

AMENDED IN SENATE JUNE 22, 2011

AMENDED IN ASSEMBLY MARCH 23, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL

No. 574

Introduced by Assembly Member Bonnie Lowenthal

February 16, 2011

An act to amend Sections 1231.5, 1343.1, 1367.63, 1580.1, 1734.5, and 100315 of the Health and Safety Code, and to amend Sections 14002.5, 14005.12, 14041.1, 14091.3, 14105.19, 14115.75, 14131.10, 14167.1, and 14168.1 of, and to add Chapter 8.75 (commencing with Section 14591) to, and to repeal Chapter 8.75 (commencing with Section 14590) of, Part 3 of Division 9 of, the Welfare and Institutions Code, relating to the elderly.

LEGISLATIVE COUNSEL'S DIGEST

AB 574, as amended, Bonnie Lowenthal. Program of All-Inclusive Care for the Elderly.

Existing law establishes the federal Medicaid Program, administered by each state, California's version of which is the Medi-Cal program. The Medi-Cal program, which is administered by the State Department of Health Care Services under the direction of the Director of Health Care Services, provides qualified low-income persons with health care services. Existing federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals so that they may continue living in the community. Federal law authorizes states to implement the PACE program as a Medicaid state option.

Existing state law authorizes the director to establish the California Program of All-Inclusive Care for the Elderly and contract with up to 10 demonstration projects to develop risk-based, long-term care pilot programs. Existing law also establishes PACE program services as a covered benefit of the Medi-Cal program. Existing law authorizes the department to enter into specified contracts for implementation of the PACE program, and also enter into separate contracts with certain PACE organizations, to fully implement the single state agency responsibilities assumed by the department, as specified. Existing law authorizes the department to enter into separate contracts with up to 10 PACE organizations, but prohibits certain contracts unless a Medicaid state plan amendment, electing PACE as a state Medicaid option, has been approved by the federal Centers for Medicare and Medicaid Services.

This bill would, instead, require the department to establish the California Program of All-Inclusive Care for the Elderly and would delete the pilot program and demonstration project requirements in these provisions. This bill would also *provide that the department may enter into contracts with public or private nonprofit organizations for implementation of the PACE program and increase to 20 15* the number of separate contracts the department may enter into with PACE organizations, as defined. *This bill would make other conforming changes.*

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

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

1 SECTION 1. Section 1231.5 of the Health and Safety Code is
2 amended to read:

3 1231.5. The department may grant to a PACE program, as
4 defined in Chapter 8.75 (commencing with Section ~~14590~~ 14591)
5 of Part 3 of Division 9 of the Welfare and Institutions Code,
6 exemptions from the provisions contained in this chapter in
7 accordance with the requirements of Section 100315.

8 SEC. 2. Section 1343.1 of the Health and Safety Code is
9 amended to read:

10 1343.1. This chapter shall not apply to any program developed
11 under the authority of Chapter 8.75 (commencing with Section
12 ~~14590~~ 14591) of Part 3 of Division 9 of the Welfare and
13 Institutions Code.

1 *SEC. 3. Section 1367.63 of the Health and Safety Code is*
2 *amended to read:*

3 1367.63. (a) Every health care service plan contract, except a
4 specialized health care service plan contract, that is issued,
5 amended, renewed, or delivered in this state on or after July 1,
6 1999, shall cover reconstructive surgery, as defined in subdivision
7 (c), that is necessary to achieve the purposes specified in
8 subparagraph (A) or (B) of paragraph (1) of subdivision (c).
9 Nothing in this section shall be construed to require a plan to
10 provide coverage for cosmetic surgery, as defined in subdivision
11 (d).

12 (b) No individual, other than a licensed physician competent to
13 evaluate the specific clinical issues involved in the care requested,
14 may deny initial requests for authorization of coverage for
15 treatment pursuant to this section. For a treatment authorization
16 request submitted by a podiatrist or an oral and maxillofacial
17 surgeon, the request may be reviewed by a similarly licensed
18 individual, competent to evaluate the specific clinical issues
19 involved in the care requested.

20 (c) (1) “Reconstructive surgery” means surgery performed to
21 correct or repair abnormal structures of the body caused by
22 congenital defects, developmental abnormalities, trauma, infection,
23 tumors, or disease to do either of the following:

24 (A) To improve function.

25 (B) To create a normal appearance, to the extent possible.

26 (2) As of July 1, 2010, “reconstructive surgery” shall include
27 medically necessary dental or orthodontic services that are an
28 integral part of reconstructive surgery, as defined in paragraph (1),
29 for cleft palate procedures.

30 (3) For purposes of this section, “cleft palate” means a condition
31 that may include cleft palate, cleft lip, or other craniofacial
32 anomalies associated with cleft palate.

33 (d) “Cosmetic surgery” means surgery that is performed to alter
34 or reshape normal structures of the body in order to improve
35 appearance.

36 (e) In interpreting the definition of reconstructive surgery, a
37 health care service plan may utilize prior authorization and
38 utilization review that may include, but need not be limited to, any
39 of the following:

1 (1) Denial of the proposed surgery if there is another more
2 appropriate surgical procedure that will be approved for the
3 enrollee.

4 (2) Denial of the proposed surgery or surgeries if the procedure
5 or procedures, in accordance with the standard of care as practiced
6 by physicians specializing in reconstructive surgery, offer only a
7 minimal improvement in the appearance of the enrollee.

8 (3) Denial of payment for procedures performed without prior
9 authorization.

10 (4) For services provided under the Medi-Cal program (Chapter
11 7 (commencing with Section 14000) of Part 3 of Division 9 of the
12 Welfare and Institutions Code), denial of the proposed surgery if
13 the procedure offers only a minimal improvement in the appearance
14 of the enrollee, as may be defined in any regulations that may be
15 promulgated by the State Department of Health Care Services.

16 (f) As applied to services described in paragraph (2) of
17 subdivision (c) only, this section shall not apply to Medi-Cal
18 managed care plans that contract with the State Department of
19 Health Care Services pursuant to Chapter 7 (commencing with
20 Section 14000) of, Chapter 8 (commencing with Section 14200)
21 of, or Chapter 8.75 (commencing with Section ~~14590~~ 14591) of,
22 Part 3 of Division 9 of the Welfare and Institutions Code, where
23 such contracts do not provide coverage for California Children's
24 Services (CCS) or dental services.

25 *SEC. 4. Section 1580.1 of the Health and Safety Code is*
26 *amended to read:*

27 1580.1. The State Department of Health Care Services, and as
28 applicable, the State Department of Public Health and the
29 California Department of Aging, may grant to entities contracting
30 with the State Department of Health Care Services under the PACE
31 program, as defined in Chapter 8.75 (commencing with Section
32 ~~14590~~ 14591) of Part 3 of Division 9 of the Welfare and
33 Institutions Code, exemptions from the provisions contained in
34 this chapter in accordance with the requirements of Section 100315.

