article shall remain in effect only until January 1,~~
16 ~~2011, and as of that date is repealed.~~

17 *This article shall become inoperative on July 1, 2011, and, as*
18 *of January 1, 2012, is repealed, unless a later enacted statute, that*
19 *becomes operative on or before January 1, 2012, deletes or extends*
20 *the dates on which it becomes inoperative and is repealed.*

21 SEC. 37. Section 12251 of the Revenue and Taxation Code,
22 as amended by Section 11 of Chapter 157 of the Statutes of 2009,
23 is amended to read:

24 12251. (a) For the calendar year 1970, and each calendar year
25 thereafter, insurers transacting insurance in this state and whose
26 annual tax for the preceding calendar year was five thousand dollars
27 (\$5,000) or more shall make prepayments of the annual tax for the
28 current calendar year imposed by Section 28 of Article XIII of the
29 California Constitution and this part, provided that no prepayments
30 shall be made with respect to the tax on ocean marine insurance
31 underwriting profit or any retaliatory tax.

32 (b) Medi-Cal managed care plans shall make prepayments of
33 the tax imposed by Section 12201 for the current calendar year,
34 except that no prepayments shall be required prior to the effective
35 date of the act adding this subdivision, and no penalties and interest
36 shall be imposed pursuant to Section 12261 for not making those
37 prepayments.

38 ~~(c) This section shall remain in effect only until January 1, 2011,~~
39 ~~and as of that date is repealed.~~

1 (c) *This section shall become inoperative on July 1, 2011, and,*
2 *as of January 1, 2012, is repealed, unless a later enacted statute,*
3 *that becomes operative on or before January 1, 2012, deletes or*
4 *extends the dates on which it becomes inoperative and is repealed.*

5 SEC. 38. Section 12251 of the Revenue and Taxation Code,
6 as added by Section 12 of Chapter 157 of the Statutes of 2009, is
7 amended to read:

8 12251. (a) For the calendar year 1970, and each calendar year
9 thereafter, insurers transacting insurance in this state and whose
10 annual tax for the preceding calendar year was five thousand dollars
11 (\$5,000) or more shall make prepayments of the annual tax for the
12 current calendar year imposed by Section 28 of Article XIII of the
13 California Constitution and this part, provided that no prepayments
14 shall be made with respect to the tax on ocean marine insurance
15 underwriting profit or any retaliatory tax.

16 (b) ~~This section shall become operative on January 1, 2011.~~

17 SEC. 39. Section 12253 of the Revenue and Taxation Code,
18 as amended by Section 13 of Chapter 157 of the Statutes of 2009,
19 is amended to read:

20 12253. (a) Each insurer and Medi-Cal managed care plan
21 required to make prepayments shall remit them on or before each
22 of the dates of April 1st, June 1st, September 1st, and December
23 1st of the current calendar year. Remittances for prepayments shall
24 be made payable to the Controller and shall be delivered to the
25 office of the commissioner, accompanied by a prepayment form
26 prescribed by the commissioner.

27 ~~(b) This section shall remain in effect only until January 1, 2011,~~
28 ~~and as of that date is repealed.~~

29 (b) *This section shall become inoperative on July 1, 2011, and,*
30 *as of January 1, 2012, is repealed, unless a later enacted statute,*
31 *that becomes operative on or before January 1, 2012, deletes or*
32 *extends the dates on which it becomes inoperative and is repealed.*

33 SEC. 40. Section 12253 of the Revenue and Taxation Code,
34 as added by Section 14 of Chapter 157 of the Statutes of 2009, is
35 amended to read:

36 12253. (a) Each insurer required to make prepayments shall
37 remit them on or before each of the dates of April 1st, June 1st,
38 September 1st, and December 1st of the current calendar year.
39 Remittances for prepayments shall be made payable to the
40 Controller and shall be delivered to the office of the commissioner,

1 accompanied by a prepayment form prescribed by the
2 commissioner.

3 (b) This section shall become operative on ~~January~~ July 1, 2011.

4 SEC. 41. Section 12254 of the Revenue and Taxation Code,
5 as amended by Section 15 of Chapter 157 of the Statutes of 2009,
6 is amended to read:

7 12254. (a) (1) For each insurer, the amount of each
8 prepayment shall be 25 percent of the amount of the annual
9 insurance tax liability reported on the return of the insurer for the
10 preceding calendar year.

11 (2) For each Medi-Cal managed care plan, the amount of each
12 prepayment shall be 25 percent of the amount of tax the plan
13 estimates as the amount of tax imposed by Section 12201 with
14 respect to the plan.

15 (b) In establishing the prepayment amount of an insurer that
16 has acquired the business of another insurer, the amount of tax
17 liability of the acquiring insurer reported for the preceding calendar
18 year shall be deemed to include the amount of tax liability of the
19 acquired insurer reported for that year.

20 ~~(c) This section shall remain in effect only until January 1, 2011,
21 and as of that date is repealed.~~

22 *(c) This section shall become inoperative on July 1, 2011, and,
23 as of January 1, 2012, is repealed, unless a later enacted statute,
24 that becomes operative on or before January 1, 2012, deletes or
25 extends the dates on which it becomes inoperative and is repealed.*

26 SEC. 42. Section 12254 of the Revenue and Taxation Code,
27 as added by Section 16 of Chapter 157 of the Statutes of 2009, is
28 amended to read:

29 12254. (a) The amount of each prepayment shall be 25 percent
30 of the amount of the annual insurance tax liability reported on the
31 return of the insurer for the preceding calendar year.

32 (b) In establishing the prepayment amount of an insurer that
33 has acquired the business of another insurer, the amount of tax
34 liability of the acquiring insurer reported for the preceding calendar
35 year shall be deemed to include the amount of tax liability of the
36 acquired insurer reported for that year.

37 (c) This section shall become operative on ~~January~~ July 1, 2011.

38 SEC. 43. Section 12257 of the Revenue and Taxation Code,
39 as amended by Section 17 of Chapter 157 of the Statutes of 2009,
40 is amended to read:

1 12257. (a) If the total amount of prepayments for any calendar
2 year exceeds the amount of annual tax for that year, the excess
3 shall be treated as an overpayment of annual tax and, at the election
4 of the insurer or Medi-Cal managed care plan, may be credited
5 against the amounts due and payable for the first prepayment of
6 the following year. Any amount of the overpayment not so credited
7 shall be allowed as a credit or refund under Article 2 (commencing
8 with Section 12977) of Chapter 7 of this part.

9 ~~(b) This section shall remain in effect only until January 1, 2011,
10 and as of that date is repealed.~~

11 *(b) This section shall become inoperative on July 1, 2011, and,
12 as of January 1, 2012, is repealed, unless a later enacted statute,
13 that becomes operative on or before January 1, 2012, deletes or
14 extends the dates on which it becomes inoperative and is repealed.*

15 SEC. 44. Section 12257 of the Revenue and Taxation Code,
16 as added by Section 18 of Chapter 157 of the Statutes of 2009, is
17 amended to read:

18 12257. (a) If the total amount of prepayments for any calendar
19 year exceeds the amount of annual tax for that year, the excess
20 shall be treated as an overpayment of annual tax and, at the election
21 of the insurer, may be credited against the amounts due and payable
22 for the first prepayment of the following year. Any amount of the
23 overpayment not so credited shall be allowed as a credit or refund
24 under Article 2 (commencing with Section 12977) of Chapter 7
25 of this part.

26 ~~(b) This section shall become operative on January July 1, 2011.~~

27 SEC. 45. Section 12258 of the Revenue and Taxation Code,
28 as amended by Section 19 of Chapter 157 of the Statutes of 2009,
29 is amended to read:

30 12258. (a) Any insurer or Medi-Cal managed care plan that
31 fails to pay any prepayment within the time required shall pay a
32 penalty of 10 percent of the amount of the required prepayment,
33 plus interest at the modified adjusted rate per month, or fraction
34 thereof, established pursuant to Section 6591.5, from the due date
35 of the prepayment until the date of payment but not for any period
36 after the due date of the annual tax. Assessments of prepayment
37 deficiencies may be made in the manner provided by deficiency
38 assessments of the annual tax.

39 ~~(b) This section shall remain in effect only until January 1, 2011,
40 and as of that date is repealed.~~

1 (b) *This section shall become inoperative on July 1, 2011, and,*
2 *as of January 1, 2012, is repealed, unless a later enacted statute,*
3 *that becomes operative on or before January 1, 2012, deletes or*
4 *extends the dates on which it becomes inoperative and is repealed.*

5 SEC. 46. Section 12258 of the Revenue and Taxation Code,
6 as added by Section 20 of Chapter 157 of the Statutes of 2009, is
7 amended to read:

8 12258. (a) Any insurer that fails to pay any prepayment within
9 the time required shall pay a penalty of 10 percent of the amount
10 of the required prepayment, plus interest at the modified adjusted
11 rate per month, or fraction thereof, established pursuant to Section
12 6591.5, from the due date of the prepayment until the date of
13 payment but not for any period after the due date of the annual
14 tax. Assessments of prepayment deficiencies may be made in the
15 manner provided by deficiency assessments of the annual tax.

16 (b) This section shall become operative on ~~January~~ July 1, 2011.

17 SEC. 47. Section 12260 of the Revenue and Taxation Code,
18 as amended by Section 21 of Chapter 157 of the Statutes of 2009,
19 is amended to read:

20 12260. (a) Notwithstanding any other provision of this article,
21 the commissioner may relieve an insurer or Medi-Cal managed
22 care plan of its obligation to make prepayments where the insurer
23 or Medi-Cal managed care plan establishes to the satisfaction of
24 the commissioner that the insurer has ceased to transact insurance
25 in this state or the Medi-Cal managed care plan has ceased to
26 operate a plan in this state, or the insurer's or Medi-Cal managed
27 care plan's annual tax for the current year will be less than five
28 thousand dollars (\$5,000).

29 ~~(b) This section shall remain in effect only until January 1, 2011,~~
30 ~~and as of that date is repealed.~~

31 (b) *This section shall become inoperative on July 1, 2011, and,*
32 *as of January 1, 2012, is repealed, unless a later enacted statute,*
33 *that becomes operative on or before January 1, 2012, deletes or*
34 *extends the dates on which it becomes inoperative and is repealed.*

35 SEC. 48. Section 12260 of the Revenue and Taxation Code,
36 as added by Section 22 of Chapter 157 of the Statutes of 2009, is
37 amended to read:

38 12260. Notwithstanding any other provision of this article, the
39 commissioner may relieve an insurer of its obligation to make
40 prepayments where the insurer establishes to the satisfaction of

1 the commissioner that either the insurer has ceased to transact
2 insurance in this state, or the insurer's annual tax for the current
3 year will be less than five thousand dollars (\$5,000).

4 (b) This section shall become operative on ~~January~~ July 1, 2011.

5 SEC. 49. Section 12301 of the Revenue and Taxation Code,
6 as amended by Section 23 of Chapter 157 of the Statutes of 2009,
7 is amended to read:

8 12301. (a) The taxes imposed upon insurers by Section 28 of
9 Article XIII of the California Constitution and this part, except
10 with respect to taxes on ocean marine insurance and retaliatory
11 taxes, are due and payable annually on or before April 1st of the
12 year following the calendar year in which the insurer engaged in
13 the business of insurance or transacted insurance in this state. The
14 taxes imposed with respect to ocean marine insurance are due and
15 payable on or before June 15th of that year.

16 (b) With respect to Medi-Cal managed care plans, the taxes
17 imposed by Section 12201 shall be due and payable on or before
18 April 1st of the year following the calendar year in which the plan
19 contracted with the State Department of Health Care Services as
20 described in Section 12009.

21 ~~(c) This section shall remain in effect only until January 1, 2011,
22 and as of that date is repealed. However, any tax imposed by
23 Section 12201 shall continue to be due and payable until the tax
24 is paid.~~

25 *(c) This section shall become inoperative on July 1, 2011, and,
26 as of January 1, 2012, is repealed, unless a later enacted statute,
27 that becomes operative on or before January 1, 2012, deletes or
28 extends the dates on which it becomes inoperative and is repealed.
29 However, any tax imposed by Section 12201 shall continue to be
30 due and payable until the tax is paid.*

31 SEC. 50. Section 12301 of the Revenue and Taxation Code,
32 as added by Section 24 of Chapter 157 of the Statutes of 2009, is
33 amended to read:

34 12301. (a) The taxes imposed upon insurers by Section 28 of
35 Article XIII of the California Constitution and this part, except
36 with respect to taxes on ocean marine insurance and retaliatory
37 taxes, are due and payable annually on or before April 1st of the
38 year following the calendar year in which the insurer engaged in
39 the business of insurance or transacted insurance in this state. The

1 taxes imposed with respect to ocean marine insurance are due and
2 payable on or before June 15th of that year.

3 (b) This section shall become operative on ~~January~~ July 1, 2011.

4 SEC. 51. Section 12302 of the Revenue and Taxation Code,
5 as amended by Section 25 of Chapter 157 of the Statutes of 2009,
6 is amended to read:

7 12302. (a) On or before April 1st (or June 15th with respect
8 to taxes on ocean marine insurance) every person that is subject
9 to any tax imposed by Section 28 of Article XIII of the California
10 Constitution or this part, in respect to the preceding calendar year
11 shall file, in duplicate, a tax return with the commissioner in the
12 form as the commissioner may prescribe. The return shall show
13 that information pertaining to its insurance business, or in the case
14 of a Medi-Cal managed care plan, pertaining to contracts for
15 providing services as described in Section 12009, in this state as
16 will reflect the basis of its tax as set forth in Chapter 2
17 (commencing with Section 12071) and Chapter 3 (commencing
18 with Section 12201) of this part, the computation of the amount
19 of tax for the period covered by the return, the total amount of any
20 tax prepayments made pursuant to Article 5 (commencing with
21 Section 12251) of Chapter 3 of this part, and any other information
22 as the commissioner may require to carry out the purposes of this
23 part. Separate returns shall be filed with respect to the following
24 kinds of insurance:

- 25 (1) Life insurance (or life insurance and disability insurance).
- 26 (2) Ocean marine insurance.
- 27 (3) Title insurance.
- 28 (4) Insurance other than life insurance (or life insurance and
29 disability insurance), ocean marine insurance or title insurance.

30 ~~(b) This section shall remain in effect only until January 1, 2011,~~
31 ~~and as of that date is repealed.~~

32 *(b) This section shall become inoperative on July 1, 2011, and,*
33 *as of January 1, 2012, is repealed, unless a later enacted statute,*
34 *that becomes operative on or before January 1, 2012, deletes or*
35 *extends the dates on which it becomes inoperative and is repealed.*

36 SEC. 52. Section 12302 of the Revenue and Taxation Code,
37 as added by Section 26 of Chapter 157 of the Statutes of 2009, is
38 amended to read:

39 12302. (a) On or before April 1st (or June 15th with respect
40 to taxes on ocean marine insurance) every person that is subject

1 to any tax imposed by Section 28 of Article XIII of the California
2 Constitution or this part, in respect to the preceding calendar year
3 shall file, in duplicate, an insurance tax return with the
4 commissioner in the form as the commissioner may prescribe. The
5 return shall show that information pertaining to its insurance
6 business, ~~or in the case of a Medi-Cal managed care plan,~~
7 ~~pertaining to its total operating revenue as defined in Section~~
8 ~~12241,~~ in this state as will reflect the basis of its tax as set forth in
9 Chapter 2 (commencing with Section 12071) and Chapter 3
10 (commencing with Section 12201) of this part, the computation
11 of the amount of tax for the period covered by the return, the total
12 amount of any tax prepayments made pursuant to Article 5
13 (commencing with Section 12251) of Chapter 3 of this part, and
14 any other information as the commissioner may require to carry
15 out the purposes of this part. Separate returns shall be filed with
16 respect to the following kinds of insurance:

- 17 (1) Life insurance (or life insurance and disability insurance).
- 18 (2) Ocean marine insurance.
- 19 (3) Title insurance.
- 20 (4) Insurance other than life insurance (or life insurance and
21 disability insurance), ocean marine insurance or title insurance.

22 (b) This section shall become operative on ~~January~~ July 1, 2011.
23 SEC. 53. Section 12303 of the Revenue and Taxation Code,
24 as amended by Section 27 of Chapter 157 of the Statutes of 2009,
25 is amended to read:

26 12303. (a) Every return required by this article to be filed with
27 the commissioner shall be signed by the insurer or Medi-Cal
28 managed care plan or an executive officer of the insurer or plan
29 and shall be made under oath or contain a written declaration that
30 it is made under penalty of perjury. A return of a foreign insurer
31 may be signed and verified by its manager residing within this
32 state. A return of an alien insurer may be signed and verified by
33 the United States manager of the insurer.

34 ~~(b) This section shall remain in effect only until January 1, 2011,~~
35 ~~and as of that date is repealed.~~

36 *(b) This section shall become inoperative on July 1, 2011, and,*
37 *as of January 1, 2012, is repealed, unless a later enacted statute,*
38 *that becomes operative on or before January 1, 2012, deletes or*
39 *extends the dates on which it becomes inoperative and is repealed.*

1 SEC. 54. Section 12303 of the Revenue and Taxation Code,
2 as added by Section 28 of Chapter 157 of the Statutes of 2009, is
3 amended to read:

4 12303. (a) Every return required by this article to be filed with
5 the commissioner shall be signed by the insurer or an executive
6 officer of the insurer and shall be made under oath or contain a
7 written declaration that it is made under penalty of perjury. A
8 return of a foreign insurer may be signed and verified by its
9 manager residing within this state. A return of an alien insurer may
10 be signed and verified by the United States manager of the insurer.

11 (b) This section shall become operative on ~~January~~ July 1, 2011.

12 SEC. 55. Section 12304 of the Revenue and Taxation Code,
13 as amended by Section 29 of Chapter 157 of the Statutes of 2009,
14 is amended to read:

15 12304. (a) Blank forms of returns shall be furnished by the
16 commissioner on application, but failure to secure the form shall
17 not relieve any insurer or Medi-Cal managed care plan from
18 making or filing a timely return.

19 ~~(b) This section shall remain in effect only until January 1, 2011,~~
20 ~~and as of that date is repealed.~~

21 *(b) This section shall become inoperative on July 1, 2011, and,*
22 *as of January 1, 2012, is repealed, unless a later enacted statute,*
23 *that becomes operative on or before January 1, 2012, deletes or*
24 *extends the dates on which it becomes inoperative and is repealed.*

25 SEC. 56. Section 12304 of the Revenue and Taxation Code,
26 as added by Section 30 of Chapter 157 of the Statutes of 2009, is
27 amended to read:

28 12304. (a) Blank forms of returns shall be furnished by the
29 commissioner on application, but failure to secure the form shall
30 not relieve any insurer from making or filing a timely return.

31 (b) This section shall become operative on ~~January~~ July 1, 2011.

32 SEC. 57. Section 12305 of the Revenue and Taxation Code,
33 as amended by Section 31 of Chapter 157 of the Statutes of 2009,
34 is amended to read:

35 12305. (a) The insurer or Medi-Cal managed care plan required
36 to file a return shall deliver the return in duplicate, together with
37 a remittance payable to the Controller, for the amount of tax
38 computed and shown thereon, less any prepayments made pursuant
39 to Article 5 (commencing with Section 12251) of Chapter 3 of this
40 part, to the office of the commissioner.

1 ~~(b) This section shall remain in effect only until January 1, 2011,~~
2 ~~and as of that date is repealed.~~

3 *(b) This section shall become inoperative on July 1, 2011, and,*
4 *as of January 1, 2012, is repealed, unless a later enacted statute,*
5 *that becomes operative on or before January 1, 2012, deletes or*
6 *extends the dates on which it becomes inoperative and is repealed.*

7 SEC. 58. Section 12305 of the Revenue and Taxation Code,
8 as added by Section 32 of Chapter 157 of the Statutes of 2009, is
9 amended to read:

10 12305. (a) The insurer required to file a return shall deliver
11 the return in duplicate, together with a remittance payable to the
12 Controller, for the amount of tax computed and shown thereon,
13 less any prepayments made pursuant to Article 5 (commencing
14 with Section 12251) of Chapter 3 of this part, to the office of the
15 commissioner.

16 (b) This section shall become operative on ~~January~~ July 1, 2011.

17 SEC. 59. Section 12307 of the Revenue and Taxation Code,
18 as amended by Section 33 of Chapter 157 of the Statutes of 2009,
19 is amended to read:

20 12307. (a) Any insurer or Medi-Cal managed care plan to
21 which an extension is granted shall pay, in addition to the tax,
22 interest at the modified adjusted rate per month, or fraction thereof,
23 established pursuant to Section 6591.5, from April 1st until the
24 date of payment.

25 ~~(b) This section shall remain in effect only until January 1, 2011,~~
26 ~~and as of that date is repealed.~~

27 *(b) This section shall become inoperative on July 1, 2011, and,*
28 *as of January 1, 2012, is repealed, unless a later enacted statute,*
29 *that becomes operative on or before January 1, 2012, deletes or*
30 *extends the dates on which it becomes inoperative and is repealed.*

31 SEC. 60. Section 12307 of the Revenue and Taxation Code,
32 as added by Section 34 of Chapter 157 of the Statutes of 2009, is
33 amended to read:

34 12307. (a) Any insurer that is granted an extension shall pay,
35 in addition to the tax, interest at the modified adjusted rate per
36 month, or fraction thereof, established pursuant to Section 6591.5,
37 from April 1st until the date of payment.

38 (b) This section shall become operative on ~~January~~ July 1, 2011.

1 SEC. 61. Section 12412 of the Revenue and Taxation Code,
2 as amended by Section 35 of Chapter 157 of the Statutes of 2009,
3 is amended to read:

4 12412. (a) Upon receipt of the duplicate copy of the return of
5 an insurer or Medi-Cal managed care plan the board shall initially
6 assess the tax in accordance with the data as reported by the insurer
7 or Medi-Cal managed care plan on the return.

8 ~~(b) This section shall remain in effect only until January 1, 2011,~~
9 ~~and as of that date is repealed.~~

10 *(b) This section shall become inoperative on July 1, 2011, and,*
11 *as of January 1, 2012, is repealed, unless a later enacted statute,*
12 *that becomes operative on or before January 1, 2012, deletes or*
13 *extends the dates on which it becomes inoperative and is repealed.*

14 SEC. 62. Section 12412 of the Revenue and Taxation Code,
15 as added by Section 36 of Chapter 157 of the Statutes of 2009, is
16 amended to read:

17 12412. (a) Upon receipt of the duplicate copy of the return of
18 an insurer the board shall initially assess the tax in accordance
19 with the data as reported by the insurer on the return.

20 (b) This section shall become operative on ~~January~~ July 1, 2011.

21 SEC. 63. Section 12413 of the Revenue and Taxation Code,
22 as amended by Section 37 of Chapter 157 of the Statutes of 2009,
23 is amended to read:

24 12413. (a) The board shall promptly transmit notice of its
25 initial assessment to the commissioner and the Controller, and if
26 the initial assessment differs from the amount computed by the
27 insurer or Medi-Cal managed care plan, notice shall also be given
28 to the insurer or Medi-Cal managed care plan.

29 ~~(b) This section shall remain in effect only until January 1, 2011,~~
30 ~~and as of that date is repealed.~~

31 *(b) This section shall become inoperative on July 1, 2011, and,*
32 *as of January 1, 2012, is repealed, unless a later enacted statute,*
33 *that becomes operative on or before January 1, 2012, deletes or*
34 *extends the dates on which it becomes inoperative and is repealed.*

35 SEC. 64. Section 12413 of the Revenue and Taxation Code,
36 as added by Section 38 of Chapter 157 of the Statutes of 2009, is
37 amended to read:

38 12413. (a) The board shall promptly transmit notice of its
39 initial assessment to the commissioner and the Controller, and if

1 the initial assessment differs from the amount computed by the
2 insurer, notice shall also be given to the insurer.

3 (b) This section shall become operative on ~~January~~ July 1, 2011.

4 SEC. 65. Section 12421 of the Revenue and Taxation Code,
5 as amended by Section 39 of Chapter 157 of the Statutes of 2009,
6 is amended to read:

7 12421. (a) As soon as practicable after an insurer's, surplus
8 line broker's, or Medi-Cal managed care plan's return is filed, the
9 commissioner shall examine it, together with any information
10 within his or her possession or that may come into his or her
11 possession, and he or she shall determine the correct amount of
12 tax of the insurer, surplus line broker, or Medi-Cal managed care
13 plan.

14 ~~(b) This section shall remain in effect only until January 1, 2011,
15 and as of that date is repealed.~~

16 *(b) This section shall become inoperative on July 1, 2011, and,
17 as of January 1, 2012, is repealed, unless a later enacted statute,
18 that becomes operative on or before January 1, 2012, deletes or
19 extends the dates on which it becomes inoperative and is repealed.*

20 SEC. 66. Section 12421 of the Revenue and Taxation Code,
21 as added by Section 40 of Chapter 157 of the Statutes of 2009, is
22 amended to read:

23 12421. (a) As soon as practicable after an insurer's or surplus
24 line broker's return is filed, the commissioner shall examine it,
25 together with any information within his or her possession or that
26 may come into his or her possession, and he or she shall determine
27 the correct amount of tax of the insurer or surplus line broker.

28 (b) This section shall become operative on ~~January~~ July 1, 2011.

29 SEC. 67. Section 12422 of the Revenue and Taxation Code,
30 as amended by Section 41 of Chapter 157 of the Statutes of 2009,
31 is amended to read:

32 12422. (a) If the commissioner determines that the amount of
33 tax disclosed by the insurer's tax return and assessed by the board
34 is less than the amount of tax disclosed by his or her examination,
35 he or she shall propose, in writing, to the board a deficiency
36 assessment for the difference. The proposal shall set forth the basis
37 for the deficiency assessment and the details of its computation.

38 (b) If the commissioner determines that the amount of tax
39 disclosed by the surplus line broker's tax return is less than the
40 amount of tax disclosed by his or her examination, he or she shall

1 propose, in writing, to the board a deficiency assessment for the
2 difference. The proposal shall set forth the basis for the deficiency
3 assessment and the details of its computation.

4 (c) If the commissioner determines that the amount of tax
5 disclosed by the Medi-Cal managed care plan's tax return is less
6 than the amount of tax disclosed by his or her examination, he or
7 she shall propose, in writing, to the board a deficiency assessment
8 for the difference. The proposal shall set forth the basis for the
9 deficiency assessment and the details of its computation.

10 ~~(d) This section shall remain in effect only until January 1, 2011,~~
11 ~~and as of that date is repealed.~~

12 *(d) This section shall become inoperative on July 1, 2011, and,*
13 *as of January 1, 2012, is repealed, unless a later enacted statute,*
14 *that becomes operative on or before January 1, 2012, deletes or*
15 *extends the dates on which it becomes inoperative and is repealed.*

16 SEC. 68. Section 12422 of the Revenue and Taxation Code,
17 as added by Section 42 of Chapter 157 of the Statutes of 2009, is
18 amended to read:

19 12422. (a) If the commissioner determines that the amount of
20 tax disclosed by the insurer's tax return and assessed by the board
21 is less than the amount of tax disclosed by his or her examination,
22 he or she shall propose, in writing, to the board a deficiency
23 assessment for the difference. The proposal shall set forth the basis
24 for the deficiency assessment and the details of its computation.

25 (b) If the commissioner determines that the amount of tax
26 disclosed by the surplus line broker's tax return is less than the
27 amount of tax disclosed by his or her examination, he or she shall
28 propose, in writing, to the board a deficiency assessment for the
29 difference. The proposal shall set forth the basis for the deficiency
30 assessment and the details of its computation.

31 (c) This section shall become operative on ~~January~~ *July* 1, 2011.

32 SEC. 69. Section 12423 of the Revenue and Taxation Code,
33 as amended by Section 43 of Chapter 157 of the Statutes of 2009,
34 is amended to read:

35 12423. (a) If an insurer, surplus line broker, or Medi-Cal
36 managed care plan fails to file a return, the commissioner may
37 require a return by mailing notice to the insurer, surplus line broker,
38 or Medi-Cal managed care plan to file a return by a specified date
39 or he or she may without requiring a return, or upon no return
40 having been filed pursuant to the demand therefor, make an

1 estimate of the amount of tax due for the calendar year or years in
2 respect to which the insurer, surplus line broker, or Medi-Cal
3 managed care plan failed to file the return. The estimate shall be
4 made from any available information which is in the
5 commissioner's possession or may come into his or her possession,
6 and the commissioner shall propose, in writing, to the board a
7 deficiency assessment for the amount of the estimated tax. The
8 proposal shall set forth the basis of the estimate and the details of
9 the computation of the tax.

10 ~~(b) This section shall remain in effect only until January 1, 2011,~~
11 ~~and as of that date is repealed.~~

12 *(b) This section shall become inoperative on July 1, 2011, and,*
13 *as of January 1, 2012, is repealed, unless a later enacted statute,*
14 *that becomes operative on or before January 1, 2012, deletes or*
15 *extends the dates on which it becomes inoperative and is repealed.*

16 SEC. 70. Section 12423 of the Revenue and Taxation Code,
17 as added by Section 44 of Chapter 157 of the Statutes of 2009, is
18 amended to read:

19 12423. (a) If an insurer or surplus line broker fails to file a
20 return, the commissioner may require a return by mailing notice
21 to the insurer or surplus line broker to file a return by a specified
22 date or he or she may without requiring a return, or upon no return
23 having been filed pursuant to the demand therefor, make an
24 estimate of the amount of tax due for the calendar year or years in
25 respect to which the insurer or surplus line broker failed to file the
26 return. The estimate shall be made from any available information
27 which is in the commissioner's possession or may come into his
28 or her possession, and the commissioner shall propose, in writing,
29 to the board a deficiency assessment for the amount of the
30 estimated tax. The proposal shall set forth the basis of the estimate
31 and the details of the computation of the tax.

32 (b) This section shall become operative on ~~January~~ *July* 1, 2011.

33 SEC. 71. Section 12427 of the Revenue and Taxation Code,
34 as amended by Section 45 of Chapter 157 of the Statutes of 2009,
35 is amended to read:

36 12427. (a) The board shall promptly notify the insurer, surplus
37 line broker, or Medi-Cal managed care plan of a deficiency
38 assessment made against the insurer, surplus line broker, or
39 Medi-Cal managed care plan.

