

AMENDED IN SENATE JUNE 12, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL

No. 1474

Introduced by Committee on Budget (Skinner (Chair), Bloom, Campos, Chesbro, Dababneh, Daly, Dickinson, Gordon, Jones-Sawyer, Mullin, Muratsuchi, Nazarian, Rodriguez, Stone, Ting, and Weber)

January 9, 2014

An act relating to the Budget Act of 2014 to amend Section 1374.34 of, to add Chapter 13.6 (commencing with Section 121287) to Part 4 of Division 105 of, and to add and repeal Section 128225.5 of, the Health and Safety Code, to amend Sections 14105.33, 14105.436, and 14105.86 of, to amend, repeal, and add Section 14593 of, and to add Sections 14087.9730 and 14132.56 to, the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

LEGISLATIVE COUNSEL'S DIGEST

AB 1474, as amended, Committee on Budget. ~~Budget Act of 2014.~~ *Health.*

(1) Existing law makes provisions for programs relating to treatment of persons with human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS). Under existing law, the Office of AIDS, in the State Department of Public Health, is the lead agency within the state responsible for coordinating state programs, services, and activities relating to HIV and AIDS, and AIDS-related conditions.

This bill would authorize the department to implement up to 4 demonstration projects that may operate for a period of up to 2 years to allow for innovative, evidence-based approaches to provide outreach,

HIV and Hepatitis C screenings, and linkage to, and retention in, quality health care for the most vulnerable and underserved individuals with a high risk for HIV infection. The bill would require, upon appropriation in the annual Budget Act, the department to award funding, on a competitive basis, to a community-based organization or local health jurisdiction to operate a demonstration project, as specified. The bill would require the department, at the conclusion of the demonstration projects, to review the effectiveness of each demonstration project and determine whether the demonstration project model can be implemented on a statewide basis.

(2) Existing law, the Song-Brown Health Care Workforce Training Act, establishes a state medical contract program with accredited medical schools, programs that train primary care physician's assistants, programs that train primary care nurse practitioners and registered nurses, hospitals, and other health care delivery systems.

Existing law establishes the California Healthcare Workforce Policy Commission to, among other things, identify specific areas of the state where unmet priority needs for primary care family physicians and registered nurses exist and to make recommendations to the Director of Statewide Health Planning and Development with regard to the funding of specific programs. Existing law requires the director to select and contract on behalf of the state with accredited medical schools and the other above-described entities for the purpose of, among other things, training medical students and residents in the specialty of family practice, subject to criteria established by the commission.

This bill would require, only until January 1, 2018, the director to select and contract on behalf of the state with accredited primary care or family medicine residency programs for the purpose of providing grants to support newly created residency positions, and would require the commission to review and make recommendations to the director concerning the provision of those grants. These provisions would be operative only if funds are appropriated for these purposes in the Budget Act of 2014.

(3) 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. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. 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 require the department to establish a 3-year pilot program in the County of Los Angeles that enables school districts to allow students enrolled in Medi-Cal managed care plans the ability to receive vision care services at the school site through the use of a mobile vision service provider. The bill would generally require the Medi-Cal managed care plans in the County of Los Angeles to, in consultation with the department, jointly identify and develop standards and participation criteria that the participating mobile vision service provider would be required to meet in order to be deemed qualified to participate in the pilot program. The bill would authorize the Director of Health Care Services to extend the pilot program to Medi-Cal managed care plans in other counties and applicable local jurisdictions, as specified.

Existing law provides for a schedule of benefits under the Medi-Cal program, which includes Early and Periodic Screening, Diagnosis, and Treatment for any individual under 21 years of age, consistent with the requirements of federal law.

This bill would provide, only to the extent required by the federal government and effective no sooner than required by the federal government, that behavioral health treatment (BHT), as defined, is a covered service for individuals under 21 years of age, as specified. The bill would require that the department only implement these provisions, or continue to implement these provisions, if the department receives all necessary federal approvals to obtain federal funds for the service, the department seeks and obtains an appropriation that would provide the necessary state funding estimated to be required for the applicable fiscal year, and the department consults with stakeholders. The bill would state that it is the intent of the Legislature, to the extent the federal government requires BHT to be a covered Medi-Cal service, that the department seek statutory authority to implement this new benefit.

Existing law also includes in the schedule of benefits for Medi-Cal prescribed drugs subject to the Medi-Cal list of contract drugs. Existing law authorizes the department to enter into contracts with manufacturers of single-source and multiple-source drugs, on a bid or nonbid basis, for drugs from each major therapeutic category. Existing law requires these contracts to provide for a state rebate to be remitted to the department quarterly. Existing law also requires pharmaceutical manufacturers to provide to the department a state rebate for any drug products that have been added to the Medi-Cal list of contract drugs related to drugs used to treat AIDS and cancer. Existing law requires

that the utilization data to determine these rebates exclude data from specified entities and capitated plans. Existing law also requires the department to collect a state rebate for blood factors reimbursed by specified programs.

This bill would make those data exclusions inoperative when the department takes specified actions, and would, commencing July 1, 2014, specify that utilization data used to determine the rebates include data from all health plans with specified exceptions. The bill would require the department to develop coverage policies, in consultation with clinical experts, Medi-Cal managed care plans, and other stakeholders, for prescription drugs that the department reimburses managed care plans through separate capitated rate payments or other supplemental payments.