35 *SEC. 5. Section 1734.5 of the Health and Safety Code is*
36 *amended to read:*

37 1734.5. The department may grant to entities contracting with
38 the department under the PACE program, as defined in Chapter
39 8.75 (commencing with Section ~~14590~~ 14591) of Part 3 of
40 Division 9 of the Welfare and Institutions Code, exemptions from

1 the provisions contained in this chapter in accordance with the
2 requirements of Section 100315.

3 *SEC. 6. Section 100315 of the Health and Safety Code is*
4 *amended to read:*

5 100315. (a) The department and as applicable, the California
6 Department of Aging, the State Department of Public Health, and
7 the State Department of Social Services, may grant to a PACE
8 program, as defined in Chapter 8.75 (commencing with Section
9 ~~14590~~ 14591) of Part 3 of Division 9 of the Welfare and
10 Institutions Code, exemptions from duplicative, conflicting, or
11 inconsistent requirements in Chapter 1 (commencing with Section
12 1200), Chapter 3 (commencing with Section 1500), Chapter 3.2
13 (commencing with Section 1569), Chapter 3.3 (commencing with
14 Section 1570), and Chapter 8 (commencing with Section 1725) of
15 Division 2, and Divisions 3 and 5 of Title 22 of the California
16 Code of Regulations, including the use of alternate concepts,
17 methods, procedures, techniques, space, equipment, personnel,
18 personnel qualifications, or the conducting of pilot projects,
19 provided that the exemptions are implemented in a manner that
20 does not jeopardize the health and welfare of participants receiving
21 services under PACE, or deprive beneficiaries of rights specified
22 in federal or state laws or regulations. In determining whether to
23 grant exemptions under this section, the departments shall consult
24 with each other.

25 (b) A written request and substantiating evidence supporting
26 the request for an exemption under subdivision (a) shall be
27 submitted by the PACE program to the department. A PACE
28 program may submit a single request for an exemption from the
29 licensing requirements applicable to two or more licenses held by
30 that organization, so long as the request lists the locations and
31 license numbers held by that organization and the requested
32 exemption is the same and appropriate for all licensed locations.
33 The written request shall include, but shall not be limited to, all
34 of the following:

35 (1) A description of how the applicable state requirement
36 duplicates, conflicts with, or is inconsistent with state or federal
37 requirements related to the PACE model.

38 (2) An analysis demonstrating why the duplication, conflict, or
39 inconsistency cannot be resolved without an exemption.

1 (3) A description of how the PACE program plans to comply
2 with the intent of the requirements described in paragraph (1).

3 (4) A description of how the PACE program will monitor its
4 compliance with the terms and conditions under which the
5 exemption is granted.

6 (c) The department shall approve or deny any request within
7 60 days of submission. An approval shall be in writing and shall
8 provide for the terms and conditions under which the exemption
9 is granted. A denial shall be in writing and shall specify the basis
10 therefor. Any decision to deny a request shall be a final
11 administrative decision.

12 (d) If, after investigation, the department determines that a
13 PACE program that has been granted an exemption under this
14 section is operating in a manner contrary to the terms and
15 conditions of the exemption, the department shall immediately
16 suspend or revoke the exemption. If the exemption is applicable
17 to more than one location or more than one category of licensure,
18 or both, the department may suspend or revoke an exemption as
19 to one or more license categories or locations as deemed
20 appropriate by the department.

21 *SEC. 7. Section 14002.5 of the Welfare and Institutions Code*
22 *is amended to read:*

23 14002.5. For the purposes of this article, the following
24 definitions shall apply:

25 (a) “Annuity” means a contract that names an annuitant and
26 gives a person or entity the right to receive periodic payments of
27 a fixed or variable sum for a described period of time, which may
28 include a lump-sum payment or periodic payments upon the death
29 of the annuitant.

30 (b) “Community spouse” means the spouse of an
31 institutionalized spouse.

32 (c) “Home and facility care” means the following services that
33 are subject to Medi-Cal reimbursement:

34 (1) Nursing facility care services.

35 (2) A level of care in any institution equivalent to that of nursing
36 facility care services.

37 (3) Home- or community-based care services furnished under
38 a waiver granted pursuant to subsection (c) or (d) of Section 1396n
39 of Title 42 of the United States Code.

1 (d) “Institutionalized spouse” means any individual to whom
2 all of the following apply:

3 (1) The individual is in a medical institution or nursing facility
4 or is a person who is receiving institutional or noninstitutional
5 services from an organization with a frail elderly demonstration
6 project waiver pursuant to Chapter 8.75 (commencing with Section
7 ~~14590~~ 14591), and is likely to meet that requirement for at least
8 30 consecutive days.

9 (2) The individual is married to a spouse who is not in a medical
10 institution or nursing facility, or to a spouse who is not receiving
11 services from any organization with a frail elderly demonstration
12 project waiver pursuant to Chapter 8.75 (commencing with Section
13 ~~14590~~ 14591).

14 (3) Except for purposes of Sections 14005.7, 14005.12,
15 14005.16, and 14005.17, an individual who is admitted to a medical
16 institution or nursing facility on or after September 30, 1989, and
17 who applies for Medi-Cal benefits on or after January 1, 1990, or
18 a Medi-Cal recipient who is admitted to a medical institution or
19 nursing facility on or after January 1, 1990.

20 (e) “Medical institution” has the same meaning as defined in
21 Section 435.1010 of Title 42 of the Code of Federal Regulations.

22 (f) “Nursing facility” has the same meaning as defined in Section
23 1250 of the Health and Safety Code.

24 *SEC. 8. Section 14005.12 of the Welfare and Institutions Code*
25 *is amended to read:*

26 14005.12. (a) For the purposes of Sections 14005.4 and
27 14005.7, the department shall establish the income levels for
28 maintenance need at the lowest levels that reasonably permit
29 medically needy persons to meet their basic needs for food,
30 clothing, and shelter, and for which federal financial participation
31 will still be provided under Title XIX of the federal Social Security
32 Act. It is the intent of the Legislature that the income levels for
33 maintenance need for medically needy aged, blind, and disabled
34 adults, in particular, shall be based upon amounts that adequately
35 reflect their needs.

36 (1) Subject to paragraph (2), reductions in the maximum aid
37 payment levels set forth in subdivision (a) of Section 11450 in the
38 1991–92 fiscal year, and thereafter, shall not result in a reduction
39 in the income levels for maintenance under this section.

1 (2) (A) The department shall seek any necessary federal
2 authorization for maintaining the income levels for maintenance
3 at the levels in effect June 30, 1991.

4 (B) If federal authorization is not obtained, medically needy
5 persons shall not be required to pay the difference between the
6 share of cost as determined based on the payment levels in effect
7 on June 30, 1991, under Section 11450, and the share of cost as
8 determined based on the payment levels in effect on July 1, 1991,
9 and thereafter.

10 (3) Any medically needy person who was eligible for benefits
11 under this chapter as categorically needy for the calendar month
12 immediately preceding the effective date of the reductions in the
13 minimum basic standards of adequate care for the Aid to Families
14 with Dependent Children program as set forth in Section 11452.018
15 made in the 1995–96 Regular Session of the Legislature shall not
16 be responsible for paying his or her share of cost if all of the
17 following apply:

18 (A) He or she had eligibility as categorically needy terminated
19 by the reductions in the minimum basic standards of adequate care.

20 (B) He or she, but for the reductions, would be eligible to
21 continue receiving benefits under this chapter as categorically
22 needy.

23 (C) He or she is not eligible to receive benefits without a share
24 of cost as a medically needy person pursuant to paragraph (1) or
25 (2).

26 (b) In the case of a single individual, the amount of the income
27 level for maintenance per month shall be 80 percent of the highest
28 amount that would ordinarily be paid to a family of two persons,
29 without any income or resources, under subdivision (a) of Section
30 11450, multiplied by the federal financial participation rate.

31 (c) In the case of a family of two adults, the income level for
32 maintenance per month shall be the highest amount that would
33 ordinarily be paid to a family of three persons without income or
34 resources under subdivision (a) of Section 11450, multiplied by
35 the federal financial participation rate.

36 (d) For the purposes of Sections 14005.4 and 14005.7, for a
37 person in a medical institution or nursing facility, or for a person
38 receiving institutional or noninstitutional services from an
39 organization with a frail elderly demonstration project waiver
40 pursuant to Chapter 8.75 (commencing with Section ~~14590~~)

1 14591), the amount considered as required for maintenance per
2 month shall be computed in accordance with, and for those
3 purposes required by, Title XIX of the federal Social Security Act,
4 and regulations adopted pursuant thereto. Those amounts shall be
5 computed pursuant to regulations which include providing for the
6 following purposes:

7 (1) Personal and incidental needs in the amount of not less than
8 thirty-five dollars (\$35) per month while a patient. The department
9 may, by regulation, increase this amount as necessitated by
10 increasing costs of personal and incidental needs. A long-term
11 health care facility shall not charge an individual for the laundry
12 services or periodic hair care specified in Section 14110.4.

13 (2) The upkeep and maintenance of the home.

14 (3) The support and care of his or her minor children, or any
15 disabled relative for whose support he or she has contributed
16 regularly, if there is no community spouse.

17 (4) If the person is an institutionalized spouse, for the support
18 and care of his or her community spouse, minor or dependent
19 children, dependent parents, or dependent siblings of either spouse,
20 provided the individuals are residing with the community spouse.

21 (5) The community spouse monthly income allowance shall be
22 established at the maximum amount permitted in accordance with
23 Section 1924(d)(1)(B) of Title XIX of the federal Social Security
24 Act (42 U.S.C. Sec. 1396r-5(d)(1)(B)).

25 (6) The family allowance for each family member residing with
26 the community spouse shall be computed in accordance with the
27 formula established in Section 1924(d)(1)(C) of Title XIX of the
28 federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(C)).

29 (e) For the purposes of Sections 14005.4 and 14005.7, with
30 regard to a person in a licensed community care facility, the amount
31 considered as required for maintenance per month shall be
32 computed pursuant to regulations adopted by the department which
33 provide for the support and care of his or her spouse, minor
34 children, or any disabled relative for whose support he or she has
35 contributed regularly.

36 (f) The income levels for maintenance per month, except as
37 specified in subdivisions (b) to (d), inclusive, shall be equal to the
38 highest amounts that would ordinarily be paid to a family of the
39 same size without any income or resources under subdivision (a)

1 of Section 11450, multiplied by the federal financial participation
2 rate.

3 (g) The “federal financial participation rate,” as used in this
4 section, shall mean 133 $\frac{1}{3}$ percent, or such other rate set forth in
5 Section 1903 of the federal Social Security Act (42 U.S.C. Sec.
6 1396(b)), or its successor provisions.

7 (h) The income levels for maintenance per month shall not be
8 decreased to reflect the presence in the household of persons
9 receiving forms of aid other than Medi-Cal.

10 (i) When family members maintain separate residences, but
11 eligibility is determined as a single unit under Section 14008, the
12 income levels for maintenance per month shall be established for
13 each household in accordance with subdivisions (b) to (h),
14 inclusive. The total of these levels shall be the level for the single
15 eligibility unit.

16 (j) The income levels for maintenance per month established
17 pursuant to subdivisions (b) to (i), inclusive, shall be calculated
18 on an annual basis, rounded to the next higher multiple of one
19 hundred dollars (\$100), and then prorated.

20 *SEC. 9. Section 14041.1 of the Welfare and Institutions Code*
21 *is amended to read:*

22 14041.1. (a) Notwithstanding any other provision of law, and
23 to the extent not otherwise conflicting with federal law, the
24 department may hold for a period of one month, or direct the
25 medical fiscal intermediary for the Medi-Cal program to hold for
26 a period of one month, payments to providers or their designated
27 agents for health care services that are provided pursuant to this
28 chapter, and payments to entities that contract with the department
29 pursuant to this chapter, Chapter 8 (commencing with Section
30 14200) and Chapter 8.75 (commencing with Section ~~14590~~ 14591)
31 for the delivery of health care services.

32 (b) The authority described in subdivision (a) shall be limited
33 to payments for one month only, and only for a month ending prior
34 to June 30, 2009.

35 *SEC. 10. Section 14091.3 of the Welfare and Institutions Code*
36 *is amended to read:*

37 14091.3. (a) For purposes of this section, the following
38 definitions shall apply:

39 (1) “Medi-Cal managed care plan contracts” means those
40 contracts entered into with the department by any individual,

1 organization, or entity pursuant to Article 2.7 (commencing with
2 Section 14087.3), Article 2.8 (commencing with Section 14087.5),
3 Article 2.91 (commencing with Section 14089) of this chapter, or
4 Article 1 (commencing with Section 14200) or Article 7
5 (commencing with Section 14490) of Chapter 8, or Chapter 8.75
6 (commencing with Section ~~14590~~ 14591).

7 (2) “Medi-Cal managed care health plan” means an individual,
8 organization, or entity operating under a Medi-Cal managed care
9 plan contract with the department under this chapter, Chapter 8
10 (commencing with Section 14200), or Chapter 8.75 (commencing
11 with Section ~~14590~~ 14591).

12 (b) The department shall take all appropriate steps to amend the
13 Medicaid State Plan, if necessary, to carry out this section. This
14 section shall be implemented only to the extent that federal
15 financial participation is available. The department shall adopt
16 rules and regulations to carry out this section. Until January 1,
17 2010, any rules and regulations adopted pursuant to this subdivision
18 may be adopted as emergency regulations in accordance with the
19 Administrative Procedure Act (Chapter 3.5 (commencing with
20 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
21 Code). The adoption of these regulations shall be deemed an
22 emergency and necessary for the immediate preservation of the
23 public peace, health, and safety or general welfare. The regulations
24 shall become effective immediately upon filing with the Secretary
25 of State.

26 (c) Any hospital that does not have in effect a contract with a
27 Medi-Cal managed care health plan, as defined in paragraph (2)
28 of subdivision (a), that establishes payment amounts for services
29 furnished to a beneficiary enrolled in that plan shall accept as
30 payment in full, from all these plans, the following amounts:

31 (1) For outpatient services, the Medi-Cal fee-for-service (FFS)
32 payment amounts.

33 (2) For emergency inpatient services, the average per diem
34 contract rate specified in paragraph (2) of subdivision (b) of Section
35 14166.245, except that the payment amount shall not be reduced
36 by 5 percent. For the purposes of this paragraph, this payment
37 amount shall apply to all hospitals, including hospitals that contract
38 with the department under the Medi-Cal Selective Provider
39 Contracting Program described in Article 2.6 (commencing with

1 Section 14081), and small and rural hospitals specified in Section
2 124840 of the Health and Safety Code.

3 (3) For poststabilization services following an emergency
4 admission, payment amounts shall be consistent with subdivision
5 (e) of Section 438.114 of Title 42 of the Code of Federal
6 Regulations. This paragraph shall only be implemented to the
7 extent that contract amendment language providing for these
8 payments is approved by CMS. For purposes of this paragraph,
9 this payment amount shall apply to all hospitals, including hospitals
10 that contract with the department under the Medi-Cal Selective
11 Provider Contracting Program pursuant to Article 2.6 (commencing
12 with Section 14081).

13 (d) Medi-Cal managed care health plans that, pursuant to the
14 department's encouragement in All Plan Letter 07003, have been
15 paying out-of-network hospitals the most recent California Medical
16 Assistance Commission regional average per diem rate as a
17 temporary rate for purposes of Section 1932(b)(2)(D) of the Social
18 Security Act (SSA), which became effective January 1, 2007, shall
19 make reconciliations and adjustments for all hospital payments
20 made since January 1, 2007, based upon rates published by the
21 department pursuant to Section 1932(b)(2)(D) of the SSA and
22 effective January 1, 2007, to June 30, 2008, inclusive, and, if
23 applicable, provide supplemental payments to hospitals as
24 necessary to make payments that conform with Section
25 1932(b)(2)(D) of the SSA. In order to provide managed care health
26 plans with 60 working days to make any necessary supplemental
27 payments to hospitals prior to these payments becoming subject
28 to the payment of interest, Section 1300.71 of Title 28 of the
29 California Code of Regulations shall not apply to these
30 supplemental payments until 30 working days following the
31 publication by the department of the rates.

32 (e) (1) The department shall provide a written report to the
33 policy and fiscal committees of the Legislature on October 1, 2009,
34 and May 1, 2010, on the implementation and impact made by this
35 section, including the impact of these changes on access to
36 hospitals by managed care enrollees and on contracting between
37 hospitals and managed care health plans, including the increase
38 or decrease in the number of these contracts.

39 (2) Not later than August 1, 2010, the department shall report
40 to the Legislature on the implementation of this section. The report

1 shall include, but not be limited to, information and analyses
2 addressing managed care enrollee access to hospital services, the
3 impact of this section on managed care health plan capitation rates,
4 the impact of this section on the extent of contracting between
5 managed care health plans and hospitals, and fiscal impact on the
6 state.

7 (3) For the purposes of preparing the annual status reports and
8 the final evaluation report required pursuant to this subdivision,
9 Medi-Cal managed care health plans shall provide the department
10 with all data and documentation, including contracts with providers,
11 including hospitals, as deemed necessary by the department to
12 evaluate the impact of the implementation of this section. In order
13 to ensure the confidentiality of managed care health plan
14 proprietary information, and thereby enable the department to have
15 access to all of the data necessary to provide the Legislature with
16 accurate and meaningful information regarding the impact of this
17 section, all information and documentation provided to the
18 department pursuant to this section shall be considered proprietary
19 and shall be exempt from disclosure as official information
20 pursuant to subdivision (k) of Section 6254 of the Government
21 Code as contained in the California Public Records Act (Division
22 7 (commencing with Section 6250) of Title 1 of the Government
23 Code).

24 (f) This section shall remain in effect only until January 1, 2013,
25 and as of that date is repealed, unless a later enacted statute, that
26 is enacted before January 1, 2013, deletes or extends that date.

27 *SEC. 11. Section 14105.19 of the Welfare and Institutions Code*
28 *is amended to read:*

29 14105.19. (a) Notwithstanding any other provision of law, in
30 order to implement changes in the level of funding for health care
31 services, the director shall reduce provider payments as specified
32 in this section.

33 (b) (1) Except as provided in subdivision (c), payments shall
34 be reduced by 10 percent for Medi-Cal fee-for-service benefits for
35 dates of service on and after July 1, 2008, through and including
36 dates of service on February 28, 2009.

37 (2) Except as provided in subdivision (c), payments shall be
38 reduced by 10 percent for non-Medi-Cal programs described in
39 Article 6 (commencing with Section 124025) of Chapter 3 of Part
40 2 of Division 106 of the Health and Safety Code, and Section

1 14105.18 of this code, for dates of service on and after July 1,
2 2008, through and including dates of service on February 28, 2009.

3 (3) For managed health care plans that contract with the
4 department pursuant to this chapter, Chapter 8 (commencing with
5 Section 14200), and Chapter 8.75 (commencing with Section
6 ~~14590~~ 14591), payments shall be reduced by the actuarial
7 equivalent amount of the payment reduction specified in this
8 subdivision pursuant to contract amendments or change orders
9 effective on July 1, 2008.

10 (4) Notwithstanding paragraphs (1) and (2), payment reductions
11 set forth in this subdivision shall apply to small and rural hospitals,
12 as defined in Section 124840 of the Health and Safety Code, for
13 dates of service on and after July 1, 2008, through and including
14 October 31, 2008.

15 (c) The services listed in this subdivision shall be exempt from
16 the payment reductions specified in subdivision (b):

17 (1) Acute hospital inpatient services, except for payments to
18 hospitals not under contract with the State Department of Health
19 Care Services, as provided in Section 14166.245.

20 (2) Federally qualified health center services, including those
21 facilities deemed to have federally qualified health center status
22 pursuant to a waiver under subdivision (a) of Section 1315 of Title
23 42 of the United States Code.

24 (3) Rural health clinic services.

25 (4) All of the following facilities:

26 (A) A skilled nursing facility licensed pursuant to subdivision
27 (c) of Section 1250 of the Health and Safety Code, except a skilled
28 nursing facility that is a distinct part of a general acute care
29 hospital. For purposes of this paragraph, “distinct part” has the
30 same meaning as defined in Section 72041 of Title 22 of the
31 California Code of Regulations.

32 (B) An intermediate care facility for the developmentally
33 disabled licensed pursuant to subdivision (e), (g), or (h) of Section
34 1250 of the Health and Safety Code, or a facility providing
35 continuous skilled nursing care to developmentally disabled
36 individuals pursuant to the pilot project established by Section
37 14495.10.

38 (C) A subacute care unit, as defined in Section 51215.5 of Title
39 22 of the California Code of Regulations.

1 (5) Payments to facilities owned or operated by the State
2 Department of Mental Health or the State Department of
3 Developmental Services.

4 (6) Hospice.

5 (7) Contract services as designated by the director pursuant to
6 subdivision (e).

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

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

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

20 (11) Breast and cervical cancer treatment provided pursuant to
21 Section 14007.71.

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

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

30 (e) Notwithstanding Chapter 3.5 (commencing with Section
31 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
32 the department may implement this section by means of a provider
33 bulletin, or similar instruction, without taking regulatory action.

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

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

1 *SEC. 12. Section 14115.75 of the Welfare and Institutions Code*
2 *is amended to read:*

3 14115.75. (a) As a condition of payment for goods, supplies,
4 and merchandise provided to Medi-Cal beneficiaries by a provider
5 that receives or makes annual payments of at least five million
6 dollars (\$5,000,000) under the Medi-Cal program, the provider
7 shall comply with the federal False Claims Act employee training
8 and policy requirements contained in Section 1902(a) of the federal
9 Social Security Act (42 U.S.C. Sec. 1396a(a)(68)), and with any
10 requirements that the United States Secretary of Health and Human
11 Services may specify. The calculation of the five million dollar
12 (\$5,000,000) threshold shall be based on federal law and
13 regulations and guidance from the United States Secretary of
14 Health and Human Services.

15 (b) For purposes of this section, “provider” has the same
16 meaning as that term is defined in Section 14043.1, and also
17 includes any Medi-Cal managed care plan authorized under this
18 chapter, Chapter 8 (commencing with Section 14200), or Chapter
19 8.75 (commencing with Section ~~14590~~ 14591).

20 *SEC. 13. Section 14131.10 of the Welfare and Institutions Code*
21 *is amended to read:*

22 14131.10. (a) Notwithstanding any other provision of this
23 chapter, Chapter 8 (commencing with Section 14200), or Chapter
24 8.75 (commencing with Section ~~14590~~ 14591), in order to
25 implement changes in the level of funding for health care services,
26 specific optional benefits are excluded from coverage under the
27 Medi-Cal program.

28 (b) (1) The following optional benefits are excluded from
29 coverage under the Medi-Cal program:

30 (A) Adult dental services, except as specified in paragraph (2).

31 (B) Acupuncture services.

32 (C) Audiology services and speech therapy services.

33 (D) Chiropractic services.

34 (E) Optometric and optician services, including services
35 provided by a fabricating optical laboratory.

36 (F) Podiatric services.

37 (G) Psychology services.

38 (H) Incontinence creams and washes.

39 (2) Medical and surgical services provided by a doctor of dental
40 medicine or dental surgery, which, if provided by a physician,

1 would be considered physician services, and which services may
2 be provided by either a physician or a dentist in this state, are
3 covered.

4 (3) Pregnancy-related services and services for the treatment of
5 other conditions that might complicate the pregnancy are not
6 excluded from coverage under this section.

7 (c) The optional benefit exclusions do not apply to either of the
8 following:

9 (1) Beneficiaries under the Early and Periodic Screening
10 Diagnosis and Treatment Program.

11 (2) Beneficiaries receiving long-term care in a nursing facility
12 that is both:

13 (A) A skilled nursing facility or intermediate care facility as
14 defined in subdivisions (c) and (d) of Section 1250 of the Health
15 and Safety Code.

16 (B) Licensed pursuant to subdivision (k) of Section 1250 of the
17 Health and Safety Code.

18 (d) This section shall only be implemented to the extent
19 permitted by federal law.

20 (e) Notwithstanding Chapter 3.5 (commencing with Section
21 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
22 the department may implement the provisions of this section by
23 means of all-county letters, provider bulletins, or similar
24 instructions, without taking further regulatory action.

25 (f) This section shall be implemented on the first day of the
26 month following 90 days after the operative date of this section.

27 *SEC. 14. Section 14167.1 of the Welfare and Institutions Code*
28 *is amended to read:*

29 14167.1. For purposes of this article, the following definitions
30 shall apply:

31 (a) “Acute psychiatric days” means the total number of
32 Short-Doyle administrative days, Short-Doyle acute care days,
33 acute psychiatric administrative days, and acute psychiatric acute
34 days identified in the Final Medi-Cal Utilization Statistics for the
35 2008–09 state fiscal year as calculated by the department on
36 September 15, 2008.

37 (b) “Converted hospital” means a private hospital that becomes
38 a designated public hospital or a nondesignated public hospital
39 after the implementation date, a nondesignated public hospital that
40 becomes a private hospital or a designated public hospital after

1 the implementation date, or a designated public hospital that
2 becomes a private hospital or a nondesignated public hospital after
3 the implementation date.

4 (c) “Current Section 1115 Waiver” means California’s Medi-Cal
5 Hospital/Uninsured Care Section 1115 Waiver Demonstration in
6 effect on the effective date of the article.

7 (d) “Designated public hospital” shall have the meaning given
8 in subdivision (d) of Section 14166.1 as that section may be
9 amended from time to time.

10 (e) “General acute care days” means the total number of
11 Medi-Cal general acute care days paid by the department to a
12 hospital in the 2008 calendar year, as reflected in the state paid
13 claims files on July 10, 2009.

14 (f) “High acuity days” means Medi-Cal coronary care unit days,
15 pediatric intensive care unit days, intensive care unit days, neonatal
16 intensive care unit days, and burn unit days paid by the department
17 during the 2008 calendar year, as reflected in the state paid claims
18 files on July 10, 2009.

19 (g) “Hospital inpatient services” means all services covered
20 under Medi-Cal and furnished by hospitals to patients who are
21 admitted as hospital inpatients and reimbursed on a fee-for-service
22 basis by the department directly or through its fiscal intermediary.
23 Hospital inpatient services include outpatient services furnished
24 by a hospital to a patient who is admitted to that hospital within
25 24 hours of the provision of the outpatient services that are related
26 to the condition for which the patient is admitted. Hospital inpatient
27 services do not include services for which a managed health care
28 plan is financially responsible.

29 (h) “Hospital outpatient services” means all services covered
30 under Medi-Cal furnished by hospitals to patients who are
31 registered as hospital outpatients and reimbursed by the department
32 on a fee-for-service basis directly or through its fiscal intermediary.
33 Hospital outpatient services do not include services for which a
34 managed health care plan is financially responsible, or services
35 rendered by a hospital-based federally qualified health center for
36 which reimbursement is received pursuant to Section 14132.100.

37 (i) (1) “Implementation date” means the latest effective date
38 of all federal approvals or waivers necessary for the implementation
39 of this article and Article 5.22 (commencing with Section
40 14167.31), including, but not limited to, any approvals on

1 amendments to contracts between the department and managed
2 health care plans or mental health plans necessary for the
3 implementation of this article. The effective date of a federal
4 approval or waiver shall be the earlier of the stated effective date
5 or the first day of the first quarter to which the computation of the
6 payments or fee under the federal approval or waiver is applicable,
7 which may be prior to the date that the federal approval or waiver
8 is granted or the applicable contract is amended.

9 (2) If federal approval is sought initially for only the 2008–09
10 federal fiscal year and separately secured for subsequent federal
11 fiscal years, the implementation date for the 2008–09 federal fiscal
12 year shall occur when all necessary federal approvals have been
13 secured for that federal fiscal year.

14 (j) “Individual hospital acute psychiatric supplemental payment”
15 means the total amount of acute psychiatric hospital supplemental
16 payments to a subject hospital for a quarter for which the
17 supplemental payments are made. The “individual hospital acute
18 psychiatric supplemental payment” shall be calculated for subject
19 hospitals by multiplying the number of acute psychiatric days for
20 the individual hospital for which a mental health plan was
21 financially responsible by four hundred eighty-five dollars (\$485)
22 and dividing the result by 4.

23 (k) (1) “Managed health care plan” means a health care delivery
24 system that manages the provision of health care and receives
25 prepaid capitated payments from the state in return for providing
26 services to Medi-Cal beneficiaries.

27 (2) (A) Managed health care plans include county organized
28 health systems and entities contracting with the department to
29 provide services pursuant to two-plan models and geographic
30 managed care. Entities providing these services contract with the
31 department pursuant to any of the following:

32 (i) Article 2.7 (commencing with Section 14087.3).

33 (ii) Article 2.8 (commencing with Section 14087.5).

34 (iii) Article 2.81 (commencing with Section 14087.96).

35 (iv) Article 2.91 (commencing with Section 14089).

36 (B) Managed health care plans do not include any of the
37 following:

38 (i) Mental health plan contracting to provide mental health care
39 for Medi-Cal beneficiaries pursuant to Part 2.5 (commencing with
40 Section 5775) of Division 5.

1 (ii) Health plan not covering inpatient services such as primary
2 care case management plans operating pursuant to Section
3 14088.85.

4 (iii) Long-Term Care Demonstration Projects for All-Inclusive
5 Care for the Elderly operating pursuant to Chapter 8.75
6 (commencing with Section ~~14590~~ 14591).

7 (l) “Medi-Cal managed care days” means the total number of
8 general acute care days, including well baby days, listed for the
9 county organized health system and prepaid health plans identified
10 in the Final Medi-Cal Utilization Statistics for the 2008–09 state
11 fiscal year, as calculated by the department on September 15, 2008,
12 except that the general acute care days, including well baby days,
13 for the Santa Barbara Health Care Initiative shall be derived from
14 the Final Medi-Cal Utilization Statistics for the 2007–08 state
15 fiscal year.

16 (m) “Medicaid inpatient utilization rate” means Medicaid
17 inpatient utilization rate as defined in Section 1396r-4 of Title 42
18 of the United States Code and as set forth in the final
19 disproportionate share hospital eligibility list for the 2008–09 state
20 fiscal year released by the department on October 22, 2008.

21 (n) “Mental health plan” means a mental health plan that
22 contracts with the State Department of Mental Health to furnish
23 or arrange for the provision of mental health services to Medi-Cal
24 beneficiaries pursuant to Part 2.5 (commencing with Section 5775)
25 of Division 5.

26 (o) “New hospital” means a hospital that was not in operation
27 under current or prior ownership as a private hospital, a
28 nondesignated public hospital, or a designated public hospital for
29 any portion of the 2008–09 state fiscal year.

30 (p) “Nondesignated public hospital” means either of the
31 following:

32 (1) A public hospital that is licensed under subdivision (a) of
33 Section 1250 of the Health and Safety Code, is not designated as
34 a specialty hospital in the hospital’s annual financial disclosure
35 report for the hospital’s latest fiscal year ending in 2007, and
36 satisfies the definition in paragraph (25) of subdivision (a) of
37 Section 14105.98, excluding designated public hospitals.

38 (2) A tax-exempt nonprofit hospital that is licensed under
39 subdivision (a) of Section 1250 of the Health and Safety Code, is
40 not designated as a specialty hospital in the hospital’s annual

1 financial disclosure report for the hospital’s latest fiscal year ending
2 in 2007, is operating a hospital owned by a local health care district,
3 and is affiliated with the health care district hospital owner by
4 means of the district’s status as the nonprofit corporation’s sole
5 corporate member.

6 (q) “Outpatient base amount” means the total amount of
7 payments for hospital outpatient services made to a hospital in the
8 2007 calendar year, as reflected in state paid claims files on January
9 26, 2008.

10 (r) “Private hospital” means a hospital that meets all of the
11 following conditions:

12 (1) Is licensed pursuant to subdivision (a) of Section 1250 of
13 the Health and Safety Code.

14 (2) Is in the Charitable Research Hospital peer group, as set
15 forth in the 1991 Hospital Peer Grouping Report published by the
16 department, or is not designated as a specialty hospital in the
17 hospital’s Office of Statewide Health Planning and Development
18 Annual Financial Disclosure Report for the hospital’s latest fiscal
19 year ending in 2007.

20 (3) Does not satisfy the Medicare criteria to be classified as a
21 long-term care hospital.

22 (4) Is a nonpublic hospital, nonpublic converted hospital, or
23 converted hospital as those terms are defined in paragraphs (26)
24 to (28), inclusive, respectively, of subdivision (a) of Section
25 14105.98.

26 (s) “Subject federal fiscal year” means a federal fiscal year that
27 ends after the implementation date and begins before December
28 31, 2010.

29 (t) “Subject fiscal quarter” means a fiscal quarter beginning on
30 or after the implementation date and ending before January 1,
31 2011.

32 (u) “Subject fiscal year” means a state fiscal year that ends after
33 the implementation date and begins before December 31, 2010.

34 (v) “Subject hospital” shall mean a hospital that meets all of the
35 following conditions:

36 (1) Is licensed pursuant to subdivision (a) of Section 1250 of
37 the Health and Safety Code.

38 (2) Is in the Charitable Research Hospital peer group, as set
39 forth in the 1991 Hospital Peer Grouping Report published by the
40 department, or is not designated as a specialty hospital in the

1 hospital's Office of Statewide Health Planning and Development
2 Annual Financial Disclosure Report for the hospital's latest fiscal
3 year ending in 2007.

4 (3) Does not satisfy the Medicare criteria to be classified as a
5 long-term care hospital.

6 (w) "Subject month" means a calendar month beginning on or
7 after the implementation date and ending before January 1, 2011.

8 (x) "Upper payment limit" means a federal upper payment limit
9 on the amount of the Medicaid payment for which federal financial
10 participation is available for a class of service and a class of health
11 care providers, as specified in Part 447 of Title 42 of the Code of
12 Federal Regulations.

13 *SEC. 15. Section 14168.1 of the Welfare and Institutions Code*
14 *is amended to read:*

15 14168.1. For the purposes of this article, the following
16 definitions shall apply:

17 (a) "Acute psychiatric days" means the total number of
18 Short-Doyle administrative days, Short-Doyle acute care days,
19 acute psychiatric administrative days, and acute psychiatric acute
20 days identified in the Final Medi-Cal Utilization Statistics for the
21 2008–09 state fiscal year as calculated by the department on
22 September 15, 2008.

23 (b) "Converted hospital" means a private hospital that becomes
24 a designated public hospital or a nondesignated public hospital on
25 or after January 1, 2011, a nondesignated public hospital that
26 becomes a private hospital or a designated public hospital on or
27 after January 1, 2011, or a designated public hospital that becomes
28 a private hospital or a nondesignated public hospital on or after
29 January 1, 2011.

30 (c) "Days data source" means the following:

31 (1) For a hospital that did not submit an Annual Financial
32 Disclosure Report to the Office of Statewide Health Planning and
33 Development for a fiscal year ending during 2007, but submitted
34 that report for a fiscal period ending in 2008 that includes at least
35 10 months of 2007, the Annual Financial Disclosure Report
36 submitted by the hospital to the Office of Statewide Health
37 Planning and Development for the fiscal period in 2008 that
38 includes at least 10 months of 2007.

39 (2) For a hospital owned by Kaiser Foundation Hospitals that
40 submitted corrections to reported patient days to the Office of

1 Statewide Health Planning and Development for its fiscal year
2 ending in 2007 before July 31, 2009, the corrected data.

3 (3) For all other hospitals, the hospital’s Annual Financial
4 Disclosure Report in the Office of Statewide Health Planning and
5 Development files as of October 31, 2008, for its fiscal year ending
6 during 2007.

7 (d) “Designated public hospital” shall have the meaning given
8 in subdivision (d) of Section 14166.1 as of January 1, 2011.

9 (e) “General acute care days” means the total number of
10 Medi-Cal general acute care days paid by the department to a
11 hospital in the 2008 calendar year, as reflected in the state paid
12 claims files on July 10, 2009.

13 (f) “High acuity days” means Medi-Cal coronary care unit days,
14 pediatric intensive care unit days, intensive care unit days, neonatal
15 intensive care unit days, and burn unit days paid by the department
16 during the 2008 calendar year, as reflected in the state paid claims
17 files on July 10, 2009.

18 (g) “Hospital inpatient services” means all services covered
19 under Medi-Cal and furnished by hospitals to patients who are
20 admitted as hospital inpatients and reimbursed on a fee-for-service
21 basis by the department directly or through its fiscal intermediary.
22 Hospital inpatient services include outpatient services furnished
23 by a hospital to a patient who is admitted to that hospital within
24 24 hours of the provision of the outpatient services that are related
25 to the condition for which the patient is admitted. Hospital inpatient
26 services do not include services for which a managed health care
27 plan is financially responsible.

28 (h) “Hospital outpatient services” means all services covered
29 under Medi-Cal furnished by hospitals to patients who are
30 registered as hospital outpatients and reimbursed by the department
31 on a fee-for-service basis directly or through its fiscal intermediary.
32 Hospital outpatient services do not include services for which a
33 managed health care plan is financially responsible, or services
34 rendered by a hospital-based federally qualified health center for
35 which reimbursement is received pursuant to Section 14132.100.

36 (i) “Individual hospital acute psychiatric supplemental payment”
37 means the total amount of acute psychiatric hospital supplemental
38 payments to a subject hospital for a quarter for which the
39 supplemental payments are made. The “individual hospital acute
40 psychiatric supplemental payment” shall be calculated for subject

1 hospitals by multiplying the number of acute psychiatric days for
2 the individual hospital for which a mental health plan was
3 financially responsible by four hundred eighty-five dollars (\$485)
4 and dividing the result by four.

5 (j) (1) “Managed health care plan” means a health care delivery
6 system that manages the provision of health care and receives
7 prepaid capitated payments from the state in return for providing
8 services to Medi-Cal beneficiaries.

9 (2) (A) Managed health care plans include county organized
10 health systems and entities contracting with the department to
11 provide services pursuant to two-plan models and geographic
12 managed care. Entities providing these services contract with the
13 department pursuant to any of the following:

14 (i) Article 2.7 (commencing with Section 14087.3).

15 (ii) Article 2.8 (commencing with Section 14087.5).

16 (iii) Article 2.81 (commencing with Section 14087.96).

17 (iv) Article 2.91 (commencing with Section 14089).

18 (B) Managed health care plans do not include any of the
19 following:

20 (i) Mental health plan contracting to provide mental health care
21 for Medi-Cal beneficiaries pursuant to Part 2.5 (commencing with
22 Section 5775) of Division 5.

23 (ii) Health plan not covering inpatient services such as primary
24 care case management plans operating pursuant to Section
25 14088.85.

26 (iii) Long-Term Care Demonstration Projects for All-Inclusive
27 Care for the Elderly operating pursuant to Chapter 8.75
28 (commencing with Section ~~14590~~ 14591).

29 (k) “Medi-Cal managed care days” means the total number of
30 general acute care days, including well baby days, listed for the
31 county organized health system and prepaid health plans identified
32 in the Final Medi-Cal Utilization Statistics for the 2008–09 fiscal
33 year, as calculated by the department on September 15, 2008,
34 except that the general acute care days, including well baby days,
35 for the Santa Barbara Health Care Initiative shall be derived from
36 the Final Medi-Cal Utilization Statistics for the 2007–08 fiscal
37 year.

38 (l) “Medicaid inpatient utilization rate” means Medicaid
39 inpatient utilization rate as defined in Section 1396r-4 of Title 42
40 of the United States Code and as set forth in the final

1 disproportionate share hospital eligibility list for the 2008–09 fiscal
2 year released by the department on October 22, 2008.

3 (m) “Mental health plan” means a mental health plan that
4 contracts with the State Department of Mental Health to furnish
5 or arrange for the provision of mental health services to Medi-Cal
6 beneficiaries pursuant to Part 2.5 (commencing with Section 5775)
7 of Division 5.

8 (n) “New hospital” means a hospital operation, business, or
9 facility functioning under current or prior ownership as a private
10 hospital that does not have a days data source or a hospital that
11 has a days data source in whole, or in part, from a previous operator
12 where there is an outstanding monetary liability owed to the state
13 in connection with the Medi-Cal program and the new operator
14 did not assume liability for the outstanding monetary obligation.

15 (o) “New noncontract hospital” means a private hospital that
16 was a contract hospital on March 1, 2011, and elects to become a
17 noncontract hospital at any time between March 1, 2011, and the
18 end of the program period.

19 (p) “Nondesignated public hospital” means either of the
20 following:

21 (1) A public hospital that is licensed under subdivision (a) of
22 Section 1250 of the Health and Safety Code, is not designated as
23 a specialty hospital in the hospital’s annual financial disclosure
24 report for the hospital’s latest fiscal year ending in 2007, and
25 satisfies the definition in paragraph (25) of subdivision (a) of
26 Section 14105.98, excluding designated public hospitals.

27 (2) A tax-exempt nonprofit hospital that is licensed under
28 subdivision (a) of Section 1250 of the Health and Safety Code, is
29 not designated as a specialty hospital in the hospital’s annual
30 financial disclosure report for the hospital’s latest fiscal year ending
31 in 2007, is operating a hospital owned by a local health care district,
32 and is affiliated with the health care district hospital owner by
33 means of the district’s status as the nonprofit corporation’s sole
34 corporate member.

35 (q) “Outpatient base amount” means the total amount of
36 payments for hospital outpatient services made to a hospital in the
37 2007 calendar year, as reflected in state paid claims files on January
38 26, 2008.

39 (r) “Private hospital” means a hospital that meets all of the
40 following conditions:

- 1 (1) Is licensed pursuant to subdivision (a) of Section 1250 of
- 2 the Health and Safety Code.
- 3 (2) Is in the Charitable Research Hospital peer group, as set
- 4 forth in the 1991 Hospital Peer Grouping Report published by the
- 5 department, or is not designated as a specialty hospital in the
- 6 hospital’s Office of Statewide Health Planning and Development
- 7 Annual Financial Disclosure Report for the hospital’s latest fiscal
- 8 year ending in 2007.
- 9 (3) Does not satisfy the Medicare criteria to be classified as a
- 10 long-term care hospital.
- 11 (4) Is a nonpublic hospital, nonpublic converted hospital, or
- 12 converted hospital as those terms are defined in paragraphs (26)
- 13 to (28), inclusive, respectively, of subdivision (a) of Section
- 14 14105.98.
- 15 (s) “Program period” means the period from January 1, 2011,
- 16 to June 30, 2011, inclusive.
- 17 (t) “Subject fiscal quarter” means a state fiscal quarter beginning
- 18 on or after January 1, 2011, and ending before July 1, 2011.
- 19 (u) “Subject hospital” shall mean a hospital that meets all of the
- 20 following conditions:
- 21 (1) Is licensed pursuant to subdivision (a) of Section 1250 of
- 22 the Health and Safety Code.
- 23 (2) Is in the Charitable Research Hospital peer group, as set
- 24 forth in the 1991 Hospital Peer Grouping Report published by the
- 25 department, or is not designated as a specialty hospital in the
- 26 hospital’s Office of Statewide Health Planning and Development
- 27 Annual Financial Disclosure Report for the hospital’s latest fiscal
- 28 year ending in 2007.
- 29 (3) Does not satisfy the Medicare criteria to be classified as a
- 30 long-term care hospital.
- 31 (v) “Subject month” means a calendar month beginning on or
- 32 after January 1, 2011, and ending before July 1, 2011.
- 33 (w) “Upper payment limit” means a federal upper payment limit
- 34 on the amount of the Medicaid payment for which federal financial
- 35 participation is available for a class of service and a class of health
- 36 care providers, as specified in Part 447 of Title 42 of the Code of
- 37 Federal Regulations.

1 (g) In response, the Legislature authorized the State Department
2 of Health Care Services to seek a waiver to contract with up to 10
3 demonstration projects to develop risk-based, long-term care pilot
4 programs modeled upon On Lok Senior Health Services.

5 (h) The demonstration projects authorized by the Legislature
6 proved to be successful at providing comprehensive,
7 community-based services to frail elderly individuals at no greater
8 cost than providing nursing home care.

9 (i) In 1997, Congress passed the Balanced Budget Act of 1997
10 (Public Law 105-33) authorizing states to offer PACE program
11 services as optional services under the state's Medicaid state plan.

12 (j) Based upon the success of the demonstration projects in
13 California, the state is now providing community-based, risk-based,
14 and capitated long-term care services under the PACE program as
15 optional services under California's Medi-Cal State Plan.

16 14592. (a) For purposes of this chapter, "PACE organization"
17 means an entity as defined in Section 460.6 of Title 42 of the Code
18 of Federal Regulations.

19 (b) The Director of Health Care Services shall establish the
20 California Program of All-Inclusive Care for the Elderly, to provide
21 community-based, risk-based, and capitated long-term care services
22 as optional services under the state's Medi-Cal State Plan and
23 under contracts entered into between the federal Centers for
24 Medicare and Medicaid Services, the department, and PACE
25 organizations, meeting the requirements of the Balanced Budget
26 Act of 1997 (Public Law 105-33) and Part 460 (commencing with
27 Section 460.2) of Title 42 of the Code of Federal Regulations.

28 14593. (a) (1) The department may enter into contracts *with*
29 *public or private nonprofit organizations* for implementation of
30 the PACE program, and also may enter into separate contracts
31 with PACE organizations, to fully implement the single state
32 agency responsibilities assumed by the department in those
33 contracts, Section 14132.94, and any other state requirement found
34 necessary by the department to provide comprehensive
35 community-based, risk-based, and capitated long-term care services
36 to California's frail elderly.

37 (2) The department may enter into separate contracts as specified
38 in subdivision (a) with up to ~~20~~ 15 PACE organizations.

39 (b) The requirements of the PACE model, as provided for
40 pursuant to Section 1894 (42 U.S.C. Sec. 1395eee) and Section

1 1934 (42 U.S.C. Sec. 1396u-4) of the federal Social Security Act,
2 shall not be waived or modified. The requirements that shall not
3 be waived or modified include all of the following:

4 (1) The focus on frail elderly qualifying individuals who require
5 the level of care provided in a nursing facility.

6 (2) The delivery of comprehensive, integrated acute and
7 long-term care services.

8 (3) The interdisciplinary team approach to care management
9 and service delivery.

10 (4) Capitated, integrated financing that allows the provider to
11 pool payments received from public and private programs and
12 individuals.

13 (5) The assumption by the provider of full financial risk.

14 (6) The provision of a PACE benefit package for all participants,
15 regardless of source of payment, that shall include all of the
16 following:

17 (A) All Medicare-covered items and services.

18 (B) All Medicaid-covered items and services, as specified in
19 the state's Medicaid plan.

20 (C) Other services determined necessary by the interdisciplinary
21 team to improve and maintain the participant's overall health status.

22 (c) Sections 14002, 14005.12, 14005.17, and 14006 shall apply
23 when determining the eligibility for Medi-Cal of a person receiving
24 the services from an organization providing services under this
25 chapter.

26 (d) Provisions governing the treatment of income and resources
27 of a married couple, for the purposes of determining the eligibility
28 of a nursing-facility certifiable or institutionalized spouse, shall
29 be established so as to qualify for federal financial participation.

30 (e) (1) The department shall establish capitation rates paid to
31 each PACE organization at no less than 90 percent of the
32 fee-for-service equivalent cost, including the department's cost of
33 administration, that the department estimates would be payable
34 for all services covered under the PACE organization contract if
35 all those services were to be furnished to Medi-Cal beneficiaries
36 under the fee-for-service Medi-Cal program provided for pursuant
37 to Chapter 7 (commencing with Section 14000).

38 (2) This subdivision shall be implemented only to the extent
39 that federal financial participation is available.

- 1 (f) Contracts under this chapter may be on a nonbid basis and
- 2 shall be exempt from Chapter 2 (commencing with Section 10290)
- 3 of Part 2 of Division 2 of the Public Contract Code.

O