1 ~~(b) This section shall remain in effect only until January 1, 2011,~~
2 ~~and as of that date is repealed.~~

3 *(b) This section shall become inoperative on July 1, 2011, and,*
4 *as of January 1, 2012, is repealed, unless a later enacted statute,*
5 *that becomes operative on or before January 1, 2012, deletes or*
6 *extends the dates on which it becomes inoperative and is repealed.*

7 SEC. 72. Section 12427 of the Revenue and Taxation Code,
8 as added by Section 46 of Chapter 157 of the Statutes of 2009, is
9 amended to read:

10 12427. (a) The board shall promptly notify the insurer or
11 surplus line broker of a deficiency assessment made against the
12 insurer or surplus line broker.

13 ~~(b) This section shall become operative on January 1, 2011.~~

14 SEC. 73. Section 12428 of the Revenue and Taxation Code,
15 as amended by Section 47 of Chapter 157 of the Statutes of 2009,
16 is amended to read:

17 12428. (a) An insurer, surplus line broker, or Medi-Cal
18 managed care plan against which a deficiency assessment is made
19 under Section 12424 or 12425 may petition for redetermination
20 of the deficiency assessment within 30 days after service upon the
21 insurer, surplus line broker, or Medi-Cal managed care plan of the
22 notice thereof, by filing with the board a written petition setting
23 forth the grounds of objection to the deficiency assessment and
24 the correction sought. At the time the petition is filed with the
25 board, a copy of the petition shall be filed with the commissioner.

26 If a petition for redetermination is not filed within the period
27 prescribed by this section, the deficiency assessment becomes final
28 and due and payable at the expiration of that period.

29 ~~(b) This section shall remain in effect only until January 1, 2011,~~
30 ~~and as of that date is repealed.~~

31 *(b) This section shall become inoperative on July 1, 2011, and,*
32 *as of January 1, 2012, is repealed, unless a later enacted statute,*
33 *that becomes operative on or before January 1, 2012, deletes or*
34 *extends the dates on which it becomes inoperative and is repealed.*

35 SEC. 74. Section 12428 of the Revenue and Taxation Code,
36 as added by Section 48 of Chapter 157 of the Statutes of 2009, is
37 amended to read:

38 12428. (a) An insurer or surplus line broker against which a
39 deficiency assessment is made under Section 12424 or 12425 may
40 petition for redetermination of the deficiency assessment within

1 30 days after service upon the insurer or surplus line broker of the
 2 notice thereof, by filing with the board a written petition setting
 3 forth the grounds of objection to the deficiency assessment and
 4 the correction sought. At the time the petition is filed with the
 5 board, a copy of the petition shall be filed with the commissioner.

6 If a petition for redetermination is not filed within the period
 7 prescribed by this section, the deficiency assessment becomes final
 8 and due and payable at the expiration of that period.

9 (b) This section shall become operative on ~~January~~ *July* 1, 2011.

10 SEC. 75. Section 12429 of the Revenue and Taxation Code,
 11 as amended by Section 49 of Chapter 157 of the Statutes of 2009,
 12 is amended to read:

13 12429. (a) If a petition for redetermination of a deficiency
 14 assessment is filed within the time allowed under Section 12428,
 15 the board shall reconsider the deficiency assessment and, if the
 16 insurer, surplus line broker, or Medi-Cal managed care plan has
 17 so requested in the petition, shall grant an oral hearing for the
 18 presentation of evidence and argument before the board or its
 19 authorized representative. The board shall give the petitioner and
 20 the commissioner at least 20 days' notice of the time and place of
 21 hearing. The hearing may be continued from time to time as may
 22 be necessary.

23 ~~(b) This section shall remain in effect only until January 1, 2011,~~
 24 ~~and as of that date is repealed.~~

25 *(b) This section shall become inoperative on July 1, 2011, and,*
 26 *as of January 1, 2012, is repealed, unless a later enacted statute,*
 27 *that becomes operative on or before January 1, 2012, deletes or*
 28 *extends the dates on which it becomes inoperative and is repealed.*

29 SEC. 76. Section 12429 of the Revenue and Taxation Code,
 30 as added by Section 50 of Chapter 157 of the Statutes of 2009, is
 31 amended to read:

32 12429. (a) If a petition for redetermination of a deficiency
 33 assessment is filed within the time allowed under Section 12428,
 34 the board shall reconsider the deficiency assessment and, if the
 35 insurer or surplus line broker has so requested in the petition, shall
 36 grant an oral hearing for the presentation of evidence and argument
 37 before the board or its authorized representative. The board shall
 38 give the petitioner and the commissioner at least 20 days' notice
 39 of the time and place of hearing. The hearing may be continued
 40 from time to time as may be necessary.

1 (b) This section shall become operative on ~~January~~ July 1, 2011.

2 SEC. 77. Section 12431 of the Revenue and Taxation Code,
3 as amended by Section 51 of Chapter 157 of the Statutes of 2009,
4 is amended to read:

5 12431. (a) The order or decision of the board upon a petition
6 for redetermination of a deficiency assessment becomes final 30
7 days after service on the insurer, surplus line broker, or Medi-Cal
8 managed care plan of a notice thereof, and any resulting deficiency
9 assessment is due and payable at the time the order or decision
10 becomes final.

11 ~~(b) This section shall remain in effect only until January 1, 2011,~~
12 ~~and as of that date is repealed.~~

13 *(b) This section shall become inoperative on July 1, 2011, and,*
14 *as of January 1, 2012, is repealed, unless a later enacted statute,*
15 *that becomes operative on or before January 1, 2012, deletes or*
16 *extends the dates on which it becomes inoperative and is repealed.*

17 SEC. 78. Section 12431 of the Revenue and Taxation Code,
18 as added by Section 52 of Chapter 157 of the Statutes of 2009, is
19 amended to read:

20 12431. (a) The order or decision of the board upon a petition
21 for redetermination of a deficiency assessment becomes final 30
22 days after service on the insurer or surplus line broker of a notice
23 thereof, and any resulting deficiency assessment is due and payable
24 at the time the order or decision becomes final.

25 (b) This section shall become operative on ~~January~~ July 1, 2011.

26 SEC. 79. Section 12433 of the Revenue and Taxation Code,
27 as amended by Section 53 of Chapter 157 of the Statutes of 2009,
28 is amended to read:

29 12433. (a) If before the expiration of the time prescribed in
30 Section 12432 for giving of a notice of deficiency assessment the
31 insurer, surplus line broker, or Medi-Cal managed care plan has
32 consented in writing to the giving of the notice after that time, the
33 notice may be given at any time prior to the expiration of the time
34 agreed upon. The period so agreed upon may be extended by
35 subsequent agreements in writing made before the expiration of
36 the period previously agreed upon.

37 ~~(b) This section shall remain in effect only until January 1, 2011,~~
38 ~~and as of that date is repealed.~~

39 *(b) This section shall become inoperative on July 1, 2011, and,*
40 *as of January 1, 2012, is repealed, unless a later enacted statute,*

1 *that becomes operative on or before January 1, 2012, deletes or*
2 *extends the dates on which it becomes inoperative and is repealed.*

3 SEC. 80. Section 12433 of the Revenue and Taxation Code,
4 as added by Section 54 of Chapter 157 of the Statutes of 2009, is
5 amended to read:

6 12433. (a) If before the expiration of the time prescribed in
7 Section 12432 for giving of a notice of deficiency assessment the
8 insurer or surplus line broker has consented in writing to the giving
9 of the notice after that time, the notice may be given at any time
10 prior to the expiration of the time agreed upon. The period so
11 agreed upon may be extended by subsequent agreements in writing
12 made before the expiration of the period previously agreed upon.

13 (b) This section shall become operative on ~~January~~ July 1, 2011.

14 SEC. 81. Section 12434 of the Revenue and Taxation Code,
15 as amended by Section 55 of Chapter 157 of the Statutes of 2009,
16 is amended to read:

17 12434. (a) Any notice required by this article shall be placed
18 in a sealed envelope, with postage paid, addressed to the insurer,
19 surplus line broker, or Medi-Cal managed care plan at its address
20 as it appears in the records of the commissioner or the board. The
21 giving of notice shall be deemed complete at the time of deposit
22 of the notice in the United States Post Office, or a mailbox, subpost
23 office, substation or mail chute or other facility regularly
24 maintained or provided by the United States Postal Service, without
25 extension of time for any reason. In lieu of mailing, a notice may
26 be served personally by delivering to the person to be served and
27 service shall be deemed complete at the time of the delivery.
28 Personal service to a corporation may be made by delivery of a
29 notice to any person designated in the Code of Civil Procedure to
30 be served for the corporation with summons and complaint in a
31 civil action.

32 ~~(b) This section shall remain in effect only until January 1, 2011,~~
33 ~~and as of that date is repealed.~~

34 *(b) This section shall become inoperative on July 1, 2011, and,*
35 *as of January 1, 2012, is repealed, unless a later enacted statute,*
36 *that becomes operative on or before January 1, 2012, deletes or*
37 *extends the dates on which it becomes inoperative and is repealed.*

38 SEC. 82. Section 12434 of the Revenue and Taxation Code,
39 as added by Section 56 of Chapter 157 of the Statutes of 2009, is
40 amended to read:

1 12434. (a) Any notice required by this article shall be placed
2 in a sealed envelope, with postage paid, addressed to the insurer
3 or surplus line broker at its address as it appears in the records of
4 the commissioner or the board. The giving of notice shall be
5 deemed complete at the time of deposit of the notice in the United
6 States Post Office, or a mailbox, subpost office, substation or mail
7 chute or other facility regularly maintained or provided by the
8 United States Postal Service, without extension of time for any
9 reason. In lieu of mailing, a notice may be served personally by
10 delivering to the person to be served and service shall be deemed
11 complete at the time of the delivery. Personal service to a
12 corporation may be made by delivery of a notice to any person
13 designated in the Code of Civil Procedure to be served for the
14 corporation with summons and complaint in a civil action.

15 (b) This section shall become operative on ~~January~~ *July* 1, 2011.

16 SEC. 83. Section 12491 of the Revenue and Taxation Code,
17 as amended by Section 57 of Chapter 157 of the Statutes of 2009,
18 is amended to read:

19 12491. (a) Every tax levied upon an insurer under Article XIII
20 of the California Constitution and this part is a lien upon all
21 property and franchises of every kind and nature belonging to the
22 insurer, and has the effect of a judgment against the insurer.

23 (b) (1) Every tax levied upon a surplus line broker under Part
24 7.5 (commencing with Section 13201) of Division 2 is a lien upon
25 all property and franchises of every kind and nature belonging to
26 the surplus line broker, and has the effect of a judgment against
27 the surplus line broker.

28 (2) A lien levied pursuant to this subdivision shall not exceed
29 the amount of unpaid tax collected by the surplus line broker.

30 (c) (1) Every tax levied upon a Medi-Cal managed care plan
31 under Chapter 1 (commencing with Section 12001) is a lien upon
32 all property and franchises of every kind and nature belonging to
33 the Medi-Cal managed care plan, and has the effect of a judgment
34 against the Medi-Cal managed care plan.

35 (2) A lien levied pursuant to this subdivision shall not exceed
36 the amount of unpaid tax collected by the Medi-Cal managed care
37 plan.

38 ~~(d) This section shall remain in effect only until January 1, 2011,~~
39 ~~and as of that date is repealed.~~

1 (d) *This section shall become inoperative on July 1, 2011, and,*
2 *as of January 1, 2012, is repealed, unless a later enacted statute,*
3 *that becomes operative on or before January 1, 2012, deletes or*
4 *extends the dates on which it becomes inoperative and is repealed.*

5 SEC. 84. Section 12491 of the Revenue and Taxation Code,
6 as added by Section 58 of Chapter 157 of the Statutes of 2009, is
7 amended to read:

8 12491. (a) Every tax levied upon an insurer under the
9 provisions of Article XIII of the California Constitution and of
10 this part is a lien upon all property and franchises of every kind
11 and nature belonging to the insurer, and has the effect of a
12 judgment against the insurer.

13 (b) (1) Every tax levied upon a surplus line broker under the
14 provisions of Part 7.5 (commencing with Section 13201) of
15 Division 2 is a lien upon all property and franchises of every kind
16 and nature belonging to the surplus line broker, and has the effect
17 of a judgment against the surplus line broker.

18 (2) A lien levied pursuant to this subdivision shall not exceed
19 the amount of unpaid tax collected by the surplus line broker.

20 (c) This section shall become operative on ~~January~~ *July 1, 2011.*

21 SEC. 85. Section 12493 of the Revenue and Taxation Code,
22 as amended by Section 59 of Chapter 157 of the Statutes of 2009,
23 is amended to read:

24 12493. (a) Every lien has the effect of an execution duly levied
25 against all property of a delinquent insurer, surplus line broker, or
26 Medi-Cal managed care plan.

27 ~~(b) This section shall remain in effect only until January 1, 2011,~~
28 ~~and as of that date is repealed.~~

29 ***(b) This section shall become inoperative on July 1, 2011, and,***
30 ***as of January 1, 2012, is repealed, unless a later enacted statute,***
31 ***that becomes operative on or before January 1, 2012, deletes or***
32 ***extends the dates on which it becomes inoperative and is repealed.***

33 SEC. 86. Section 12493 of the Revenue and Taxation Code,
34 as added by Section 60 of Chapter 157 of the Statutes of 2009, is
35 amended to read:

36 12493. (a) Every lien has the effect of an execution duly levied
37 against all property of a delinquent insurer or surplus line broker.

38 (b) This section shall become operative on ~~January~~ *July 1, 2011.*

1 SEC. 87. Section 12494 of the Revenue and Taxation Code,
2 as amended by Section 61 of Chapter 157 of the Statutes of 2009,
3 is amended to read:

4 12494. (a) No judgment is satisfied nor lien removed until
5 either:

- 6 (1) The taxes, interest, penalties, and costs are paid.
- 7 (2) The insurer's, surplus line broker's, or Medi-Cal managed
8 care plan's property is sold for the payment thereof.

9 ~~(b) This section shall remain in effect only until January 1, 2011,~~
10 ~~and as of that date is repealed.~~

11 *(b) This section shall become inoperative on July 1, 2011, and,*
12 *as of January 1, 2012, is repealed, unless a later enacted statute,*
13 *that becomes operative on or before January 1, 2012, deletes or*
14 *extends the dates on which it becomes inoperative and is repealed.*

15 SEC. 88. Section 12494 of the Revenue and Taxation Code,
16 as added by Section 62 of Chapter 157 of the Statutes of 2009, is
17 amended to read:

18 12494. (a) No judgment is satisfied nor lien removed until
19 either:

- 20 (1) The taxes, interest, penalties, and costs are paid.
- 21 (2) The insurer's or surplus line broker's property is sold for
22 the payment thereof.

23 ~~(b) This section shall become operative on January July 1, 2011.~~

24 SEC. 89. Section 12601 of the Revenue and Taxation Code,
25 as amended by Section 63 of Chapter 157 of the Statutes of 2009,
26 is amended to read:

27 12601. (a) Amounts of taxes, interest, and penalties not
28 remitted to the commissioner with the original return of the insurer
29 or Medi-Cal managed care plan shall be payable to the Controller.

30 ~~(b) This section shall remain in effect only until January 1, 2011,~~
31 ~~and as of that date is repealed.~~

32 *(b) This section shall become inoperative on July 1, 2011, and,*
33 *as of January 1, 2012, is repealed, unless a later enacted statute,*
34 *that becomes operative on or before January 1, 2012, deletes or*
35 *extends the dates on which it becomes inoperative and is repealed.*

36 SEC. 90. Section 12601 of the Revenue and Taxation Code,
37 as added by Section 64 of Chapter 157 of the Statutes of 2009, is
38 amended to read:

1 12601. (a) Amounts of taxes, interest, and penalties not
2 remitted to the commissioner with the original return of the insurer
3 shall be payable to the Controller.

4 (b) This section shall become operative on ~~January~~ *July* 1, 2011.

5 SEC. 91. Section 12602 of the Revenue and Taxation Code,
6 as amended by Section 65 of Chapter 157 of the Statutes of 2009,
7 is amended to read:

8 12602. (a) (1) On and after January 1, 1994, and before
9 January 1, 1995, each insurer whose annual taxes exceed fifty
10 thousand dollars (\$50,000) shall make payment by electronic funds
11 transfer, as defined by Section 45 of the Insurance Code. On and
12 after January 1, 1995, each insurer whose annual taxes exceed
13 twenty thousand dollars (\$20,000) shall make payment by
14 electronic funds transfer. The insurer shall choose one of the
15 acceptable methods described in Section 45 of the Insurance Code
16 for completing the electronic funds transfer.

17 (2) Each Medi-Cal managed care plan shall make payment by
18 electronic funds transfer, as defined by Section 45 of the Insurance
19 Code. The plan shall choose one of the acceptable methods
20 described in Section 45 of the Insurance Code for completing the
21 electronic funds transfer.

22 (b) Payment shall be deemed complete on the date the electronic
23 funds transfer is initiated, if settlement to the state's demand
24 account occurs on or before the banking day following the date
25 the transfer is initiated. If settlement to the state's demand account
26 does not occur on or before the banking day following the date the
27 transfer is initiated, payment shall be deemed to occur on the date
28 settlement occurs.

29 (c) (1) Any insurer or Medi-Cal managed care plan required to
30 remit taxes by electronic funds transfer pursuant to this section
31 that remits those taxes by means other than an appropriate
32 electronic funds transfer, shall be assessed a penalty in an amount
33 equal to 10 percent of the taxes due at the time of the payment.

34 (2) If the Department of Insurance finds that an insurer's or
35 Medi-Cal managed care plan's failure to make payment by an
36 appropriate electronic funds transfer in accordance with subdivision
37 (a) is due to reasonable cause or circumstances beyond the insurer's
38 or Medi-Cal managed care plan's control, and occurred
39 notwithstanding the exercise of ordinary care and in the absence

1 of willful neglect, that insurer or Medi-Cal managed care plan
2 shall be relieved of the penalty provided in paragraph (1).

3 (3) Any insurer or Medi-Cal managed care plan seeking to be
4 relieved of the penalty provided in paragraph (1) shall file with
5 the Department of Insurance a statement under penalty of perjury
6 setting forth the facts upon which the claim for relief is based.

7 ~~(d) This section shall remain in effect only until January 1, 2011,~~
8 ~~and as of that date is repealed.~~

9 *(d) This section shall become inoperative on July 1, 2011, and,*
10 *as of January 1, 2012, is repealed, unless a later enacted statute,*
11 *that becomes operative on or before January 1, 2012, deletes or*
12 *extends the dates on which it becomes inoperative and is repealed.*

13 SEC. 92. Section 12602 of the Revenue and Taxation Code,
14 as added by Section 66 of Chapter 157 of the Statutes of 2009, is
15 amended to read:

16 12602. (a) On and after January 1, 1994, and before January
17 1, 1995, each insurer whose annual taxes exceed fifty thousand
18 dollars (\$50,000) shall make payment by electronic funds transfer,
19 as defined by Section 45 of the Insurance Code. On and after
20 January 1, 1995, each insurer whose annual taxes exceed twenty
21 thousand dollars (\$20,000) shall make payment by electronic funds
22 transfer. The insurer shall choose one of the acceptable methods
23 described in Section 45 of the Insurance Code for completing the
24 electronic funds transfer.

25 (b) Payment shall be deemed complete on the date the electronic
26 funds transfer is initiated, if settlement to the state's demand
27 account occurs on or before the banking day following the date
28 the transfer is initiated. If settlement to the state's demand account
29 does not occur on or before the banking day following the date the
30 transfer is initiated, payment shall be deemed to occur on the date
31 settlement occurs.

32 (c) (1) Any insurer required to remit taxes by electronic funds
33 transfer pursuant to this section that remits those taxes by means
34 other than an appropriate electronic funds transfer, shall be assessed
35 a penalty in an amount equal to 10 percent of the taxes due at the
36 time of the payment.

37 (2) If the Department of Insurance finds that an insurer's failure
38 to make payment by an appropriate electronic funds transfer in
39 accordance with subdivision (a) is due to reasonable cause or
40 circumstances beyond the insurer's control, and occurred

1 notwithstanding the exercise of ordinary care and in the absence
2 of willful neglect, that insurer shall be relieved of the penalty
3 provided in paragraph (1).

4 (3) Any insurer seeking to be relieved of the penalty provided
5 in paragraph (1) shall file with the Department of Insurance a
6 statement under penalty of perjury setting forth the facts upon
7 which the claim for relief is based.

8 (d) This section shall become operative on ~~January~~ July 1, 2011.

9 SEC. 93. Section 12631 of the Revenue and Taxation Code,
10 as amended by Section 67 of Chapter 157 of the Statutes of 2009,
11 is amended to read:

12 12631. (a) Any insurer or Medi-Cal managed care plan that
13 fails to pay any tax, except a tax determined as a deficiency
14 assessment by the board under Article 3 (commencing with Section
15 12421) of Chapter 4, within the time required, shall pay a penalty
16 of 10 percent of the amount of the tax in addition to the tax, plus
17 interest at the modified adjusted rate per month, or fraction thereof,
18 established pursuant to Section 6591.5, from the due date of the
19 tax until the date of payment.

20 ~~(b) This section shall remain in effect only until January 1, 2011,~~
21 ~~and as of that date is repealed.~~

22 *(b) This section shall become inoperative on July 1, 2011, and,*
23 *as of January 1, 2012, is repealed, unless a later enacted statute,*
24 *that becomes operative on or before January 1, 2012, deletes or*
25 *extends the dates on which it becomes inoperative and is repealed.*

26 SEC. 94. Section 12631 of the Revenue and Taxation Code,
27 as added by Section 68 of Chapter 157 of the Statutes of 2009, is
28 amended to read:

29 12631. (a) Any insurer that fails to pay any tax, except a tax
30 determined as a deficiency assessment by the board under Article
31 3 (commencing with Section 12421) of Chapter 4, within the time
32 required, shall pay a penalty of 10 percent of the amount of the
33 tax in addition to the tax, plus interest at the modified adjusted rate
34 per month, or fraction thereof, established pursuant to Section
35 6591.5, from the due date of the tax until the date of payment.

36 (b) This section shall become operative on ~~January~~ July 1, 2011.

37 SEC. 95. Section 12632 of the Revenue and Taxation Code,
38 as amended by Section 69 of Chapter 157 of the Statutes of 2009,
39 is amended to read:

1 12632. (a) An insurer or Medi-Cal managed care plan that
2 fails to pay any deficiency assessment when it becomes due and
3 payable shall, in addition to the deficiency assessment, pay a
4 penalty of 10 percent of the amount of the deficiency assessment,
5 exclusive of interest and penalties. The amount of any deficiency
6 assessment, exclusive of penalties, shall bear interest at the
7 modified adjusted rate per month, or fraction thereof, established
8 pursuant to Section 6591.5, from the date on which the amount,
9 or any portion thereof, would have been payable if properly
10 reported and assessed until the date of payment.

11 ~~(b) This section shall remain in effect only until January 1, 2011,~~
12 ~~and as of that date is repealed.~~

13 *(b) This section shall become inoperative on July 1, 2011, and,*
14 *as of January 1, 2012, is repealed, unless a later enacted statute,*
15 *that becomes operative on or before January 1, 2012, deletes or*
16 *extends the dates on which it becomes inoperative and is repealed.*

17 SEC. 96. Section 12632 of the Revenue and Taxation Code,
18 as added by Section 70 of Chapter 157 of the Statutes of 2009, is
19 amended to read:

20 12632. (a) An insurer that fails to pay any deficiency
21 assessment when it becomes due and payable shall, in addition to
22 the deficiency assessment, pay a penalty of 10 percent of the
23 amount of the deficiency assessment, exclusive of interest and
24 penalties. The amount of any deficiency assessment, exclusive of
25 penalties, shall bear interest at the modified adjusted rate per
26 month, or fraction thereof, established pursuant to Section 6591.5,
27 from the date on which the amount, or any portion thereof, would
28 have been payable if properly reported and assessed until the date
29 of payment.

30 (b) This section shall become operative on ~~January~~ July 1, 2011.

31 SEC. 97. Section 12636 of the Revenue and Taxation Code,
32 as amended by Section 71 of Chapter 157 of the Statutes of 2009,
33 is amended to read:

34 12636. (a) If the board finds that an insurer's or Medi-Cal
35 managed care plan's failure to make a timely return or payment
36 is due to reasonable cause and to circumstances beyond the
37 insurer's or Medi-Cal managed care plan's control, and which
38 occurred despite the exercise of ordinary care and in the absence
39 of willful neglect, the insurer or Medi-Cal managed care plan may

1 be relieved of the penalty provided by Section 12258, 12282,
2 12287, 12631, 12632, or 12633.

3 Any insurer or Medi-Cal managed care plan seeking to be
4 relieved of the penalty shall file with the board a statement under
5 penalty of perjury setting forth the facts upon which the claim for
6 relief is based.

7 ~~(b) This section shall remain in effect only until January 1, 2011,~~
8 ~~and as of that date is repealed.~~

9 *(b) This section shall become inoperative on July 1, 2011, and,*
10 *as of January 1, 2012, is repealed, unless a later enacted statute,*
11 *that becomes operative on or before January 1, 2012, deletes or*
12 *extends the dates on which it becomes inoperative and is repealed.*

13 SEC. 98. Section 12636 of the Revenue and Taxation Code,
14 as added by Section 72 of Chapter 157 of the Statutes of 2009, is
15 amended to read:

16 12636. (a) If the board finds that an insurer's failure to make
17 a timely return or payment is due to reasonable cause and to
18 circumstances beyond the insurer's control, and which occurred
19 despite the exercise of ordinary care and in the absence of willful
20 neglect, the insurer may be relieved of the penalty provided by
21 Section 12258, 12282, 12287, 12631, 12632, or 12633.

22 Any insurer seeking to be relieved of the penalty shall file with
23 the board a statement under penalty of perjury setting forth the
24 facts upon which the claim for relief is based.

25 (b) This section shall become operative on ~~January~~ July 1, 2011.

26 SEC. 99. Section 12636.5 of the Revenue and Taxation Code,
27 as amended by Section 73 of Chapter 157 of the Statutes of 2009,
28 is amended to read:

29 12636.5. (a) Every payment on an insurer's, surplus line
30 broker's, or Medi-Cal managed care plan's delinquent annual tax
31 shall be applied as follows:

- 32 (1) First, to any interest due on the tax.
- 33 (2) Second, to any penalty imposed by this part.
- 34 (3) The balance, if any, to the tax itself.

35 ~~(b) This section shall remain in effect only until January 1, 2011,~~
36 ~~and as of that date is repealed.~~

37 *(b) This section shall become inoperative on July 1, 2011, and,*
38 *as of January 1, 2012, is repealed, unless a later enacted statute,*
39 *that becomes operative on or before January 1, 2012, deletes or*
40 *extends the dates on which it becomes inoperative and is repealed.*

1 SEC. 100. Section 12636.5 of the Revenue and Taxation Code,
2 as added by Section 74 of Chapter 157 of the Statutes of 2009, is
3 amended to read:

4 12636.5. (a) Every payment on an insurer's or surplus line
5 broker's delinquent annual tax shall be applied as follows:

- 6 (1) First, to any interest due on the tax.
- 7 (2) Second, to any penalty imposed by this part.
- 8 (3) The balance, if any, to the tax itself.

9 (b) This section shall become operative on ~~January~~ *July 1, 2011*.

10 SEC. 101. Section 12679 of the Revenue and Taxation Code,
11 as amended by Section 75 of Chapter 157 of the Statutes of 2009,
12 is amended to read:

13 12679. (a) If an insurer's or Medi-Cal managed care plan's
14 right to do business has been forfeited or its corporate powers
15 suspended, service of summons may be made upon the persons
16 designated by law to be served as agents or officers of the insurer
17 or Medi-Cal managed care plan, and these persons are the agents
18 of the insurer or Medi-Cal managed care plan for all purposes
19 necessary in order to prosecute the action. In the case of
20 corporations whose powers have been suspended, the persons
21 constituting the board of directors may defend the action.

22 ~~(b) This section shall remain in effect only until January 1, 2011,~~
23 ~~and as of that date is repealed.~~

24 *(b) This section shall become inoperative on July 1, 2011, and,*
25 *as of January 1, 2012, is repealed, unless a later enacted statute,*
26 *that becomes operative on or before January 1, 2012, deletes or*
27 *extends the dates on which it becomes inoperative and is repealed.*

28 SEC. 102. Section 12679 of the Revenue and Taxation Code,
29 as added by Section 76 of Chapter 157 of the Statutes of 2009, is
30 amended to read:

31 12679. (a) If an insurer's right to do business has been forfeited
32 or its corporate powers suspended, service of summons may be
33 made upon the persons designated by law to be served as agents
34 or officers of the insurer, and these persons are the agents of the
35 insurer for all purposes necessary in order to prosecute the action.
36 In the case of corporations whose powers have been suspended,
37 the persons constituting the board of directors may defend the
38 action.

39 (b) This section shall become operative on ~~January~~ *July 1, 2011*.

1 SEC. 103. Section 12681 of the Revenue and Taxation Code,
2 as amended by Section 77 of Chapter 157 of the Statutes of 2009,
3 is amended to read:

4 12681. (a) In the action, a certificate of the Controller or of
5 the secretary of the board, showing unpaid taxes against an insurer
6 or Medi-Cal managed care plan is prima facie evidence of:

7 (1) The assessment of the taxes.

8 (2) The delinquency.

9 (3) The amount of the taxes, interest, and penalties due and
10 unpaid to the state.

11 (4) That the insurer or Medi-Cal managed care plan is indebted
12 to the state in the amount of taxes, interest, and penalties appearing
13 unpaid.

14 (5) That there has been compliance with all the requirements
15 of law in relation to the assessment of the taxes.

16 ~~(b) This section shall remain in effect only until January 1, 2011,
17 and as of that date is repealed.~~

18 *(b) This section shall become inoperative on July 1, 2011, and,
19 as of January 1, 2012, is repealed, unless a later enacted statute,
20 that becomes operative on or before January 1, 2012, deletes or
21 extends the dates on which it becomes inoperative and is repealed.*

22 SEC. 104. Section 12681 of the Revenue and Taxation Code,
23 as added by Section 78 of Chapter 157 of the Statutes of 2009, is
24 amended to read:

25 12681. (a) In the action, a certificate of the Controller or of
26 the secretary of the board, showing unpaid taxes against an insurer
27 is prima facie evidence of:

28 (1) The assessment of the taxes.

29 (2) The delinquency.

30 (3) The amount of the taxes, interest, and penalties due and
31 unpaid to the state.

32 (4) That the insurer is indebted to the state in the amount of
33 taxes, interest, and penalties appearing unpaid.

34 (5) That there has been compliance with all the requirements
35 of law in relation to the assessment of the taxes.

36 (b) This section shall become operative on ~~January~~ July 1, 2011.

37 SEC. 105. Section 12801 of the Revenue and Taxation Code,
38 as amended by Section 79 of Chapter 157 of the Statutes of 2009,
39 is amended to read:

1 12801. (a) Annually, between December 10th and 15th, the
2 Controller shall transmit to the commissioner a statement showing
3 the names of all insurers and Medi-Cal managed care plans that
4 failed to pay on or before December 10th the whole or any portion
5 of the tax that became delinquent in the preceding June or which
6 has been unpaid for more than 30 days from the date it became
7 due and payable as a deficiency assessment under this part or the
8 whole or any part of the interest or penalties due with respect to
9 the tax. The statement shall show the amount of the tax, interest,
10 and penalties due from each insurer or Medi-Cal managed care
11 plan.

12 ~~(b) This section shall remain in effect only until January 1, 2011,~~
13 ~~and as of that date is repealed.~~

14 *(b) This section shall become inoperative on July 1, 2011, and,*
15 *as of January 1, 2012, is repealed, unless a later enacted statute,*
16 *that becomes operative on or before January 1, 2012, deletes or*
17 *extends the dates on which it becomes inoperative and is repealed.*

18 SEC. 106. Section 12801 of the Revenue and Taxation Code,
19 as added by Section 80 of Chapter 157 of the Statutes of 2009, is
20 amended to read:

21 12801. (a) Annually, between December 10th and 15th, the
22 Controller shall transmit to the commissioner a statement showing
23 the names of all insurers that failed to pay on or before December
24 10th the whole or any portion of the tax that became delinquent
25 in the preceding June or which has been unpaid for more than 30
26 days from the date it became due and payable as a deficiency
27 assessment under this part or the whole or any part of the interest
28 or penalties due with respect to the tax. The statement shall show
29 the amount of the tax, interest, and penalties due from each insurer.

30 (b) This section shall become operative on ~~January~~ July 1, 2011.

31 SEC. 107. Section 12951 of the Revenue and Taxation Code,
32 as amended by Section 81 of Chapter 157 of the Statutes of 2009,
33 is amended to read:

34 12951. (a) If any amount has been illegally assessed, the board
35 shall set forth that fact in its records, certify the amount determined
36 to be assessed in excess of the amount legally assessed and the
37 insurer, surplus line broker, or Medi-Cal managed care plan against
38 which the assessment was made, and authorize the cancellation of
39 the amount upon the records of the Controller and the board. The
40 board shall mail a notice to the insurer, surplus line broker, or

1 Medi-Cal managed care plan of any cancellation authorized. Any
2 proposed determination by the board pursuant to this section with
3 respect to an amount in excess of fifty thousand dollars (\$50,000)
4 shall be available as a public record for at least 10 days prior to
5 the effective date of that determination.

6 ~~(b) This section shall remain in effect only until January 1, 2011,~~
7 ~~and as of that date is repealed.~~

8 *(b) This section shall become inoperative on July 1, 2011, and,*
9 *as of January 1, 2012, is repealed, unless a later enacted statute,*
10 *that becomes operative on or before January 1, 2012, deletes or*
11 *extends the dates on which it becomes inoperative and is repealed.*

12 SEC. 108. Section 12951 of the Revenue and Taxation Code,
13 as added by Section 82 of Chapter 157 of the Statutes of 2009, is
14 amended to read:

15 12951. (a) If any amount has been illegally assessed, the board
16 shall set forth that fact in its records, certify the amount determined
17 to be assessed in excess of the amount legally assessed and the
18 insurer or surplus line broker against which the assessment was
19 made, and authorize the cancellation of the amount upon the
20 records of the Controller and the board. The board shall mail a
21 notice to the insurer or surplus line broker of any cancellation
22 authorized. Any proposed determination by the board pursuant to
23 this section with respect to an amount in excess of fifty thousand
24 dollars (\$50,000) shall be available as a public record for at least
25 10 days prior to the effective date of that determination.

26 (b) This section shall become operative on ~~January~~ July 1, 2011.

27 SEC. 109. Section 12977 of the Revenue and Taxation Code,
28 as amended by Section 83 of Chapter 157 of the Statutes of 2009,
29 is amended to read:

30 12977. (a) If the board determines that any tax, interest, or
31 penalty has been paid more than once or has been erroneously or
32 illegally collected or computed, the board shall set forth that fact
33 in its records of the board, certify the amount of the taxes, interest,
34 or penalties collected in excess of what was legally due, and from
35 whom they were collected or by whom paid, and certify the excess
36 to the Controller for credit or refund.

37 (b) The Controller upon receipt of a certification for credit or
38 refund shall credit the excess on any amounts then due and payable
39 from the insurer, surplus line broker, or Medi-Cal managed care
40 plan under this part and refund the balance.

1 (c) Any proposed determination by the board pursuant to this
2 section with respect to an amount in excess of fifty thousand dollars
3 (\$50,000) shall be available as a public record for at least 10 days
4 prior to the effective date of that determination.

5 ~~(d) This section shall remain in effect only until January 1, 2011,~~
6 ~~and as of that date is repealed.~~

7 *(d) This section shall become inoperative on July 1, 2011, and,*
8 *as of January 1, 2012, is repealed, unless a later enacted statute,*
9 *that becomes operative on or before January 1, 2012, deletes or*
10 *extends the dates on which it becomes inoperative and is repealed.*

11 SEC. 110. Section 12977 of the Revenue and Taxation Code,
12 as added by Section 84 of Chapter 157 of the Statutes of 2009, is
13 amended to read:

14 12977. (a) If the board determines that any tax, interest, or
15 penalty has been paid more than once or has been erroneously or
16 illegally collected or computed, the board shall set forth that fact
17 in its records of the board, certify the amount of the taxes, interest,
18 or penalties collected in excess of what was legally due, and from
19 whom they were collected or by whom paid, and certify the excess
20 to the Controller for credit or refund.

21 (b) The Controller upon receipt of a certification for credit or
22 refund shall credit the excess on any amounts then due and payable
23 from the insurer or surplus line broker under this part and refund
24 the balance.

25 (c) Any proposed determination by the board pursuant to this
26 section with respect to an amount in excess of fifty thousand dollars
27 (\$50,000) shall be available as a public record for at least 10 days
28 prior to the effective date of that determination.

29 (d) This section shall become operative on ~~January~~ July 1, 2011.

30 SEC. 111. Section 12983 of the Revenue and Taxation Code,
31 as amended by Section 85 of Chapter 157 of the Statutes of 2009,
32 is amended to read:

33 12983. (a) Interest shall be allowed upon the amount of any
34 overpayment of tax by an insurer or Medi-Cal managed care plan
35 pursuant to this part at the modified adjusted rate per month
36 established pursuant to Section 6591.5, from the first day of the
37 monthly period following the period during which the overpayment
38 was made. For purposes of this section, "monthly period" means
39 the month commencing on the day after the due date of the payment
40 through the same date as the due date in each successive month.

1 In addition, a refund or credit shall be made of any interest imposed
2 upon the claimant with respect to the amount being refunded or
3 credited.

4 The interest shall be paid as follows:

5 (1) In the case of a refund, to the last day of the calendar month
6 following the date upon which the claimant is notified in writing
7 that a claim may be filed or the date upon which the claim is
8 approved by the board, whichever date is the earlier.

9 (2) In the case of a credit, to the same date as that to which
10 interest is computed on the tax or amount against which the credit
11 is applied.

12 ~~(b) This section shall remain in effect only until January 1, 2011,~~
13 ~~and as of that date is repealed.~~

14 *(b) This section shall become inoperative on July 1, 2011, and,*
15 *as of January 1, 2012, is repealed, unless a later enacted statute,*
16 *that becomes operative on or before January 1, 2012, deletes or*
17 *extends the dates on which it becomes inoperative and is repealed.*

18 SEC. 112. Section 12983 of the Revenue and Taxation Code,
19 as added by Section 86 of Chapter 157 of the Statutes of 2009, is
20 amended to read:

21 12983. (a) Interest shall be allowed upon the amount of any
22 overpayment of tax by an insurer pursuant to this part at the
23 modified adjusted rate per month established pursuant to Section
24 6591.5, from the first day of the monthly period following the
25 period during which the overpayment was made. For purposes of
26 this section, “monthly period” means the month commencing on
27 the day after the due date of the payment through the same date
28 as the due date in each successive month. In addition, a refund or
29 credit shall be made of any interest imposed upon the claimant
30 with respect to the amount being refunded or credited.

31 The interest shall be paid as follows:

32 (1) In the case of a refund, to the last day of the calendar month
33 following the date upon which the claimant is notified in writing
34 that a claim may be filed or the date upon which the claim is
35 approved by the board, whichever date is the earlier.

36 (2) In the case of a credit, to the same date as that to which
37 interest is computed on the tax or amount against which the credit
38 is applied.

39 (b) This section shall become operative on ~~January~~ July 1, 2011.

1 SEC. 113. Section 12984 of the Revenue and Taxation Code,
2 as amended by Section 87 of Chapter 157 of the Statutes of 2009,
3 is amended to read:

4 12984. (a) If the board determines that any overpayment has
5 been made intentionally or made not incident to a bona fide and
6 orderly discharge of a liability reasonably assumed by the insurer,
7 surplus line broker, or Medi-Cal managed care plan to be imposed
8 by law, no interest shall be allowed on the overpayment.

9 (b) If any insurer, surplus line broker, or Medi-Cal managed
10 care plan which has filed a claim for refund requests the board to
11 defer action on its claim, the board, as a condition to deferring
12 action, may require the claimant to waive interest for the period
13 during which the insurer, surplus line broker, or Medi-Cal managed
14 care plan requests the board to defer action on the claim.

15 ~~(c) This section shall remain in effect only until January 1, 2011,~~
16 ~~and as of that date is repealed.~~

17 *(c) This section shall become inoperative on July 1, 2011, and,*
18 *as of January 1, 2012, is repealed, unless a later enacted statute,*
19 *that becomes operative on or before January 1, 2012, deletes or*
20 *extends the dates on which it becomes inoperative and is repealed.*

21 SEC. 114. Section 12984 of the Revenue and Taxation Code,
22 as added by Section 88 of Chapter 157 of the Statutes of 2009, is
23 amended to read:

24 12984. (a) If the board determines that any overpayment has
25 been made intentionally or made not incident to a bona fide and
26 orderly discharge of a liability reasonably assumed by the insurer
27 or surplus line broker to be imposed by law, no interest shall be
28 allowed on the overpayment.

29 (b) If any insurer or surplus line broker which has filed a claim
30 for refund requests the board to defer action on its claim, the board,
31 as a condition to deferring action, may require the claimant to
32 waive interest for the period during which the insurer or surplus
33 line broker requests the board to defer action on the claim.

34 (c) This section shall become operative on ~~January~~ July 1, 2011.

35 SEC. 115. Section 13108 of the Revenue and Taxation Code,
36 as amended by Section 89 of Chapter 157 of the Statutes of 2009,
37 is amended to read:

38 13108. (a) A judgment shall not be rendered in favor of the
39 plaintiff when the action is brought by or in the name of an assignee
40 of the insurer paying the tax, interest, or penalties, or by any person

1 other than the insurer or Medi-Cal managed care plan that has paid
2 the tax, interest, or penalties.

3 ~~(b) This section shall remain in effect only until January 1, 2011,~~
4 ~~and as of that date is repealed.~~

5 *(b) This section shall become inoperative on July 1, 2011, and,*
6 *as of January 1, 2012, is repealed, unless a later enacted statute,*
7 *that becomes operative on or before January 1, 2012, deletes or*
8 *extends the dates on which it becomes inoperative and is repealed.*

9 SEC. 116. Section 13108 of the Revenue and Taxation Code,
10 as added by Section 90 of Chapter 157 of the Statutes of 2009, is
11 amended to read:

12 13108. (a) A judgment shall not be rendered in favor of the
13 plaintiff when the action is brought by or in the name of an assignee
14 of the insurer paying the tax, interest, or penalties, or by any person
15 other than the insurer that has paid the tax, interest, or penalties.

16 (b) This section shall become operative on ~~January~~ July 1, 2011.

17 SEC. 117. Section 4101.5 is added to the Welfare and
18 Institutions Code, to read:

19 4101.5. (a) Notwithstanding any other law, the State
20 Department of Mental Health may contract with providers of health
21 care services and health care network providers, including, but not
22 limited to, health plans, preferred provider organizations, and other
23 health care network managers. Hospitals that do not contract with
24 the department for emergency health care services shall provide
25 these services to the department on the same basis as they are
26 required to provide these services pursuant to Section 489.24 of
27 Title 42 of the Code of Federal Regulations.

28 (b) The department may only reimburse a noncontract provider
29 of hospital or physician services at a rate equal to or less than the
30 amount payable under the Medicare Fee Schedule, regardless of
31 whether the hospital is located within or outside of California. An
32 entity that provides ambulance or any other emergency or
33 nonemergency response service to the department, and that does
34 not contract with the department for that service, shall be
35 reimbursed for the service at the rate payable under the Medicare
36 Fee Schedule, regardless of whether the provider is located within
37 or outside of California.

38 (c) Until regulations or emergency regulations are adopted in
39 accordance with subdivision (g), the department shall not reimburse
40 a contract provider of hospital services at a rate that exceeds 130

1 percent of the amount payable under the Medicare Fee Schedule,
2 a contract provider of physician services at a rate that exceeds 110
3 percent of the amount payable under the Medicare Fee Schedule,
4 or a contract provider of ambulance services at a rate that exceeds
5 120 percent of the amount payable under the Medicare Fee
6 Schedule. The maximum rates established by this subdivision shall
7 not apply to reimbursement for administrative days, transplant
8 services, services provided pursuant to competitively bid contracts,
9 or services provided pursuant to a contract executed prior to
10 September 1, 2009.

11 (d) The maximum rates set forth in this section shall not apply
12 to contracts entered into through the department's designated health
13 care network provider, if any. The rates for those contracts shall
14 be negotiated at the lowest rate possible under the circumstances.

15 (e) The department and its designated health care network
16 provider may enter into exclusive or nonexclusive contracts on a
17 bid or negotiated basis for hospital, physician, and ambulance
18 services contracts.

19 (f) The Director of Mental Health may adopt regulations to
20 implement this section. The adoption, amendment, or repeal of a
21 regulation authorized by this section is hereby exempted from the
22 rulemaking provisions of the Administrative Procedure Act
23 (Chapter 3.5 (commencing with Section 11340) of Part 1 of
24 Division 3 of Title 2 of the Government Code).

25 (g) The Director of Mental Health may change the maximum
26 rates set forth in this section by regulation or emergency regulation,
27 adopted in accordance with the Administrative Procedure Act, but
28 no sooner than 30 days after notification to the Joint Legislative
29 Budget Committee. Those changes may include, but are not limited
30 to, increasing or decreasing rates, or adding location-based
31 differentials such as those provided to small and rural hospitals as
32 defined in Section 124840 of the Health and Safety Code. The
33 adoption, amendment, repeal, or readoption of a regulation
34 authorized by this subdivision is deemed to address an emergency,
35 for purposes of Sections 11346.1 and 11349.6 of the Government
36 Code, and the director is hereby exempted for this purpose from
37 the requirements of subdivision (b) of Section 11346.1 of the
38 Government Code.

39 (h) For persons who are transferred from the Department of
40 Corrections and Rehabilitation to, or are housed in, a state hospital

1 or psychiatric program under the jurisdiction of the State
2 Department of Mental Health, and while these persons remain
3 under the jurisdiction of the Department of Corrections and
4 Rehabilitation as inmates or parolees, health care or emergency
5 services provided for these persons outside of a State Department
6 of Mental Health state hospital or psychiatric program shall
7 continue to be paid for or reimbursed by the Department of
8 Corrections and Rehabilitation in accordance with Section 5023.5
9 of the Penal Code.

10 SEC. 118. Section 4474.2 of the Welfare and Institutions Code
11 is amended to read:

12 4474.2. (a) Notwithstanding any provision of law to the
13 contrary, the department may operate any facility, provide its
14 employees to assist in the operation of any facility, or provide
15 other necessary services and supports if, in the discretion of the
16 department, it determines that the activity will assist in meeting
17 the goal of ~~an~~ *the orderly closure* of Agnews
18 Developmental Center *and Lanterman Developmental Center*. The
19 department may contract with any entity for the use of the
20 department's employees to provide services in furtherance of ~~an~~
21 *the orderly closure* of Agnews Developmental Center *and*
22 *Lanterman Developmental Center*. *For the Lanterman*
23 *Developmental Center, the use of department employees is in effect*
24 *for up to two years following the transfer of the last resident of*
25 *the Lanterman Developmental Center, unless a later enacted*
26 *statute deletes or extends this provision.*

27 (b) *The department shall prepare a report on the use of the*
28 *department's employees in providing services in the community*
29 *to assist in the orderly closures of Agnews Developmental Center*
30 *and Lanterman Developmental Center. The report shall include*
31 *data on the number and classification of state employees working*
32 *in the community program. The report shall be submitted with the*
33 *Governor's proposed budget for the 2012–13 fiscal year to the*
34 *fiscal committees of both houses of the Legislature and annually*
35 *thereafter.*

36 SEC. 119. Section 4474.3 of the Welfare and Institutions Code
37 is amended to read:

38 4474.3. The provisions of Section 10411 of the Public Contract
39 Code shall not apply to any person who, in connection with the

1 ~~closure~~ *closures* of Agnews Developmental Center *or Lanterman*
2 *Developmental Center*, provides developmental services.

3 SEC. 120. Section 4474.4 of the Welfare and Institutions Code
4 is amended to read:

5 4474.4. Notwithstanding any other provision of law to the
6 contrary, the Secretary of California Health and Human Services
7 shall verify that the State Department of Developmental Services
8 and the State Department of Health Care Services have established
9 protocols in place between the departments, as well as with the
10 regional centers and health care plans participating in the Medi-Cal
11 Program who will be providing services, including health, dental,
12 and vision care, to people with developmental disabilities
13 transitioning from Agnews Developmental Center *and Lanterman*
14 *Developmental Center*.

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

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

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

37 SEC. 121. Section 4474.5 of the Welfare and Institutions Code
38 is amended to read:

39 4474.5. (a) In order to meet the unique medical health needs
40 of consumers transitioning from Agnews Developmental Center

1 into Alameda, San Mateo, and Santa Clara Counties pursuant to
2 the Plan for the Closure of Agnews Developmental Center, *and*
3 *consumers transitioning from Lanterman Developmental Center*
4 *into various health plans*, whose individual program plans
5 document the need for coordinated medical and specialty care that
6 cannot be met using the traditional Medi-Cal Fee-For-Service
7 system, services provided under the contract shall be provided by
8 Medi-Cal managed care health plans that are currently operational
9 in these counties as a county organized health system or a local
10 initiative if consumers, where applicable, choose to enroll.
11 Reimbursement shall be by the State Department of Health Care
12 Services for all Medi-Cal services provided under the contract that
13 are not reimbursed by the Medicare program.

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

36 (c) Until the State Department of Health Care Services is able
37 to determine by actuarial methods, prospective per capita rates of
38 payment for services for those members who enroll in the Medi-Cal
39 managed care health plans specified in subdivision (a), the State
40 Department of Health Care Services shall reimburse the Medi-Cal

1 managed care health plans for the net reasonable cost of direct
2 patient care services and supplies set forth in the scope of services
3 in the contract between the Medi-Cal managed care health plans
4 and the State Department of Health Care Services and that are not
5 reimbursed by the Medicare Program. Net reasonable cost is
6 defined as the actual cost incurred by the Medi-Cal managed care
7 health plans, as measured by the Medi-Cal managed care health
8 plan's payments to providers of services and supplies, less
9 payments made to the plans by third parties other than Medicare,
10 and shall not include any incurred cost found to be unnecessary
11 by the State Department of Health Care Services in the efficient
12 delivery of necessary health services. Reimbursement shall be
13 accomplished by the State Department of Health Care Services
14 making estimated payments at reasonable intervals, with these
15 estimates being reconciled to actual net reasonable cost at least
16 semiannually.

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

25 SEC. 122. Section 4474.8 of the Welfare and Institutions Code
26 is amended to read:

27 4474.8. Notwithstanding any other provision of law to the
28 contrary, the State Department of Developmental Services shall
29 continue the operation of the Agnews Outpatient Clinic *and the*
30 *Lanterman Outpatient Clinic* until such time as the State
31 Department of Developmental Services is no longer responsible
32 for the property *at the respective developmental center, as*
33 *applicable.*

34 SEC. 123. Section 4646.55 is added to the Welfare and
35 Institutions Code, to read:

36 4646.55. (a) Notwithstanding any other provision of law or
37 regulation to the contrary, and to the extent federal financial
38 participation is available, effective July 1, 2007, the State
39 Department of Developmental Services is hereby authorized to
40 make supplemental payment to an enrolled Medi-Cal provider that

1 is a licensed intermediate care facility/developmentally
2 disabled-habilitative, licensed intermediate care
3 facility/developmentally disabled-nursing, or licensed intermediate
4 care facility/developmentally disabled, for day treatment and
5 transportation services provided pursuant to Sections 4646 and
6 4646.5, applicable regulations, and Section 14132.925, to Medi-Cal
7 beneficiaries residing in a licensed intermediate care
8 facility/developmentally disabled-habilitative, licensed intermediate
9 care facility/developmentally disabled-nursing, or licensed
10 intermediate care facility/developmentally disabled. These
11 payments shall be considered supplemental payments to the
12 enrolled Medi-Cal provider and shall be comprised of the full costs
13 of reimbursing regional centers for making disbursements to day
14 treatment and transportation service providers, plus a coordination
15 fee which will include an administrative fee and reimbursement
16 for the increased costs associated with the quality assurance fee
17 paid accordingly and without a separate State Department of
18 Developmental Services contract.

19 (b) Notwithstanding any other provision of law and to the extent
20 federal financial participation is available, and in furtherance of
21 this section and Section 14132.925, the State Department of
22 Developmental Services shall amend the regional center contracts
23 for the 2007–08 fiscal year to extend the contract liquidation period
24 until June 30, 2011. The contract amendments and budget
25 adjustments shall be exempt from the provisions of Article 1
26 (commencing with Section 4620).

27 SEC. 124. The heading of Article 3.5 (commencing with
28 Section 4684.50) of Chapter 6 of Division 4.5 of the Welfare and
29 Institutions Code is amended to read:

30

31 Article 3.5. Adult Residential Facilities for Persons with Special
32 Health Care ~~Needs: Pilot Program Needs~~ Needs

33

34 SEC. 125. Section 4684.50 of the Welfare and Institutions
35 Code is amended to read:

36 4684.50. (a) (1) “Adult Residential Facility for Persons with
37 Special Health Care Needs (ARFPSHN)” means any adult
38 residential facility that provides 24-hour health care and intensive
39 support services in a homelike setting that is licensed to serve up

1 to five adults with developmental disabilities as defined in Section
2 4512.

3 (2) For purposes of this article, an ARFPSHN may *only* be
4 established in a facility ~~financed~~ *approved* pursuant to Section
5 4688.5 *or through an approved regional center community*
6 *placement plan pursuant to Section 4418.25.*

7 (b) “Consultant” means a person professionally qualified by
8 training and experience to give expert advice, information, training,
9 or to provide health-related assessments and interventions specified
10 in a consumer’s individual health care plan.

11 (c) “Direct care personnel” means all personnel who directly
12 provide program or nursing services to consumers. Administrative
13 and licensed personnel shall be considered direct care personnel
14 when directly providing program or nursing services to clients.
15 Consultants shall not be considered direct care personnel.

16 (d) “Individual health care plan” means the plan that identifies
17 and documents the health care and intensive support service needs
18 of a consumer.

19 (e) “Individual health care plan team” means those individuals
20 who develop, monitor, and revise the individual health care plan
21 for consumers residing in an Adult Residential Facility for Persons
22 with Special Health Care Needs. The team shall, at a minimum,
23 be composed of all of the following individuals:

24 (1) Regional center service coordinator and other regional center
25 representative, as necessary.

26 (2) Consumer, and, where appropriate, his or her parents, legal
27 guardian or conservator, or authorized representative.

28 (3) Consumer’s primary care physician, or other physician as
29 designated by the regional center.

30 (4) ARFPSHN administrator.

31 (5) ARFPSHN registered nurse.

32 (6) Others deemed necessary for developing a comprehensive
33 and effective plan.

34 (f) “Intensive support needs” means the consumer requires
35 physical assistance in performing four or more of the following
36 activities of daily living:

37 (1) Eating.

38 (2) Dressing.

39 (3) Bathing.

40 (4) Transferring.

1 (5) Toileting.

2 (6) Continence.

3 (g) “Special health care needs” means the consumer has health
4 conditions that are predictable and stable, as determined by the
5 individual health care plan team, and for which the individual
6 requires nursing supports for any of the following types of care:

7 (1) Nutrition support, including total parenteral feeding and
8 gastrostomy feeding, and hydration.

9 (2) Cardiorespiratory monitoring.

10 (3) Oxygen support, including continuous positive airway
11 pressure and bilevel positive airway pressure, and use of other
12 inhalation-assistive devices.

13 (4) Nursing interventions for tracheostomy care and suctioning.

14 (5) Nursing interventions for colostomy, ileostomy, or other
15 medical or surgical procedures.

16 (6) Special medication regimes including injection and
17 intravenous medications.

18 (7) Management of insulin-dependent diabetes.

19 (8) Manual fecal impaction, removal, enemas, or suppositories.

20 (9) Indwelling urinary catheter/catheter procedure.

21 (10) Treatment for staphylococcus infection.

22 (11) Treatment for wounds or pressure ulcers (stages 1 and 2).

23 (12) Postoperative care and rehabilitation.

24 (13) Pain management and palliative care.

25 (14) Renal dialysis.

26 SEC. 126. Section 4684.53 of the Welfare and Institutions
27 Code is amended to read:

28 4684.53. (a) The State Department of Developmental Services
29 and the State Department of Social Services shall jointly implement
30 ~~a pilot project to test the effectiveness of providing licensing~~
31 *program to provide* special health care and intensive support
32 services to adults in homelike community settings.

33 (b) The pilot project shall be implemented through the following
34 regional centers only:

35 (1) The San Andreas Regional Center.

36 (2) The Regional Center of the East Bay.

37 (3) The Golden Gate Regional Center.

38 (4) *All regional centers involved in the closure of the Lanterman*
39 *Developmental Center, as determined by the State Department of*
40 *Developmental Services.*

1 ~~(e) The regional centers participating in this pilot project may~~
2 ~~contract for an aggregate total of services for no more than 120~~
3 ~~persons in an ARFPSHN.~~

4 ~~(d)~~

5 (c) Each ARFPSHN shall possess a community care facility
6 license issued pursuant to Article 9 (commencing with Section
7 1567.50) of Chapter 3 of Division 2 of the Health and Safety Code,
8 and shall be subject to the requirements of Chapter 1 (commencing
9 with Section 80000) of Division 6 of Title 22 of the California
10 Code of Regulations, except for Article 8 (commencing with
11 Section 80090).

12 ~~(e)~~

13 (d) For purposes of this article, a health facility licensed pursuant
14 to subdivision (e) or (h) of Section 1250 may place its licensed
15 bed capacity in voluntary suspension for the purpose of ~~using~~
16 *licensing* the facility to operate an ARFPSHN if the facility is
17 selected to participate ~~in the pilot project~~ pursuant to Section
18 4684.58. Consistent with subdivision (a) of Section 4684.50, any
19 ~~facility selected to participate in the program shall be licensed to~~
20 *pursuant to this section shall* serve up to five adults. A facility's
21 bed capacity shall not be placed in voluntary suspension until all
22 consumers residing in the facility under the license to be suspended
23 have been relocated. No consumer may be relocated unless it is
24 reflected in the consumer's individual program plan developed
25 pursuant to Sections 4646 and 4646.5.

26 ~~(f)~~

27 (e) Each ARFPSHN shall be subject to the requirements of
28 Subchapters 5 through 9 of Chapter 1 of, and Subchapters 2 and
29 4 of Chapter 3 of, Division 2 of Title 17 of the California Code of
30 Regulations.

31 ~~(g)~~

32 (f) Each ARFPSHN shall ensure that an operable automatic fire
33 sprinkler system is installed and maintained.

34 ~~(h)~~

35 (g) Each ARFPSHN shall have an operable automatic fire
36 sprinkler system that is approved by the State Fire Marshal and
37 that meets the National Fire Protection Association (NFPA) 13D
38 standard for the installation of sprinkler systems in single- and
39 two-family dwellings and manufactured homes. A local jurisdiction
40 shall not require a sprinkler system exceeding this standard by

1 amending the standard or by applying standards other than NFPA
 2 13D. A public water agency shall not interpret this section as
 3 changing the status of a facility from a residence entitled to
 4 residential water rates, nor shall a new meter or larger connection
 5 pipe be required of the facility.

6 (i)

7 (h) Each ARFPSHN shall provide an alternative power source
 8 to operate all functions of the facility for a minimum of six hours
 9 in the event the primary power source is interrupted. The alternative
 10 power source shall comply with ~~Section 517-50 of the California~~
 11 ~~Electric Code~~ *the manufacturer's recommendations for installation*
 12 *and operation*. The alternative power source shall be maintained
 13 in safe operating condition, and shall be tested every 14 days under
 14 the full load condition for a minimum of 10 minutes. Written
 15 records of inspection, performance, exercising period, and repair
 16 of the alternative power source shall be regularly maintained on
 17 the premises and available for inspection by the State Department
 18 of Developmental Services.

19 SEC. 127. Section 4684.55 of the Welfare and Institutions
 20 Code is amended to read:

21 4684.55. (a) No regional center may pay a rate to any
 22 ARFPSHN for any consumer that exceeds the ~~average annual cost~~
 23 ~~of serving a consumer at Agnews Developmental Center, as~~
 24 ~~determined by the State Department of Developmental Services~~
 25 *rate in the State Department of Developmental Services' approved*
 26 *community placement plan for that facility unless the regional*
 27 *center demonstrates that a higher rate is necessary to protect a*
 28 *consumer's health and safety, and the department has granted*
 29 *prior written authorization.*

30 (b) The payment rate for ARFPSHN services shall be negotiated
 31 between the regional center and the ARFPSHN, and shall be paid
 32 by the regional center under the service code "Specialized
 33 Residential Facility (Habilitation)."

34 (c) The established rate for a full month of service shall be made
 35 by the regional center when a consumer is temporarily absent from
 36 the ARFPSHN 14 days or less per month. When the consumer's
 37 temporary absence is due to the need for inpatient care in a health
 38 facility, as defined in subdivision (a), (b), or (c) of Section 1250
 39 of the Health and Safety Code, the regional center shall continue
 40 to pay the established rate as long as no other consumer occupies

1 the vacancy created by the consumer's temporary absence, or until
2 the individual health care plan team has determined that the
3 consumer will not return to the facility. In all other cases, the
4 established rate shall be prorated for a partial month of service by
5 dividing the established rate by 30.44 then by multiplying the
6 quotient by the number of days the consumer resided in the facility.

7 SEC. 128. Section 4684.58 of the Welfare and Institutions
8 Code is amended to read:

9 4684.58. (a) The regional center may recommend for
10 participation, *to* the State Department of Developmental Services,
11 an applicant ~~for this pilot project to provide services as part of an~~
12 *approved community placement plan* when the applicant meets all
13 of the following ~~requirements and has been selected through a~~
14 ~~request for proposals process issued by one or more of the three~~
15 ~~participating regional centers:~~ *requirements:*

16 (a)

17 (1) The applicant employs or contracts with a program
18 administrator who has a successful record of administering
19 residential services for at least two years, as evidenced by
20 substantial compliance with the applicable state licensing
21 requirements.

22 (b)

23 (2) The applicant prepares and submits, to the regional center,
24 a complete facility program plan that includes, but is not limited
25 to, all of the following:

26 (1)

27 (A) The total number of the consumers to be served.

28 (2)

29 (B) A profile of the consumer population to be served, including
30 their health care and intensive support needs.

31 (3)

32 (C) A description of the program components, including a
33 description of the health care and intensive support services to be
34 provided.

35 (4)

36 (D) A week's program schedule, including proposed consumer
37 day and community integration activities.

38 (5)

1 (E) A week's proposed program staffing pattern, including
2 licensed, unlicensed, and support personnel and the number and
3 distribution of hours for such personnel.

4 ~~(6)~~

5 (F) An organizational chart, including identification of lead and
6 supervisory personnel.

7 ~~(7)~~

8 (G) The consultants to be utilized, including their professional
9 disciplines and hours to be worked per week or month, as
10 appropriate.

11 ~~(8)~~

12 (H) The plan for accessing and retaining consultant and health
13 care services, including assessments, in the areas of physical
14 therapy, occupational therapy, respiratory therapy, speech
15 pathology, audiology, pharmacy, dietary/nutrition, dental, and
16 other areas required for meeting the needs identified in consumers'
17 individual health care plans.

18 ~~(9)~~

19 (I) A description, including the size, layout, location, and
20 condition of the proposed home.

21 ~~(10)~~

22 (J) A description of the equipment and supplies available, or to
23 be obtained, for programming and care.

24 ~~(11)~~

25 (K) The type, location, and response time of emergency medical
26 service personnel.

27 ~~(12)~~

28 (L) The in-service training program plan for at least the next 12
29 months, *which shall include the plan for ensuring that the direct*
30 *care personnel understands their roles and responsibilities related*
31 *to implementing individual health care plans, prior to, or within,*
32 *the first seven days of providing direct care in the home and for*
33 *ensuring the administrator understands the unique roles,*
34 *responsibilities, and expectations for administrators of*
35 *community-based facilities.*

36 ~~(13)~~

37 (M) The plan for ensuring that outside services are coordinated,
38 integrated, and consistent with those provided by the ARFPSHN.

39 ~~(14)~~

1 (N) Written certification that an alternative power system
2 required by subdivision ~~(i)~~ (g) of Section 4684.53 meets the
3 manufacturer’s recommendations for installation and operation.

4 ~~(e)~~

5 (3) Submits a proposed budget itemizing direct and indirect
6 costs, total costs, and the rate for services.

7 ~~(d) Certifies, in writing,~~

8 (4) ~~The applicant submits written certification that the applicant~~
9 ~~has they have~~ the ability to comply with all of the requirements of
10 Section 1520 of the Health and Safety Code.

11 ~~(e)~~

12 (b) The regional center shall provide all documentation specified
13 ~~in subdivisions (b) to (d), inclusive, of Section 4684.58 paragraphs~~
14 ~~(2) to (4), inclusive, of subdivision (a)~~ and a letter recommending
15 program certification to the State Department of Developmental
16 Services.

17 ~~(f)~~

18 (c) The State Department of Developmental Services shall either
19 approve or deny the recommendation and transmit its written
20 decision to the regional center and to the State Department of
21 Social Services within 30 days of its decision. The decision of the
22 State Department of Developmental Services not to approve an
23 application for program certification shall be the final
24 administrative decision.

25 ~~(g)~~

26 (d) Any change in the ARFPSHN operation that alters the
27 contents of the approved program plan shall be reported to the
28 State Department of Developmental Services and the contracting
29 regional center, and approved by both agencies, prior to
30 implementation.

31 SEC. 129. Section 4684.60 of the Welfare and Institutions
32 Code is amended to read:

33 4684.60. The vendoring regional center shall, before placing
34 any consumer into an ARFPSHN, ensure that the ARFPSHN has
35 a license issued by the State Department of Social Services for not
36 more than five adults and a contract with the regional center that
37 includes, at a minimum, all of the following:

38 (a) The names of the regional center and the licensee.

39 ~~(b) The purpose of the pilot project.~~

40 ~~(e)~~

- 1 (b) A requirement that the contractor shall comply with all
 2 applicable statutes and regulations, including Section 4681.1.
 3 ~~(d)~~
 4 (c) The effective date and termination date of the contract.
 5 ~~(e) A requirement that, under no circumstances, shall the~~
 6 ~~contract extend beyond the stated termination date, which shall~~
 7 ~~not be longer than the pilot legislation end date of January 1, 2011.~~
 8 ~~(f)~~
 9 (d) The definition of terms.
 10 ~~(g)~~
 11 (e) A requirement that the execution of any amendment or
 12 modification to the contract be in accordance with all applicable
 13 federal and state statutes and regulations and be by mutual
 14 agreement of both parties.
 15 ~~(h)~~
 16 (f) A requirement that the licensee and the agents and employees
 17 of the licensee, in the performance of the contract, shall act in an
 18 independent capacity, and not as officers or employees or agents
 19 of the regional center.
 20 ~~(i)~~
 21 (g) A requirement that the assignment of the contract for
 22 consumer services shall not be allowed.
 23 ~~(j)~~
 24 (h) The rate of payment per consumer.
 25 ~~(k)~~
 26 (i) Incorporation, by reference, of the ARFPSHN's approved
 27 program plan.
 28 ~~(l)~~
 29 (j) A requirement that the contractor verify, and maintain for
 30 the duration of the project, possession of commercial general
 31 liability insurance in the amount of at least one million dollars
 32 (\$1,000,000) per occurrence.
 33 ~~(m)~~
 34 (k) Contractor performance criteria.
 35 ~~(n) An agreement to provide, to the evaluation contractor~~
 36 ~~engaged pursuant to subdivision (a) of Section 4684.74, all~~
 37 ~~information necessary for evaluating the project.~~
 38 SEC. 130. Section 4684.63 of the Welfare and Institutions
 39 Code is amended to read:
 40 4684.63. (a) Each ARFPSHN shall do all of the following:

- 1 (1) Meet the minimum requirements for a Residential Facility
2 Service Level 4-i pursuant to Sections 56004 and 56013 of Title
3 17 of the California Code of Regulations, and ensure that all of
4 the following conditions are met:
- 5 (A) That a licensed registered nurse, licensed vocational nurse,
6 or licensed psychiatric technician, is awake and on duty 24-hours
7 per day, seven days per week.
- 8 (B) That a licensed registered nurse is awake and on duty at
9 least eight hours per person, per week.
- 10 (C) That at least two staff on the premises are awake and on
11 duty when providing care to four or more consumers.
- 12 (2) Ensure the consumer remains under the care of a physician
13 at all times and is examined by the primary care physician at least
14 once every 60 days, or more often if required by the consumer's
15 individual health care plan.
- 16 (3) Ensure that an administrator is on duty at least 20 hours per
17 week to ensure the effective operation of the ARFPSHN.
- 18 (4) ~~The~~ *Ensure that the administrator shall have completes the*
19 *35-hour administrator certification program pursuant to paragraph*
20 *(1) of subdivision (c) of Section 1562.3 of the Health and Safety*
21 *Code without exception, has at least one year of administrative*
22 *and supervisory experience in a licensed residential program for*
23 *persons with developmental disabilities, and shall meet is one or*
24 *more of the following qualifications:*
- 25 (A) ~~Be a~~ *A licensed registered nurse.*
- 26 (B) ~~Be a~~ *A licensed nursing home administrator.*
- 27 (C) ~~Be a~~ *A licensed psychiatric technician with at least five*
28 *years of experience serving individuals with developmental*
29 *disabilities.*
- 30 (D) ~~Be an~~ *An individual with a bachelors degree or more*
31 *advanced degree in the health or human services field and two*
32 *years experience working in a licensed residential program for*
33 *persons with developmental disabilities and special health care*
34 *needs.*
- 35 (b) The regional center ~~may~~ *shall* require an ARFPSHN to
36 provide additional professional, administrative, or supportive
37 personnel whenever the regional center determines, in consultation
38 with the individual health care plan team, that additional personnel
39 are needed to provide for the health and safety of consumers.

1 ~~(e) ARFPSHNs may utilize appropriate staff from Agnews~~
2 ~~Developmental Center.~~

3 ~~(d) AH~~

4 (c) *An ARFPSHN shall ensure that all direct care personnel*
5 ~~shall be subject to~~ *complete the training requirements specified in*
6 *Section 4695.2.*

7 SEC. 131. Section 4684.65 of the Welfare and Institutions
8 Code is amended to read:

9 4684.65. (a) A regional center shall not place, or fund the
10 placement for, any consumer in an ARFPSHN until the individual
11 health care plan team has prepared a written individual health care
12 plan that can be fully and immediately implemented upon the
13 consumer's placement.

14 (b) (1) An ARFPSHN shall only accept, for initial admission,
15 consumers who meet the following requirements:

16 (A) Reside at ~~Agnews Lanterman~~ Developmental Center at the
17 time of the proposed placement.

18 (B) Have an individual program plan that specifies placement
19 in an ARFPSHN.

20 (C) Have special health care and intensive support needs.

21 (2) Except as provided in paragraph (3), when a vacancy in an
22 ARFPSHN occurs due to the permanent relocation or death of a
23 resident, the vacancy may only be filled by a consumer who meets
24 the requirements of paragraph (1).

25 (3) If there is no resident residing at ~~Agnews Developmental~~
26 ~~Center~~ *in a developmental center* who meets the requirements of
27 subparagraphs (B) and (C) of paragraph (1), a vacancy may be
28 filled by a consumer who is ~~residing at another developmental~~
29 ~~center or who is~~ at risk of placement into a developmental center,
30 as determined by the regional center, and who meets the
31 requirements of subparagraphs (B) and (C) of paragraph (1).

32 (c) The ARFPSHN shall not admit a consumer if the individual
33 health care plan team determines that the consumer is likely to
34 exhibit behaviors posing a threat of substantial harm to others, or
35 has a serious health condition that is unpredictable or unstable. A
36 determination that the individual is a threat to others may only be
37 based on objective evidence or recent behavior and a determination
38 that the threat cannot be mitigated by reasonable interventions.

39 SEC. 132. Section 4684.70 of the Welfare and Institutions
40 Code is amended to read:

1 4684.70. (a) The State Department of Social Services, in
2 administering the licensing program, shall not have any
3 responsibility for evaluating consumers' level of care or health
4 care provided by ARFPSHN. Any suspected deficiencies in a
5 consumer's level of care or health care identified by the State
6 Department of Social Services' personnel shall be reported
7 immediately to the appropriate regional center and the State
8 Department of Developmental Services for investigation.

9 (b) The regional center shall have responsibility for monitoring
10 and evaluating the implementation of the consumer's individual
11 plan objectives, including, but not limited to, the health care and
12 intensive support service needs identified in the consumer's
13 individual health care plan and the consumer's integration and
14 participation in community life.

15 (c) For each consumer placed in an ARFPSHN, the regional
16 center shall assign a service coordinator pursuant to subdivision
17 (b) of Section 4647.

18 (d) A regional center licensed registered nurse shall visit, with
19 or without prior notice, the consumer, in person, at least monthly
20 in the ARFPSHN, or more frequently if specified in the consumer's
21 individual health care plan. At least four of these visits, annually,
22 shall be unannounced.

23 (e) The State Department of Developmental Services shall
24 monitor and ensure the regional centers' compliance with the
25 requirements of this article. The monitoring shall include onsite
26 visits to all the ARFPSHNs at least every six months ~~for the~~
27 ~~duration of the pilot project.~~

28 SEC. 133. Section 4684.74 of the Welfare and Institutions
29 Code is repealed.

30 ~~4684.74. (a) By July 1, 2006, the State Department of~~
31 ~~Developmental Services shall contract with an independent agency~~
32 ~~or organization to evaluate the pilot project and prepare a written~~
33 ~~report of its findings. The scope of services for the contractor shall~~
34 ~~be jointly prepared by the State Department of Developmental~~
35 ~~Services, the State Department of Social Services, the State~~
36 ~~Department of Public Health, and the State Department of Health~~
37 ~~Care Services and, at a minimum, shall address all of the following:~~

38 ~~(1) The number, business status, and location of all the~~
39 ~~ARFPSHNs.~~

40 ~~(2) The number and characteristics of the consumers served.~~

- 1 ~~(3) The effectiveness of the pilot project in addressing~~
- 2 ~~consumers' health care and intensive support needs.~~
- 3 ~~(4) The extent of consumers' community integration and~~
- 4 ~~satisfaction.~~
- 5 ~~(5) The consumers' access to, and quality of, community-based~~
- 6 ~~health care and dental services.~~
- 7 ~~(6) The types, amounts, qualifications, and sufficiency of~~
- 8 ~~staffing.~~
- 9 ~~(7) The overall impressions, problems encountered, and~~
- 10 ~~satisfaction with the ARFPSHN service model by ARFPSHN~~
- 11 ~~employees, regional center participants, state licensing and~~
- 12 ~~monitoring personnel, and consumers and families.~~
- 13 ~~(8) The costs of all direct, indirect, and ancillary services.~~
- 14 ~~(9) An analysis and summary findings of all ARFPSHN~~
- 15 ~~consumer special incident reports and unusual occurrences reported~~
- 16 ~~during the evaluation period.~~
- 17 ~~(10) The recommendations for improving the ARFPSHN service~~
- 18 ~~model.~~
- 19 ~~(11) The cost-effectiveness of the ARFPSHN model of care~~
- 20 ~~compared with other existing public and private models of care~~
- 21 ~~servicing similar consumers.~~
- 22 ~~(b) The contractor's written report shall be submitted to the~~
- 23 ~~State Department of Developmental Services, the State Department~~
- 24 ~~of Social Services, the State Department of Public Health, and the~~
- 25 ~~State Department of Health Care Services. The State Department~~
- 26 ~~of Developmental Services shall submit the report to the~~
- 27 ~~appropriate fiscal and policy committees of the Legislature by~~
- 28 ~~January 1, 2010.~~
- 29 SEC. 134. Section 4684.74 is added to the Welfare and
- 30 Institutions Code, to read:
- 31 4684.74. The State Department of Developmental Services
- 32 shall only approve the development of Adult Residential Facilities
- 33 for Persons with Special Health Care Needs (ARFPSHNs) that are
- 34 directly associated with the orderly closure of the Lanterman
- 35 Developmental Center, unless a later enacted statute deletes or
- 36 extends this provision.
- 37 SEC. 135. Section 4684.75 of the Welfare and Institutions
- 38 Code is amended to read:
- 39 4684.75. (a) The State Department of Developmental Services
- 40 may adopt emergency regulations to implement this article. The

1 adoption, amendment, repeal, or re adoption of a regulation
2 authorized by this section is deemed to be necessary for the
3 immediate preservation of the public peace, health and safety, or
4 general welfare, for purposes of Sections 11346.1 and 11349.6 of
5 the Government Code, and the State Department of Developmental
6 Services is hereby exempted from the requirement that it describe
7 specific facts showing the need for immediate action. A certificate
8 of compliance for these implementing regulations shall be filed
9 within 24 months following the adoption of the first emergency
10 regulations filed pursuant to this section.

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

14 (e)

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

18 SEC. 136. Section 4701.1 is added to the Welfare and
19 Institutions Code, to read:

20 4701.1. Adequate notice, as defined by Section 4701, shall
21 inform the recipient and authorized representative of both of the
22 following:

23 (a) Whether or not the individual is eligible for an exemption
24 or exception to the action the service agency proposes to take as
25 specified in subparagraph (D) of paragraph (6) of subdivision (a)
26 of Section 4648, subdivision (d) of Section 4648.35, subdivision
27 (c) of Section 4648.5, subdivision (d) of Section 4659,
28 subparagraph (A) of paragraph (3) of subdivision (a) of Section
29 4686.5, subdivision (i) of Section 4689, and subdivisions (a) and
30 (d) of Section 4689.05, subdivision (b) of Section 95004 of the
31 Government Code, and paragraph (3) of subdivision (e) of Section
32 95020 of the Government Code.

33 (b) The specific law supporting any of the above-specified
34 exemptions or exceptions.

35 SEC. 137. Section 4791 is added to the Welfare and Institutions
36 Code, to read:

37 4791. (a) Notwithstanding any other provision of law or
38 regulation, between July 1, 2010, and June 30, 2011, inclusive,
39 regional centers may temporarily modify personnel requirements,
40 functions, or qualifications, or staff training requirements for

1 providers, except for licensed or certified residential providers,
2 whose payments are reduced by 4.25 percent pursuant to the
3 amendments to Section 10 of Chapter 13 of the Third Extraordinary
4 Session of the Statutes of 2009, as contained in Section 164 of the
5 act that adds this section.

6 (b) A temporary modification pursuant to subdivision (a),
7 effective during any agreed upon period of time between July 1,
8 2010, and June 30, 2011, inclusive, may only be approved when
9 the regional center determines that the change will not do any of
10 the following:

11 (1) Adversely affect the health and safety of a consumer
12 receiving services or supports from the provider.

13 (2) Result in a consumer receiving services in a more restrictive
14 environment.

15 (3) Negatively impact the availability of federal financial
16 participation.

17 (4) Violate any state licensing or labor laws or other provisions
18 of Title 17 of the California Code of Regulations not eligible for
19 modification pursuant to this section.

20 (c) A temporary modification pursuant to subdivision (a) shall
21 be described in a written services contract between the regional
22 center purchasing the services and the provider, and a copy of the
23 written services contract and any related documentation shall be
24 retained by the provider and the regional center purchasing the
25 services from the provider.

26 (d) Notwithstanding any other provision of law or regulation,
27 the department shall suspend, from July 1, 2010, to June 30, 2011,
28 inclusive, the requirements described in Sections 56732 and 56800
29 of Title 17 of the California Code of Regulations requiring
30 community-based day programs and in-home respite agencies to
31 conduct annual reviews and to submit written reports to vendoring
32 regional centers, user regional centers, and the department.

33 (e) Notwithstanding any other provision of law or regulation,
34 from July 1, 2010, to June 30, 2011, inclusive, a residential service
35 provider, vendored by a regional center and whose payment is
36 reduced by 4.25 percent pursuant to the amendments to Section
37 10 of Chapter 13 of the Third Extraordinary Session of the Statutes
38 of 2009, as contained in Section 163 of the act that adds this
39 section, shall not be required to complete quarterly and semiannual
40 progress reports required in subdivisions (b) and (c) of Section

1 56026 of Title 17 of the California Code of Regulations. During
2 program review, the provider shall inform the regional center case
3 manager of the consumer's progress and any barrier to the
4 implementation of the individual program plan for each consumer
5 residing in the residence.

6 SEC. 138. Section 5370.2 of the Welfare and Institutions Code
7 is amended to read:

8 5370.2. (a) Beginning January 1, 1996, the State Department
9 of Mental Health shall contract with a single nonprofit agency that
10 meets the criteria specified in subdivision (b) of Section 5510 to
11 conduct the following activities:

12 (1) Provide patients' rights advocacy services for, and conduct
13 investigations of alleged or suspected abuse and neglect of,
14 including deaths of, persons with mental disabilities residing in
15 state hospitals.

16 (2) Investigate and take action as appropriate and necessary to
17 resolve complaints from or concerning recipients of mental health
18 services residing in licensed health or community care facilities
19 regarding abuse, and unreasonable denial, or punitive withholding
20 of rights guaranteed under this division that cannot be resolved by
21 county patients' rights advocates.

22 (3) Provide consultation, technical assistance, and support to
23 county patients' rights advocates in accordance with their duties
24 under Section 5520.

25 (4) Conduct program review of patients' rights programs.

26 (b) The services shall be provided in coordination with the
27 appropriate mental health patients' rights advocates.

28 (c) (1) The contractor shall develop a plan to provide patients'
29 rights advocacy services for, and conduct investigations of alleged
30 or suspected abuse and neglect of, including the deaths of, persons
31 with mental disabilities residing in state hospitals.

32 (2) The contractor shall develop the plan in consultation with
33 the statewide organization of mental health patients' rights
34 advocates, the statewide organization of mental health clients, and
35 the statewide organization of family members of persons with
36 mental disabilities, and the statewide organization of county mental
37 health directors.

38 (3) In order to ensure that persons with mental disabilities have
39 access to high quality advocacy services, the contractor shall
40 establish a grievance procedure and shall advise persons receiving

1 services under the contract of the availability of other advocacy
2 services, including services provided by the protection and
3 advocacy agency specified in Section 4901 and the county patients'
4 rights advocates specified in Section 5520.

5 (d) Nothing contained in this section shall be construed to restrict
6 or limit the authority of the department to conduct the reviews and
7 investigations it deems necessary for personnel, criminal, and
8 litigation purposes.

9 (e) The State Department of Mental Health shall contract on a
10 multiyear basis for a contract term of up to ~~three~~ *five* years.

11 SEC. 139. Section 5813.6 is added to the Welfare and
12 Institutions Code, to read:

13 5813.6. (a) At the time of the release of the January 10 budget
14 plan and the May Revision, the Director of Mental Health shall
15 submit to the Legislature information regarding the projected
16 expenditure of Proposition 63 funding for each state department,
17 and for each major program category specified in the measure, for
18 local assistance. This shall include actual past-year expenditures,
19 estimated current-year expenditures, and projected budget-year
20 expenditures of local assistance funding. In addition, it shall include
21 a complete listing of state support expenditures for the current year
22 and for the budget year by the State Department of Mental Health,
23 including the number of state positions and any contract funds. A
24 description of these state expenditures shall accompany the fiscal
25 information the director is required to submit to the Legislature
26 pursuant to this section.

27 (b) During each fiscal year, the Director of Mental Health shall
28 submit to the fiscal committees of the Legislature, 30 days in
29 advance, written notice of the intention to expend Proposition 63
30 local assistance funding in excess of the amounts presented in its
31 May Revision projection for that fiscal year. The written notice
32 shall include information regarding the amount of the additional
33 spending and its purpose.

34 SEC. 140. Section 10022 of the Welfare and Institutions Code
35 is amended to read:

36 10022. (a) Each publicly funded health care program, *as*
37 *defined in paragraph (1) of subdivision (b) of Section 10020*, that
38 furnishes or pays for health care items or services under this
39 division to a person having private health care coverage shall be
40 entitled to be subrogated to the rights that person has against the

1 carrier of the coverage to the extent of the health care items
2 provided or services rendered.

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

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

10 (2) Respond to any inquiry by the state *or a provider, as defined*
11 *in subdivision (o) of Section 14043.1, including a billing agent or*
12 *a billing agent of the provider, as defined in subdivision (a) of*
13 *Section 14040.1*, regarding a claim for payment for any health care
14 item or service that is submitted not later than three years after the
15 date of the provision of that health care item or service.

16 (3) Agree not to deny a claim submitted by the state *or a*
17 *provider, as defined in paragraph (2)*, solely on the basis of the
18 date of submission of the claim, the type or format of the claim
19 form, or a failure to present proper documentation at the
20 point-of-sale that is the basis of the claim if both of the following
21 occur:

22 (A) The claim is submitted by the state *or a provider, as defined*
23 *in paragraph (2)*, within the three-year period beginning on the
24 date on which the item or service was furnished.

25 (B) Any action by the state *or a provider, as defined in*
26 *paragraph (2)*, to enforce its rights with respect to that claim is
27 commenced within six years of the state's *or provider's* submission
28 of the claim.

29 SEC. 141. Section 14005.11 of the Welfare and Institutions
30 Code is amended to read:

31 14005.11. (a) To the extent required by federal law for
32 qualified Medicare beneficiaries, the department shall pay the
33 premiums, deductibles, and coinsurance for elderly and disabled
34 persons entitled to benefits under Title XVIII of the federal Social
35 Security Act, whose income does not exceed the federal poverty
36 level and whose resources do not exceed 200 percent of the
37 Supplemental Security Income program standard.

38 (b) The department shall, in addition to subdivision (a), pay
39 applicable additional premiums, deductibles, and coinsurance for
40 drug coverage extended to qualified Medicare beneficiaries.

1 (c) The deductible payments required by subdivision (b) may
2 be covered by providing the same drug coverage as offered to
3 categorically needy recipients, as defined in Section 14050.1.

4 (d) As specified in this section, it is the intent of the Legislature
5 to assist in the payment of Medicare Part B premiums for qualified
6 low-income Medi-Cal beneficiaries who are ineligible for federal
7 sharing or federal contribution for the payment of those premiums.

8 (e) ~~Except as provided in subdivision (f), for~~ For a Medi-Cal
9 beneficiary who has a share of cost but who is ineligible for the
10 assistance provided pursuant to subdivision (a), or who is ineligible
11 for any other federally funded assistance for the payment of the
12 beneficiary's Medicare Part B premium, the department shall pay
13 for the beneficiary's Medicare Part B premium in the month
14 following each month that the beneficiary's share of cost has been
15 met.

16 (f) ~~For a Medi-Cal beneficiary who has a share of cost at or~~
17 ~~below five hundred dollars (\$500) but who is ineligible for the~~
18 ~~assistance provided pursuant to subdivision (a), and is ineligible~~
19 ~~for any other federally funded assistance for the payment of the~~
20 ~~beneficiary's Medicare Part B premium, the department shall pay~~
21 ~~for the beneficiary's Medicare Part B premium on a monthly basis,~~
22 ~~regardless of whether the beneficiary's share of cost has been met.~~

23 (g)

24 (f) When a county is informed that an applicant or beneficiary
25 is eligible for Medicare benefits, the county shall determine
26 whether that individual is eligible under the Qualified Medicare
27 Beneficiary (QMB) program, the Specified Low-Income Medicare
28 Beneficiary (SLMB) program, or the Qualifying Individual
29 program and enroll the applicant or beneficiary in the appropriate
30 program.

31 SEC. 142. Section 14005.25 of the Welfare and Institutions
32 Code, as amended by Section 1 of Chapter 24 of the 3rd
33 Extraordinary Session of the Statutes of 2009, is repealed.

34 14005.25. (a) ~~To the extent federal financial participation is~~
35 ~~available, the department shall exercise the option under Section~~
36 ~~1902(e)(12) of the federal Social Security Act (42 U.S.C. Sec.~~
37 ~~1396a(e)(12)) to extend continuous eligibility to children 19 years~~
38 ~~of age and younger. A child shall remain eligible pursuant to this~~
39 ~~subdivision from the date of a determination of eligibility for~~
40 ~~Medi-Cal benefits until the earlier of either:~~

1 ~~(1) The end of a 12-month period following the eligibility~~
2 ~~determination.~~

3 ~~(2) The date the individual exceeds the age of 19 years.~~

4 ~~(b) This section shall be implemented only if, and to the extent~~
5 ~~that, federal financial participation is available.~~

6 ~~(e) Notwithstanding Chapter 3.5 (commencing with Section~~
7 ~~11340) of Part 1 of Division 3 of Title 2 of the Government Code,~~
8 ~~the department shall, without taking regulatory action, implement~~
9 ~~this section by means of all county letters or similar instructions.~~
10 ~~Thereafter, the department shall adopt regulations in accordance~~
11 ~~with the requirements of Chapter 3.5 (commencing with Section~~
12 ~~11340) of Part 1 of Division 3 of Title 2 of the Government Code.~~

13 ~~(d) In order to implement changes in the level of funding for~~
14 ~~health care services, commencing on the first day of the month~~
15 ~~following 90 days after the operative date of amendments to this~~
16 ~~section that added this subdivision, the continuous eligibility time~~
17 ~~period provided in paragraph (1) of subdivision (a) shall be reduced~~
18 ~~to six months.~~

19 ~~(e) (1) Subdivision (d) shall be inoperative from the date the~~
20 ~~act adding this subdivision becomes effective until the date the~~
21 ~~Director of Health Care Services executes a declaration specifying~~
22 ~~that increased federal financial participation is no longer available~~
23 ~~pursuant to the federal American Recovery and Reinvestment Act~~
24 ~~of 2009 (Public Law 111-5).~~

25 ~~(2) The department shall redetermine the continuous eligibility~~
26 ~~period of any child whose continuous eligibility period was~~
27 ~~determined or redetermined pursuant to subdivision (d) during the~~
28 ~~first calendar year quarter of 2009 and shall grant to that child the~~
29 ~~period of continuous eligibility provided for in subdivision (a),~~
30 ~~retroactive to the date that the determination or redetermination~~
31 ~~under subdivision (d) was made.~~

32 ~~(f) This section shall become inoperative on July 1, 2012, and~~
33 ~~as of January 1, 2013, is repealed, unless a later enacted statute,~~
34 ~~that is enacted before January 1, 2013, deletes or extends that date.~~

35 SEC. 143. Section 14005.25 of the Welfare and Institutions
36 Code, as amended by Section 2 of Chapter 24 of the 3rd
37 Extraordinary Session of the Statutes of 2009, is amended to read:

38 14005.25. (a) To the extent federal financial participation is
39 available, the department shall exercise the option under Section
40 1902(e)(12) of the federal Social Security Act (42 U.S.C. Sec.

1 1396a(e)(12)) to extend continuous eligibility to children 19 years
 2 of age and younger. A child shall remain eligible pursuant to this
 3 subdivision from the date of a determination of eligibility for
 4 Medi-Cal benefits until the earlier of either:

5 (1) The end of a 12-month period following the eligibility
 6 determination.

7 (2) The date the individual exceeds the age of 19 years.

8 (b) This section shall be implemented only if, and to the extent
 9 that, federal financial participation is available.

10 (c) Notwithstanding Chapter 3.5 (commencing with Section
 11 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
 12 the department shall, without taking regulatory action, implement
 13 this section by means of all county letters or similar instructions.
 14 Thereafter, the department shall adopt regulations in accordance
 15 with the requirements of Chapter 3.5 (commencing with Section
 16 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

17 ~~(d) This section shall become operative on July 1, 2012.~~

18 SEC. 144. Section 14089 of the Welfare and Institutions Code
 19 is amended to read:

20 14089. (a) The purpose of this article is to provide a
 21 comprehensive program of managed health care plan services to
 22 Medi-Cal recipients residing in clearly defined geographical areas.
 23 It is, further, the purpose of this article to create maximum
 24 accessibility to health care services by permitting Medi-Cal
 25 recipients the option of choosing from among two or more managed
 26 health care plans or fee-for-service managed case arrangements,
 27 including, but not limited to, health maintenance organizations,
 28 prepaid health plans, *and* primary care case management plans.
 29 Independent practice associations, health insurance carriers, private
 30 foundations, and university medical centers systems, not-for-profit
 31 clinics, and other primary care providers, may be offered as choices
 32 to Medi-Cal recipients under this article if they are organized and
 33 operated as managed care plans, for the provision of preventive
 34 managed health care plan services.

35 (b) ~~The negotiator~~ *department* may seek proposals and then
 36 shall ~~contract~~ *enter into contracts* based on relative costs, extent
 37 of coverage offered, quality of health services to be provided,
 38 financial stability of the health care plan or carrier, recipient access
 39 to services, cost-containment strategies, peer and community
 40 participation in quality control, emphasis on preventive and

1 managed health care services and the ability of the health plan to
2 meet all requirements for both of the following:

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

6 (2) Compliance with all of the following:

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

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

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

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

17 (B) Enrollment in a Medi-Cal managed health care plan under
18 this article shall be voluntary for beneficiaries eligible for the
19 federal Supplemental Security Income for the Aged, Blind, and
20 Disabled Program (Subchapter 16 (commencing with Section
21 1381) of Chapter 7 of Title 42 of the United States Code).

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

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

29 (e)

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

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

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

13 (A) Each beneficiary or eligible applicant shall be provided, at
14 a minimum, with the name, address, telephone number, and
15 specialty, if any, of each primary care provider, by specialty or
16 clinic participating in each managed health care plan option through
17 a personalized provider directory for that beneficiary or applicant.
18 This information shall be presented under the geographic area
19 designations by the name of the primary care provider and clinic,
20 and shall be updated based on information electronically provided
21 monthly by the health care plans to the department, setting forth
22 any changes in the health care plan provider network. The
23 geographic areas shall be based on the applicant's residence
24 address, the minor applicant's school address, the applicant's work
25 address, or any other factor deemed appropriate by the department,
26 in consultation with health plan representatives, legislative staff,
27 and consumer stakeholders. In addition, directories of the entire
28 service area, including, but not limited to, the name, address, and
29 telephone number of each primary care provider and hospital, of
30 all Geographic Managed Care health plan provider networks shall
31 be made available to beneficiaries or applicants who request them
32 from the health care options contractor. Each personalized provider
33 directory shall include information regarding the availability of a
34 directory of the entire service area, provide telephone numbers for
35 the beneficiary to request a directory of the entire service area, and
36 include a postage-paid mail card to send for a directory of the
37 entire service area. The personalized provider directory shall be
38 implemented as a pilot project in Sacramento County pursuant to
39 this article, and in Los Angeles County (Two-Plan Model) pursuant
40 to Article 2.7 (commencing with Section 14087.305). The content,

1 form, and geographic areas used shall be determined by the
2 department in consultation with a workgroup to include health
3 plan representatives, legislative staff, and consumer stakeholders,
4 with an emphasis on the inclusion of stakeholders from Los
5 Angeles and Sacramento Counties. The personalized provider
6 directories may include a section for each health plan. Prior to
7 implementation of the pilot project, the department, in consultation
8 with consumer stakeholders, legislative staff, and health plans,
9 shall determine the parameters, methodology, and evaluation
10 process of the pilot project. The pilot project shall thereafter be in
11 effect for a minimum of two years. Three months prior to the end
12 of the first two years of the pilot project, the department shall
13 promptly provide the fiscal and policy committees of the
14 Legislature with an evaluation of the personalized provider
15 directory pilot project and its impact on the Medi-Cal managed
16 care program, including whether the pilot project resulted in a
17 reduction of default assignments and a more informed choice
18 process for beneficiaries, and its overall cost-benefit to the state.
19 Following two years of operation as a pilot project in two counties
20 and submission of the evaluation to the Legislature, the department,
21 in consultation with consumer stakeholders, legislative staff, and
22 health plans, shall determine whether to implement personalized
23 provider directories as a permanent program statewide. This
24 determination shall be based on the outcomes set forth in the
25 evaluation provided to the Legislature. If necessary, the pilot
26 project shall continue beyond the initial two-year period until this
27 determination is made. This pilot project shall only be implemented
28 to the extent that it is budget neutral to the department.

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

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

38 (4) At the time the beneficiary or eligible applicant selects a
39 health care plan, the department shall, when applicable, encourage
40 the beneficiary or eligible applicant to also indicate, in writing,

1 his or her choice of primary care provider or clinic contracting
2 with the selected health care plan.

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

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

16 (7) ~~Any~~ A Medi-Cal or CalWORKs beneficiary dissatisfied with
17 the primary care provider or health care plan shall be allowed to
18 select or be assigned to another primary care provider within the
19 same health care plan. In addition, the beneficiary shall be allowed
20 to select or be assigned to another health care plan contracted for
21 pursuant to this article that is in effect for the geographic area in
22 which he or she resides in accordance with Section
23 1903(m)(2)(F)(ii) of the Social Security Act.

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

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

33 (f)

34 (e) A participating county may include within the plan or plans
35 providing coverage pursuant to this section, employees of county
36 government, and others who reside in the geographic area and who
37 depend upon county funds for all or part of their health care costs.

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

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

5 ~~(i)~~

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

10 ~~(j)~~

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

17 *(h) Notwithstanding any other provision of law, on and after*
18 *the effective date of the act adding this subdivision, the department*
19 *shall have exclusive authority to set the rates, terms, and conditions*
20 *of geographic managed care contracts and contract amendments*
21 *under this article. As of that date, all references to this article to*
22 *the negotiator or to the California Medical Assistance Commission*
23 *shall be deemed to mean the department.*

24 *(i) Notwithstanding subdivision (q) of Section 6254 of the*
25 *Government Code, a contract or contract amendments executed*
26 *by both parties after the effective date of the act adding this*
27 *subdivision shall be considered a public record for purposes of*
28 *the California Public Records Act (Chapter 3.5 (commencing with*
29 *Section 6250) of Division 7 of Title 1 of the Government Code)*
30 *and shall be disclosed upon request. This subdivision includes*
31 *contracts that reveal the department's rates of payment for health*
32 *care services, the rates themselves, and rate manuals.*

33 SEC. 145. Section 14089.05 of the Welfare and Institutions
34 Code is amended to read:

35 14089.05. (a) (1) ~~Pursuant to subdivision (g) of Section 14089,~~
36 ~~the~~ ~~The~~ ~~department~~ ~~and~~ ~~the~~ ~~California~~ ~~Medical~~ ~~Assistance~~
37 ~~Commission~~ may implement a multiplan project in the County of
38 San Diego, upon approval of the Board of Supervisors of the
39 County of San Diego, for the provision of benefits under this
40 chapter to eligible Medi-Cal recipients. The multiplan project

1 implemented in San Diego County pursuant to this section shall
2 provide diagnostic, therapeutic, and preventive services provided
3 under the Medi-Cal program, and additional benefits including,
4 but not limited to, medical-related transportation, comprehensive
5 patient management, and referral to other support services.

6 (2) The County of San Diego shall be eligible to receive funds
7 transferred pursuant to paragraph (1) of subdivision (p) of Section
8 14163 for the development and implementation of this section.
9 These funds in the amount allocated by the department for the
10 County of San Diego shall be paid by the department upon the
11 enactment of this section to the County of San Diego to reimburse
12 a portion of the costs of the development of the project. To the full
13 extent permitted by state and federal law, these funds shall be
14 distributed by the department for expenditure by the County of
15 San Diego in a manner that qualifies for federal financial
16 participation under the medicaid program and the department shall
17 expedite the payment of the federal funds to the County of San
18 Diego. The department shall seek additional state, federal, and
19 other funds to pay for costs that are incurred by the County of San
20 Diego to develop the multiplan project in excess of the payment
21 required by this section, and the department shall assist the county
22 in obtaining the additional funds.

23 (b) (1) The County of San Diego may establish two advisory
24 boards, one of which shall be composed of consumer
25 representatives and the other of which shall be composed of health
26 care professional's representatives. Each board shall advise the
27 Department of Health Services of the County of San Diego and
28 review and comment on all aspects of the implementation of the
29 multiplan project. At least one of the members of each advisory
30 board shall be appointed by the board of supervisors. The board
31 of supervisors shall establish a number of members to serve on
32 each advisory board, with each supervisor to appoint an equal
33 number of members from his or her district. Each advisory board
34 shall vote on all pilot project policies and issues that are submitted
35 to the board of supervisors.

36 (2) Notwithstanding any other provision of law, a member of
37 an advisory board established pursuant to this section shall not be
38 deemed to be interested in a contract entered into by the department
39 within the meaning of Article 4 (commencing with Section 1090)

1 of Chapter 1 of Division 4 of Title 1 of the Government Code if
2 the member is a Medi-Cal recipient or if all of the following apply:

3 (A) The member was appointed to represent the interests of
4 physicians, health care practitioners, hospitals, pharmacies, or
5 other health care organizations.

6 (B) The contract authorizes the member or the organization the
7 member represents to provide Medi-Cal services under the
8 multiplan project.

9 (C) The contract contains substantially the same terms and
10 conditions as contracts entered into with other individuals or
11 organizations the member was appointed to represent.

12 (D) The member does not influence or attempt to influence the
13 joint advisory board or another member of the joint advisory board
14 to recommend that the department enter into the contract in which
15 the member is interested.

16 (E) The member discloses the interest to the joint advisory board
17 and abstains from voting on any recommendation on the contract.

18 (F) The advisory board notes the member's disclosure and
19 abstention in its official records.

20 (3) Members of the advisory boards shall not be paid
21 compensation for activities relating to their duties as members,
22 but members who are Medi-Cal recipients shall be reimbursed an
23 appropriate amount by the County of San Diego for travel and
24 child care expenses incurred in performing their duties under this
25 section.

26 (c) At the discretion of the department, the County of San Diego,
27 the department, or other appropriate entities may perform any of
28 the following in a manner that accomplishes the integration of the
29 intake of eligible beneficiaries to the project, the assessment of
30 beneficiary individual and family needs and circumstances, and
31 the timely referral of beneficiaries to health care and other services
32 to respond to their individual and family needs:

33 (1) Determine the eligibility of Medi-Cal applicants and
34 recipients in a manner and environment that is accessible to the
35 recipients and applicants.

36 (2) Perform enrollment activities in a manner that ensures that
37 recipients be given the opportunity to select the provider of their
38 choice in a manner and environment that is accessible to the
39 recipients.

1 (3) The department may negotiate and amend its contract with
2 the county to provide for specified quality improvement activities,
3 and may require each of the health plans to participate in those
4 activities. The department shall also participate in the county's
5 quality improvement activities.

6 (d) Notwithstanding Section 14089 or any other provision of
7 law, the County of San Diego, when contracting with the
8 department pursuant to this section or subdivision (d), (i), or (j) of
9 Section 14089, shall not be liable for damages for injury to persons
10 or property arising out of the actions or inactions of the department,
11 the department's other contractors, or providers of health care or
12 other services, or Medi-Cal recipients. This section shall not relieve
13 the County of San Diego from liability arising out of its actions
14 or inactions.

15 (e) The County of San Diego, when contracting with the
16 department pursuant to Section 14089 or this section, shall have
17 no legal duty to provide health care or other services to Medi-Cal
18 recipients, and shall have no financial responsibility for the
19 department's other contractors or providers of health care or other
20 services, except to the extent specifically set forth in contracts
21 between the department and the county.

22 (f) Notwithstanding Section 14089.6, the department may
23 terminate any existing managed care contract with either a prepaid
24 health plan or a primary care case management plan for services
25 in the County of San Diego in accordance with the terms and
26 conditions set forth in the existing contract, at any time that the
27 department determines that termination is in the best interest of
28 the state. The department shall notify an existing prepaid health
29 plan at least 90 days prior to termination. The department shall
30 notify a primary care case management plan at least 30 days prior
31 to termination.

32 (g) All contracts entered into by the department and the County
33 of San Diego pursuant to Section 14089 or this section shall not
34 be for the benefit of any third party, and no third-party beneficiary
35 relationship shall be established between the county and any other
36 party, except as may be specifically set forth in contracts between
37 the department and the County of San Diego.

38 (h) The department shall report to the appropriate committees
39 of the Legislature on the project implemented pursuant to this
40 section.

1 (i) (1) For purposes of this section, “multiplan project” means
2 a program authorized by this section in which a number of
3 Knox-Keene licensed health plans designated by the county and
4 approved by the department ~~to negotiate with the California~~
5 ~~Medical Assistance Commission~~ shall be the only Medi-Cal
6 managed care health plans authorized to operate within San Diego
7 County, with the exception of special projects approved by the
8 department.

9 (2) Designated health plans shall include, but not be limited to,
10 health plans sponsored by traditional Medi-Cal physicians,
11 neighborhood health centers, community clinics, health systems,
12 including hospitals and other providers, or a combination thereof.

13 (3) Participating health plans shall first be designated by the
14 county for approval by the department. Health plans approved by
15 the department shall be eligible to ~~negotiate contract rates, terms,~~
16 ~~and conditions~~ with the ~~California Medical Assistance Commission~~
17 *department*. Designation by the county and approval by the
18 department provides the health plan only with the opportunity to
19 compete for a contract ~~through negotiations with the California~~
20 ~~Medical Assistance Commission~~ and does not guarantee a contract
21 with the state.

22 (4) Designation requirements imposed by the county shall not
23 conflict with the requirements imposed by the department, the
24 federal medicaid program, and the Medi-Cal program, and may
25 not impose stricter requirements, without the department’s
26 approval, than those imposed by the department, the federal
27 medicaid program, and the Medi-Cal program.

28 (5) Designation of health plans by the county will continue for
29 the term of the Medi-Cal contract.

30 (j) Nothing in this section relieves the county of duties or
31 liabilities imposed by Part 5 (commencing with Section 17000) or
32 which it has assumed through contract with entities other than the
33 department.

34 (k) Indian health facilities in San Diego County may contract
35 directly with the department as Medi-Cal fee-for-service case
36 management providers apart from the geographic managed care
37 program or may participate in the network of one or more of the
38 geographic managed care plans. Indian health service facilities
39 that contract with the department as fee-for-service case
40 management providers may enroll Medi-Cal recipients, including,

1 but not limited to, recipients who are in any of the geographic
2 managed care mandatory enrollment aid codes.

3 SEC. 146. Section 14089.4 of the Welfare and Institutions
4 Code is amended to read:

5 14089.4. The ~~negotiator~~ *department* may consult with the
6 Department of Insurance or the Department of Managed Health
7 Care and shall consult with the Department of Justice Medi-Cal
8 Fraud Unit, the appropriate licensing boards, and the laboratory
9 field services unit of the department for the purposes of determining
10 the qualifications, performance capability, and financial stability
11 of prospective contractors.

12 SEC. 147. Section 14091.3 of the Welfare and Institutions
13 Code is amended to read:

14 14091.3. (a) For purposes of this section, the following
15 definitions shall apply:

16 (1) “Medi-Cal managed care plan contracts” means those
17 contracts entered into with the department by any individual,
18 organization, or entity pursuant to Article 2.7 (commencing with
19 Section 14087.3), Article 2.8 (commencing with Section 14087.5),
20 Article 2.91 (commencing with Section 14089), or Article 1
21 (commencing with Section 14200) or Article 7 (commencing with
22 Section 14490) of Chapter 8, or Chapter 8.75 (commencing with
23 Section 14590).

24 (2) “Medi-Cal managed care health plan” means an individual,
25 organization, or entity operating under a Medi-Cal managed care
26 plan contract with the department under this chapter, Chapter 8
27 (commencing with Section 14200), or Chapter 8.75 (commencing
28 with Section 14590).

29 (b) The department shall take all appropriate steps to amend the
30 Medicaid State Plan, if necessary, to carry out this section. This
31 section shall be implemented only to the extent that federal
32 financial participation is available. The department shall adopt
33 rules and regulations to carry out this section. Until January 1,
34 2010, any rules and regulations adopted pursuant to this subdivision
35 may be adopted as emergency regulations in accordance with the
36 Administrative Procedure Act (Chapter 3.5 (commencing with
37 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
38 Code). The adoption of these regulations shall be deemed an
39 emergency and necessary for the immediate preservation of the
40 public peace, health, and safety or general welfare. The regulations

1 shall become effective immediately upon filing with the Secretary
2 of State.

3 (c) Any hospital that does not have in effect a contract with a
4 Medi-Cal managed care health plan, as defined in paragraph (2)
5 of subdivision (a), that establishes payment amounts for services
6 furnished to a beneficiary enrolled in that plan shall accept as
7 payment in full, from all these plans, the following amounts:

8 (1) For outpatient services, the Medi-Cal Fee-For-Service (FFS)
9 payment amounts.

10 (2) For emergency inpatient services, the average per diem
11 contract rate specified in paragraph (2) of subdivision (b) of Section
12 14166.245, except that the payment amount shall not be reduced
13 by 5 percent. For the purposes of this paragraph, this payment
14 amount shall apply to all hospitals, including hospitals that contract
15 with the department under the Medi-Cal Selective Provider
16 Contracting Program described in Article 2.6 (commencing with
17 Section 14081), and small and rural hospitals specified in Section
18 124840 of the Health and Safety Code.

19 (3) For poststabilization services following an emergency
20 admission, payment amounts shall be consistent with subdivision
21 (e) of Section 438.114 of Title 42 of the Code of Federal
22 Regulations. This paragraph shall only be implemented to the
23 extent that contract amendment language providing for these
24 payments is approved by CMS. For purposes of this paragraph,
25 this payment amount shall apply to all hospitals, including hospitals
26 that contract with the department under the Medi-Cal Selective
27 Provider Contracting Program pursuant to Article 2.6 (commencing
28 with Section 14081).

29 (d) Medi-Cal managed care health plans that, pursuant to the
30 department's encouragement in All Plan Letter 07003, have been
31 paying out-of-network hospitals the most recent California Medical
32 Assistance Commission regional average per diem rate as a
33 temporary rate for purposes of Section 1932(b)(2)(D) of the Social
34 Security Act (SSA), which became effective January 1, 2007, shall
35 make reconciliations and adjustments for all hospital payments
36 made since January 1, 2007, based upon rates published by the
37 department pursuant to Section 1932(b)(2)(D) of the SSA and
38 effective January 1, 2007, to June 30, 2008, inclusive, and, if
39 applicable, provide supplemental payments to hospitals as
40 necessary to make payments that conform with Section

1 1932(b)(2)(D) of the SSA. In order to provide managed care health
2 plans with 60 working days to make any necessary supplemental
3 payments to hospitals prior to these payments becoming subject
4 to the payment of interest, Section 1300.71 of Title 28 of the
5 California Code of Regulations shall not apply to these
6 supplemental payments until 30 working days following the
7 publication by the department of the rates.

8 (e) (1) The department shall provide a written report to the
9 policy and fiscal committees of the Legislature on October 1, 2009,
10 and May 1, 2010, on the implementation and impact made by this
11 section, including the impact of these changes on access to
12 hospitals by managed care enrollees and on contracting between
13 hospitals and managed care health plans, including the increase
14 or decrease in the number of these contracts.

15 (2) Not later than August 1, 2010, the department shall report
16 to the Legislature on the implementation of this section. The report
17 shall include, but not be limited to, information and analyses
18 addressing managed care enrollee access to hospital services, the
19 impact of this section on managed care health plan capitation rates,
20 the impact of this section on the extent of contracting between
21 managed care health plans and hospitals, and fiscal impact on the
22 state.

23 (3) For the purposes of preparing the annual status reports and
24 the final evaluation report required pursuant to this subdivision,
25 Medi-Cal managed care health plans shall provide the department
26 with all data and documentation, including contracts with providers,
27 including hospitals, as deemed necessary by the department to
28 evaluate the impact of the implementation of this section. In order
29 to ensure the confidentiality of managed care health plan
30 proprietary information, and thereby enable the department to have
31 access to all of the data necessary to provide the Legislature with
32 accurate and meaningful information regarding the impact of this
33 section, all information and documentation provided to the
34 department pursuant to this section shall be considered proprietary
35 and shall be exempt from disclosure as official information
36 pursuant to subdivision (k) of Section 6254 of the Government
37 Code as contained in the California Public Records Act (Division
38 7 (commencing with Section 6250) of Title 1 of the Government
39 Code).

1 (f) This section shall remain in effect only until January 1, ~~2011~~
2 2012, and as of that date is repealed, unless a later enacted statute,
3 that is enacted before January 1, ~~2011~~ 2012, deletes or extends
4 that date.

5 SEC. 148. Section 14105.08 is added to the Welfare and
6 Institutions Code, to read:

7 14105.08. (a) Notwithstanding any other provision of law, in
8 order to implement changes in the level of funding for radiology
9 services, as defined in Section 51139 of Title 22 of the California
10 Code of Regulations, the director shall reduce reimbursement rates
11 applicable to radiology services, as specified in this section.

12 (b) Except as otherwise provided in this section, reimbursement
13 rates applicable to radiology services shall not exceed 80 percent
14 of the lowest maximum allowance established under the federal
15 Medicare program for the same or similar services with dates of
16 service on or after October 1, 2010.

17 (c) Notwithstanding the rulemaking provisions of Chapter 3.5
18 (commencing with Section 11340) of Part 1 of Division 3 of Title
19 2 of the Government Code, the department may take the actions
20 specified in this section by means of a provider bulletin or notice,
21 policy letter, or other similar instruction, without taking regulatory
22 action.

23 (d) (1) The reimbursement rates provided for in this section
24 shall be implemented only if the director determines that the rates,
25 as established by this section, will comply with applicable federal
26 Medicaid requirements and that federal financial participation will
27 be available.

28 (2) In assessing whether federal financial participation is
29 available, the director shall determine whether the rates comply
30 with applicable federal Medicaid requirements, including those
31 set forth in Section 1396a(a)(30)(A) of Title 42 of the United States
32 Code.

33 (3) To the extent that the director determines that the rates do
34 not comply with applicable federal Medicaid requirements, the
35 director shall retain the discretion not to implement that rate and
36 may revise the rate as necessary to comply with the federal
37 Medicaid requirements.

38 (e) The director shall seek any necessary federal approval for
39 the implementation of this section. To the extent that federal
40 financial participation is not available with respect to any rate of

1 reimbursement described by this section, the director shall retain
2 the discretion not to implement that rate and may revise the rate
3 as necessary to comply with the federal Medicaid requirements.

4 SEC. 149. Section 14105.28 is added to the Welfare and
5 Institutions Code, to read:

6 14105.28. (a) It is the intent of the Legislature to design a new
7 Medi-Cal inpatient hospital reimbursement methodology based
8 on diagnosis-related groups that more effectively ensures all of
9 the following:

10 (1) Encouragement of access by setting higher payments for
11 patients with more serious conditions.

12 (2) Rewards for efficiency by allowing hospitals to retain
13 savings from decreased length of stays and decreased cost per day.

14 (3) Improvement of transparency and understanding by defining
15 the “product” of a hospital in a way that is understandable to both
16 clinical and financial managers.

17 (4) Improvement of fairness so that different hospitals receive
18 similar payment for similar care and payments to hospitals are
19 adjusted for significant cost factors that are outside the hospital’s
20 control.

21 (5) Encouragement of administrative efficiency and minimizing
22 administrative burdens on hospitals and the Medi-Cal program.

23 (6) That payments depend on data that has high consistency and
24 credibility.

25 (7) Simplification of the process for determining and making
26 payments to the hospitals.

27 (8) Facilitation of improvement of quality and outcomes.

28 (9) Facilitation of implementation of state and federal provisions
29 related to hospital acquired conditions.

30 (10) Support of provider compliance with all applicable state
31 and federal requirements.

32 (b) (1) (A) (i) The department shall develop and implement
33 a payment methodology based on diagnosis-related groups, subject
34 to federal approval, that reflects the costs and staffing levels
35 associated with quality of care for patients in all general acute care
36 hospitals in state and out of state, including Medicare critical access
37 hospitals, but excluding public hospitals, psychiatric hospitals,
38 and rehabilitation hospitals, which include alcohol and drug
39 rehabilitation hospitals.

1 (ii) This section shall be implemented on the date that the
2 replacement Medicaid Management Information System, described
3 in subparagraph (C), becomes fully operational, but no later than
4 June 30, 2014. The director shall execute a declaration stating the
5 date on which the replacement system has become fully
6 operational.

7 (B) The diagnosis-related group-based payments shall apply to
8 all claims, except claims for psychiatric inpatient days,
9 rehabilitation inpatient days, managed care inpatient days, and
10 swing bed stays for long-term care services, provided, however,
11 that psychiatric and rehabilitation inpatient days shall be excluded
12 regardless of whether the stay was in a distinct-part unit. The
13 department may exclude or include other claims and services as
14 may be determined during the development of the payment
15 methodology.

16 (C) Implementation of the new payment methodology shall be
17 coordinated with the development and implementation of the
18 replacement Medicaid Management Information System pursuant
19 to the contract entered into pursuant to Section 14104.3, effective
20 on May 3, 2010.

21 (2) The department shall evaluate alternative diagnosis-related
22 group algorithms for the new Medi-Cal reimbursement system for
23 the hospitals to which paragraph (1) applies. The evaluation shall
24 include, but not be limited to, consideration of all of the following
25 factors:

26 (A) The basis for determining diagnosis-related group base
27 price, and whether different base prices should be used taking into
28 account factors such as geographic location, hospital size, teaching
29 status, the local hospital wage area index, and any other variables
30 that may be relevant.

31 (B) Classification of patients based on appropriate acuity
32 classification systems.

33 (C) Hospital case mix factors.

34 (D) Geographic or regional differences in the cost of operating
35 facilities and providing care.

36 (E) Payment models based on diagnosis-related groups used in
37 other states.

38 (F) Frequency of grouper updates for the diagnosis-related
39 groups.

1 (G) The extent to which the particular grouping algorithm for
2 the diagnosis-related groups accommodates ICD-10 diagnosis and
3 procedure codes, and applicable requirements of the federal Health
4 Insurance Portability and Accountability Act of 1996.

5 (H) The basis for calculating relative weights for the various
6 diagnosis-related groups.

7 (I) Whether policy adjusters should be used, for which care
8 categories they should be used, and the frequency of updates to
9 the policy adjusters.

10 (J) The extent to which the payment system is budget neutral
11 and can be expected to result in state budget savings in future
12 years.

13 (K) Other factors that may be relevant to determining payments,
14 including, but not limited to, add-on payments, outlier payments,
15 capital payments, payments for medical education, payments in
16 the case of early transfers of patients, and payments based on
17 performance and quality of care.

18 (c) The department shall submit to the Legislature a status report
19 on the implementation of this section on April 1, 2011, April 1,
20 2012, April 1, 2013, and April 1, 2014.

21 (d) The alternatives for a new system described in paragraph
22 (2) of subdivision (b) shall be developed in consultation with
23 recognized experts with experience in hospital reimbursement,
24 economists, the federal Centers for Medicare and Medicaid
25 Services, and other interested parties.

26 (e) In implementing this section, the department may contract,
27 as necessary, on a bid or nonbid basis, for professional consulting
28 services from nationally recognized higher education and research
29 institutions, or other qualified individuals and entities not
30 associated with a particular hospital or hospital group, with
31 demonstrated expertise in hospital reimbursement systems. The
32 rate setting system described in subdivision (b) shall be developed
33 with all possible expediency. This subdivision establishes an
34 accelerated process for issuing contracts pursuant to this section
35 and contracts entered into pursuant to this subdivision shall be
36 exempt from the requirements of Chapter 1 (commencing with
37 Section 10100) and Chapter 2 (commencing with Section 10290)
38 of Part 2 of Division 2 of the Public Contract Code.

39 (f) (1) The department may adopt emergency regulations to
40 implement the provisions of this section in accordance with

1 rulemaking provisions of the Administrative Procedure Act
2 (Chapter 3.5 (commencing with Section 11340) of Part 1 of
3 Division 3 of Title 2 of the Government Code). The initial adoption
4 of emergency regulations and one readoption of the initial
5 regulations shall be deemed to be an emergency and necessary for
6 the immediate preservation of the public peace, health, and safety
7 or general welfare. Initial emergency regulations and the one
8 readoption of those regulations shall be exempt from review by
9 the Office of Administrative Law. The initial emergency
10 regulations and the one readoption of those regulations authorized
11 by this section shall be submitted to the Office of Administrative
12 Law for filing with the Secretary of State and publication in the
13 California Code of Regulations.

14 (2) As an alternative to paragraph (1), and notwithstanding the
15 rulemaking provisions of Chapter 3.5 (commencing with Section
16 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
17 or any other provision of law, the department may implement and
18 administer this section by means of provider bulletins, all-county
19 letters, manuals, or other similar instructions, without taking
20 regulatory action. The department shall notify the fiscal and
21 appropriate policy committees of the Legislature of its intent to
22 issue a provider bulletin, all-county letter, manual, or other similar
23 instruction, at least five days prior to issuance. In addition, the
24 department shall provide a copy of any provider bulletin, all-county
25 letter, manual, or other similar instruction issued under this
26 paragraph to the fiscal and appropriate policy committees of the
27 Legislature.

28 SEC. 150. Section 14105.281 is added to the Welfare and
29 Institutions Code, to read:

30 14105.281. (a) The Legislature finds and declares all of the
31 following:

32 (1) That because the implementation of Section 14105.28 is
33 expected to require several years and further rate changes may
34 make the transition to an inpatient hospital reimbursement
35 methodology based on diagnosis-related groups more difficult,
36 and because of the need to take into account the amount of base
37 payments when combined with supplemental payments made to
38 inpatient hospitals, including payments provided as a result of the
39 hospital fee set forth in Article 5.22 (commencing with Section

1 14167.31) and Article 5.225 (commencing with Section 14167.41),
2 it is necessary to impose the rate freeze enacted in this section.

3 (2) (A) Upon implementation of Article 5.21 (commencing
4 with Section 14167.1) and Article 5.22 (commencing with Section
5 14167.31), as added by Assembly Bill 1383 of the 2009–10 Regular
6 Session, supplemental payments shall be made to hospitals that
7 have contracts negotiated pursuant to the Selective Provider
8 Contracting Program, provided that rates under these contracts are
9 not reduced below the contract rates in effect on the effective date
10 of Article 5.21 (commencing with Section 14167.1), as added by
11 Assembly Bill 1383 of the 2009–10 Regular Session.

12 (B) Assembly Bill 1383 of the 2009–10 Regular Session was
13 signed into law on October 11, 2009, and the effective date of
14 Article 5.21 (commencing with Section 14167.1) was January 1,
15 2010. Therefore, in consideration of the notice provided by
16 Assembly Bill 1383 of the 2009–10 Regular Session, and in further
17 consideration that the negotiated contract rates in effect on January
18 1, 2010, or the rates in effect on July 1, 2010, to the extent those
19 rates are lower than the rates in effect on January 1, 2010, as
20 provided in paragraph (1) of subdivision (c), are sufficient to
21 conform with the standards set forth in Section 1396a(a)(30)(A)
22 of Title 42 of the United States Code, as well as the existence of
23 supplemental payments to be made under Article 5.21
24 (commencing with Section 14167.1), the Legislature exercises its
25 discretion, in consultation with the department, to freeze rates at
26 the levels in effect for these hospitals on January 1, 2010, or the
27 rates in effect on July 1, 2010, to the extent that those rates are
28 lower than the rates in effect on January 1, 2010, as provided in
29 paragraph (1) of subdivision (c).

30 (3) The freeze shall remain in effect during the period of time
31 supplemental payments are made under Article 5.21 (commencing
32 with Section 14167.1), and thereafter, to the extent that the rates,
33 alone or in combination with any available supplemental payments,
34 are consistent with federal law as provided in this section.

35 (b) Notwithstanding any other provision of law, in order to
36 develop and implement changes in the methodology for payments
37 for hospital inpatient services, the director shall freeze rates
38 applicable to inpatient hospital services, as specified in this section.

39 (c) (1) Reimbursement rates for inpatient hospital services for
40 all hospitals, except designated public hospitals, as defined in

1 subdivision (d) of Section 14166.1, that receive Medi-Cal
2 reimbursement from the State Department of Health Care Services,
3 both under contract with the Selective Provider Contracting
4 Program as well as noncontract hospitals, shall be frozen to the
5 lesser of the amount paid on January 1, 2010, or the amount paid
6 on July 1, 2010. The rate freeze shall be in effect for
7 reimbursements for inpatient hospital services provided to
8 Medi-Cal beneficiaries beginning on July 1, 2010, through and
9 including the date on which the Medicaid Management Information
10 System converts to claim processing based on the new
11 reimbursement methodology developed pursuant to Section
12 14105.28 and described in paragraph (1) of subdivision (b) of that
13 section.

14 (2) In the event a contract hospital terminates its contract and
15 becomes a noncontract hospital, the hospital shall receive the same
16 rate or rates as provided in paragraph (1) as a contract hospital for
17 inpatient hospital services provided to Medi-Cal eligible individuals
18 while the rate freeze specified in paragraph (1) remains in effect.

19 (3) This section nullifies any agreement between the state and
20 a hospital for rate adjustments that would be inconsistent with this
21 section. Other provisions of any of those agreements shall be
22 unchanged by this section.

23 (4) In the event a noncontract hospital elects to become a
24 contract hospital after July 1, 2010, at a negotiated rate or
25 negotiated rates less than the freeze amount provided in paragraph
26 (1), the hospital shall receive the contract rate or rates while the
27 freeze remains in effect.

28 (d) For purposes of this section, the reimbursement for inpatient
29 hospital services includes the amounts paid for all categories of
30 inpatient services allowable by Medi-Cal and shall not include any
31 supplemental payments. The reimbursement includes the amounts
32 paid for routine services together with all related ancillary services.

33 (e) Within 90 days of the date this section becomes effective,
34 the department shall develop and provide to all hospitals the
35 methodology that will be utilized to implement the rate freeze
36 required by this section for noncontract hospitals.

37 (f) (1) For dates of service on and after July 1, 2010, the
38 department shall reconcile the payments, as limited by subdivision
39 (c), to the amounts that the hospitals, that are subject to the new
40 methodology set forth in Section 14105.28, would have received

1 if the new methodology had been in effect. The department shall
2 identify the data that will be used in making the reconciliations.

3 (2) The department shall implement the reconciliation process
4 on the date that the payment methodology based on
5 diagnosis-related groups has been made final, but no later than
6 June 30, 2012. The director shall execute a declaration stating the
7 date on which the new payment methodology has become final.

8 (3) In the process of reconciliation, no payment, with respect
9 to dates of service prior to the effective date of the act that added
10 this section, shall be reduced below the amount paid pursuant to
11 subdivision (c).

12 (4) Rates paid to hospitals, or for specified services, that are not
13 subject to the methodology in paragraph (1) of subdivision (b) of
14 Section 14105.28, shall be increased subject to the annual Budget
15 Act.

16 (g) Notwithstanding subdivision (c) or any other provision of
17 this section, for the 2011–12 fiscal year and each fiscal year
18 thereafter, or portion thereof, in which subdivision (c) remains in
19 effect, the department shall, subject to an appropriation in the
20 annual Budget Act applicable to the particular fiscal year, apply
21 an increase in reimbursement rates for all hospital services that
22 result from the freeze imposed pursuant to subdivision (c).

23 (h) Notwithstanding the rulemaking provisions of Chapter 3.5
24 (commencing with Section 11340) of Part 1 of Division 3 of Title
25 2 of the Government Code, the department may take the actions
26 specified in this section by means of provider bulletins or notices,
27 policy letters, or other similar instructions, without taking
28 regulatory action.

29 (i) (1) The rates provided for in this section shall be
30 implemented only if the director determines that the rates, as
31 established by this section, will comply with applicable federal
32 Medicaid requirements and that federal financial participation will
33 be available.

34 (2) In assessing whether federal financial participation is
35 available, the director shall determine whether the rates comply
36 with applicable federal Medicaid requirements, including those
37 set forth in Section 1396a(a)(30)(A) of Title 42 of the United States
38 Code.

39 (3) To the extent that the director determines that the rates do
40 not comply with the federal Medicaid requirements, the director

1 retains the discretion not to implement that rate and may revise
2 the rate as necessary to comply with federal Medicaid requirements.

3 (j) The director shall seek any necessary federal approval for
4 the implementation of this section. To the extent that federal
5 financial participation is not available with respect to any rate of
6 reimbursement described by this section, the director retains the
7 discretion not to implement that rate and may revise the rate as
8 necessary to comply with the federal Medicaid requirements.

9 SEC. 151. Section 14105.456 is added to the Welfare and
10 Institutions Code, to read:

11 14105.456. (a) For purposes of this section, the following
12 definitions shall apply:

13 (1) “Generically equivalent drugs” means drug products with
14 the same active chemical ingredients of the same strength, quantity,
15 and dosage form, and of the same generic drug name, as determined
16 by the United States Adopted Names Council (USANC) and
17 accepted by the federal Food and Drug Administration (FDA), as
18 those drug products having the same chemical ingredients.

19 (2) “Legend drug” means any drug with a label that states
20 “Caution: Federal law prohibits dispensing without prescription,”
21 “Rx only,” or words of similar import.

22 (3) “Medicare rate” means the rate of reimbursement established
23 by the Centers for Medicare and Medicaid Services for the
24 Medicare program.

25 (4) “Nonlegend drug” means any drug with a label that does
26 not contain a statement referenced in paragraph (2).

27 (5) “Pharmacy rate of reimbursement” means the reimbursement
28 to a Medi-Cal pharmacy provider pursuant to the provisions of
29 paragraph (2) of subdivision (b) of Section 14105.45.

30 (6) “Physician-administered drug” means any legend drug,
31 nonlegend drug, or vaccine administered or dispensed to a
32 beneficiary by a Medi-Cal provider other than a pharmacy provider
33 and billed to the department on a fee-for-service basis.

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

1 (b) The department may reimburse providers for a
2 physician-administered drug using either a Healthcare Common
3 Procedure Coding System code or a National Drug Code.

4 (c) The Healthcare Common Procedure Coding System code
5 rate of reimbursement for a physician-administered drug shall be
6 equal to the volume-weighted average of the pharmacy rate of
7 reimbursement for generically equivalent drugs. The department
8 shall publish the Healthcare Common Procedure Coding System
9 code rates of reimbursement.

10 (d) The National Drug Code rate of reimbursement shall equal
11 the pharmacy rate of reimbursement.

12 (e) Notwithstanding subdivisions (c) and (d), the department
13 may reimburse providers for physician-administered drugs at a
14 rate not less than the Medicare rate.

15 (f) Notwithstanding Chapter 3.5 (commencing with Section
16 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
17 the department may implement this section by means of a provider
18 bulletin or notice, policy letter, or other similar instructions, without
19 taking regulatory action.

20 (g) (1) The rates provided for in this section shall be
21 implemented commencing January 1, 2011, but only if the director
22 determines that the rates comply with applicable federal Medicaid
23 requirements and that federal financial participation will be
24 available.

25 (2) In assessing whether federal financial participation is
26 available, the director shall determine whether the rates comply
27 with the federal Medicaid requirements, including those set forth
28 in Section 1396a(a)(30)(A) of Title 42 of the United States Code.
29 To the extent that the director determines that a rate of
30 reimbursement described in this section does not comply with the
31 federal Medicaid requirements, the director retains the discretion
32 not to implement that rate and may revise the rate as necessary to
33 comply with the federal Medicaid requirements.

34 (h) The director shall seek any necessary federal approval for
35 the implementation of this section. To the extent that federal
36 financial participation is not available with respect to a rate of
37 reimbursement described in this section, the director retains the
38 discretion not to implement that rate and may revise the rate as
39 necessary to comply with the federal Medicaid requirements.

1 SEC. 152. Section 14126.022 is added to the Welfare and
2 Institutions Code, to read:

3 14126.022. (a) (1) By August 1, 2011, the department shall
4 develop the Skilled Nursing Facility Quality and Accountability
5 Supplemental Payment System, subject to approval by the federal
6 Centers for Medicare and Medicaid Services, and the availability
7 of federal, state, or other funds.

8 (2) The system shall be utilized to provide supplemental
9 payments to skilled nursing facilities that improve the quality and
10 accountability of care rendered to residents in skilled nursing
11 facilities, as defined in subdivision (c) of Section 1250 of the
12 Health and Safety Code, and to penalize those facilities that do
13 not meet measurable standards.

14 (3) The system shall be phased in, beginning with the 2010–11
15 rate year.

16 (4) The department may utilize the system to do all of the
17 following:

18 (A) Assess overall facility quality of care and quality of care
19 improvement, and assign quality and accountability payments to
20 skilled nursing facilities pursuant to performance measures
21 described in subdivision (i).

22 (B) Assign quality and accountability payments or penalties
23 relating to quality of care, or direct care staffing levels, wages, and
24 benefits, or both.

25 (C) Limit the reimbursement of legal fees incurred by skilled
26 nursing facilities engaged in the defense of governmental legal
27 actions filed against the facilities.

28 (D) Publish each facility's quality assessment and quality and
29 accountability payments in a manner and form determined by the
30 director, or his or her designee.

31 (b) (1) There is hereby created in the State Treasury, the Skilled
32 Nursing Facility Quality and Accountability Special Fund. The
33 fund shall contain moneys deposited pursuant to subdivisions (g)
34 and (j) to (l), inclusive. Notwithstanding Section 16305.7 of the
35 Government Code, the fund shall contain all interest and dividends
36 earned on moneys in the fund.

37 (2) Notwithstanding Section 13340 of the Government Code,
38 the fund shall be continuously appropriated without regard to fiscal
39 year to the department for making quality and accountability

1 payments, in accordance with subdivision (m), to facilities that
2 meet or exceed predefined measures as established by this section.

3 (3) Upon appropriation by the Legislature, moneys in the fund
4 may also be used for any of the following purposes:

5 (A) To cover the administrative costs incurred by the State
6 Department of Public Health for positions and contract funding
7 required to implement this section.

8 (B) To cover the administrative costs incurred by the State
9 Department of Health Care Services for positions and contract
10 funding required to implement this section.

11 (C) To provide funding assistance for the Long-Term Care
12 Ombudsman for program activities pursuant to Chapter 11
13 (commencing with Section 9700) of Division 8.5.

14 (c) No appropriation associated with this bill is intended to
15 implement the provisions of Section 1276.65 of the Health and
16 Safety Code.

17 (d) (1) There is hereby appropriated for the 2010–11 fiscal year,
18 one million nine hundred thousand dollars (\$1,900,000) from the
19 Skilled Nursing Facility Quality and Accountability Special Fund
20 to the California Department of Aging for the Long-Term Care
21 Ombudsman program activities pursuant to Chapter 11
22 (commencing with Section 9700) of Division 8.5. It is the intent
23 of the Legislature for the one million nine hundred thousand dollars
24 (\$1,900,000) from the fund to be in addition to the four million
25 one hundred sixty-eight thousand dollars (\$4,168,000) proposed
26 in the Governor’s May Revision for the 2010-11 Budget. It is
27 further the intent of the Legislature to increase this level of
28 appropriation in subsequent years to provide support sufficient to
29 carry out the mandates and activities pursuant to Chapter 11
30 (commencing with Section 9700) of Division 8.5.

31 (2) The department, in partnership with the California
32 Department of Aging, shall seek approval from the federal Centers
33 for Medicare and Medicaid Services to obtain federal Medicaid
34 reimbursement for activities conducted by the Long-Term Care
35 Ombudsman program. The department shall report to the fiscal
36 committees of the Legislature during budget hearings on progress
37 being made and any unresolved issues during the 2011–12 budget
38 deliberations.

39 (e) There is hereby created in the Special Deposit Fund
40 established pursuant to Section 16370 of the Government Code,

1 the Skilled Nursing Facility Minimum Staffing Penalty Account.
2 The account shall contain all moneys deposited pursuant to
3 subdivision (f).

4 (f) (1) Beginning with the 2010–11 fiscal year, the State
5 Department of Public Health shall use the direct care staffing level
6 data it collects to determine whether a skilled nursing facility has
7 met the nursing hours per patient per day requirements pursuant
8 to Section 1276.5 of the Health and Safety Code.

9 (2) (A) Beginning with the 2010–11 fiscal year, the State
10 Department of Public Health shall assess a skilled nursing facility,
11 licensed pursuant to subdivision (c) of Section 1250 of the Health
12 and Safety Code, an administrative penalty if the State Department
13 of Public Health determines that the skilled nursing facility fails
14 to meet the nursing hours per patient per day requirements pursuant
15 to Section 1276.5 of the Health and Safety Code as follows:

16 (i) Fifteen thousand dollars (\$15,000) if the facility fails to meet
17 the requirements for 5 percent or more of the audited days up to
18 49 percent.

19 (ii) Thirty thousand dollars (\$30,000) if the facility fails to meet
20 the requirements for over 49 percent or more of the audited days.

21 (B) (i) If the skilled nursing facility does not dispute the
22 determination or assessment, the penalties shall be paid in full by
23 the licensee to the State Department of Public Health within 30
24 days of the facility’s receipt of the notice of penalty and deposited
25 into the Skilled Nursing Facility Minimum Staffing Penalty
26 Account.

27 (ii) The State Department of Public Health may, upon written
28 notification to the licensee, request that the department offset any
29 moneys owed to the licensee by the Medi-Cal program or any other
30 payment program administered by the department to recoup the
31 penalty provided for in this section.

32 (C) (i) If a facility disputes the determination or assessment
33 made pursuant to this paragraph, the facility shall, within 15 days
34 of the facility’s receipt of the determination and assessment,
35 simultaneously submit a request for appeal to both the department
36 and the State Department of Public Health. The request shall
37 include a detailed statement describing the reason for appeal and
38 include all supporting documents the facility will present at the
39 hearing.

1 (ii) Within 10 days of the State Department of Public Health's
2 receipt of the facility's request for appeal, the State Department
3 of Public Health shall submit, to both the facility and the
4 department, all supporting documents that will be presented at the
5 hearing.

6 (D) The department shall hear a timely appeal and issue a
7 decision as follows:

8 (i) The hearing shall commence within 60 days from the date
9 of receipt by the department of the facility's timely request for
10 appeal.

11 (ii) The department shall issue a decision within 120 days from
12 the date of receipt by the department of the facility's timely request
13 for appeal.

14 (iii) The decision of the department's hearing officer, when
15 issued, shall be the final decision of the State Department of Public
16 Health.

17 (E) The appeals process set forth in this paragraph shall be
18 exempt from Chapter 4.5 (commencing with Section 11400) and
19 Chapter 5 (commencing with Section 11500), of Part 1 of Division
20 3 of Title 2 of the Government Code. The provisions of Section
21 100171 and 131071 of the Health and Safety Code shall not apply
22 to appeals under this paragraph.

23 (F) If a hearing decision issued pursuant to subparagraph (D)
24 is in favor of the State Department of Public Health, the skilled
25 nursing facility shall pay the penalties to the State Department of
26 Public Health within 30 days of the facility's receipt of the
27 decision. The penalties collected shall be deposited into the Skilled
28 Nursing Facility Minimum Staffing Penalty Account.

29 (G) The assessment of a penalty under this subdivision does not
30 supplant the State Department of Public Health's investigation
31 process or issuance of deficiencies or citations under Chapter 2.4
32 (commencing with Section 1417) of Division 2 of the Health and
33 Safety Code.

34 (g) The State Department of Public Health shall transfer, on a
35 monthly basis, all penalty payments collected pursuant to
36 subdivision (f) into the Skilled Nursing Facility Quality and
37 Accountability Special Fund.

38 (h) Nothing in this section shall impact the effectiveness or
39 utilization of Section 1278.5 or 1432 of the Health and Safety Code

1 relating to whistleblower protections, or Section 1420 of the Health
2 and Safety Code relating to complaints.

3 (i) (1) Beginning in the 2010–11 fiscal year, the department,
4 in consultation with representatives from the long-term care
5 industry, organized labor, and consumers, shall establish and
6 publish quality and accountability measures, benchmarks, and data
7 submission deadlines by November 30, 2010.

8 (2) The methodology developed pursuant to this section shall
9 include, but not be limited to, the following requirements and
10 performance measures:

11 (A) Beginning in the 2011–12 rate year:

12 (i) Immunization rates.

13 (ii) Facility acquired pressure ulcer incidence.

14 (iii) The use of physical restraints.

15 (iv) Compliance with the nursing hours per patient per day
16 requirements pursuant to Section 1276.5 of the Health and Safety
17 Code.

18 (v) Resident and family satisfaction.

19 (vi) Direct care staff retention, if sufficient data is available.

20 (B) If this act is extended beyond the dates on which it becomes
21 inoperative and is repealed, in accordance with Section 14126.033,
22 the department, in consultation with representatives from the
23 long-term care industry, organized labor, and consumers, beginning
24 in the 2012–13 rate year, shall incorporate additional measures
25 into the system, including, but not limited to, quality and
26 accountability measures required by federal health care reform
27 that are identified by the federal Centers for Medicare and Medicaid
28 Services.

29 (C) The department, in consultation with representatives from
30 the long-term care industry, organized labor, and consumers, may
31 incorporate additional performance measures, including, but not
32 limited to, the following:

33 (i) Compliance with state policy associated with the United
34 States Supreme Court decision in *Olmstead v. L.C. ex rel. Zimring*
35 (1999) 527 U.S. 581.

36 (ii) Direct care staff retention, if not addressed in the 2011–12
37 rate year.

38 (iii) The use of chemical restraints.

39 (j) Beginning with the 2010–11 rate year, and pursuant to
40 subparagraph (B) of paragraph (5) of subdivision (a) of Section

1 14126.023, the department shall set aside savings achieved from
2 setting the professional liability insurance cost category, including
3 any insurance deductible costs paid by the facility, at the 75th
4 percentile. From this amount, the department shall transfer the
5 General Fund portion into the Skilled Nursing Facility Quality and
6 Accountability Special Fund. A skilled nursing facility shall
7 provide supplemental data on insurance deductible costs to
8 facilitate this adjustment, in the format and by the deadlines
9 determined by the department. If this data is not provided, a
10 facility's insurance deductible costs will remain in the
11 administrative costs category.

12 (k) Beginning with the 2011–12 rate year, the department shall
13 set aside 1 percent of the weighted average Medi-Cal
14 reimbursement rate, from which the department shall transfer the
15 General Fund portion into the Skilled Nursing Facility Quality and
16 Accountability Special Fund.

17 (l) If this act is extended beyond the dates on which it becomes
18 inoperative and is repealed, in accordance with Section 14126.033,
19 beginning with the 2012–13 rate year, in addition to the amount
20 set aside pursuant to subdivision (k), if there is a rate increase in
21 the weighted average Medi-Cal reimbursement rate, the department
22 shall set aside at least one-third of the weighted average Medi-Cal
23 reimbursement rate increase, up to a maximum of 1 percent, from
24 which the department shall transfer the General Fund portion of
25 this amount into the Skilled Nursing Facility Quality and
26 Accountability Special Fund.

27 (m) (1) Beginning with the 2011–12 rate year, the department
28 shall pay a supplemental payment, by April 30, 2012, to skilled
29 nursing facilities based on all of the criteria in subdivision (i), as
30 published by the department, and according to performance
31 measure benchmarks determined by the department in consultation
32 with stakeholders.

33 (2) Skilled nursing facilities that do not submit required
34 performance data by the department's specified data submission
35 deadlines pursuant to subdivision (i) shall not be eligible to receive
36 supplemental payments.

37 (3) Notwithstanding paragraph (1), if a facility appeals the
38 performance measure of compliance with the nursing hours per
39 patient per day requirements, pursuant to Section 1276.5 of the
40 Health and Safety Code, to the State Department of Public Health,

1 and it is unresolved by the department's published due date, the
2 department shall not use that performance measure when
3 determining the facility's supplemental payment.

4 (4) Notwithstanding paragraph (1), if the department is unable
5 to pay the supplemental payments by April 30, 2012, then on May
6 1, 2012, the department shall use the funds available in the Skilled
7 Nursing Facility Quality and Accountability Special Fund as a
8 result of savings identified in subdivisions (k) and (l), less the
9 administrative costs required to implement subparagraphs (A) and
10 (B) of paragraph (3) of subdivision (b), in addition to any Medicaid
11 funds that are available as of December 31, 2011, to increase
12 provider rates retroactively to August 1, 2011.

13 (n) The department shall seek necessary approvals from the
14 federal Centers for Medicare and Medicaid Services to implement
15 this section. The department shall implement this section only in
16 a manner that is consistent with federal Medicaid law and
17 regulations, and only to the extent that approval is obtained from
18 the federal Centers for Medicare and Medicaid Services and federal
19 financial participation is available.

20 (o) In implementing this section, the department and the State
21 Department of Public Health may contract as necessary, with
22 California's Medicare Quality Improvement Organization, or other
23 entities deemed qualified by the department or the State
24 Department of Public Health, not associated with a skilled nursing
25 facility, to assist with development, collection, analysis, and
26 reporting of the performance data pursuant to subdivision (i), and
27 with demonstrated expertise in long-term care quality, data
28 collection or analysis, and accountability performance measurement
29 models pursuant to subdivision (i). This subdivision establishes
30 an accelerated process for issuing any contract pursuant to this
31 section. Any contract entered into pursuant to this subdivision shall
32 be exempt from the requirements of the Public Contract Code,
33 through December 31, 2012.

34 (p) Notwithstanding Chapter 3.5 (commencing with Section
35 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
36 the following shall apply:

37 (1) The director shall implement this section, in whole or in
38 part, by means of provider bulletins, or other similar instructions
39 without taking regulatory action.

1 (2) The State Public Health Officer may implement this section
 2 by means of all facility letters, or other similar instructions without
 3 taking regulatory action.

4 (q) Notwithstanding paragraph (1) of subdivision (m), if a final
 5 judicial determination is made by any state or federal court that is
 6 not appealed, in any action by any party, or a final determination
 7 by the administrator of the federal Centers for Medicare and
 8 Medicaid Services, that any payments pursuant to subdivisions (a)
 9 and (m), are invalid, unlawful, or contrary to any provision of
 10 federal law or regulations, or of state law, these subdivisions shall
 11 become inoperative, and for the 2011–12 rate year, the rate increase
 12 provided under subparagraph (A) of paragraph (4) of subdivision
 13 (a) of Section 14126.033 shall be reduced by the amounts described
 14 in subdivisions (j) and (k). For the 2012–13 rate year and for each
 15 subsequent rate year, any rate increase shall be reduced by the
 16 amounts described in subdivisions (j) and (l).

17 SEC. 153. Section 14126.023 of the Welfare and Institutions
 18 Code is amended to read:

19 14126.023. (a) The methodology developed pursuant to this
 20 article shall be facility specific and reflect the sum of the projected
 21 cost of each cost category and passthrough costs, as follows:

22 (1) Labor costs limited as specified in ~~subdivision (e)~~
 23 *subdivisions (d) and (e)*.

24 (2) Indirect care nonlabor costs limited to the 75th percentile.

25 (3) (A) Administrative costs limited to the 50th percentile.

26 (B) *Notwithstanding subparagraph (A), beginning with the*
 27 *2010–11 rate year and in each subsequent rate year, the*
 28 *administrative cost category shall not include any legal and*
 29 *consultant fees in connection with a fair hearing or other litigation*
 30 *against or involving any governmental agency or department until*
 31 *all issues related to the fair hearing or litigation issues are*
 32 *ultimately decided or resolved.*

33 (C) *Notwithstanding subparagraph (A), beginning with the*
 34 *2010–11 rate year and in each subsequent rate year, the*
 35 *department shall not allow any cost associated with legal or*
 36 *consultant fees in connection with a fair hearing or other litigation*
 37 *against any governmental agency or department where any of the*
 38 *following apply:*

39 (i) *A decision has been rendered in favor of the governmental*
 40 *agency or department.*

1 (ii) *The determination of the governmental agency or department*
2 *otherwise stands.*

3 (iii) *A settlement or similar resolution has been reached*
4 *regarding any citation issued under subdivision (c), (d), or (e) of*
5 *Section 1424 of the Health and Safety Code or regarding any*
6 *remedy imposed under Subpart F of Part 489 of Title 42 of the*
7 *Code of Federal Regulations.*

8 (iv) *A settlement or similar resolution has been reached under*
9 *the provisions of Section 14123 or 14171.*

10 (D) *Facilities shall report supplemental data required to*
11 *disallow costs described in subparagraph (C) in a format and by*
12 *the deadline determined by the department.*

13 (4) *Capital costs based on a fair rental value system (FRVS)*
14 *limited as specified in subdivision ~~(d)~~ (f).*

15 (5) (A) *Direct passthrough of proportional Medi-Cal costs for*
16 *property taxes, facility license fees, new state and federal mandates,*
17 *caregiver training costs, and liability insurance projected on the*
18 *prior year's costs.*

19 (B) (i) *Notwithstanding subparagraph (A), for the 2010–11*
20 *rate year and each rate year thereafter, professional liability*
21 *insurance costs, including any insurance deductible costs paid by*
22 *the facility, shall be limited to the 75th percentile computed on a*
23 *specific geographic peer group basis.*

24 (ii) *Facilities shall report supplemental data described in this*
25 *subparagraph in a format and by the deadline determined by the*
26 *department, or the insurance deductible costs shall continue to be*
27 *reimbursed in the administrative cost category.*

28 (b) (1) *The percentiles in paragraphs (1) through (3) of*
29 *subdivision (a) shall be based on annualized costs divided by total*
30 *resident days and computed on a specific geographic peer group*
31 *basis. Costs within a specific cost category shall not be shifted to*
32 *any other cost category.*

33 (2) *Notwithstanding paragraph (1), for the 2010–11 and*
34 *2011–12 rate years, the percentiles in paragraphs (1) to (5),*
35 *inclusive, of subdivision (a) shall be based on annualized audited*
36 *costs divided by total resident days and computed on a specific*
37 *geographic peer group basis. Costs within a specific category*
38 *shall not be shifted to any other cost category.*

39 (c) (1) *Facilities newly certified to participate in the Medi-Cal*
40 *program shall receive a reimbursement rate based on the peer*

1 group weighted average Medi-Cal reimbursement rate. Facilities
2 shall continue to receive the peer group weighted average
3 Medi-Cal reimbursement rate until either of the following
4 conditions is met:

5 (A) The department shall calculate the Freestanding Skilled
6 Nursing Facility-B facility specific rate when a minimum of six
7 months of Medi-Cal cost data has been audited. The facility specific
8 rate shall be calculated prospectively and shall be effective on
9 August 1 of each rate year, pursuant to Section 14126.021.

10 (B) The department shall calculate the Freestanding Subacute
11 Skilled Nursing Facility-B facility specific rate when a cost report
12 with a minimum of 12 months of Medi-Cal cost data has been
13 audited. The facility specific rate shall be calculated prospectively
14 and shall be effective on August 1 of each rate year, pursuant to
15 Section 14126.021.