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 law authorizes the department to enter into contracts with up to 15 PACE organizations, as defined, to implement the PACE program, as specified. Existing law requires the department to establish capitation rates paid to each PACE organization at no less than 90% of the fee-for-service equivalent cost, including the department's cost of administration, that the department estimates would be payable for all services covered under the PACE organization contract if all those services were to be furnished to Medi-Cal beneficiaries under the fee-for-service program.

This bill would instead require, on and after April 1, 2015, that the department establish capitation rates paid to each PACE organization at no less than 95% of that amount.

(4) Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the Knox-Keene Act a crime. Existing law establishes the Independent Medical Review System to make determinations when a health care service that is eligible for coverage has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. Existing law requires the Director of the Department of Managed Health Care to review individual cases submitted for independent medical review to determine

whether any enforcement actions, including penalties, may be appropriate.

This bill would prohibit the director from taking an enforcement action against a plan if the plan provides prescription drugs to a Medi-Cal beneficiary pursuant to State Department of Health Care Services guidelines.

(5) This bill would state the intent of the Legislature that the State Department of Health Care Services continue to monitor access to and utilization of Medi-Cal services in the fee-for-service and managed care settings during the 2014–15 fiscal year, as specified and would require the department to use this information to evaluate current reimbursement levels for Medi-Cal providers and to make recommendations for targeted changes to the extent the department finds those changes appropriate.

(6) Item 4300-101-0001 of the Budget Act of 2009, as added by Chapter 1 of the 3rd Extraordinary Session, appropriated \$24,553,000 to the State Department of Developmental Services for the support of the department, payable from the General Fund. Item 4300-101-0001 of the Budget Act of 2010, as added by Chapter 712 of the Statutes of 2010, appropriated \$24,391,000 to the department for its support, payable from the General Fund.

This bill would reappropriate the balances of those amounts to the department, subject to specified purposes, and would provide that those funds would be available for liquidation until June 30, 2015.

The bill also would, for the 2014–15 fiscal year, appropriate \$3,200,000 from the Major Risk Medical Insurance Fund to the State Department of Health Care Services for allocation to health benefit plans that meet specified requirements.

This bill would, for the 2014–15 fiscal year, appropriate \$3,750,000 from the Major Risk Medical Insurance Fund to the State Department of Health Care Services for purposes of electronic health records technical assistance in accordance with the State Medicaid Health Information Technology Plan, as specified.

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

~~*This bill would express the intent of the Legislature to enact statutory changes relating to the Budget Act of 2014.*~~

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

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

1 **SECTION 1.** *Section 1374.34 of the Health and Safety Code*
2 *is amended to read:*

3 1374.34. (a) Upon receiving the decision adopted by the
4 director pursuant to Section 1374.33 that a disputed health care
5 service is medically necessary, the plan shall promptly implement
6 the decision. In the case of reimbursement for services already
7 rendered, the plan shall reimburse the provider or enrollee,
8 whichever applies, within five working days. In the case of services
9 not yet rendered, the plan shall authorize the services within five
10 working days of receipt of the written decision from the director,
11 or sooner if appropriate for the nature of the enrollee's medical
12 condition, and shall inform the enrollee and provider of the
13 authorization in accordance with the requirements of paragraph
14 (3) of subdivision (h) of Section 1367.01.

15 (b) A plan shall not engage in any conduct that has the effect
16 of prolonging the independent review process. The engaging in
17 that conduct or the failure of the plan to promptly implement the
18 decision is a violation of this chapter and, in addition to any other
19 fines, penalties, and other remedies available to the director under
20 this chapter, the plan shall be subject to an administrative penalty
21 of not less than five thousand dollars (\$5,000) for each day that
22 the decision is not implemented. The administrative penalties shall
23 be paid to the Managed Care Administrative Fines and Penalties
24 Fund and shall be used for the purposes specified in Section
25 1341.45.

26 (c) The director shall require the plan to promptly reimburse
27 the enrollee for any reasonable costs associated with those services
28 when the director finds that the disputed health care services were
29 a covered benefit under the terms and conditions of the health care
30 service plan contract, and the services are found by the independent
31 medical review organization to have been medically necessary
32 pursuant to Section 1374.33, and either the enrollee's decision to
33 secure the services outside of the plan provider network was
34 reasonable under the emergency or urgent medical circumstances,
35 or the health care service plan contract does not require or provide
36 prior authorization before the health care services are provided to
37 the enrollee.

1 (d) In addition to requiring plan compliance regarding
2 subdivisions (a), (b), and (c) the director shall review individual
3 cases submitted for independent medical review to determine
4 whether any enforcement actions, including penalties, may be
5 appropriate. In particular, where substantial harm, as defined in
6 Section 3428 of the Civil Code, to an enrollee has already occurred
7 because of the decision of a plan, or one of its contracting
8 providers, to delay, deny, or modify covered health care services
9 that an independent medical review determines to be medically
10 necessary pursuant to Section 1374.33, the director shall impose
11 penalties.

12 (e) Pursuant to Section 1368.04, the director shall perform an
13 annual audit of independent medical review cases for the dual
14 purposes of education and the opportunity to determine if any
15 investigative or enforcement actions should be undertaken by the
16 department, particularly if a plan repeatedly fails to act promptly
17 and reasonably to resolve grievances associated with a delay,
18 denial, or modification of medically necessary health care services
19 when the obligation of the plan to provide those health care services
20 to enrollees or subscribers is reasonably clear.

21 (f) *A plan's provision of prescription drugs to a Medi-Cal*
22 *beneficiary pursuant to paragraph (5) of subdivision (b) of Section*
23 *14105.33 of the Welfare and Institutions Code and in accordance*
24 *with the State Department of Health Care Services coverage*
25 *policies shall not be a ground for an enforcement action. Nothing*
26 *in this article is intended to limit a plan's responsibility to provide*
27 *medically necessary health care services pursuant to this chapter.*

28 *SEC. 2. Chapter 13.6 (commencing with Section 121287) is*
29 *added to Part 4 of Division 105 of the Health and Safety Code, to*
30 *read:*

31

32 *CHAPTER 13.6. PUBLIC HEALTH DEMONSTRATION PROJECTS*

33

34 *121287. (a) There are hereby established public health*
35 *demonstration projects to allow for innovative, evidence-based*
36 *approaches to provide outreach, HIV and Hepatitis C screenings,*
37 *and linkage to, and retention in, quality health care for the most*
38 *vulnerable and underserved individuals with a high risk for HIV*
39 *infection.*

1 (b) The demonstration projects may operate for a period of up
2 to two years. The department shall implement up to four
3 demonstration projects. The demonstration projects shall be
4 designed to be capable of replication and expansion on a statewide
5 basis.

6 (c) After conclusion of the demonstration projects, the
7 department shall review the effectiveness of each demonstration
8 project and make a determination of whether the demonstration
9 project model can be implemented on a statewide basis.

10 121288. Upon an appropriation for this purpose in the annual
11 Budget Act, the department shall award funding, on a competitive
12 basis, to a community-based organization or local health
13 jurisdiction to operate a demonstration project pursuant to this
14 chapter. The department shall determine the funding levels of each
15 demonstration project based on scope and geographic area. An
16 applicant shall demonstrate each of the following qualifications:

17 (a) Leadership on access to HIV care and testing issues and
18 experience addressing the needs of highly marginalized populations
19 in accessing medical and HIV care and support.

20 (b) Experience with the target population or relationships with
21 community-based organizations or nongovernmental organizations,
22 or both, that demonstrate expertise, history, and credibility working
23 successfully in engaging the target population.

24 (c) Experience working with nontraditional collaborators who
25 work within and beyond the field of HIV/AIDS education and
26 outreach, including areas of reproductive health, housing,
27 immigration, and mental health.

28 (d) Strong relationships with community-based HIV health care
29 providers that have the trust of the targeted populations.

30 (e) Strong relationships with the state and local health
31 departments.

32 (f) Capacity to coordinate a communitywide planning phase
33 involving multiple community collaborators.

34 (g) Experience implementing evidence-based programs or
35 generating innovative strategies, or both, with at least preliminary
36 evidence of program effectiveness.

37 (h) Administrative systems and accountability mechanisms for
38 grant management.

39 (i) Capacity to participate in evaluation activities.

1 (j) *Strong communication systems that are in place to participate*
2 *in public relations activities.*

3 *121289. Each demonstration project shall prepare and*
4 *disseminate information regarding best practices for, and the*
5 *lessons learned regarding, providing outreach and education to*
6 *the most vulnerable and underserved individuals with a high risk*
7 *for HIV infection for use by providers, the Office of AIDS, State*
8 *Department of Public Health, federal departments and agencies,*
9 *including the Department of Health and Human Services, and*
10 *other national HIV/AIDS groups.*

11 *SEC. 3. Section 128225.5 is added to the Health and Safety*
12 *Code, to read:*

13 *128225.5. (a) The commission shall review and make*
14 *recommendations to the Director of the Office of Statewide Health*
15 *Planning and Development concerning the provision of grants*
16 *pursuant to this section. In making recommendations, the*
17 *commission shall give priority to residency programs that*
18 *demonstrate all of the following:*

19 *(1) That the grant will be used to support new primary care*
20 *physician slots.*

21 *(2) That priority in filling the position shall be given to*
22 *physicians who have graduated from a California-based medical*
23 *school.*

24 *(3) That the new primary care physician residency positions*
25 *have been, or will be, approved by the Accreditation Council for*
26 *Graduate Medical Education prior to the first distribution of grant*
27 *funds.*

28 *(b) The director shall do both of the following:*

29 *(1) Determine whether the residency programs recommended*
30 *by the commission meet the standards established by this section.*

31 *(2) Select and contract on behalf of the state with accredited*
32 *primary care or family medicine residency programs for the*
33 *purpose of providing grants for the support of newly created*
34 *residency positions.*

35 *(c) This section does not apply to funding appropriated in the*
36 *annual Budget Act for the Song-Brown Health Care Workforce*
37 *Training Act (Article 1 (commencing with Section 128200)).*

38 *(d) This section shall be operative only if funds are appropriated*
39 *in the Budget Act of 2014 for the purposes described in this section.*

1 (e) *This section shall remain in effect only until January 1, 2018,*
2 *and as of that date is repealed, unless a later enacted statute, that*
3 *is enacted before January 1, 2018, deletes or extends that date.*

4 SEC. 4. *Section 14087.9730 is added to the Welfare and*
5 *Institutions Code, immediately following Section 14087.9725, to*
6 *read:*

7 14087.9730. (a) *In an effort to determine whether children's*
8 *access to, and utilization of, vision care services can be increased*
9 *by providing vision care services at schools, the department shall*
10 *establish a pilot program in the County of Los Angeles that enables*
11 *school districts to allow students enrolled in Medi-Cal managed*
12 *care plans to receive vision care services at the school site through*
13 *the use of a mobile vision service provider. The vision care services*
14 *available under this pilot program are limited to vision*
15 *examinations and providing eyeglasses.*

16 (b) *The Medi-Cal managed care plans in the County of Los*
17 *Angeles shall jointly identify and develop standards and*
18 *participation criteria that the participating mobile vision service*
19 *provider shall meet in order to be deemed qualified to participate*
20 *in the pilot program, in consultation with the department and*
21 *consistent with any applicable federal requirements governing*
22 *Medicaid managed care contracts. In the event the Medi-Cal*
23 *managed care plans have not developed standards and*
24 *participation criteria by January 1, 2015, or by the scheduled start*
25 *date of the pilot program if later, the department shall determine*
26 *the standards and participating criteria for purposes of this pilot*
27 *program.*

28 (c) *This section shall not be construed to preclude Los Angeles*
29 *County school district students not enrolled in Medi-Cal managed*
30 *care from accessing vision care services from a mobile vision*
31 *service provider participating in this pilot program.*

32 (d) *Under the pilot program, if a school district in the County*
33 *of Los Angeles enters into a written memorandum of understanding*
34 *with a mobile vision care service provider allowing the provider*
35 *to offer the vision care services described in this section to students,*
36 *all of the following shall apply:*

37 (1) *The two Medi-Cal managed care plans in the County of Los*
38 *Angeles shall contract with one or more mobile vision care service*
39 *providers that meets the standards and participation criteria*
40 *developed pursuant to subdivision (b) for the delivery of those*

1 vision care services to any student enrolled in the Medi-Cal
2 managed care plan who chooses to receive his or her vision care
3 services from the provider at that school site. This contracting
4 requirement is contingent upon agreement between each of the
5 two Medi-Cal managed care plans in the County of Los Angeles
6 and a mobile vision care service provider with respect to
7 reimbursement rates applicable to the services under this pilot.

8 (2) Neither this pilot program nor the Medi-Cal managed care
9 plan shall require that a Medi-Cal beneficiary receive the vision
10 care services described in this section through a mobile vision
11 care provider on site at the school.

12 (3) Prior to a Medi-Cal beneficiary receiving mobile vision care
13 services at the school site, the parents, guardians, or legal
14 representative of the student shall consent in writing to the
15 Medi-Cal beneficiary receiving the services through a mobile
16 vision care provider on site at the school.

17 (e) An optometrist or ophthalmologist prescribing glasses to a
18 Medi-Cal managed care beneficiary as part of services provided
19 at a school site by a mobile vision care service provider pursuant
20 to this pilot program shall be enrolled in the Medi-Cal program
21 as an Ordering/Referring/Prescribing provider. For any other
22 purposes under the pilot program, the licensed health professional
23 shall satisfy all requirements for enrollment as a provider in the
24 Medi-Cal program.

25 (f) (1) The Medi-Cal managed care plan shall compensate the
26 mobile vision services provider for the cost of the vision
27 examination, dispensing of the lenses, and eyeglass frames.

28 (2) Ophthalmic eyeglasses lenses prescribed by optometrists or
29 ophthalmologists for a Medi-Cal managed care plan enrollee as
30 part of the services provided at a school site by a mobile vision
31 services provider shall be fabricated through optical laboratories
32 the department contracts with pursuant to subdivision (b) of Section
33 14105.3.

34 (g) (1) The department shall annually adjust capitation rates
35 for the Medi-Cal managed care plans operating in the County of
36 Los Angeles as necessary to account for projected changes in the
37 costs and utilization of the services provided pursuant to this
38 section by mobile vision service providers.

39 (2) Capitation rate adjustments pursuant to this section shall
40 be actuarially based and developed using projections of contingent

1 events including targeted populations who will receive these
2 services, and shall otherwise be in accordance with requirements
3 necessary to secure federal financial participation.

4 (3) Capitation rate adjustments pursuant to this section shall
5 be limited to those related to vision examinations, dispensing of
6 lenses, and eyeglass frames. The fabrication of optical lenses
7 pursuant to this section shall be paid on a fee-for-service basis in
8 accordance with the department's applicable contract under
9 subdivision (b) of Section 14105.3.

10 (h) The pilot program shall last three years, starting no sooner
11 than January 1, 2015, and concluding December 31, 2017, or
12 three years from the start date of the pilot if later. The department
13 shall evaluate the impact of the pilot program on access to, and
14 utilization of, vision care services by children by monitoring the
15 managed care plan utilization data for vision services, as well as
16 the lens fabrication data.

17 (i) The department may terminate the pilot program at any time
18 with 90 days advance notice to the Medi-Cal managed care plans
19 for reasons that include, but are not limited to, any of the following:

20 (1) The department determines that the pilot program is
21 resulting in a lower level of access to, or use of, vision care
22 services for children under the participating health plans.

23 (2) The department determines that the pilot program is
24 resulting in fraud, waste, or abuse of Medi-Cal funds.

25 (3) The department determines there is a lack of funding for the
26 vision care services provided in the pilot program.

27 (j) Notwithstanding Chapter 3.5 (commencing with Section
28 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
29 the department may implement, interpret, or make specific this
30 section and any applicable federal waivers and state plan
31 amendments by means of all-county letters, plan letters, plan or
32 provider bulletins, or similar instructions, without taking
33 regulatory action.

34 (k) The department shall obtain any federal approvals necessary
35 to implement this section and to obtain federal matching funds to
36 the maximum extent permitted by federal law.

37 (l) This section shall be implemented only if and to the extent
38 all federal approvals are obtained and federal financial
39 participation is available.

1 (m) *This section shall be implemented only to the extent an*
2 *annual appropriation is made available to the department each*
3 *fiscal year for the specific purpose of implementing this section.*

4 (n) *If the department determines, pursuant to subdivision (h),*
5 *that the pilot program is having a positive impact on access and*
6 *utilization and that additional funds are available, the director*
7 *may extend the pilot program described in this section to Medi-Cal*
8 *managed care plans in other counties and applicable local*
9 *jurisdictions. Any extension shall be implemented only to the extent*
10 *that any additional and necessary federal approvals are obtained,*
11 *and if sufficient funds are made available to participating plans*
12 *for this purpose. The department may accept funding from private*
13 *foundations in order to implement an extension under this*
14 *subdivision to the extent that federal financial participation is*
15 *available.*

16 (o) *The department shall post on its Internet Web site a notice*
17 *that has terminated or expanded the pilot program, including*
18 *identification of the geographic locations, and shall notify*
19 *appropriate fiscal and policy committees of both houses of the*
20 *Legislature.*

21 *SEC. 5. Section 14105.33 of the Welfare and Institutions Code*
22 *is amended to read:*

23 14105.33. (a) *The department may enter into contracts with*
24 *manufacturers of single-source and multiple-source drugs, on a*
25 *bid or nonbid basis, for drugs from each major therapeutic category,*
26 *and shall maintain a list of those drugs for which contracts have*
27 *been executed.*

28 (b) (1) *Contracts executed pursuant to this section shall be for*
29 *the manufacturer's best price, as defined in Section 14105.31,*
30 *which shall be specified in the contract, and subject to agreed-upon*
31 *price escalators, as defined in that section. The contracts shall*
32 *provide for a state rebate, as defined in Section 14105.31, to be*
33 *remitted to the department quarterly. The department shall submit*
34 *an invoice to each manufacturer for the state rebate, including*
35 *supporting utilization data from the department's prescription drug*
36 *paid claims tapes within 30 days of receipt of the federal Centers*
37 *for Medicare and Medicaid Services' file of manufacturer rebate*
38 *information. In lieu of paying the entire invoiced amount, a*
39 *manufacturer may contest the invoiced amount pursuant to*
40 *procedures established by the federal Centers for Medicare and*

1 Medicaid Services' Medicaid Drug Rebate Program Releases or
2 regulations by mailing a notice, that shall set forth its grounds for
3 contesting the invoiced amount, to the department within 38 days
4 of the department's mailing of the state invoice and supporting
5 utilization data. For purposes of state accounting practices only,
6 the contested balance shall not be considered an accounts receivable
7 amount until final resolution of the dispute pursuant to procedures
8 established by the federal Centers for Medicare and Medicaid
9 Services' Medicaid Drug Rebate Program Releases or regulations
10 that results in a finding of an underpayment by the manufacturer.
11 Manufacturers may request, and the department shall timely
12 provide, at cost, Medi-Cal provider level drug utilization data, and
13 other Medi-Cal utilization data necessary to resolve a contested
14 department-invoiced rebate amount.

15 (2) The department shall provide for an annual audit of
16 utilization data used to calculate the state rebate to verify the
17 accuracy of that data. The findings of the audit shall be documented
18 in a written audit report to be made available to manufacturers
19 within 90 days of receipt of the report from the auditor. Any
20 manufacturer may receive a copy of the audit report upon written
21 request. Contracts between the department and manufacturers shall
22 provide for any equalization payment adjustments determined
23 necessary pursuant to an audit.

24 (3) (A) Utilization data used to determine the state rebate shall
25 exclude data from both of the following:

26 ~~(A)~~

27 (i) Health maintenance organizations, as defined in Section
28 300e(a) of Title 42 of the United States Code, including those
29 organizations that contract under Section 1396b(m) of Title 42 of
30 the United States Code.

31 ~~(B)~~

32 (ii) Capitated plans that include a prescription drug benefit in
33 the capitated rate, and that have negotiated contracts for rebates
34 or discounts with manufacturers.

35 (B) *This paragraph shall become inoperative on July 1, 2014.*

36 (4) ~~Except as provided in paragraph (3),~~ *Commencing July 1,*
37 *2014, utilization data used to determine the state rebate shall*
38 *include data from all programs, including, but not limited to,*
39 *fee-for-service Medi-Cal, and utilization data, as limited in*
40 *paragraph (5), from health plans contracting with the department*

1 to provide services to beneficiaries pursuant to this chapter,
2 Chapter 8 (commencing with Section 14200), or Chapter 8.75
3 (commencing with Section 14591), that qualify for federal drug
4 rebates pursuant to Section 1927 of the federal Social Security Act
5 (42 U.S.C. Sec. 1396r-8) or that otherwise qualify for federal funds
6 under Title XIX of the federal Social Security Act (42 U.S.C. Sec.
7 1396 et seq.) pursuant to the Medicaid state plan or waivers.

8 (5) Health plan utilization data shall be limited to those drugs
9 for which a health plan is authorizing a prescription drug described
10 in subparagraph (A), and pursuant to the coverage policies
11 established in subparagraph (B):

12 (A) A prescription drug for which the department reimburses
13 the health plan through a separate capitated payment or other
14 supplemental payment. Payment shall not be withheld for decisions
15 determined pursuant to Section 1374.34 of the Health and Safety
16 Code.

17 (B) The department shall develop coverage policies, consistent
18 with the criteria set forth in paragraph (1) of subdivision (c) of
19 Section 14105.39 and in consultation with clinical experts,
20 Medi-Cal managed care plans, and other stakeholders, for
21 prescription drugs described in subparagraph (A). These coverage
22 policies shall apply to the entire Medi-Cal program, including
23 fee-for-service and Medi-Cal managed care, through the Medi-Cal
24 List of Contract Drugs or through provider bulletins, all plan
25 letters, or similar instructions. Coverage policies developed
26 pursuant to this section shall be revised on a semiannual basis or
27 upon approval by the Food and Drug Administration of a new
28 drug subject to subparagraph (A). For the purposes of this section,
29 “coverage policies” include, but are not limited to, clinical
30 guidelines and treatment and utilization policies.

31 (6) For prescription drugs not subject to the requirements of
32 paragraph (5), utilization data used to determine the state rebate
33 shall include all data from health plans, except for health
34 maintenance organizations, as defined in Section 300e(a) of Title
35 42 of the United States Code, including those organizations that
36 contract pursuant to Section 1396b(m) of Title 42 of the United
37 States Code.

38 (7) Notwithstanding Chapter 3.5 (commencing with Section
39 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
40 the department, without taking any further regulatory action, shall

1 *implement, interpret, or make specific paragraph (5) by means of*
2 *all-county letters, plan letters, plan or provider bulletins, or similar*
3 *instructions, until the time regulations are adopted. The department*
4 *shall adopt regulations by October 1, 2017, in accordance with*
5 *the requirements of Chapter 3.5 (commencing with Section 11340)*
6 *of Part 1 of Division 3 of Title 2 of the Government Code.*
7 *Notwithstanding Section 10231.5 of the Government Code,*
8 *beginning six months after the effective date of this section, the*
9 *department shall provide a status report to the Legislature on a*
10 *semiannual basis, in compliance with Section 9795 of the*
11 *Government Code, until regulations have been adopted.*

12 (c) In order that Medi-Cal beneficiaries may have access to a
13 comprehensive range of therapeutic agents, the department shall
14 ensure that there is representation on the list of contract drugs in
15 all major therapeutic categories. Except as provided in subdivision
16 (a) of Section 14105.35, the department shall not be required to
17 contract with all manufacturers who negotiate for a contract in a
18 particular category. The department shall ensure that there is
19 sufficient representation of single-source and multiple-source
20 drugs, as appropriate, in each major therapeutic category.

21 (d) The department shall select the therapeutic categories to be
22 included on the list of contract drugs, and the order in which it
23 seeks contracts for those categories. The department may establish
24 different contracting schedules for single-source and
25 multiple-source drugs within a given therapeutic category.

26 (e) (1) In order to fully implement subdivision (d), the
27 department shall, to the extent necessary, negotiate or renegotiate
28 contracts to ensure there are as many single-source drugs within
29 each therapeutic category or subcategory as the department
30 determines necessary to meet the health needs of the Medi-Cal
31 population. The department may determine in selected therapeutic
32 categories or subcategories that no single-source drugs are
33 necessary because there are currently sufficient multiple-source
34 drugs in the therapeutic category or subcategory on the list of
35 contract drugs to meet the health needs of the Medi-Cal population.
36 However, in no event shall a beneficiary be denied continued use
37 of a drug which is part of a prescribed therapy in effect as of
38 September 2, 1992, until the prescribed therapy is no longer
39 prescribed.

1 (2) In the development of decisions by the department on the
2 required number of single-source drugs in a therapeutic category
3 or subcategory, and the relative therapeutic merits of each drug in
4 a therapeutic category or subcategory, the department shall consult
5 with the Medi-Cal Contract Drug Advisory Committee. The
6 committee members shall communicate their comments and
7 recommendations to the department within 30 business days of a
8 request for consultation, and shall disclose any associations with
9 pharmaceutical manufacturers or any remuneration from
10 pharmaceutical manufacturers.

11 (f) In order to achieve maximum cost savings, the Legislature
12 declares that an expedited process for contracts under this section
13 is necessary. Therefore, contracts entered into on a nonbid basis
14 shall be exempt from Chapter 2 (commencing with Section 10290)
15 of Part 2 of Division 2 of the Public Contract Code.

16 (g) In no event shall a beneficiary be denied continued use of
17 a drug that is part of a prescribed therapy in effect as of September
18 2, 1992, until the prescribed therapy is no longer prescribed.

19 (h) Contracts executed pursuant to this section shall be
20 confidential and shall be exempt from disclosure under the
21 California Public Records Act (Chapter 3.5 (commencing with
22 Section 6250) of Division 7 of Title 1 of the Government Code).

23 (i) The department shall provide individual notice to Medi-Cal
24 beneficiaries at least 60 calendar days prior to the effective date
25 of the deletion or suspension of any drug from the list of contract
26 drugs. The notice shall include a description of the beneficiary's
27 right to a fair hearing and shall encourage the beneficiary to consult
28 a physician to determine if an appropriate substitute medication
29 is available from Medi-Cal.

30 (j) In carrying out the provisions of this section, the department
31 may contract either directly, or through the fiscal intermediary,
32 for pharmacy consultant staff necessary to initially accomplish the
33 treatment authorization request reviews.

34 (k) (1) Manufacturers shall calculate and pay interest on late
35 or unpaid rebates. The interest shall not apply to any prior period
36 adjustments of unit rebate amounts or department utilization
37 adjustments.

38 (2) For state rebate payments, manufacturers shall calculate and
39 pay interest on late or unpaid rebates for quarters that begin on or
40 after the effective date of the act that added this subdivision.

1 (3) Following final resolution of any dispute pursuant to
2 procedures established by the federal Centers for Medicare and
3 Medicaid Services' Medicaid Drug Rebate Program Releases or
4 regulations regarding the amount of a rebate, any underpayment
5 by a manufacturer shall be paid with interest calculated pursuant
6 to subdivisions (m) and (n), and any overpayment, together with
7 interest at the rate calculated pursuant to subdivisions (m) and (n),
8 shall be credited by the department against future rebates due.

9 (l) Interest pursuant to subdivision (k) shall begin accruing 38
10 calendar days from the date of mailing of the invoice, including
11 supporting utilization data sent to the manufacturer. Interest shall
12 continue to accrue until the date of mailing of the manufacturer's
13 payment.

14 (m) Except as specified in subdivision (n), interest rates and
15 calculations pursuant to subdivision (k) for Medicaid rebates and
16 state rebates shall be identical and shall be determined by the
17 federal Centers for Medicare and Medicaid Services' Medicaid
18 Drug Rebate Program Releases or regulations.

19 (n) If the date of mailing of a state rebate payment is 69 days
20 or more from the date of mailing of the invoice, including
21 supporting utilization data sent to the manufacturer, the interest
22 rate and calculations pursuant to subdivision (k) shall be as
23 specified in subdivision (m), however the interest rate shall be
24 increased by 10 percentage points. This subdivision shall apply to
25 payments for amounts invoiced for any quarters that begin on or
26 after the effective date of the act that added this subdivision.

27 (o) If the rebate payment is not received, the department shall
28 send overdue notices to the manufacturer at 38, 68, and 98 days
29 after the date of mailing of the invoice, and supporting utilization
30 data. If the department has not received a rebate payment, including
31 interest, within 180 days of the date of mailing of the invoice,
32 including supporting utilization data, the manufacturer's contract
33 with the department shall be deemed to be in default and the
34 contract may be terminated in accordance with the terms of the
35 contract. For all other manufacturers, if the department has not
36 received a rebate payment, including interest, within 180 days of
37 the date of mailing of the invoice, including supporting utilization
38 data, all of the drug products of those manufacturers shall be made
39 available only through prior authorization effective 270 days after

1 the date of mailing of the invoice, including utilization data sent
2 to manufacturers.

3 (p) If the manufacturer provides payment or evidence of
4 payment to the department at least 40 days prior to the proposed
5 date the drug is to be made available only through prior
6 authorization pursuant to subdivision (o), the department shall
7 terminate its actions to place the manufacturers' drug products on
8 prior authorization.

9 (q) The department shall direct the state's fiscal intermediary
10 to remove prior authorization requirements imposed pursuant to
11 subdivision (o) and notify providers within 60 days after payment
12 by the manufacturer of the rebate, including interest. If a contract
13 was in place at the time the manufacturers' drugs were placed on
14 prior authorization, removal of prior authorization requirements
15 shall be contingent upon good faith negotiations and a signed
16 contract with the department.

17 (r) A beneficiary may obtain drugs placed on prior authorization
18 pursuant to subdivision (o) if the beneficiary qualifies for
19 continuing care status. To be eligible for continuing care status, a
20 beneficiary must be taking the drug when its manufacturer is placed
21 on prior authorization status. Additionally, the department shall
22 have received a claim for the drug with a date of service that is
23 within 100 days prior to the date the manufacturer was placed on
24 prior authorization.

25 (s) A beneficiary may remain eligible for continuing care status,
26 provided that a claim is submitted for the drug in question at least
27 every 100 days and the date of service of the claim is within 100
28 days of the date of service of the last claim submitted for the same
29 drug.

30 (t) Drugs covered pursuant to Sections 14105.43 and 14133.2
31 shall not be subject to prior authorization pursuant to subdivision
32 (o), and any other drug may be exempted from prior authorization
33 by the department if the director determines that an essential need
34 exists for that drug, and there are no other drugs currently available
35 without prior authorization that meet that need.

36 (u) It is the intent of the Legislature in enacting subdivisions
37 (k) to (t), inclusive, that the department and manufacturers shall
38 cooperate and make every effort to resolve rebate payment disputes
39 within 90 days of notification by the manufacturer to the
40 department of a dispute in the calculation of rebate payments.

1 *SEC. 6. Section 14105.436 of the Welfare and Institutions Code*
2 *is amended to read:*

3 14105.436. (a) Effective July 1, 2002, all pharmaceutical
4 manufacturers shall provide to the department a state rebate, in
5 addition to rebates pursuant to other provisions of state or federal
6 law, for any drug products that have been added to the Medi-Cal
7 list of contract drugs pursuant to Section 14105.43 or 14133.2 and
8 reimbursed through the Medi-Cal outpatient fee-for-service drug
9 program. The state rebate shall be negotiated as necessary between
10 the department and the pharmaceutical manufacturer. The
11 negotiations shall take into account offers such as rebates,
12 discounts, disease management programs, and other cost savings
13 offerings and shall be retroactive to July 1, 2002.

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

20 (c) For purposes of this section, “Medi-Cal utilization data”
21 means the data used by the department to reimburse providers
22 under all programs that qualify for federal drug rebates pursuant
23 to Section 1927 of the federal Social Security Act (42 U.S.C. Sec.
24 1396r-8) or that otherwise qualify for federal funds under Title
25 XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et
26 seq.) pursuant to the Medicaid state plan or waivers. Medi-Cal
27 utilization data excludes data from covered entities identified in
28 Section 256b(a)(4) of Title 42 of the United States Code in
29 accordance with Sections 256b(a)(5)(A) and 1396r-8(a)(5)(C) of
30 Title 42 of the United States Code, and those capitated plans that
31 include a prescription drug benefit in the capitated rate and that
32 have negotiated contracts for rebates or discounts with
33 manufacturers.

34 (d) *Subdivision (c) shall become inoperative when the*
35 *department implements paragraphs (4) and (5) of subdivision (b)*
36 *of Section 14105.33. The department shall post on its Internet Web*
37 *site a notice that it has implemented paragraphs (4) and (5) of*
38 *subdivision (b) of Section 14105.33.*

39 (†)

1 (e) Effective July 1, 2009, all pharmaceutical manufacturers
2 shall provide to the department a state rebate, in addition to rebates
3 pursuant to other provisions of state or federal law, equal to an
4 amount not less than 10 percent of the average manufacturer price
5 based on Medi-Cal utilization data for any drug products that have
6 been added to the Medi-Cal list of contract drugs pursuant to
7 Section 14105.43 or 14133.2.

8 ~~(e)~~

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

13 ~~(f)~~

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

27 ~~(g)~~

28 (h) For a drug product added to the Medi-Cal list of contract
29 drugs pursuant to Section 14105.43 or 14133.2 on or after January
30 1, 2010, a pharmaceutical manufacturer shall provide to the
31 department a state rebate pursuant to subdivision (d). If the
32 pharmaceutical manufacturer does not enter into a supplemental
33 rebate agreement within 60 days after the addition of the drug to
34 the Medi-Cal list of contract drugs, the manufacturer shall provide
35 to the department a state rebate equal to not less than 20 percent
36 of the average manufacturers price based on Medi-Cal utilization
37 data for any drug products that have been added to the Medi-Cal
38 list of contract drugs pursuant to Section 14105.43 or 14133.2. If
39 the pharmaceutical manufacturer does not enter into a supplemental
40 rebate agreement within 120 days after the addition of the drug to

1 the Medi-Cal list of contract drugs, the pharmaceutical
2 manufacturer’s drug product shall be made available only through
3 an approved treatment authorization request pursuant to subdivision
4 (h). For supplemental rebate agreements executed more than 120
5 days after the addition of the drug product to the Medi-Cal list of
6 contract drugs, the state rebate shall equal an amount not less than
7 20 percent of the average manufacturers price based on Medi-Cal
8 utilization data for any drug products that have been added to the
9 Medi-Cal list of contract drugs pursuant to Section 14105.43 or
10 14133.2.

11 ~~(h)~~

12 (i) Notwithstanding any other provision of law, drug products
13 added to the Medi-Cal list of contract drugs pursuant to Section
14 14105.43 or 14133.2 of manufacturers who do not execute an
15 agreement to pay additional rebates pursuant to this section, shall
16 be available only through an approved treatment authorization
17 request.

18 ~~(i)~~

19 (j) For drug products added on or before December 31, 2009,
20 a beneficiary may obtain a drug product that requires a treatment
21 authorization request pursuant to subdivision (h) if the beneficiary
22 qualifies for continuing care status. To be eligible for continuing
23 care status, a beneficiary must be taking the drug product and the
24 department must have record of a reimbursed claim for the drug
25 product with a date of service that is within 100 days prior to the
26 date the drug product was placed on treatment authorization request
27 status. A beneficiary may remain eligible for continuing care status,
28 provided that a claim is submitted for the drug product in question
29 at least every 100 days and the date of service of the claim is within
30 100 days of the date of service of the last claim submitted for the
31 same drug product.

32 ~~(j)~~

33 (k) Changes made to the Medi-Cal list of contract drugs under
34 this section shall be exempt from the requirements of the
35 Administrative Procedure Act (Chapter 3.5 (commencing with
36 Section 11340), