Assembly Bill No. 102

CHAPTER 29

An act to amend Sections 12693.55, 12696.05, 12697.10, 12698, and 12698.26 of, and to repeal Sections 12695.04 and 12696.5 of, the Insurance Code, to amend Sections 14017.7, 14105.18, 14105.28, 14105.191, 14105.192, 14105.45, 14105.451, 14105.455, 14154, and 14165 of, to add Sections 14011.78, 14301.4, and 15916 to, and to add Chapter 8.9 (commencing with Section 14700) to Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor June 28, 2011. Filed with Secretary of State June 29, 2011.]

LEGISLATIVE COUNSEL'S DIGEST

AB 102, Committee on Budget. Health.

(1) Existing law creates the Healthy Families Program and the Access for Infants and Mothers Program, which are administered by the Managed Risk Medical Insurance Board, to provide specified health care coverage to individuals that meet prescribed eligibility requirements. Existing law requires a person to be a resident of the state for at least 6 continuous months prior to application to the Access for Infants and Mothers Program. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. Existing law authorizes the board to negotiate contracts or enter interagency agreements with entities that are not participating plans, such as the department, to provide or pay for benefits to subscribers of the Healthy Families Program or the Access for Infants and Mothers Program.

This bill would delete the 6-month residency requirement. This bill would authorize the department to contract with public or private entities, or utilize existing health care service provider payment mechanisms, in order to implement these provisions, and would make conforming changes.

(2) Existing law requires the Managed Risk Medical Insurance Board to appoint a 7-member Access for Infants and Mothers Advisory Panel. Existing law requires the board to provide for the transfer of coverage of a subscriber of the Access for Infants and Mothers Program to another participating health plan if a subscriber's coverage under his or her plan is canceled or not renewed.

This bill would delete this requirement and would repeal the provisions establishing the Access for Infants and Mothers Advisory Board.

(3) Existing law requires the department, no later than June 30, 2014, and subject to federal approval, to develop and implement a Medi-Cal

payment methodology based on diagnosis-related groups that reflects the costs and staffing levels associated with quality of care for patients in all general acute care hospitals, as specified. Existing law also establishes the California Medical Assistance Commission in the Governor's office for the purpose of contracting with health care delivery systems for the provision of health care services to recipients under the Medi-Cal program.

This bill would require that the payment methodology be implemented on July 1, 2012, or upon the date the Director of Health Care Services executes a specified declaration, whichever is later. This bill would also require the California Medical Assistance Commission to be dissolved after June 30, 2012, that all powers, duties, and responsibilities of the commission be transferred to the director, and that on or before July 1, 2012, staff positions serving the commission, including the executive director, be transferred to the department. This bill would further provide that upon a finding by the director that the payment methodology has been designed and implemented and is sufficient to replace the contract-based payment system, as performed by the commission, the powers, duties, and responsibilities transferred to the director shall no longer be exercised.

(4) Existing law requires, except as otherwise provided, Medi-Cal provider payments to be reduced by 1% or 5%, and provider payments for specified non-Medi-Cal programs to be reduced by 1% for dates of service on and after March 1, 2009, and until June 1, 2011. For dates of service on and after June 1, 2011, existing law requires, except as provided, that these provider payments be reduced by 10%.

This bill would, instead, require that the 1% and 5% reductions cease to be implemented when and to the extent that federal approval is obtained for one or more specified payment reductions and adjustments, including, but not limited to, the 10% provider payment reductions.

(5) Existing law requires the reimbursement to Medi-Cal pharmacy providers for legend and nonlegend drugs, as defined, to consist of the estimated acquisition cost of the drug, as defined, plus a professional fee for dispensing. Existing law requires the estimated acquisition cost for specified legend and nonlegend drugs to be equal to the lowest of the average wholesale price minus 17%, the selling price, the federal upper limit, or the maximum allowable ingredient cost.

This bill would, instead, require that reimbursement to Medi-Cal pharmacy providers for legend and nonlegend drugs shall not exceed the lowest of the estimated acquisition cost of the drug plus a professional fee for dispensing or the pharmacy's usual and customary charge, as defined. This bill would also modify the way in which reimbursement is calculated by permitting the estimated acquisition cost to be equal to the average acquisition cost, as defined.

(6) Existing law requires the department to establish and maintain the County Administrative Cost Control Plan to control costs for county administration of the determination of eligibility for benefits under the Medi-Cal program.

This bill would, instead, require the department to develop and implement, in consultation with county program and fiscal representatives, a new budgeting methodology to reimburse counties for eligibility determinations for applicants for and beneficiaries of the Medi-Cal program.

(7) 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.

This bill would, to the extent permitted by federal law, authorize a transferring entity, as defined, to make an intergovernmental transfer (IGT) to the state, and would authorize the department to accept all IGTs from a transferring entity, for the purposes of providing support for the nonfederal share of risk-based payments to managed care health plans, as defined, to compensate providers designated by the transferring entity for Medi-Cal health care services and for the support of the Medi-Cal program. This bill would require the state to assess a fee of 20% on each IGT the state accepts pursuant to these provisions to reimburse the department for the administrative costs associated with implementing these provisions and for the support of the Medi-Cal program. This bill would require that these provisions be implemented on July 1, 2011, or the date on which all necessary federal approvals have been received, whichever is later.

(8) Under existing law, the State Department of Mental Health is required to implement mental health care services, as specified, for Medi-Cal recipients.

This bill would, effective July 1, 2012, require that the state administrative functions for the operation of Medi-Cal specialty mental health managed care and the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, and applicable functions related to federal Medicaid requirements that were performed by the State Department of Mental Health be transferred to the department. This bill would require the department, in collaboration with the State Department of Mental Health and the California Health and Human Services Agency, to create a transition plan to be provided, as prescribed, to the fiscal and appropriate policy committees of the Legislature no later than October 1, 2011, or May 15, 2012, as applicable.

(9) Existing law requires the department to seek a demonstration project or federal waiver of Medicaid law to implement specified objectives, which may include better care coordination for seniors, persons with disabilities, and children with special health care needs. Existing law provides for the Health Care Coverage Initiative (HCCI), which is a federal waiver demonstration project established to expand health care coverage to low-income uninsured individuals who are not currently eligible for the Medi-Cal program, the Healthy Families Program, or the Access for Infants and Mothers Program. Existing law also requires the department, on or after November 1, 2010, but no later than March 1, 2011, or 180 days after federal approval of the demonstration project, to authorize the provision of scheduled health care benefits for uninsured adults, as specified.

This bill would require the department to annually seek authority from the federal Centers for Medicare and Medicaid Services under the Special

Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration to redirect HCCI funds within the safety net care pool, as defined, that are not fully utilized by the end of a demonstration year, as defined, to the category of uncompensated care to be used by designated public hospitals, on a voluntary basis, for allowable certified public expenditures, as specified.

(10) This bill would appropriate $1,000 from the General Fund to the State Department of Health Care Services for administration.

(11) This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.

Appropriation: yes.

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

SECTION 1. Section 12693.55 of the Insurance Code is amended to read:

12693.55. (a) A health care provider who is furnished documentation of a person's enrollment in the program shall not seek reimbursement nor attempt to obtain payment for any covered services provided to that person other than from the participating health plan covering that person or from other entities that the board enters into contracts or interagency agreements with to provide or pay for benefits under this part pursuant to Section 12693.26.

(b) The provisions of subdivision (a) do not apply to any copayments required under this part for the covered services provided to the person.

(c) For purposes of this section, "health care provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

SEC. 2. Section 12695.04 of the Insurance Code is repealed.

SEC. 3. Section 12696.05 of the Insurance Code is amended to read:

12696.05. The board may do all of the following:

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

(b) Determine the eligibility of applicants.

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

(d) Determine subscriber contribution amounts schedules.

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

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

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

(e) Provide coverage through participating health plans or through coordination with other state programs, including, but not limited to, through interagency agreements with the State Department of Health Care Services to provide or pay for benefits to subscribers under this part, and contract for the processing of applications and the enrollment of subscribers. Any contract entered into pursuant to this part shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The board shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on projected and actual subscriber enrollments in a total amount not to exceed the amount appropriated for the program.

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

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

(h) Issue rules and regulations as necessary to administer the program.

(1) All rules and regulations issued pursuant to this subdivision that manage program integrity, revise the benefit package, or reduce the eligibility criteria below 300 percent of the federal poverty level may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety, or general welfare. The regulations shall become effective immediately upon filing with the Secretary of State.

(2) During the 2011–12, 2012–13, and 2013–14 fiscal years, the adoption and readoption of regulations pursuant to this part shall be deemed to be an emergency that calls for immediate action to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that the board describe facts showing the need for immediate action and from review by the Office of Administrative Law.

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

SEC. 4. Section 12696.5 of the Insurance Code is repealed.

SEC. 5. Section 12697.10 of the Insurance Code is amended to read:

12697.10. The board shall include, within contracts negotiated pursuant to this part, terms regarding the cancellation of the contracts, and may cancel any contract negotiated pursuant to this part with any participating health plan as provided for in the contract.

SEC. 6. Section 12698 of the Insurance Code is amended to read:

12698. To be eligible to participate in the program, a person shall meet all of the following requirements:

(a) Be a resident of the state. A person who is a member of a federally recognized California Indian tribe is a resident of the state for these purposes.

(b) (1) Until the first day of the second month following the effective date of the amendment made to this subdivision in 1994, have a household income that does not exceed 250 percent of the official federal poverty level unless the board determines that the program funds are adequate to serve households above that level.

(2) Upon the first day of the second month following the effective date of the amendment made to this subdivision in 1994, have a household income that is above 200 percent of the official federal poverty level but does not exceed 250 percent of the official federal poverty level unless the board determines that the program funds are adequate to serve households above the 250 percent of the official federal poverty level.

(c) Pay an initial subscriber contribution of not more than fifty dollars ($50), and agree to the payment of the complete subscriber contribution. A federally recognized California Indian tribal government may make the initial and complete subscriber contributions on behalf of a member of the tribe only if a contribution on behalf of members of federally recognized California Indian tribes does not limit or preclude federal financial participation under Title XXI of the Social Security Act. If a federally recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health plan options available in the county where the member resides.

SEC. 7. Section 12698.26 of the Insurance Code is amended to read:

12698.26. (a) A health care provider who is furnished documentation of a subscriber's enrollment in the program shall not seek reimbursement nor attempt to obtain payment for any covered services provided to that subscriber other than from the participating health plan covering the subscriber or from other entities that the board enters into contracts or interagency agreements with to provide or pay for benefits under this part pursuant to subdivision (e) of Section 12696.05.

(b) The provisions of subdivision (a) do not apply to any copayments required under this part for the covered services provided to the subscriber.

(c) For purposes of this section, "health care provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

SEC. 8. Section 14011.78 is added to the Welfare and Institutions Code, to read:

14011.78. (a) The department may contract with public or private entities, or utilize existing health care service provider payment mechanisms, including the Medi-Cal program's fiscal intermediary, in order to implement subdivision (b) of Section 12693.26 and subdivision (e) of Section 12696.05 of the Insurance Code, only if services provided under those sections are specifically identified and reimbursed in a manner that appropriately claims federal financial reimbursement.

(b) Contracts under this section, including the Medi-Cal fiscal intermediary contract, and including any contract amendment, any system change pursuant to a change order, and any project or systems development notice, shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and any policies, procedures, or regulations authorized by these laws.

SEC. 9. Section 14017.7 of the Welfare and Institutions Code is amended to read:

14017.7. (a) In addition to the issuance of Medi-Cal cards, pursuant to Section 14017.8, the department may issue a benefits identification card for the purpose of identifying an individual who has been determined eligible for health care benefits under this chapter or health care benefits under another health care program administered by the department, or both.

(b) The department may also issue a benefits identification card for the purpose of identifying an individual who has been determined eligible to receive health care services from a Medi-Cal provider under one of the following programs:

(1) The Healthy Families Program under Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(2) The Access for Infants and Mothers Program under Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code.

(c) In no event shall a benefits identification card be issued to an individual described in subdivision (a) or (b) unless appropriate and adequate safeguards have been implemented to ensure all of the following:

(1) If the individual has been determined eligible for health care benefits under another health care program administered by the department or a program identified in subdivision (b), that health care program pays for any and all health care benefits delivered to the individual by that health care program.

(2) State funds appropriated to or federal Medicaid financial participation claimed by the Medi-Cal program shall only be used for the delivery of health care benefits authorized pursuant to this chapter.

(d) The individual described in subdivision (a) or (b) may present the benefits identification card to obtain health care benefits for which that individual has been determined eligible under this chapter, or health care benefits under another health care program administered by the department or a program identified in subdivision (b), or all of them.

(e) Where applicable, all laws, regulations, restrictions, conditions, and terms of participation regarding the possession, billing, and use of Medi-Cal cards shall also apply to a benefits identification card.

(f) For the purposes of this section, “benefits” includes medically necessary services, goods, supplies, or merchandise.

SEC. 10. Section 14105.18 of the Welfare and Institutions Code is amended to read:

14105.18. (a) Notwithstanding any other provision of law, provider rates of payment for services rendered in all of the following programs shall

be identical to the rates of payment for the same service performed by the same provider type pursuant to the Medi-Cal program.

(1) The California Children's Services Program established pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code.

(2) The Genetically Handicapped Person's Program established pursuant to Article 1 (commencing with Section 125125) of Chapter 2 of Part 5 of Division 106 of the Health and Safety Code.

(3) The Breast and Cervical Cancer Early Detection Program established pursuant to Article 1.3 (commencing with Section 104150) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code and the breast cancer programs specified in Section 30461.6 of the Revenue and Taxation Code.

(4) The State-Only Family Planning Program established pursuant to Division 24 (commencing with Section 24000).

(5) The Family Planning, Access, Care, and Treatment (Family PACT) Program established pursuant to subdivision (aa) of Section 14132.

(6) The Healthy Families Program established pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code if the health care services are provided by a Medi-Cal provider.

(7) The Access for Infants and Mothers Program established pursuant to Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code if the health care services are provided by a Medi-Cal provider.

(b) The director may identify in regulations other programs not listed in subdivision (a) in which providers shall be paid rates of payment that are identical to the rates of payments in the Medi-Cal program pursuant to subdivision (a).

(c) Notwithstanding subdivision (a), services provided under any of the programs described in subdivisions (a) and (b) may be reimbursed at rates greater than the Medi-Cal rate that would otherwise be applicable if those rates are adopted by the director in regulations.

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

SEC. 11. Section 14105.28 of the Welfare and Institutions Code is amended to read:

14105.28. (a) It is the intent of the Legislature to design a new Medi-Cal inpatient hospital reimbursement methodology based on diagnosis-related groups that more effectively ensures all of the following:

(1) Encouragement of access by setting higher payments for patients with more serious conditions.

(2) Rewards for efficiency by allowing hospitals to retain savings from decreased length of stays and decreased costs per day.

(3) Improvement of transparency and understanding by defining the "product" of a hospital in a way that is understandable to both clinical and financial managers.

(4) Improvement of fairness so that different hospitals receive similar payment for similar care and payments to hospitals are adjusted for significant cost factors that are outside the hospital's control.

(5) Encouragement of administrative efficiency and minimizing administrative burdens on hospitals and the Medi-Cal program.

(6) That payments depend on data that has high consistency and credibility.

(7) Simplification of the process for determining and making payments to the hospitals.

(8) Facilitation of improvement of quality and outcomes.

(9) Facilitation of implementation of state and federal provisions related to hospital acquired conditions.

(10) Support of provider compliance with all applicable state and federal requirements.

(b) (1) (A) (i) The department shall 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 in state and out of state, including Medicare critical access hospitals, but excluding public hospitals, psychiatric hospitals, and rehabilitation hospitals, which include alcohol and drug rehabilitation hospitals.

(ii) The payment methodology developed pursuant to this section shall be implemented on July 1, 2012, or on the date upon which the director executes a declaration certifying that all necessary federal approvals have been obtained and the methodology is sufficient for formal implementation, whichever is later.

(B) The diagnosis-related group-based payments shall apply to all claims, except claims for psychiatric inpatient days, rehabilitation inpatient days, managed care inpatient days, and swing bed stays for long-term care services, provided, however, that psychiatric and rehabilitation inpatient days shall be excluded regardless of whether the stay was in a distinct-part unit. The department may exclude or include other claims and services as may be determined during the development of the payment methodology.

(C) Implementation of the new payment methodology shall be coordinated with the development and implementation of the replacement Medicaid Management Information System pursuant to the contract entered into pursuant to Section 14104.3, effective on May 3, 2010.

(2) The department shall evaluate alternative diagnosis-related group algorithms for the new Medi-Cal reimbursement system for the hospitals to which paragraph (1) applies. The evaluation shall include, but not be limited to, consideration of all of the following factors:

(A) The basis for determining diagnosis-related group base price, and whether different base prices should be used taking into account factors such as geographic location, hospital size, teaching status, the local hospital wage area index, and any other variables that may be relevant.

(B) Classification of patients based on appropriate acuity classification systems.

(C) Hospital case mix factors.

(D) Geographic or regional differences in the cost of operating facilities and providing care.

(E) Payment models based on diagnosis-related groups used in other states.

(F) Frequency of grouper updates for the diagnosis-related groups.

(G) The extent to which the particular grouping algorithm for the diagnosis-related groups accommodates ICD-10 diagnosis and procedure codes, and applicable requirements of the federal Health Insurance Portability and Accountability Act of 1996.

(H) The basis for calculating relative weights for the various diagnosis-related groups.

(I) Whether policy adjusters should be used, for which care categories they should be used, and the frequency of updates to the policy adjusters.

(J) The extent to which the payment system is budget neutral and can be expected to result in state budget savings in future years.

(K) Other factors that may be relevant to determining payments, including, but not limited to, add-on payments, outlier payments, capital payments, payments for medical education, payments in the case of early transfers of patients, and payments based on performance and quality of care.

(c) The department shall submit to the Legislature a status report on the implementation of this section on April 1, 2011, April 1, 2012, April 1, 2013, and April 1, 2014.

(d) The alternatives for a new system described in paragraph (2) of subdivision (b) shall be developed in consultation with recognized experts with experience in hospital reimbursement, economists, the federal Centers for Medicare and Medicaid Services, and other interested parties.

(e) In implementing this section, the department may contract, as necessary, on a bid or nonbid basis, for professional consulting services from nationally recognized higher education and research institutions, or other qualified individuals and entities not associated with a particular hospital or hospital group, with demonstrated expertise in hospital reimbursement systems. The rate setting system described in subdivision (b) shall be developed with all possible expediency. This subdivision establishes an accelerated process for issuing contracts pursuant to this section and contracts entered into pursuant to this subdivision shall be exempt from the requirements of Chapter 1 (commencing with Section 10100) and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(f) (1) The department may adopt emergency regulations to implement the provisions of this section in accordance with rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Initial emergency regulations and the one readoption of those regulations shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of those

regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations.

(2) As an alternative to paragraph (1), and notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, or any other provision of law, the department may implement and administer this section by means of provider bulletins, all-county letters, manuals, or other similar instructions, without taking regulatory action. The department shall notify the fiscal and appropriate policy committees of the Legislature of its intent to issue a provider bulletin, all-county letter, manual, or other similar instruction, at least five days prior to issuance. In addition, the department shall provide a copy of any provider bulletin, all-county letter, manual, or other similar instruction issued under this paragraph to the fiscal and appropriate policy committees of the Legislature.

SEC. 12. Section 14105.191 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

(C) Rural swing-bed facilities.

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

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

(F) Adult day health care centers.

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

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

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

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

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

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

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

(3) Rural health clinic services.

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

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

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

(7) Hospice services.

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

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

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

(11) Payments to Medi-Cal managed care plans pursuant to Section 4474.5 for services to consumers transitioning from Agnews Developmental

Center into the Counties of Alameda, San Mateo, and Santa Clara pursuant to the Plan for the Closure of Agnews Developmental Center.

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

(13) The Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to subdivision (aa) of Section 14132.

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

(e) Subject to the exemptions listed in subdivision (d), the payment reductions required by paragraph (1) of subdivision (b) shall apply to the benefits rendered by any provider who may be authorized to bill for provision of the benefit, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse midwives, nurse anesthetists, and organized outpatient clinics.

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

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

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

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

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

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

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

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

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

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

SEC. 13. Section 14105.192 of the Welfare and Institutions Code is amended to read:

14105.192. (a) The Legislature finds and declares the following:

(1) Costs within the Medi-Cal program continue to grow due to the rising cost of providing health care throughout the state and also due to increases in enrollment, which are more pronounced during difficult economic times.

(2) In order to minimize the need for drastically cutting enrollment standards or benefits during times of economic crisis, it is crucial to find areas within the program where reimbursement levels are higher than required under the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and can be reduced in accordance with federal law.

(3) The Medi-Cal program delivers its services and benefits to Medi-Cal beneficiaries through a wide variety of health care providers, some of which deliver care via managed care or other contract models while others do so through fee-for-service arrangements.

(4) The setting of rates within the Medi-Cal program is complex and is subject to close supervision by the United States Department of Health and Human Services.

(5) As the single state agency for Medicaid in California, the department has unique expertise that can inform decisions that set or adjust reimbursement methodologies and levels consistent with the requirements of federal law.

(b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and consistent with federal and state law and policies, including any exemptions contained in the provisions of the act that added this section, provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services and products.

(c) Notwithstanding any other provision of law, the director shall adjust provider payments, as specified in this section.

(d) (1) Except as otherwise provided in this section, payments shall be reduced by 10 percent for Medi-Cal fee-for-service benefits for dates of service on and after June 1, 2011.

(2) For managed health care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except contracts with Senior Care Action Network and AIDS Healthcare Foundation, payments shall be reduced by the actuarial equivalent amount of the payment reductions specified in this section pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.

(3) Payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after June 1, 2011. This paragraph shall not apply

to inpatient hospital services provided in a hospital that is paid under contract pursuant to Article 2.6 (commencing with Section 14081).

(4) (A) Notwithstanding any other provision of law, the director may adjust the payments specified in paragraphs (1) and (3) of this subdivision with respect to one or more categories of Medi-Cal providers, or for one or more products or services rendered, or any combination thereof, so long as the resulting reductions to any category of Medi-Cal providers, in the aggregate, total no more than 10 percent.

(B) The adjustments authorized in subparagraph (A) shall be implemented only if the director determines that, for each affected product, service or provider category, the payments resulting from the adjustment comply with subdivision (m).

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

(f) Notwithstanding any other provision of this section, the following shall apply:

(1) Payments to providers that are paid pursuant to Article 3.8 (commencing with Section 14126) shall be governed by that article.

(2) (A) Subject to subparagraph (B), for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates for intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, as determined by the applicable methodology for setting reimbursement rates for these facilities, shall not exceed the reimbursement rates that were applicable to providers in the 2008–09 rate year.

(B) (i) If Section 14105.07 is added to the Welfare and Institutions Code during the 2011–12 Regular Session of the Legislature, subparagraph (A) shall become inoperative.

(ii) If Section 14105.07 is added to the Welfare and Institutions Code during the 2011–12 Regular Session of the Legislature, then for dates of service on and after June 1, 2011, payments to intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, shall be governed by the applicable methodology for setting reimbursement rates for these facilities and by Section 14105.07.

(g) The department may enter into contracts with a vendor for the purposes of implementing this section on a bid or nonbid basis. In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this subdivision is necessary. Therefore, contracts entered into to implement this section and all contract amendments and

change orders shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 Division 2 of the Public Contract Code.

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

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

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

(3) Rural health clinic services.

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

(5) Hospice services.

(6) Contract services, as designated by the director pursuant to subdivision (k).

(7) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations. This paragraph shall apply to payments described in paragraph (3) of subdivision (d) only to the extent that they are also exempt from reduction pursuant to subdivision (*l*).

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

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

(10) The Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to subdivision (aa) of Section 14132.

(i) Subject to the exception for services listed in subdivision (h), the payment reductions required by subdivision (d) shall apply to the benefits rendered by any provider who may be authorized to bill for the service, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse-midwives, nurse anesthetists, and organized outpatient clinics.

(j) Notwithstanding any other provision of law, for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates applicable to the following classes of providers shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008–09 rate year, as described in subdivision (f) of Section 14105.191, reduced by 10 percent:

(1) Intermediate care facilities, excluding those facilities identified in paragraph (2) of subdivision (f). For purposes of this section, “intermediate care facility” has the same meaning as defined in Section 51118 of Title 22 of the California Code of Regulations.

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

(3) Rural swing-bed facilities.

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

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

(6) Adult day health care centers.

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

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

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

(m) Notwithstanding any other provision of this section, the payment reductions and adjustments provided for in subdivision (d) shall be implemented only if the director determines that the payments that result from the application of this section will comply with applicable federal Medicaid requirements and that federal financial participation will be available.

(1) In determining whether federal financial participation is available, the director shall determine whether the payments comply with applicable federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(2) To the extent that the director determines that the payments do not comply with the federal Medicaid requirements or that federal financial participation is not available with respect to any payment that is reduced pursuant to this section, the director retains the discretion to not implement the particular payment reduction or adjustment and may adjust the payment as necessary to comply with federal Medicaid requirements.

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

(o) (1) The payment reductions and adjustments set forth in this section shall not be implemented until federal approval is obtained.

(2) To the extent that federal approval is obtained for one or more of the payment reductions and adjustments in this section and Section 14105.07, the payment reductions and adjustments set forth in Section 14105.191 shall

cease to be implemented for the same services provided by the same class of providers. In the event of a conflict between this section and Section 14105.191, other than the provisions setting forth a payment reduction or adjustment, this section shall govern.

(3) When federal approval is obtained, the payments resulting from the application of this section shall be implemented retroactively to June 1, 2011, or on any other date or dates as may be applicable.

(4) The director may clarify the application of this subdivision by means of provider bulletins or similar instructions, pursuant to subdivision (k).

(p) Adjustments to pharmacy drug product payment pursuant to this section shall no longer apply when the department determines that the average acquisition cost methodology pursuant to Section 14105.45 has been fully implemented and the department's pharmacy budget reduction targets, consistent with payment reduction levels pursuant to this section, have been met.

SEC. 14. Section 14105.45 of the Welfare and Institutions Code is amended to read:

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

(1) "Average acquisition cost" means the average weighted cost determined by the department to represent the actual acquisition cost paid for drugs by Medi-Cal pharmacy providers, including those that provide specialty drugs. The average acquisition cost shall not be considered confidential and shall be subject to disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(2) "Average manufacturers price" means the price reported to the department by the federal Centers for Medicare and Medicaid Services pursuant to Section 1927 of the Social Security Act (42 U.S.C. Sec. 1396r-8).

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

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

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

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

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

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

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

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

(11) "Pharmacy warehouse," as defined in Section 4163 of the Business and Professions Code, means a physical location licensed as a wholesaler for prescription drugs that acts as a central warehouse and performs intracompany sales or transfers of those drugs to a group of pharmacies under common ownership and control.

(12) "Specialty drugs" means drugs determined by the department pursuant to subdivision (f) of Section 14105.3 to generally require special handling, complex dosing regimens, specialized self-administration at home by a beneficiary or caregiver, or specialized nursing facility services, or may include extended patient education, counseling, monitoring, or clinical support.

(13) "Volume weighted average" means the aggregated average volume for a group of legend or nonlegend drugs, weighted by each drug's percentage of the group's total volume in the Medi-Cal fee-for-service program during the previous six months. For purposes of this paragraph, volume is based on the standard billing unit used for the legend or nonlegend drugs.

(14) "Wholesaler" means a drug wholesaler that is engaged in wholesale distribution of prescription drugs to retail pharmacies in California.

(15) "Wholesaler acquisition cost" means the price for a drug product listed as the wholesaler acquisition cost in the department's primary price reference source.

(b) (1) Reimbursement to Medi-Cal pharmacy providers for legend and nonlegend drugs shall not exceed the lowest of either of the following:

(A) The estimated acquisition cost of the drug plus a professional fee for dispensing.

(B) The pharmacy's usual and customary charge as defined in Section 14105.455.

(2) The professional fee shall be seven dollars and twenty-five cents ($7.25) per dispensed prescription. The professional fee for legend drugs dispensed to a beneficiary residing in a skilled nursing facility or intermediate care facility shall be eight dollars ($8) per dispensed prescription. For purposes of this paragraph "skilled nursing facility" and "intermediate care facility" shall have the same meaning as defined in Division 5 (commencing with Section 70001) of Title 22 of the California Code of Regulations. If the department determines that a change in dispensing fee is necessary pursuant to this section, the department shall establish the new dispensing fee through the budget process and implement the new dispensing fee pursuant to subdivision (d).

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

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

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

(C) Average wholesale price shall not be used to establish the estimated acquisition cost once the department has determined that the average acquisition cost methodology has been fully implemented.

(4) For purposes of paragraph (3), the department shall establish a list of MAICs for generically equivalent drugs, which shall be published in pharmacy provider bulletins and manuals. The department shall establish a MAIC only when three or more generically equivalent drugs are available for purchase and dispensing by retail pharmacies in California. The department shall update the list of MAICs and establish additional MAICs in accordance with all of the following:

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

(B) If average manufacturer prices are unavailable, the department shall establish the MAIC in one of the following ways:

(i) Based on the volume weighted average of wholesaler acquisition costs of drugs generically equivalent to the particular innovator drug plus a percent markup determined by the department to be necessary for the MAIC to represent the average purchase price paid by retail pharmacies in California.

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

(iii) Based on the volume weighted average acquisition cost of drugs generically equivalent to the particular innovator drug adjusted by the department to represent the average purchase price paid by Medi-Cal pharmacy providers.

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

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

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

that are included in the costs of the dispensing shall not be used to determine the average purchase price.

(5) (A) The department may establish the average acquisition cost in one of the following ways:

(i) Based on the volume weighted average acquisition cost adjusted by the department to ensure that the average acquisition cost represents the average purchase price paid by retail pharmacies in California.

(ii) Based on the proposed average acquisition cost as calculated by the vendor pursuant to subparagraph (B).

(iii) Based on a national pricing benchmark obtained from the federal Centers for Medicare and Medicaid Services or on a similar benchmark listed in the department's primary price reference source adjusted by the department to ensure that the average acquisition cost represents the average purchase price paid by retail pharmacies in California.

(B) For the purposes of paragraph (3), the department may contract with a vendor for the purposes of surveying drug price information, collecting data from providers, wholesalers, or drug manufacturers, and calculating a proposed average acquisition cost.

(C) (i) Medi-Cal pharmacy providers shall submit drug price information to the department or a vendor designated by the department for the purposes of establishing the average acquisition cost. The information submitted by pharmacy providers shall include, but not be limited to, invoice prices and all discounts, rebates, and refunds known to the provider that would apply to the acquisition cost of the drug products purchased during the calendar quarter. Pharmacy warehouses shall be exempt from the survey process, but shall provide drug cost information upon audit by the department for the purposes of validating individual pharmacy provider acquisition costs.

(ii) Pharmacy providers that fail to submit drug price information to the department or the vendor as required by this subparagraph shall receive notice that if they do not provide the required information within five working days, they shall be subject to suspension under subdivisions (a) and (c) of Section 14123.

(D) (i) For new drugs or new formulations of existing drugs, where drug price information is unavailable pursuant to clause (i) of subparagraph (C), drug manufacturers and wholesalers shall submit drug price information to the department or a vendor designated by the department for the purposes of establishing the average acquisition cost. Drug price information shall include, but not be limited to, net unit sales of a drug product sold to retail pharmacies in California divided by the total number of units of the drug sold by the manufacturer or wholesaler in a specified period of time determined by the department.

(ii) Drug products from manufacturers and wholesalers that fail to submit drug price information to the department or the vendor as required by this subparagraph may not be a reimbursable benefit of the Medi-Cal program for those manufacturers and wholesalers until the department has established the average acquisition cost for those drug products.

(E) Drug pricing information provided to the department or a vendor designated by the department for the purposes of establishing the average acquisition cost pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(F) Prior to the implementation of an average acquisition cost methodology, the department shall collect data through a survey of pharmacy providers for purposes of establishing a professional fee for dispensing in compliance with federal Medicaid requirements.

(i) The department shall seek stakeholder input on the retail pharmacy factors and elements used for the pharmacy survey relative to both average acquisition costs and dispensing costs. Any adjustment to the dispensing fee shall not exceed the aggregate savings associated with the implementation of the average acquisition cost methodology.

(ii) For drug products provided by pharmacy providers pursuant to subdivision (f) of Section 14105.3, a differential professional fee or payment for services to provide specialized care may be considered as part of the contracts established pursuant to that section.

(G) When the department implements the average acquisition cost methodology, the department shall update the Medi-Cal claims processing system to reflect the average acquisition cost of drugs not later than 30 days after the department has established average acquisition cost pursuant to subparagraph (A).

(H) Notwithstanding any other provision of law, if the department implements average acquisition cost pursuant to clause (i) or (ii) of subparagraph (A), the department shall update actual acquisition costs at least every three months and notify Medi-Cal providers at least 30 days prior to the effective date of any change in an actual acquisition cost.

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

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

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of a provider bulletin or notice, policy letter, or other similar instructions, without taking regulatory action.

(e) The department may enter into contracts with a vendor for the purposes of implementing this section on a bid or nonbid basis. In order to

achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this section is necessary. Therefore, contracts entered into to implement this section, and all contract amendments and change orders, shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(f) (1) The rates provided for in this section shall be implemented only if the director determines that the rates will comply with applicable federal Medicaid requirements and that federal financial participation will be available.

(2) In determining whether federal financial participation is available, the director shall determine whether the rates comply with applicable federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(3) To the extent that the director determines that the rates do not comply with applicable federal Medicaid requirements or that federal financial participation is not available with respect to any rate of reimbursement described in this section, the director retains the discretion not to implement that rate and may revise the rate as necessary to comply with federal Medicaid requirements.

(g) The director shall seek any necessary federal approvals for the implementation of this section.

(h) This section shall not be construed to require the department to collect cost data, to conduct cost studies, or to set or adjust a rate of reimbursement based on cost data that has been collected.

(i) Adjustments to pharmacy drug product payment pursuant to Section 14105.192 shall no longer apply when the department determines that the average acquisition cost methodology has been fully implemented and the department's pharmacy budget reduction targets, consistent with payment reduction levels pursuant to Section 14105.192, have been met.

(j) Prior to implementation of this section, the department shall provide the appropriate fiscal and policy committees of the Legislature with information on the department's plan for implementation of the average acquisition cost methodology pursuant to this section.

SEC. 15. Section 14105.451 of the Welfare and Institutions Code is amended to read:

14105.451. (a) (1) The Legislature finds and declares all of the following:

(A) The United States Department of Health and Human Services has identified the critical need for state Medicaid agencies to establish pharmacy reimbursement rates based on a pricing benchmark that reflects actual acquisition costs.

(B) The Medi-Cal program currently uses a methodology based on average wholesale price (AWP).

(C) Investigations by the federal Office of Inspector General have found that average wholesale price is inflated relative to average acquisition cost.

(2) Therefore, it is the intent of the Legislature to enact legislation by August 1, 2011, that provides for development of a new reimbursement

methodology that will enable the department to achieve savings while continuing to reimburse pharmacy providers in compliance with federal law.

(b) Subject to Section 14105.45, the department may require providers, manufacturers, and wholesalers to submit any data the director determines necessary or useful in preparing for the transition from a methodology based on average wholesale price to a methodology based on actual acquisition cost.

(c) If the AWP ceases to be listed by the department's primary price reference source vendor, the department may direct the fiscal intermediary to establish a process with the primary price reference source vendor to temporarily report the AWP consistent with the definition of AWP in Section 14105.45. If this process is established, it shall be limited in scope and duration, and shall cease when the department has fully implemented the average acquisition cost methodology pursuant to Section 14105.45.

SEC. 16. Section 14105.455 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of a provider bulletin or notice, policy letter, or other similar instructions, without taking regulatory action.

SEC. 17. Section 14154 of the Welfare and Institutions Code is amended to read:

14154. (a) (1) The department shall establish and maintain a plan whereby costs for county administration of the determination of eligibility for benefits under this chapter will be effectively controlled within the amounts annually appropriated for that administration. The plan, to be known as the County Administrative Cost Control Plan, shall establish standards and performance criteria, including workload, productivity, and support services standards, to which counties shall adhere. The plan shall include

standards for controlling eligibility determination costs that are incurred by performing eligibility determinations at county hospitals, or that are incurred due to the outstationing of any other eligibility function. Except as provided in Section 14154.15, reimbursement to a county for outstationed eligibility functions shall be based solely on productivity standards applied to that county's welfare department office.

(2) (A) The plan shall delineate both of the following:

(i) The process for determining county administration base costs, which include salaries and benefits, support costs, and staff development.

(ii) The process for determining funding for caseload changes, cost-of-living adjustments, and program and other changes.

(B) The annual county budget survey document utilized under the plan shall be constructed to enable the counties to provide sufficient detail to the department to support their budget requests.

(3) The plan shall be part of a single state plan, jointly developed by the department and the State Department of Social Services, in conjunction with the counties, for administrative cost control for the California Work Opportunity and Responsibility to Kids (CalWORKs), CalFresh, and Medical Assistance (Medi-Cal) programs. Allocations shall be made to each county and shall be limited by and determined based upon the County Administrative Cost Control Plan. In administering the plan to control county administrative costs, the department shall not allocate state funds to cover county cost overruns that result from county failure to meet requirements of the plan. The department and the State Department of Social Services shall budget, administer, and allocate state funds for county administration in a uniform and consistent manner.

(4) The department and county welfare departments shall develop procedures to ensure the data clarity, consistency, and reliability of information contained in the county budget survey document submitted by counties to the department. These procedures shall include the format of the county budget survey document and process, data submittal and its documentation, and the use of the county budget survey documents for the development of determining county administration costs. Communication between the department and the county welfare departments shall be ongoing as needed regarding the content of the county budget surveys and any potential issues to ensure the information is complete and well understood by involved parties. Any changes developed pursuant to this section shall be incorporated within the state's annual budget process by no later than the 2011–12 fiscal year.

(5) The department shall provide a clear narrative description along with fiscal detail in the Medi-Cal estimate package, submitted to the Legislature in January and May of each year, of each component of the county administrative funding for the Medi-Cal program. This shall describe how the information obtained from the county budget survey documents was utilized and, where applicable, modified and the rationale for the changes.

(6) Notwithstanding any other provision of law, the department shall develop and implement, in consultation with county program and fiscal

representatives, a new budgeting methodology for Medi-Cal county administrative costs. The new budgeting methodology shall be used to reimburse counties for eligibility determinations for applicants and beneficiaries, including one-time eligibility processing and ongoing case maintenance.

(A) The budgeting methodology shall include, but is not limited to, identification of the costs of eligibility determinations for applicants, and the costs of eligibility redeterminations and case maintenance activities for recipients, for different groupings of cases. The groupings of cases shall be based on variations in time and resources needed to conduct eligibility determinations. The calculation of time and resources shall be based on the following factors: complexity of eligibility rules, ongoing eligibility requirements, and other factors as determined appropriate by the department.

(B) The new budgeting methodology shall be clearly described, state the necessary data elements to be collected from the counties, and establish the timeframes for counties to provide the data to the state.

(C) The department may develop a process for counties to phase in the requirements of the new budgeting methodology.

(D) To the extent a county does not submit the requested data pursuant to subparagraph (B), the new budgeting methodology may include a process to use peer-based proxy costs in developing the county budget.

(E) The department shall provide the new budgeting methodology to the legislative fiscal committees by March 1, 2012, and may include the methodology in the May Medi-Cal Local Assistance Estimate, beginning with the May 2012 estimate, for the 2012–13 fiscal year and each fiscal year thereafter.

(F) To the extent that the funding for the county budgets developed pursuant to the new budget methodology is not fully appropriated in any given fiscal year, the department, with input from the counties, shall identify and consider options to align funding and workload responsibilities.

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

(c) (1) The Legislature finds and declares that in order for counties to do the work that is expected of them, it is necessary that they receive adequate funding, including adjustments for reasonable annual cost-of-doing-business increases. The Legislature further finds and declares that linking appropriate funding for county Medi-Cal administrative operations, including annual cost-of-doing-business adjustments, with performance standards will give counties the incentive to meet the performance standards and enable them to continue to do the work they do on behalf of the state. It is therefore the Legislature’s intent to provide appropriate funding to the counties for the effective administration of the Medi-Cal program at the local level to ensure that counties can reasonably meet the purposes of the performance measures as contained in this section.

(2) It is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2008–09, 2009–10, 2010–11, and 2011–12 fiscal years.

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

(1) Complete eligibility determinations as follows:

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

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

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

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

(3) Perform timely annual redeterminations, as follows:

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

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

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

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

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

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

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

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

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

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

(g) If the department finds that a county is not in compliance with one or more of the standards set forth in this section, the county shall, within 60 days, submit a corrective action plan to the department for approval. The corrective action plan shall, at a minimum, include steps that the county shall take to improve its performance on the standard or standards with which the county is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the county in order to avoid a sanction.

(h) (1) If a county does not meet the performance standards for completing eligibility determinations and redeterminations as specified in this section, the department may, at its sole discretion, reduce the allocation of funds to that county in the following year by 2 percent. Any funds so reduced may be restored by the department if, in the determination of the department, sufficient improvement has been made by the county in meeting the performance standards during the year for which the funds were reduced. If the county continues not to meet the performance standards, the department may reduce the allocation by an additional 2 percent for each year thereafter in which sufficient improvement has not been made to meet the performance standards.

(2) No reduction of the allocation of funds to a county shall be imposed pursuant to this subdivision for failure to meet performance standards during any period of time in which the cost-of-doing-business increase is suspended.

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

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

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

(*l*) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any further regulatory action, implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters or similar instructions.

SEC. 18. Section 14165 of the Welfare and Institutions Code is amended to read:

14165. (a) There is hereby created in the Governor's office the California Medical Assistance Commission, for the purpose of contracting with health care delivery systems for the provision of health care services to recipients under the California Medical Assistance program.

(b) Notwithstanding any other provision of law, the commission created pursuant to subdivision (a) shall continue through June 30, 2012, after which, it shall be dissolved and the term of any commissioner serving at that time shall end.

(1) Upon dissolution of the commission, all powers, duties, and responsibilities of the commission shall be transferred to the Director of Health Care Services. These powers, duties, and responsibilities shall include, but are not limited to, those exercised in the operation of the selective provider contracting program pursuant to Article 2.6 (commencing with Section 14081).

(2) On or before July 1, 2012, the position of executive director described in Section 14165.5 and all other staff positions serving the commission shall be transferred to the State Department of Health Care Services. The Department of Health Care Services shall consult with the commission, the Department of Finance, and the Department of Personnel Administration to develop a staff transition plan that will be included in the 2012–13 Governor's Budget. The transition plan shall outline the transition of staff positions serving the commission to the State Department of Health Care Services.

(3) Upon a determination by the director that a payment system based on diagnosis-related groups as described in Section 14105.28 that is sufficient to replace the contract-based payment system described in subdivision (a) has been developed and implemented, the powers, duties, and responsibilities conferred on the commission and transferred to the director shall no longer be exercised.

(4) Protections afforded to the negotiations and contracts of the commission of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) shall be applicable to the negotiations and contracts conducted or entered into pursuant to this section by the State Department of Health Care Services.

(c) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, or any other provision of law, the State Department of Health Care Services may implement and administer this section by means of provider bulletins or other similar instructions, without taking regulatory action. The authority to implement this section as set forth in this subdivision shall include the authority to give notice by provider bulletin or other similar instruction of a determination made pursuant to paragraph (3) of subdivision (b) and to modify or supersede existing regulations in Title 22 of the California Code of Regulations that conflict with implementation of this section.

SEC. 19. Section 14301.4 is added to the Welfare and Institutions Code, to read:

14301.4. (a) It is the intent of the Legislature, to the extent federal financial participation is not jeopardized and consistent with federal law, that the intergovernmental transfers described in this section provide support for the nonfederal share of risk-based payments to managed care health plans to enable those plans to compensate providers designated by the transferring entity for Medi-Cal health care services and for support of the Medi-Cal program.

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

(1) “Intergovernmental transfer” or “IGT” means the transfer of public funds by the transferring entity to the state in accordance with the requirements of this section.

(2) “Managed care health plan” means a Medi-Cal managed care plan contracting with the department under this chapter or Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), or Article 2.91 (commencing with Section 14089) of Chapter 7.

(3) “Public provider” means any provider that is able to certify public expenditures under state and federal Medicaid law.

(4) “Rate range increases” means increases to risk-based payments to managed care health plans to increase the payments from the lower bound of the range determined to be actuarially sound to the upper bound of that range, as determined by the department’s actuaries to take into account the variations in underwriting, risk, return on investment, and contingencies.

(5) "Transferring entity" means a public entity, which may be a city, county, special purpose district, or other governmental unit in the state, regardless of whether the unit of government is also a health care provider, except as prohibited by federal law.

(c) To the extent permitted by federal law, a transferring entity may elect to make an intergovernmental transfer to the state, and the department may accept all intergovernmental transfers from a transferring entity, for the purposes of providing support for the nonfederal share of risk-based payments to managed care health plans to enable those plans to compensate providers designated by the transferring entity for Medi-Cal health care services and for the support of the Medi-Cal program. The transferring entity shall certify to the department that the funds it proposes to transfer satisfy the requirements of this section and are in compliance with all federal rules and regulations.

(d) (1) Pursuant to paragraphs (2), (3), and (4), the state shall, upon acceptance of the IGT described in subdivision (c), assess a fee of 20 percent on each IGT subject to this section to reimburse the department for the administrative costs of operating the IGT program pursuant to this section and for the support of the Medi-Cal program.

(2) The IGTs subject to the fee shall be limited to those made by a transferring entity to provide the nonfederal share of rate range increases.

(3) The 20-percent assessment shall not apply to IGTs designated for increases to risk-based payments to managed care health plans intended to increase reimbursement for designated public providers for purposes of equaling the amount of reimbursement the public provider would have received through certified public expenditures under the fee-for-service payment methodology.

(4) The 20-percent assessment shall not apply to IGTs authorized pursuant to Sections 14168.7 and 14182.15.

(e) Participation in the intergovernmental transfers pursuant to this section is voluntary on the part of the transferring entities for the purposes of all applicable federal laws.

(f) The director shall seek any necessary federal approvals for the implementation of this section.

(g) To the extent that the director determines that the payments made pursuant to this section do not comply with the federal Medicaid requirements, the director retains the discretion to return the IGTs or not accept the IGTs.

(h) This section shall be implemented only to the extent that federal financial participation is not jeopardized.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of policy letters or similar instructions, without taking further regulatory action.

(j) This section shall be implemented on July 1, 2011, or the date on which all necessary federal approvals have been received, whichever is later.

SEC. 20. Chapter 8.9 (commencing with Section 14700) is added to Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Chapter 8.9. Transition of Community-Based Medi-Cal Mental Health

14700. (a) (1) It is the intent of the Legislature to transfer to the State Department of Health Care Services, no later than July 1, 2012, the state administration of Medi-Cal specialty mental health managed care, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, and applicable functions related to federal Medicaid requirements, from the State Department of Mental Health.

(2) It is further the intent of the Legislature for this transfer to occur in an efficient and effective manner, with no unintended interruptions in service delivery to clients and families. This transfer is intended to do all of the following:

(A) Improve access to culturally appropriate community-based mental health services, including a focus on client recovery, social rehabilitation services, and peer support.

(B) Effectively integrate the financing of services, including the receipt of federal funds, to more effectively provide services.

(C) Improve state accountabilities and outcomes.

(D) Provide focused, high-level leadership for behavioral health services within the state administrative structure.

(b) Effective July 1, 2012, the state administrative functions for the operation of Medi-Cal specialty mental health managed care, the EPSDT Program, and applicable functions related to federal Medicaid requirements, that were performed by the State Department of Mental Health shall be transferred to the State Department of Health Care Services. This state administrative transfer shall conform to a state administrative transition plan provided to the fiscal and applicable policy committees of the Legislature as soon as feasible, but no later than October 1, 2011. This state administrative transition plan may also be updated by the Governor and provided to all fiscal and applicable policy committees of the Legislature upon its completion, but no later than May 15, 2012.

(c) All regulations and orders concerning Medi-Cal specialty mental health managed care and the EPSDT Program shall remain in effect and shall be fully enforceable unless and until readopted, amended, or repealed by the State Department of Health Care Services, or until they expire by their own terms.

14701. (a) The State Department of Health Care Services, in collaboration with the State Department of Mental Health and the California Health and Human Services Agency, shall create a state administrative and programmatic transition plan, either as one comprehensive transition plan or separately, to guide the transfer of the Medi-Cal specialty mental health

managed care and the EPSDT Program to the State Department of Health Care Services effective July 1, 2012.

(1) Commencing no later than July 15, 2011, the State Department of Health Care Services, together with the State Department of Mental Health, shall convene a series of stakeholder meetings and forums to receive input from clients, family members, providers, counties, and representatives of the Legislature concerning the transition and transfer of Medi-Cal specialty mental health managed care and the EPSDT Program. This consultation shall inform the creation of a state administrative transition plan and a programmatic transition plan that shall include, but is not limited to, the following components:

(A) Plan shall ensure it is developed in a way that continues access and quality of service during and immediately after the transition, preventing any disruption of services to clients and family members, providers and counties and others affected by this transition.

(B) A detailed description of the state administrative functions currently performed by the State Department of Mental Health regarding Medi-Cal specialty mental health managed care and the EPSDT Program.

(C) Explanations of the operational steps, timelines, and key milestones for determining when and how each function or program will be transferred. These explanations shall also be developed for the transition of positions and staff serving Medi-Cal specialty mental health managed care and the EPSDT Program, and how these will relate to, and align with, positions at the State Department of Health Care Services. The State Department of Health Care Services and the California Health and Human Services Agency shall consult with the Department of Personnel Administration in developing this aspect of the transition plan.

(D) A list of any planned or proposed changes or efficiencies in how the functions will be performed, including the anticipated fiscal and programmatic impacts of the changes.

(E) A detailed organization chart that reflects the planned staffing at the State Department of Health Care Services in light of the requirements of subparagraphs (A) through (C) and includes focused, high-level leadership for behavioral health issues.

(F) A description of how stakeholders were included in the various phases of the planning process to formulate the transition plans and a description of how their feedback will be taken into consideration after transition activities are underway.

(2) The State Department of Health Care Services, together with the State Department of Mental Health and the California Health and Human Services Agency, shall convene and consult with stakeholders at least twice following production of a draft of the transition plans and before submission of transition plans to the Legislature. Continued consultation with stakeholders shall occur in accordance with the requirement in subparagraph (F) of paragraph (1).

(3) The State Department of Health Care Services shall provide the transition plans described in paragraph (1) to all fiscal committees and

appropriate policy committees of the Legislature no later than October 1, 2011. The transition plans may also be updated by the Governor and provided to all fiscal and applicable policy committees of the Legislature upon its completion, but no later than May 15, 2012.

SEC. 21. Section 15916 is added to the Welfare and Institutions Code, to read:

15916. (a) It is the intent of the Legislature that the State Department of Health Care Services and all other departments take all appropriate steps to fully maximize and claim all available expenditures for Designated State Health Programs listed in the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration under the safety net care pool (SNCP) for an applicable demonstration year.

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

(1) "California's Bridge to Reform Section 1115(a) Demonstration" means the Section 1115(a) Medicaid demonstration project, No. 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services (CMS), effective for the period of November 1, 2010, through October 31, 2015.

(2) "Demonstration year" means a specific period of time during California's Bridge to Reform Section 1115(a) Wavier as identified in the Special Terms and Conditions.

(3) "Designated public hospital" has the meaning given in subdivision (d) of Section 14166.1.

(4) "Excess certified public expenditures" means the amount of allowable uncompensated care expenditures reported and certified for the applicable demonstration year under Section 14166.8 by designated public hospitals (DPHs), including the governmental entities with which they are affiliated, that is in excess of the amount necessary to draw the maximum amount of federal funding for DPHs for uncompensated care under the safety net care pool and for disproportionate share hospital payments without regard to subdivision (c) or to the amount authorized pursuant to paragraph (5).

(5) "Reserved SNCP funds for DSHP" means the amount of SNCP uncompensated care funds used to fund expenditures for the Designated State Health Programs, as specified in the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration.

(6) "Redirected SNCP funds" means the amount of federal funding available for a specified demonstration year that would otherwise be restricted for expenditures associated with the Health Care Coverage Initiative (HCCI) program, for which there are insufficient HCCI expenditures to draw the federal funds and which CMS has authorized to be available for uncompensated care expenditures under the safety net care pool in either the demonstration year for which the funds were initially reserved or a subsequent demonstration year.

(7) "Safety net care pool" or "SNCP" means the federal funds available under the Medi-Cal Hospital/Uninsured Care Demonstration Project and the successor demonstration project, California's Bridge to Reform, to

ensure continued government support for the provision of health care services to uninsured populations.

(c) Notwithstanding any other provision of law, the state shall annually seek authority from CMS under the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration to redirect to the uncompensated care category within the SNCP the portion of the restricted funds used to fund expenditures under the HCCI that will not be fully utilized by the end of the demonstration year.

(d) Designated public hospitals may utilize the redirected SNCP funds described in subdivision (c) as follows:

(1) Designated public hospitals may opt to utilize excess certified public expenditures to claim the redirected SNCP funds.

(2) As a condition of exercising the option in paragraph (1), DPHs voluntarily agree that to the extent the state is unable to fully claim the maximum annual amount of reserved SNCP funds for DSHP, the excess certified public expenditures are to be allocated equally between the state and the DPHs, such that for every dollar of excess certified public expenditure used by the DPHs, the DPHs will voluntarily allow the state to use a corresponding excess certified public expenditure amount for claiming purposes. The amount in excess certified public expenditures that may be used by the state shall be limited to that amount necessary to enable the state to receive total SNCP uncompensated care funds, in conjunction with its claims for expenditures for DSHP, to the maximum amount described in paragraph (5) of subdivision (b).

(3) After the state achieves its maximum claiming amount described in paragraph (5) of subdivision (b), or to the extent the condition in subdivision (e) is not satisfied, the DPHs may use any remaining excess certified public expenditures to claim SNCP uncompensated care funds as authorized by the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration.

(e) As a condition for the state's use of the excess certified public expenditures pursuant to paragraph (2) of subdivision (d), the department shall seek any necessary authorization from the federal Centers for Medicare and Medicaid Services.

(f) Participation in the utilization of the excess certified public expenditures and redirected SNCP funds under this section is voluntary on the part of the DPHs for the purpose of all applicable federal laws.

(g) The department shall consult with DPH representatives regarding the availability of excess certified public expenditures and the appropriate allocation of SNCP funds under paragraph (2) of subdivision (d). The department may make interim determinations and allocations of such SNCP funds, provided that the interim determinations and allocations take into account adjustments to reported expenditures for possible audit disallowances, consistent with the type of adjustments applied in prior projects years under Article 5.2 (commencing with Section 14166). Any interim determinations and allocations of redirected SNCP funds based on

excess certified public expenditures shall be subject to interim and final reconciliations.

(h) Notwithstanding any other provision of law, upon the receipt of a notice of disallowance or deferral from the federal government related to any certified public expenditures for uncompensated care incurred by DPHs that are used for federal claiming under the SNCP pursuant to California's Bridge to Reform Section 1115(a) Demonstration after this section is implemented, and subject to the processes described in subdivisions (a) through (d) of Section 14166.24, the following shall apply with respect to the disallowance or deferral:

(1) First, the DPH shall be solely responsible for the repayment of the federal portion of any federal disallowance or deferral related to the claiming of a certified public expenditure in a particular year up to the amount claimed pursuant to paragraph (3) of subdivision (d), after paragraph (2) of subdivision (d) was satisfied for that particular year.

(2) Second, if there are additional disallowances or deferrals beyond those described in paragraph (1), the department and the DPH shall each be responsible for half of the repayment of the federal portion of any federal disallowance or deferral for the applicable demonstration year, up to the amount claimed and allocated pursuant to paragraph (2) of subdivision (d) for that particular year.

(3) Third, if there are additional disallowances or deferrals beyond those described in paragraphs (1) and (2) for the applicable demonstration year, the DPH shall be solely responsible for the repayment of the federal portion of all remaining federal disallowances or deferrals for that particular year.

(i) The department shall obtain federal approvals or waivers as necessary to implement this section and to obtain federal matching funds to the maximum extent permitted by federal law. This section shall be implemented only to the extent federal financial participation is not jeopardized.

SEC. 22. The sum of one thousand dollars ($1,000) is hereby appropriated from the General Fund to the State Department of Health Care Services for administration.

SEC. 23. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

O