16 (2) Facilities that have been decertified for less than six months
17 and upon recertification shall continue to receive the facility per
18 diem reimbursement rate in effect prior to decertification. Facilities
19 shall continue to receive the facility per diem reimbursement rate
20 until either of the following conditions is met:

21 (A) The department shall calculate the Freestanding Skilled
22 Nursing Facility-B facility specific rate when a minimum of six
23 months of Medi-Cal cost data has been audited. The facility specific
24 rate based on the audited six months of Medi-Cal cost data shall
25 be calculated prospectively and shall be effective on August 1 of
26 each rate year, pursuant to Section 14126.021.

27 (B) The department shall calculate the Freestanding Subacute
28 Skilled Nursing Facility-B facility specific rate when a cost report
29 with a minimum of 12 months of Medi-Cal cost data has been
30 audited. The facility-specific rate shall be calculated prospectively
31 and shall be effective on August 1 of each rate year, pursuant to
32 Section 14126.021.

33 (3) Facilities that have been decertified for six months or longer
34 and upon recertification shall receive a reimbursement rate based
35 on the peer group weighted average Medi-Cal reimbursement rate.
36 Facilities shall continue to receive the peer group weighted
37 average Medi-Cal reimbursement rate until either of the following
38 conditions is met:

39 (A) The department shall calculate the Freestanding Skilled
40 Nursing Facility-B facility specific rate when a minimum of six

1 months of Medi-Cal cost data has been audited. The
2 facility-specific rate shall be calculated prospectively and shall
3 be effective on August 1 of each rate year, pursuant to Section
4 14126.021.

5 (B) The department shall calculate the Freestanding Subacute
6 Skilled Nursing Facility-B facility specific rate when a cost report
7 with a minimum of 12 months of Medi-Cal cost data has been
8 audited. The facility-specific rate shall be calculated prospectively
9 and shall be effective on August 1 of each rate year, pursuant to
10 Section 14126.021.

11 (4) Facilities that have a change of ownership or change of the
12 licensed operator shall continue to receive the facility per diem
13 reimbursement rate in effect with the previous owner. Facilities
14 shall continue to receive the facility per diem reimbursement rate
15 until either of the following conditions is met:

16 (A) The department shall calculate the Freestanding Skilled
17 Nursing Facility-B facility specific rate when a minimum of six
18 months of Medi-Cal cost data has been audited. The
19 facility-specific rate shall be calculated prospectively and shall
20 be effective on August 1 of each rate year, pursuant to Section
21 14126.021.

22 (B) The department shall calculate the Freestanding Subacute
23 Skilled Nursing Facility B facility-specific rate when a cost report
24 with a minimum of 12 months of Medi-Cal cost data has been
25 audited. The facility-specific rate shall be calculated prospectively
26 and shall be effective on August 1 of each rate year, pursuant to
27 Section 14126.021.

28 (5) This subdivision represents codification of existing rules
29 promulgated by the department under the authority of Section
30 14126.027.

31 ~~(e)~~

32 (d) The labor costs category shall be comprised of a direct
33 resident care labor cost category, an indirect care labor cost
34 category, and a labor-driven operating allocation cost category, as
35 follows:

36 (1) Direct resident care labor cost category which shall include
37 all labor costs related to routine nursing services including all
38 nursing, social services, activities, and other direct care personnel.
39 These costs shall be limited to the 90th percentile.

1 (2) Indirect care labor cost category which shall include all labor
2 costs related to staff supporting the delivery of patient care
3 including, but not limited to, housekeeping, laundry and linen,
4 dietary, medical records, inservice education, and plant operations
5 and maintenance. These costs shall be limited to the 90th percentile.

6 (3) Labor-driven operating allocation shall include an amount
7 equal to 8 percent of labor costs, minus expenditures for temporary
8 staffing, which may be used to cover allowable Medi-Cal
9 expenditures. In no instance shall the operating allocation exceed
10 5 percent of the facility’s total Medi-Cal reimbursement rate.

11 *(e) Notwithstanding subdivision (d), beginning with the 2010–11*
12 *rate year and each rate year thereafter, the labor cost category*
13 *shall not include the labor-driven operating allocation and shall*
14 *be comprised only of a direct resident care labor cost category*
15 *and an indirect care labor cost category.*

16 ~~(d)~~

17 (f) The capital cost category shall be based on a FRVS that
18 recognizes the value of the capital related assets necessary to care
19 for Medi-Cal residents. The capital cost category includes mortgage
20 principal and interest, leases, leasehold improvements, depreciation
21 of real property, equipment, and other capital related expenses.
22 The FRVS methodology shall be based on the formula developed
23 by the department that assesses facility value based on age and
24 condition and uses a recognized market interest factor. Capital
25 investment and improvement expenditures included in the FRVS
26 formula shall be documented in cost reports or supplemental reports
27 required by the department. The capital costs based on FRVS shall
28 be limited as follows:

29 (1) For the 2005–06 rate year, the capital cost category for all
30 facilities in the aggregate shall not exceed the department’s
31 estimated value for this cost category for the 2004–05 rate year.

32 (2) For the 2006–07 rate year and subsequent rate years, the
33 maximum annual increase for the capital cost category for all
34 facilities in the aggregate shall not exceed 8 percent of the prior
35 rate year’s FRVS cost component.

36 (3) If the total capital costs for all facilities in the aggregate for
37 the 2005–06 rate year exceeds the value of the capital costs for all
38 facilities in the aggregate for the 2004–05 rate year, or if that capital
39 cost category for all facilities in the aggregate for the 2006–07 rate
40 year or any rate year thereafter exceeds 8 percent of the prior rate

1 year's value, the department shall reduce the capital cost category
2 for all facilities in equal proportion in order to comply with
3 paragraphs (1) and (2).

4 ~~(e)~~

5 (g) For the 2005–06 and 2006–07 rate years, the facility specific
6 Medi-Cal reimbursement rate calculated under this article shall
7 not be less than the Medi-Cal rate that the specific facility would
8 have received under the rate methodology in effect as of July 31,
9 2005, plus Medi-Cal's projected proportional costs for new state
10 or federal mandates for rate years 2005–06 and 2006–07,
11 respectively.

12 ~~(f)~~

13 (h) The department shall update each facility specific rate
14 calculated under this methodology annually. The update process
15 shall be prescribed in the Medicaid–state plan *State Plan*,
16 regulations, and the provider bulletins or similar instructions
17 described in Section 14126.027, and shall be adjusted in accordance
18 with the results of facility specific audit and review findings in
19 accordance with subdivisions ~~(h) and (i)~~ (i), (j), and (k).

20 ~~(g)~~

21 (i) (1) The department shall establish rates pursuant to this
22 article on the basis of facility cost data reported in the integrated
23 long-term care disclosure and Medi-Cal cost report required by
24 Section 128730 of the Health and Safety Code for the most recent
25 reporting period available, and cost data reported in other facility
26 financial disclosure reports or supplemental information required
27 by the department in order to implement this article.

28 (2) *Notwithstanding paragraph (1), or any other provision of*
29 *law, beginning with the 2010–11 and 2011–12 rate years, the*
30 *department shall establish rates pursuant to this article on the*
31 *basis of facility audited cost data reported in the integrated*
32 *long-term care disclosure and Medi-Cal cost report described in*
33 *Section 128730 of the Health and Safety Code and audited cost*
34 *data reported in other facility financial disclosure reports or*
35 *audited supplemental information required by the department in*
36 *order to implement this article.*

37 (3) *Notwithstanding paragraph (1), or any other provision of*
38 *law, beginning with the 2010–11 rate year and each rate year*
39 *thereafter, the department may determine a facility ineligible to*
40 *receive supplemental payments pursuant to Section 14126.022 if*

1 a facility fails to provide supplemental data as requested by the
2 department.

3 (4) This subdivision represents codification of existing rules
4 promulgated by the department under the authority of Section
5 14126.027.

6 ~~(h)~~

7 (j) The department shall conduct financial audits of facility and
8 home office cost data as follows:

9 (1) The department shall audit facilities a minimum of once
10 every three years to ensure accuracy of reported costs.

11 (2) It is the intent of the Legislature that the department develop
12 and implement limited scope audits of key cost centers or
13 categories to assure that the rate paid in the years between each
14 full scope audit required in paragraph (1) accurately reflects actual
15 costs.

16 (3) For purposes of updating facility specific rates, the
17 department shall adjust or reclassify costs reported consistent with
18 applicable requirements of the Medicaid state plan as required by
19 Part 413 (commencing with Section 413.1) of Title 42 of the Code
20 of Federal Regulations.

21 (4) Overpayments to any facility shall be recovered in a manner
22 consistent with applicable recovery procedures and requirements
23 of state and federal laws and regulations.

24 ~~(i)~~

25 (k) (1) On an annual basis, the department shall use the results
26 of audits performed pursuant to ~~subdivision (h)~~ subdivisions (i)
27 and (j), the results of any federal audits, and facility cost reports,
28 including supplemental reports of actual costs incurred in specific
29 cost centers or categories as required by the department, to
30 determine any difference between reported costs used to calculate
31 a facility’s rate and audited facility expenditures in the rate year.

32 (2) If the department determines that there is a difference
33 between reported costs and audited facility expenditures pursuant
34 to paragraph (1), the department shall adjust a facility’s
35 reimbursement prospectively over the intervening years between
36 audits by an amount that reflects the difference, consistent with
37 the methodology specified in this article.

38 ~~(j)~~

39 (l) For nursing facilities that obtain an audit appeal decision that
40 results in revision of the facility’s allowable costs, the facility shall

1 be entitled to seek a retroactive adjustment in its facility specific
2 reimbursement rate.

3 ~~(k) Compliance~~

4 (m) *Except as provided in Section 14126.022, compliance by*
5 *each facility with state laws and regulations regarding staffing*
6 *levels shall be documented annually either through facility cost*
7 *reports, including supplemental reports, or through the annual*
8 *licensing inspection process specified in Section 1422 of the Health*
9 *and Safety Code.*

10 SEC. 154. Section 14126.027 of the Welfare and Institutions
11 Code is amended to read:

12 14126.027. (a) (1) The Director of Health Care Services, or
13 his or her designee, shall administer this article.

14 (2) The regulations and other similar instructions adopted
15 pursuant to this article shall be developed in consultation with
16 representatives of the long-term care industry, organized labor,
17 seniors, and consumers.

18 (b) (1) The director may adopt regulations as are necessary to
19 implement this article. The adoption, amendment, repeal, or
20 readoption of a regulation authorized by this section is deemed to
21 be necessary for the immediate preservation of the public peace,
22 health and safety, or general welfare, for purposes of Sections
23 11346.1 and 11349.6 of the Government Code, and the department
24 is hereby exempted from the requirement that it describe specific
25 facts showing the need for immediate action.

26 (2) The regulations adopted pursuant to this section may include,
27 but need not be limited to, any regulations necessary for any of
28 the following purposes:

29 (A) The administration of this article, including the specific
30 analytical process for the proper determination of long-term care
31 rates.

32 (B) The development of any forms necessary to obtain required
33 cost data and other information from facilities subject to the
34 ratesetting methodology.

35 (C) To provide details, definitions, formulas, and other
36 requirements.

37 (c) As an alternative to the adoption of regulations pursuant to
38 subdivision (b), and notwithstanding Chapter 3.5 (commencing
39 with Section 11340) of Part 1 of Division 3 of Title 2 of the
40 Government Code, the director may implement this article, in

1 whole or in part, by means of a provider bulletin or other similar
2 instructions, without taking regulatory action, provided that no
3 such bulletin or other similar instructions shall remain in effect
4 after July 31, ~~2010~~ 2012. It is the intent that regulations adopted
5 pursuant to subdivision (b) shall be in place on or before July 31,
6 ~~2010~~ 2012.

7 SEC. 155. Section 14126.033 of the Welfare and Institutions
8 Code is amended to read:

9 14126.033. (a) This article, including Section 14126.031, shall
10 be funded as follows:

11 (1) General Fund moneys appropriated for purposes of this
12 article pursuant to Section 6 of the act adding this section shall be
13 used for increasing rates, except as provided in Section 14126.031,
14 for freestanding skilled nursing facilities, and shall be consistent
15 with the approved methodology required to be submitted to the
16 federal Centers for Medicare and Medicaid Services pursuant to
17 Article 7.6 (commencing with Section 1324.20) of Chapter 2 of
18 Division 2 of the Health and Safety Code.

19 (2) (A) Notwithstanding Section 14126.023, for the 2005–06
20 rate year, the maximum annual increase in the weighted average
21 Medi-Cal rate required for purposes of this article shall not exceed
22 8 percent of the weighted average Medi-Cal reimbursement rate
23 for the 2004–05 rate year as adjusted for the change in the cost to
24 the facility to comply with the nursing facility quality assurance
25 fee for the 2005–06 rate year, as required under subdivision (b) of
26 Section 1324.21 of the Health and Safety Code, plus the total
27 projected Medi-Cal cost to the facility of complying with new state
28 or federal mandates.

29 (B) Beginning with the 2006–07 rate year, the maximum annual
30 increase in the weighted average Medi-Cal reimbursement rate
31 required for purposes of this article shall not exceed 5 percent of
32 the weighted average Medi-Cal reimbursement rate for the prior
33 fiscal year, as adjusted for the projected cost of complying with
34 new state or federal mandates.

35 (C) Beginning with the 2007–08 rate year and continuing
36 through the 2008–09 rate year, the maximum annual increase in
37 the weighted average Medi-Cal reimbursement rate required for
38 purposes of this article shall not exceed 5.5 percent of the weighted
39 average Medi-Cal reimbursement rate for the prior fiscal year, as

1 adjusted for the projected cost of complying with new state or
2 federal mandates.

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

9 ~~(E) To the extent that new rates are projected to exceed the
10 adjusted limits calculated pursuant to subparagraphs (A) to (D),
11 inclusive, as applicable, the department shall adjust each skilled
12 nursing facility's projected rate for the applicable rate year by an
13 equal percentage.~~

14 (3) (A) *For the 2010–11 rate year, if the increase in the federal
15 medical assistance percentage (FMAP) pursuant to the federal
16 American Recovery and Reinvestment Act of 2009 (ARRA) (Public
17 Law 111-5) is extended for the entire 2010–11 rate year, the
18 maximum annual increase in the weighted average Medi-Cal
19 reimbursement rate for the purposes of this article shall not exceed
20 3.93 percent, or 3.14 percent, if the increase in the FMAP pursuant
21 to ARRA is not extended for that period of time, plus the projected
22 cost of complying with new state or federal mandates. If the
23 increase in the FMAP pursuant to ARRA is extended at a different
24 rate, or for a different time period, the rate adjustment for facilities
25 shall be adjusted accordingly.*

26 (B) *The weighted average Medi-Cal reimbursement rate
27 increase specified in subparagraph (A) shall be adjusted by the
28 department for the following reasons:*

29 (i) *If the federal Centers for Medicare and Medicaid Services
30 does not approve exemption changes to the facilities subject to the
31 quality assurance fee.*

32 (ii) *If the federal Centers for Medicare and Medicaid Services
33 does not approve any proposed modification to the methodology
34 for calculation of the quality assurance fee.*

35 (iii) *To ensure that the state does not incur any additional
36 General Fund expenses to pay for the 2010–11 weighted average
37 Medi-Cal reimbursement rate increase.*

38 (C) *If the maximum annual increase in the weighted average
39 Medi-Cal rate is reduced pursuant to subparagraph (B), the*

1 department shall recalculate and publish the final maximum annual
2 increase in the weighted average Medi-Cal reimbursement rate.

3 (4) (A) Subject to the following provisions, for the 2011–12
4 rate year, the maximum annual increase in the weighted average
5 Medi-Cal reimbursement rate for the purpose of this article shall
6 not exceed 2.4 percent, plus the projected cost of complying with
7 new state or federal mandate.

8 (B) The weighted average Medi-Cal reimbursement rate
9 increase specified in subparagraph (A) shall be adjusted by the
10 department for the following reasons:

11 (i) For the 2011–12 rate year, the department shall set aside 1
12 percent of the weighted average Medi-Cal reimbursement rate,
13 from which the department shall transfer the General Fund portion
14 into the Skilled Nursing Facility Quality and Accountability Fund,
15 to be used for the supplemental rate pool.

16 (ii) If the federal Centers for Medicare and Medicaid Services
17 does not approve exemption changes to the facilities subject to the
18 quality assurance fee.

19 (iii) If the federal Centers for Medicare and Medicaid Services
20 does not approve any proposed modification to the methodology
21 for calculation of the quality assurance fee.

22 (iv) To ensure that the state does not incur any additional
23 General Fund expenses to pay for the 2011–12 weighted average
24 Medi-Cal reimbursement rate increase.

25 (C) The department may recalculate and publish the weighted
26 average Medi-Cal reimbursement rate increase for the 2011–12
27 rate year if the difference in the projected quality assurance fee
28 collections from the 2011–12 rate year, compared to the projected
29 quality assurance fee collections for the 2010–11 rate year, would
30 result in any additional General Fund expense to pay for the
31 2011–12 rate year weighted average reimbursement rate increase.

32 (5) To the extent that rates are projected to exceed the adjusted
33 limits calculated pursuant to subparagraphs (A) to (D), inclusive,
34 of paragraph (2) and, as applicable, paragraphs (3) and (4), the
35 department shall adjust each skilled nursing facility's projected
36 rate for the applicable rate year by an equal percentage.

37 (b) The rate methodology shall cease to be implemented ~~on and~~
38 after July 31, ~~2011~~ 2012.

39 (c) (1) It is the intent of the Legislature that the implementation
40 of this article result in individual access to appropriate long-term

1 care services, quality resident care, decent wages and benefits for
2 nursing home workers, a stable workforce, provider compliance
3 with all applicable state and federal requirements, and
4 administrative efficiency.

5 (2) Not later than December 1, 2006, the Bureau of State Audits
6 shall conduct an accountability evaluation of the department's
7 progress toward implementing a facility-specific reimbursement
8 system, including a review of data to ensure that the new system
9 is appropriately reimbursing facilities within specified cost
10 categories and a review of the fiscal impact of the new system on
11 the General Fund.

12 (3) Not later than January 1, 2007, to the extent information is
13 available for the three years immediately preceding the
14 implementation of this article, the department shall provide baseline
15 information in a report to the Legislature on all of the following:

16 (A) The number and percent of freestanding skilled nursing
17 facilities that complied with minimum staffing requirements.

18 (B) The staffing levels prior to the implementation of this article.

19 (C) The staffing retention rates prior to the implementation of
20 this article.

21 (D) The numbers and percentage of freestanding skilled nursing
22 facilities with findings of immediate jeopardy, substandard quality
23 of care, or actual harm, as determined by the certification survey
24 of each freestanding skilled nursing facility conducted prior to the
25 implementation of this article.

26 (E) The number of freestanding skilled nursing facilities that
27 received state citations and the number and class of citations issued
28 during calendar year 2004.

29 (F) The average wage and benefits for employees prior to the
30 implementation of this article.

31 (4) Not later than January 1, 2009, the department shall provide
32 a report to the Legislature that does both of the following:

33 (A) Compares the information required in paragraph (2) to that
34 same information two years after the implementation of this article.

35 (B) Reports on the extent to which residents who had expressed
36 a preference to return to the community, as provided in Section
37 1418.81 of the Health and Safety Code, were able to return to the
38 community.

39 (5) The department may contract for the reports required under
40 this subdivision.

1 (d) ~~This section~~ *article* shall become inoperative ~~on~~ *after* July
2 31, ~~2011~~ 2012, and as of January 1, ~~2012~~ 2013, is repealed, unless
3 a later enacted statute, that is enacted before January 1, ~~2012~~ 2013,
4 deletes or extends the dates on which it becomes inoperative and
5 is repealed.

6 SEC. 156. Section 14132 of the Welfare and Institutions Code
7 is amended to read:

8 14132. The following is the schedule of benefits under this
9 chapter:

10 (a) Outpatient services are covered as follows:

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

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

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

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

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

37 (3) (A) To the extent required by federal law, the purchase of
38 outpatient prescribed drugs, for which the prescription is executed
39 by a prescriber in written, nonelectronic form on or after April 1,
40 2008, is covered only when executed on a tamper resistant

1 prescription form. The implementation of this paragraph shall
2 conform to the guidance issued by the federal Centers of Medicare
3 and Medicaid Services but shall not conflict with state statutes on
4 the characteristics of tamper resistant prescriptions for controlled
5 substances, including Section 11162.1 of the Health and Safety
6 Code. The department shall provide providers and beneficiaries
7 with as much flexibility in implementing these rules as allowed
8 by the federal government. The department shall notify and consult
9 with appropriate stakeholders in implementing, interpreting, or
10 making specific this paragraph.

11 (B) Notwithstanding Chapter 3.5 (commencing with Section
12 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
13 the department may take the actions specified in subparagraph (A)
14 by means of a provider bulletin or notice, policy letter, or other
15 similar instructions without taking regulatory action.

16 (4) (A) *Nonlegend acetaminophen-containing products, with*
17 *the exception of children's Tylenol, selected by the department are*
18 *not covered benefits. For the purposes of this paragraph,*
19 *nonlegend has the same meaning as defined in subdivision (a) of*
20 *Section 14105.45.*

21 (B) *Notwithstanding Chapter 3.5 (commencing with Section*
22 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*
23 *the department may take the actions specified in subparagraph*
24 *(A) by means of a provider bulletin or notice, policy letter, or other*
25 *similar instruction without taking regulatory action.*

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

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

40 (g) Blood and blood derivatives are covered.

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

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

18 (A) Periodontal treatment is not a benefit.

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

21 (C) Laboratory processed crowns are not a benefit.

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

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

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

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

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

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

35 (k) Prosthetic and orthotic devices and eyeglasses are covered,
36 subject to utilization controls. Utilization controls shall allow
37 replacement of prosthetic and orthotic devices and eyeglasses
38 necessary because of loss or destruction due to circumstances
39 beyond the beneficiary's control. Frame styles for eyeglasses

1 replaced pursuant to this subdivision shall not change more than
2 once every two years, unless the department so directs.

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

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

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

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

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

38 (o) Inpatient intensive rehabilitation hospital services, including
39 respiratory rehabilitation services, in a general acute care hospital

1 are covered, subject to utilization controls, when either of the
2 following criteria are met:

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

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

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

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

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

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

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

26 (2) All dental hygiene services provided by a registered dental
27 hygienist in alternative practice pursuant to Sections 1768 and
28 1770 of the Business and Professions Code may be covered as
29 long as they are within the scope of Denti-Cal benefits and they
30 are necessary services provided by a registered dental hygienist
31 in alternative practice.

32 (r) (1) Paramedic services performed by a city, county, or
33 special district, or pursuant to a contract with a city, county, or
34 special district, and pursuant to a program established under Article
35 3 (commencing with Section 1480) of Chapter 2.5 of Division 2
36 of the Health and Safety Code by a paramedic certified pursuant
37 to that article, and consisting of defibrillation and those services
38 specified in subdivision (3) of Section 1482 of the article.

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

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

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

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

21 (1) Level of care and cost of care evaluations.

22 (2) Expenses, directly attributable to home care activities, for
23 materials.

24 (3) Physician fees for home visits.

25 (4) Expenses directly attributable to home care activities for
26 shelter and modification to shelter.

27 (5) Expenses directly attributable to additional costs of special
28 diets, including tube feeding.

29 (6) Medically related personal services.

30 (7) Home nursing education.

31 (8) Emergency maintenance repair.

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

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

37 (11) Emergency and nonemergency medical transportation.

38 (12) Medical supplies.

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

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

3 (15) Special drugs and medications.

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

7 (17) Therapy services.

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

10 (19) Modification of medical equipment for home use.

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

13 (21) Respiratory care practitioner services as defined in Sections
14 3702 and 3703 of the Business and Professions Code, subject to
15 prescription by a physician and surgeon.

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

24 (t) Home- and community-based services approved by the
25 United States Department of Health and Human Services may be
26 covered to the extent that federal financial participation is available
27 for those services under waivers granted in accordance with Section
28 1396n of Title 42 of the United States Code. The director may
29 seek waivers for any or all home- and community-based services
30 approvable under Section 1396n of Title 42 of the United States
31 Code. Coverage for those services shall be limited by the terms,
32 conditions, and duration of the federal waivers.

33 (u) Comprehensive perinatal services, as provided through an
34 agreement with a health care provider designated in Section
35 14134.5 and meeting the standards developed by the department
36 pursuant to Section 14134.5, subject to utilization controls.

37 The department shall seek any federal waivers necessary to
38 implement the provisions of this subdivision. The provisions for
39 which appropriate federal waivers cannot be obtained shall not be
40 implemented. Provisions for which waivers are obtained or for

1 which waivers are not required shall be implemented
2 notwithstanding any inability to obtain federal waivers for the
3 other provisions. No provision of this subdivision shall be
4 implemented unless matching funds from Subchapter XIX
5 (commencing with Section 1396) of Chapter 7 of Title 42 of the
6 United States Code are available.

7 (v) Early and periodic screening, diagnosis, and treatment for
8 any individual under 21 years of age is covered, consistent with
9 the requirements of Subchapter XIX (commencing with Section
10 1396) of Chapter 7 of Title 42 of the United States Code.

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

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

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

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

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

39 (z) Respiratory care when provided in organized health care
40 systems as defined in Section 3701 of the Business and Professions

1 Code, and as an in-home medical service as outlined in subdivision
2 (s).

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

11 (2) The department shall seek a waiver *in accordance with*
12 *Section 1315 of Title 42 of the United States Code, or a state plan*
13 *amendment adopted in accordance with Section*
14 *1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United States*
15 *Code, which was added to Section 1396a of Title 42 of the United*
16 *States Code by Section 2303(a)(2) of the federal Patient Protection*
17 *and Affordable Care Act (PPACA) (Public Law 111-148), for a*
18 *program to provide comprehensive clinical family planning*
19 *services as described in paragraph (8).* ~~The~~ *Under the waiver, the*
20 *program shall be operated only in accordance with the waiver and*
21 *the statutes and regulations in paragraph (4) and subject to the*
22 *terms, conditions, and duration of the waiver. Under the state plan*
23 *amendment, which shall replace the waiver and shall be known*
24 *as the Family PACT successor state plan amendment, the program*
25 *shall be operated only in accordance with this subdivision and the*
26 *statutes and regulations in paragraph (4). The state shall use the*
27 *standards and processes imposed by the state on January 1, 2007,*
28 *including the application of an eligibility discount factor to the*
29 *extent required by the federal Centers for Medicare and Medicaid*
30 *Services, for purposes of determining eligibility as permitted under*
31 *Section 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United*
32 *States Code. To the extent that federal financial participation is*
33 *available, the program shall continue to conduct education,*
34 *outreach, enrollment, service delivery, and evaluation services as*
35 *specified under the waiver. The services shall be provided under*
36 *the program only if the waiver ~~is~~ and, when applicable, the*
37 *successor state plan amendment are approved by the federal*
38 *Centers for Medicare and Medicaid Services ~~in accordance with~~*
39 *Section 1396n of Title 42 of the United States Code and only to*
40 *the extent that federal financial participation is available for the*

1 services. *Nothing in this section shall prohibit the department from*
2 *seeking the Family PACT successor state plan amendment during*
3 *the operation of the waiver.*

4 (3) Solely for the purposes of the waiver *or Family PACT*
5 *successor state plan amendment* and notwithstanding any other
6 provision of law, the collection and use of an individual's social
7 security number shall be necessary only to the extent required by
8 federal law.

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

15 (5) Notwithstanding Chapter 3.5 (commencing with Section
16 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
17 the department may implement, without taking regulatory action,
18 the provisions of the waiver after its approval by the federal Health
19 Care Financing Administration and the provisions of this section
20 by means of an all-county letter or similar instruction to providers.
21 Thereafter, the department shall adopt regulations to implement
22 this section and the approved waiver in accordance with the
23 requirements of Chapter 3.5 (commencing with Section 11340) of
24 Part 1 of Division 3 of Title 2 of the Government Code. Beginning
25 six months after the effective date of the act adding this
26 subdivision, the department shall provide a status report to the
27 Legislature on a semiannual basis until regulations have been
28 adopted.

29 (6) In the event that the Department of Finance determines that
30 the program operated under the authority of the waiver described
31 in paragraph (2) *or the Family PACT successor state plan*
32 *amendment* is no longer cost effective, this subdivision shall
33 become inoperative on the first day of the first month following
34 the issuance of a 30-day notification of that determination in
35 writing by the Department of Finance to the chairperson in each
36 house that considers appropriations, the chairpersons of the
37 committees, and the appropriate subcommittees in each house that
38 considers the State Budget, and the Chairperson of the Joint
39 Legislative Budget Committee.

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

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

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

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

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

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

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

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

32 (F) *Services, drugs, devices, and supplies deemed by the federal
33 Centers for Medicare and Medicaid Services to be appropriate
34 for inclusion in the program.*

35 (9) *In order to maximize the availability of federal financial
36 participation under this subdivision, the director shall have the
37 discretion to implement the Family PACT successor state plan
38 amendment retroactively to July 1, 2010.*

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

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

3 SEC. 157. Section 14132.925 is added to the Welfare and
4 Institutions Code, to read:

5 14132.925. (a) (1) Notwithstanding any other provision of
6 law or regulation to the contrary, to the extent federal financial
7 participation is available, in furtherance of Section 14105.06 and
8 subdivisions (a) and (c) of Section 14132.92, effective July 1,
9 2007, a licensed intermediate care facility/developmentally
10 disabled-habilitative, licensed intermediate care
11 facility/developmentally disabled-nursing, or licensed intermediate
12 care facility/developmentally disabled shall be responsible for
13 providing day treatment and transportation services consistent with
14 Section 14105.06 and subdivision (a) of Section 14132.92, that
15 are selected and authorized through the individual program plan
16 process pursuant to Sections 4646 and 4646.5 and applicable
17 regulations, for each beneficiary receiving those services who
18 resides in that licensed intermediate care facility/developmentally
19 disabled-habilitative, licensed intermediate care
20 facility/developmentally disabled-nursing, or licensed intermediate
21 care facility/developmentally disabled.

22 (2) (A) The services described in paragraph (1) shall be
23 arranged by the regional center pursuant to Sections 4646 and
24 4646.5 and applicable regulations.

25 (B) The licensed intermediate care facility/developmentally
26 disabled-habilitative, licensed intermediate care
27 facility/developmentally disabled-nursing, or licensed intermediate
28 care facility/developmentally disabled shall reimburse the regional
29 center for the full costs of making the disbursements to day
30 treatment and transportation service providers.

31 (3) Nothing in this section shall authorize the licensed
32 intermediate care facility/developmentally disabled-habilitative,
33 licensed intermediate care facility/developmentally
34 disabled-nursing, or licensed intermediate care
35 facility/developmentally disabled to substitute day treatment or
36 transportation services not selected and authorized through the
37 individual program plan process pursuant to Sections 4646 and
38 4646.5 and applicable regulations.

39 (b) (1) The State Department of Developmental Services shall
40 be responsible for reimbursing a licensed intermediate care

1 facility/developmentally disabled-habilitative, licensed intermediate
2 care facility/developmentally disabled-nursing, or licensed
3 intermediate care facility/developmentally disabled for the costs
4 of reimbursing the regional center for the full cost of making
5 disbursements for day treatment and transportation services, plus
6 a coordination fee which will include an administrative fee and
7 reimbursement for increased costs associated with the quality
8 assurance fee. This payment shall be a supplement to the Medi-Cal
9 payment from the State Department of Health Care Services
10 described in Sections 14105.06 and 14132.92.

11 (2) A licensed intermediate care facility/developmentally
12 disabled-habilitative, licensed intermediate care
13 facility/developmentally disabled-nursing, or licensed intermediate
14 care facility/developmentally disabled may authorize the regional
15 center to invoice the State Department of Developmental Services
16 on its behalf for the services described in subdivision (a).

17 (3) (A) The licensed intermediate care facility/developmentally
18 disabled-habilitative, licensed intermediate care
19 facility/developmentally disabled-nursing, or licensed intermediate
20 care facility/developmentally disabled shall reimburse the regional
21 center for the full costs of making disbursements for day treatment
22 and transportation services within 30 days of receipt of payment
23 from the State Department of Developmental Services pursuant
24 to instructions from the State Department of Developmental
25 Services.

26 (B) If there is a failure to reimburse the regional center within
27 30 days of receipt of payment from the State Department of
28 Developmental Services, for all or part of the costs associated with
29 disbursement for day treatment and transportation services, the
30 outstanding amount shall be recovered by any of the following
31 methods:

32 (i) Lump sum payment by the provider.

33 (ii) Offset against current payments due to the provider from
34 the State of California.

35 (iii) A repayment agreement between the provider and the State
36 of California.

37 (c) (1) A licensed intermediate care facility/developmentally
38 disabled-habilitative, licensed intermediate care
39 facility/developmentally disabled-nursing, or licensed intermediate
40 care facility/developmentally disabled shall report the costs

1 incurred pursuant to subdivision (a) according to instructions from
2 the State Department of Health Care Services.

3 (2) Notwithstanding Chapter 3.5 (commencing with Section
4 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
5 the department may implement this subdivision by means of a
6 provider bulletin or similar instruction.

7 (d) (1) If the services meeting the conditions of subdivision (a)
8 have been provided to a Medi-Cal beneficiary on or after July 1,
9 2007, and, notwithstanding Section 14115, a licensed intermediate
10 care facility/developmentally disabled-habilitative, licensed
11 intermediate care facility/developmentally disabled-nursing, or
12 licensed intermediate care facility/developmentally disabled may
13 authorize the regional center to invoice the State Department of
14 Developmental Services on its behalf for arranging for the services
15 described in subdivision (a). The licensed intermediate care
16 facility/developmentally disabled-habilitative, licensed intermediate
17 care facility/developmentally disabled-nursing, or licensed
18 intermediate care facility/developmentally disabled shall reimburse
19 the regional center the full cost of making disbursements for day
20 treatment and transportation services within 30 days of receipt of
21 payment from the State Department of Developmental Services
22 pursuant to instruction from the State Department of
23 Developmental Services. If a licensed intermediate care
24 facility/developmentally disabled-habilitative, licensed intermediate
25 care facility/developmentally disabled-nursing, or licensed
26 intermediate care facility/developmentally disabled fails to
27 reimburse the regional center within 30 days of receipt of payment
28 from the State Department of Developmental Services, for all or
29 part of the costs associated with the day treatment and
30 transportation services, the outstanding amount shall be recovered
31 by any of the following methods:

32 (A) Lump sum payment by the provider.

33 (B) Offset against current payments due to the provider from
34 the State of California.

35 (C) A repayment agreement between the provider and the State
36 of California.

37 (2) The department shall seek federal financial participation,
38 including any moneys available pursuant to the American Recovery
39 and Reinvestment Act of 2009 (Public Law 111-5), pursuant to a
40 federally approved state plan amendment authorizing

1 reimbursement for costs incurred pursuant to subdivision (a) for
2 day treatment and transportation services provided on or after July
3 1, 2007.

4 (3) Upon approval of the state plan amendment, the
5 reimbursement payments made pursuant to this section by the State
6 Department of Developmental Services to a licensed intermediate
7 care facility/developmentally disabled-habilitative, licensed
8 intermediate care facility/developmentally disabled-nursing, or
9 licensed intermediate care facility/developmentally disabled shall
10 be subject to the quality assurance fee imposed upon designated
11 intermediate care facilities pursuant to Article 7.5 (commencing
12 with Section 1324) of Chapter 2 of Division 2 of the Health and
13 Safety Code.

14 (4) If federal financial participation is not made available for
15 day treatment and transportation services provided on or after July
16 1, 2007, the services nonetheless shall be reimbursed from the
17 General Fund by the State Department of Developmental Services.

18 (e) The State Department of Health Care Services shall request
19 approval from the federal Centers for Medicare and Medicaid
20 Services for the implementation of this section. The Director of
21 Health Care Services, with the concurrence of the Director of
22 Developmental Services, may alter the methodology specified in
23 this section to the extent necessary to meet the requirements of
24 federal law or regulations or to obtain federal approval. If after
25 seeking federal approval, federal approval is not obtained or federal
26 financial participation is no longer available, this section and
27 Section 4646.55 shall not be implemented or shall become
28 inoperative.

29 SEC. 158. Section 14154 of the Welfare and Institutions Code
30 is amended to read:

31 14154. (a) (1) The department shall establish and maintain a
32 plan whereby costs for county administration of the determination
33 of eligibility for benefits under this chapter will be effectively
34 controlled within the amounts annually appropriated for that
35 administration. The plan, to be known as the County Administrative
36 Cost Control Plan, shall establish standards and performance
37 criteria, including workload, productivity, and support services
38 standards, to which counties shall adhere. The plan shall include
39 standards for controlling eligibility determination costs that are
40 incurred by performing eligibility determinations at county

1 hospitals, or that are incurred due to the outstationing of any other
2 eligibility function. Except as provided in Section 14154.15,
3 reimbursement to a county for outstationed eligibility functions
4 shall be based solely on productivity standards applied to that
5 county's welfare department office. ~~The~~

6 (2) (A) *The plan shall delineate both of the following:*

7 (i) *The process for determining county administration base*
8 *costs, which include salaries and benefits, support costs, and staff*
9 *development.*

10 (ii) *The process for determining funding for caseload changes,*
11 *cost-of-living adjustments, and program and other changes.*

12 (B) *The annual county budget survey document utilized under*
13 *the plan shall be constructed to enable the counties to provide*
14 *sufficient detail to the department to support their budget requests.*

15 (3) *The plan shall be part of a single state plan, jointly developed*
16 *by the department and the State Department of Social Services, in*
17 *conjunction with the counties, for administrative cost control for*
18 *the California Work Opportunity and Responsibility to Kids*
19 *(CalWORKs), Food Stamp, and Medical Assistance (Medi-Cal)*
20 *programs. Allocations shall be made to each county and shall be*
21 *limited by and determined based upon the County Administrative*
22 *Cost Control Plan. In administering the plan to control county*
23 *administrative costs, the department shall not allocate state funds*
24 *to cover county cost overruns that result from county failure to*
25 *meet requirements of the plan. The department and the State*
26 *Department of Social Services shall budget, administer, and*
27 *allocate state funds for county administration in a uniform and*
28 *consistent manner.*

29 (4) *The department and county welfare departments shall*
30 *develop procedures to ensure the data clarity, consistency, and*
31 *reliability of information contained in the county budget survey*
32 *document submitted by counties to the department. These*
33 *procedures shall include the format of the county budget survey*
34 *document and process, data submittal and its documentation, and*
35 *the use of the county budget survey documents for the development*
36 *of determining county administration costs. Communication*
37 *between the department and the county welfare departments shall*
38 *be ongoing as needed regarding the content of the county budget*
39 *surveys and any potential issues to ensure the information is*
40 *complete and well understood by involved parties. Any changes*

1 *developed pursuant to this section shall be incorporated within*
2 *the state's annual budget process by no later than the 2011–12*
3 *fiscal year.*

4 (5) *The department shall provide a clear narrative description*
5 *along with fiscal detail in the Medi-Cal estimate package,*
6 *submitted to the Legislature in January and May of each year, of*
7 *each component of the county administrative funding for the*
8 *Medi-Cal program. This shall describe how the information*
9 *obtained from the county budget survey documents was utilized*
10 *and, where applicable, modified and the rationale for the changes.*

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

16 (c) (1) The Legislature finds and declares that in order for
17 counties to do the work that is expected of them, it is necessary
18 that they receive adequate funding, including adjustments for
19 reasonable annual cost-of-doing-business increases. The Legislature
20 further finds and declares that linking appropriate funding for
21 county Medi-Cal administrative operations, including annual
22 cost-of-doing-business adjustments, with performance standards
23 will give counties the incentive to meet the performance standards
24 and enable them to continue to do the work they do on behalf of
25 the state. It is therefore the Legislature's intent to provide
26 appropriate funding to the counties for the effective administration
27 of the Medi-Cal program at the local level to ensure that counties
28 can reasonably meet the purposes of the performance measures as
29 contained in this section.

30 (2) It is the intent of the Legislature to not appropriate funds for
31 the cost-of-doing-business adjustment for the 2008–09–~~and,~~
32 2009–10, *and 2010–11* fiscal years.

33 (d) The department is responsible for the Medi-Cal program in
34 accordance with state and federal law. A county shall determine
35 Medi-Cal eligibility in accordance with state and federal law. If
36 in the course of its duties the department becomes aware of
37 accuracy problems in any county, the department shall, within
38 available resources, provide training and technical assistance as
39 appropriate. Nothing in this section shall be interpreted to eliminate
40 any remedy otherwise available to the department to enforce

1 accurate county administration of the program. In administering
2 the Medi-Cal eligibility process, each county shall meet the
3 following performance standards each fiscal year:

4 (1) Complete eligibility determinations as follows:

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

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

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

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

23 (C) Notwithstanding the rulemaking procedures of Chapter 3.5
24 (commencing with Section 11340) of Part 1 of Division 3 of Title
25 2 of the Government Code, the department may implement this
26 section by means of all-county letters or similar instructions,
27 without further regulatory action.

28 (3) Perform timely annual redeterminations, as follows:

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

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

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

1 (D) When a child is determined by the county to change from
2 no share of cost to a share of cost and the child meets the eligibility
3 criteria for the Healthy Families Program established under Section
4 12693.98 of the Insurance Code, the child shall be placed in the
5 Medi-Cal-to-Healthy Families Bridge Benefits Program, and these
6 cases shall be processed as follows:

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

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

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

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

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

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

36 (g) If the department finds that a county is not in compliance
37 with one or more of the standards set forth in this section, the
38 county shall, within 60 days, submit a corrective action plan to the
39 department for approval. The corrective action plan shall, at a
40 minimum, include steps that the county shall take to improve its

1 performance on the standard-~~of~~ *or* standards with which the county
2 is out of compliance. The plan shall establish interim benchmarks
3 for improvement that shall be expected to be met by the county in
4 order to avoid a sanction.

5 (h) (1) If a county does not meet the performance standards for
6 completing eligibility determinations and redeterminations as
7 specified in this section, the department may, at its sole discretion,
8 reduce the allocation of funds to that county in the following year
9 by 2 percent. Any funds so reduced may be restored by the
10 department if, in the determination of the department, sufficient
11 improvement has been made by the county in meeting the
12 performance standards during the year for which the funds were
13 reduced. If the county continues not to meet the performance
14 standards, the department may reduce the allocation by an
15 additional 2 percent for each year thereafter in which sufficient
16 improvement has not been made to meet the performance standards.

17 (2) No reduction of the allocation of funds to a county shall be
18 imposed pursuant to this subdivision for failure to meet
19 performance standards during any period of time in which the
20 cost-of-doing-business increase is suspended.

21 (i) The department shall develop procedures, in collaboration
22 with the counties and stakeholders, for developing instructions for
23 the performance standards established under subparagraph (D) of
24 paragraph (3) of subdivision-~~(e)~~ *(d)*, no later than September 1,
25 2005.

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

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

37 SEC. 159. Section 14165.4 of the Welfare and Institutions
38 Code is amended to read:

39 14165.4. It is the intent of the Legislature that beginning July
40 1, 1983, the functions, powers, and duties contained in Article 2.6

1 (~~commencing with Section 14081), Article 2.8 (commencing with~~
2 ~~Section 14087.5), and Article 2.91 (commencing with Section~~
3 ~~14089)~~ become subject to the provisions contained herein. ~~Between~~
4 ~~January 1, 1983, and July 1, 1983, the commission shall monitor~~
5 ~~and review the activities undertaken pursuant to Article 2.6~~
6 ~~(commencing with Section 14081), Article 2.8 (commencing with~~
7 ~~Section 14087.5), and Article 2.91 (commencing with Section~~
8 ~~14089).~~

9 SEC. 160. Section 14167.351 is added to the Welfare and
10 Institutions Code, to read:

11 14167.351. It is the intent of the Legislature that the funds in
12 the Hospital Quality Assurance Revenue Fund identified pursuant
13 to paragraph (2) of subdivision (c) of Section 14167.35 are to be
14 used to expand and enhance health services for children when the
15 health of the economy and state budget are strong enough to allow
16 for the expansion of children’s health services programs, and strong
17 enough to ensure that these funds supplement, rather than supplant,
18 existing funding for children’s health services during the time that
19 this article is in effect.

20 SEC. 161. Section 14183.6 is added to the Welfare and
21 Institutions Code, to read:

22 14183.6. The department shall enter into an interagency
23 agreement with the Department of Managed Health Care to have
24 the Department of Managed Health Care, on behalf of the
25 department, conduct financial audits, medical surveys, and a review
26 of the provider networks of the managed care health plans
27 participating in the demonstration project. The interagency
28 agreement shall be updated, as necessary, on an annual basis in
29 order to maintain functional clarity regarding the roles and
30 responsibilities of these core activities. The department shall not
31 delegate its authority under this division to the Department of
32 Managed Health Care.

33 SEC. 162. Section 14301.1 of the Welfare and Institutions
34 Code is amended to read:

35 14301.1. (a) For rates established on or after August 1, 2007,
36 the department shall pay capitation rates to health plans
37 participating in the Medi-Cal managed care program using actuarial
38 methods and may establish health-plan- and county-specific rates.
39 The department shall utilize a county- and model-specific rate
40 methodology to develop Medi-Cal managed care capitation rates

1 for contracts entered into between the department and any entity
2 pursuant to Article 2.7 (commencing with Section 14087.3), Article
3 2.8 (commencing with Section 14087.5), and Article 2.91
4 (commencing with Section 14089) of Chapter 7 that includes, but
5 is not limited to, all of the following:

6 (1) Health-plan-specific encounter and claims data.

7 (2) Supplemental utilization and cost data submitted by the
8 health plans.

9 (3) Fee-for-service data for the underlying county of operation
10 or other appropriate counties as deemed necessary by the
11 department.

12 (4) Department of Managed Health Care financial statement
13 data specific to Medi-Cal operations.

14 (5) Other demographic factors, such as age, gender, or
15 diagnostic-based risk adjustments, as the department deems
16 appropriate.

17 (b) To the extent that the department is unable to obtain
18 sufficient actual plan data, it may substitute plan model, similar
19 plan, or county-specific fee-for-service data.

20 (c) The department shall develop rates that include
21 administrative costs, and may apply different administrative costs
22 with respect to separate aid code groups.

23 (d) The department shall develop rates that shall include, but
24 are not limited to, assumptions for underwriting, return on
25 investment, risk, contingencies, changes in policy, and a detailed
26 review of health plan financial statements to validate and reconcile
27 costs for use in developing rates.

28 (e) The department may develop rates that pay plans based on
29 performance incentives, including quality indicators, access to
30 care, and data submission.

31 (f) The department may develop and adopt condition-specific
32 payment rates for health conditions, including, but not limited to,
33 childbirth delivery.

34 (g) (1) Prior to finalizing Medi-Cal managed care capitation
35 rates, the department shall provide health plans with information
36 on how the rates were developed, including rate sheets for that
37 specific health plan, and provide the plans with the opportunity to
38 provide additional supplemental information.

39 (2) For contracts entered into between the department and any
40 entity pursuant to Article 2.8 (commencing with Section 14087.5)

1 of Chapter 7, the department, by June 30 of each year, or, if the
2 budget has not passed by that date, no later than five working days
3 after the budget is signed, shall provide preliminary rates for the
4 upcoming fiscal year.

5 (h) For the purposes of developing capitation rates through
6 implementation of this ratesetting methodology, Medi-Cal managed
7 care health plans shall provide the department with financial and
8 utilization data in a form and substance as deemed necessary by
9 the department to establish rates. This data shall be considered
10 proprietary and shall be exempt from disclosure as official
11 information pursuant to subdivision (k) of Section 6254 of the
12 Government Code as contained in the California Public Records
13 Act (Division 7 (commencing with Section 6250) of Title 1 of the
14 Government Code).

15 (i) The department shall report, upon request, to the fiscal and
16 policy committees of the respective houses of the Legislature
17 regarding implementation of this section.

18 (j) *Prior to October 1, 2011, the risk-adjusted countywide*
19 *capitation rate shall comprise no more than 20 percent of the total*
20 *capitation rate paid to each Medi-Cal managed care plan.*

21 SEC. 163. Section 14301.11 of the Welfare and Institutions
22 Code is amended to read:

23 14301.11. (a) The department shall use funds attributable to
24 the tax on Medi-Cal managed care plans imposed by Section 12201
25 of the Revenue and Taxation Code for the purpose specified in
26 paragraph (1) of subdivision (b) of Section 12201 of the Revenue
27 and Taxation Code.

28 ~~(b) This section shall remain in effect only until January 1, 2011,~~
29 ~~and as of that date is repealed.~~

30 *(b) This section shall become inoperative on July 1, 2011, and,*
31 *as of January 1, 2012, is repealed, unless a later enacted statute,*
32 *that becomes operative on or before January 1, 2012, deletes or*
33 *extends the dates on which it becomes inoperative and is repealed.*

34 SEC. 164. Section 10 of Chapter 13 of the Third Extraordinary
35 Session of the Statutes of 2009, as amended by Section 3 of
36 Chapter 4 of the Eighth Extraordinary Session of the Statutes of
37 2010, is amended to read:

38 Sec. 10. (a) Notwithstanding any other provision of law, in
39 order to implement changes in the level of funding for regional
40 center purchase of services, regional centers shall reduce payments

1 for services and supports provided pursuant to Title 14
2 (commencing with Section 95000) of the Government Code and
3 Division 4.1 (commencing with Section 4400) and Division 4.5
4 (commencing with Section 4500) of the Welfare and Institutions
5 Code. From February 1, 2009, to June 30, ~~2011~~ 2010, inclusive,
6 regional centers shall reduce all payments for these services and
7 supports paid from purchase of services funds for services delivered
8 on or after February 1, 2009, by 3 percent, *and from July 1, 2010,*
9 *to June 30, 2011, inclusive, by 4.25 percent,* unless the regional
10 center demonstrates that a nonreduced payment is necessary to
11 protect the health and safety of the individual for whom the services
12 and supports are proposed to be purchased, and the State
13 Department of Developmental Services has granted prior written
14 approval.

15 (b) Regional centers shall not reduce payments pursuant to
16 subdivision (a) for the following:

17 (1) Supported employment services with rates set by Section
18 4860 of the Welfare and Institutions Code.

19 (2) Services with “usual and customary” rates established
20 pursuant to Section 57210 of Title 17 of the California Code of
21 Regulations.

22 (3) Payments to offset reductions in Supplemental Security
23 Income/State Supplementary Payment (SSI/SSP) benefits for
24 consumers receiving supported and independent living services.

25 (c) Notwithstanding any other provision of law, in order to
26 implement changes in the level of funding appropriated for regional
27 centers, the department shall amend regional center contracts to
28 adjust regional center budgets accordingly for the 2008–09 fiscal
29 year through the 2010–11 fiscal year. The contract amendments
30 and budget adjustments shall be exempt from the provisions of
31 Article 1 (commencing with Section 4620) of Chapter 5 of Division
32 4.5 of the Welfare and Institutions Code.

33 SEC. 165. Due to a change in the availability of federal funding
34 that addresses the ability of California to capture additional federal
35 financial participation for day treatment and transportation services
36 provided to a Medi-Cal beneficiary residing in a licensed
37 intermediate care facility/developmentally disabled-habilitative,
38 a licensed intermediate care facility/developmentally
39 disabled-nursing, or a licensed intermediate care
40 facility/developmental disability, as specified in Sections 4646.55

1 and 14132.925 of the Welfare and Institutions Code, funds
2 appropriated in Item 4300-101-0001 of the Budget Act of 2007
3 (Chapters 171 and 172, Statutes of 2007) shall be available for
4 liquidation until June 30, 2011.

5 SEC. 166. (a) The State Department of Health Care Services
6 shall provide the appropriate fiscal and policy committees of the
7 Legislature, the Legislative Analyst’s Office, the Office of the
8 State Chief Information Officer (OCIO), and the Bureau of State
9 Audits (BSA) with quarterly reports on the transition and takeover
10 progress efforts of the Medi-Cal Fiscal Intermediary Contract.
11 These quarterly reports shall be provided within 30 days of the
12 close of each quarter, commencing July 1, 2010, and continuing
13 throughout the life of the new system implementation project.
14 These quarterly reports shall contain the following information:

15 (1) A project status summary that identifies the progress or key
16 milestones and objectives for the quarter on transition and takeover
17 efforts by the prime contractor and the legacy contractor.

18 (2) A description of whether the project is on budget.

19 (3) Copies of any oversight reports developed by contractors
20 of the department for the California Medicaid Management
21 Information System (CA-MMIS) project and any subsequent
22 responses from the department.

23 (b) Upon request from the Chair of the Joint Legislative Budget
24 Committee (JLBC), the department shall provide updates on the
25 Implementation Advanced Planning Document provided to the
26 federal Centers for Medicare and Medicaid Services pertaining to
27 the CA-MMIS project.

28 (c) The CA-MMIS project shall be subject to the reviews and
29 recommendations of the OCIO. The OCIO shall submit a copy of
30 its reviews and recommendations to the JLBC. In conducting its
31 review, the OCIO shall consult with the department to review the
32 project governance and management framework to ensure that it
33 is best designed for success and will serve as a resource throughout
34 the project implementation.

35 (d) The BSA shall review the appropriate project documents
36 and quarterly reports and make recommendations about the new
37 system implementation project, as necessary. The BSA shall submit
38 a copy of any reviews and recommendations to the JLBC.

1 (e) The Chair of the JLBC may request an audit of the progress
2 of the transition, development, and implementation of the
3 CA-MMIS.

4 SEC. 167. By no later than January 10 and May 14 of each
5 year, the State Department of Public Health shall provide the fiscal
6 committees of the Legislature with an estimate package for the
7 California Special Supplemental Food Program for Women,
8 Infants, and Children (the WIC program). This estimate package
9 shall include all significant assumptions underlying the estimate
10 for the WIC program's current-year and budget-year proposals,
11 and shall contain concise information identifying applicable
12 estimate components, such as caseload, policy changes, federal
13 fund information, manufacturer rebate information, state positions
14 and organization charts, and other assumptions necessary to support
15 the estimate.

16 SEC. 168. By no later than January 10 and May 14 of each
17 year, the State Department of Public Health shall provide the fiscal
18 committees of the Legislature with an estimate package for the
19 Every Woman Counts Program. This estimate package shall
20 include all significant assumptions underlying the estimate for the
21 Every Woman Counts Program's current-year and budget-year
22 proposals, and shall contain concise information identifying
23 applicable estimate components, such as caseload, policy changes,
24 contractor information, special fund and federal fund information,
25 and other assumptions necessary to support the estimate.

26 SEC. 169. The State Department of Public Health shall provide
27 the fiscal and appropriate policy committees of the Legislature
28 with quarterly updates on caseload, estimated expenditures, and
29 related program monitoring data for the Every Woman Counts
30 Program. These updates shall be provided by no later than the 15th
31 day of the month following the end of each quarter of the fiscal
32 year, which would be October 15, January 15, April 15, and August
33 15. The purpose of these updates is to provide the Legislature with
34 the most recent information on the program, and is in response to
35 previously failed efforts by the State Department of Public Health
36 to adequately track, monitor, and report information regarding the
37 Every Woman Counts Program as articulated in two recent audits
38 conducted by the Department of Finance and the Bureau of State
39 Audits in Spring 2010.

1 SEC. 170. By no later than January 10 and May 14 of each
2 year, the State Department of Public Health shall provide the fiscal
3 committees of the Legislature with an estimate package for the
4 Licensing and Certification Program. This estimate package shall
5 include all significant assumptions underlying the estimate for the
6 Licensing and Certification Program, including current-year and
7 budget-year proposals, and shall contain concise information
8 identifying applicable estimate components, such as licensing
9 visits, personnel needs, policy changes, all fund sources, and any
10 other applicable information, including organization charts and
11 other assumptions necessary to support the estimate. This estimate
12 package shall not serve as a replacement for any other reporting
13 requirements regarding Licensing and Certification Program fees.

14 SEC. 171. No later than January 20 of each year, the State
15 Department of Public Health shall provide a vacancy report,
16 effective as of December 1 of the previous calendar year, to the
17 Joint Legislative Budget Committee and the chairs of the fiscal
18 committees of both houses of the Legislature. This report shall
19 identify both filled and vacant positions within the department by
20 center, division, branch, and classification.

21 SEC. 172. (a) The State Department of Health Care Services
22 shall seek support from one or more foundations to support and
23 develop a study or studies of the California Children's Services
24 (CCS) Program to be provided to interested stakeholders and the
25 fiscal and appropriate policy committees of the Legislature by no
26 later than May 2011. Issues to be addressed by these analyses may
27 include the following:

28 (1) Systems analysis of core business processes and practices
29 of the program, including service authorization requests (SARs),
30 requests for durable medical equipment, and reimbursement
31 processing.

32 (2) Review of CCS provider certification and enrollment
33 process.

34 (3) Review of medical eligibility processing.

35 (4) Oversight and monitoring of quality of care.

36 (5) Identification of best practices for case management and
37 care coordination functions, including discharge planning.

38 (6) Opportunities for the use of web-based tools, telemedicine,
39 e-prescribing, and other technologies to reduce costs and to
40 streamline.

1 (b) It is the intent of the Legislature for the study or studies to
2 be used to do all of the following:

3 (1) Administratively streamline the CCS Program.

4 (2) Serve as a tool to facilitate the development of statewide
5 policies and procedures to improve the program.

6 (3) Serve as a baseline for development of CCS Program pilots
7 implemented through the state's Section 1115 Medicaid Waiver.

8 SEC. 173. The State Department of Health Care Services shall
9 provide the fiscal and appropriate policy committees of the
10 Legislature with semiannual updates regarding all of California's
11 Medicaid waivers to be provided in March and October of each
12 year. At a minimum, the semiannual updates shall include a listing
13 of all Medicaid waivers with all of the following information for
14 each waived:

15 (a) Description of what federal laws or regulations are being
16 waived.

17 (b) Description of the purpose of the waiver.

18 (c) Description of whom the waiver serves and the number of
19 enrollees.

20 (d) Status of the waiver, including its expiration date and
21 pending renewal dates where applicable.

22 (e) State plan amendment number listing and date that is
23 applicable to the waiver.

24 (f) Department that administers the program.

25 (g) Any other information deemed useful by the department,
26 including any separate attachments or reports on a particular
27 waiver.

28 SEC. 174. (a) It is the intent of the Legislature, consistent with
29 current law contained in subdivision (e) of Section 1324.21 of the
30 Health and Safety Code, that beginning in the 2010–11 rate year
31 or in any other rate year thereafter, a multilevel facility, as defined
32 in paragraph (1) of subdivision (a) of Section 1324.20 of the Health
33 and Safety Code, may be assessed the amount the facility would
34 be required to pay the department, but shall not be required to pay
35 the quality assurance fee until both of the following occur:

36 (1) Changes to both the quality assurance fee and the rate
37 methodology enacted in the 2010 portion of the 2009–10 Regular
38 Session of the Legislature are approved by the federal Centers for
39 Medicare and Medicaid Services.

1 (2) The State Department of Health Care Services has increased
2 Medi-Cal rates and the increased rates are paid to facilities.

3 (b) A multilevel facility, as defined in paragraph (1) of
4 subdivision (a) of Section 1324.20 of the Health and Safety Code,
5 that has been assessed a fee by the department shall pay the fee
6 assessed within 60 days of the date rates are increased in
7 accordance with Section 1324.28 and paid to the facilities.

8 SEC. 175. No reimbursement is required by this act pursuant
9 to Section 6 of Article XIII B of the California Constitution for
10 certain costs that may be incurred by a local agency or school
11 district because, in that regard, this act creates a new crime or
12 infraction, eliminates a crime or infraction, or changes the penalty
13 for a crime or infraction, within the meaning of Section 17556 of
14 the Government Code, or changes the definition of a crime within
15 the meaning of Section 6 of Article XIII B of the California
16 Constitution.

17 However, if the Commission on State Mandates determines that
18 this act contains other costs mandated by the state, reimbursement
19 to local agencies and school districts for those costs shall be made
20 pursuant to Part 7 (commencing with Section 17500) of Division
21 4 of Title 2 of the Government Code.

22 SEC. 176. This act is an urgency statute necessary for the
23 immediate preservation of the public peace, health, or safety within
24 the meaning of Article IV of the Constitution and shall go into
25 immediate effect. The facts constituting the necessity are:

26 In order to make the necessary statutory changes to implement
27 the Budget Act of 2010, it is necessary that this act take effect
28 immediately.

29 ~~SECTION 1. It is the intent of the Legislature to enact statutory~~
30 ~~changes relating to the Budget Act of 2010.~~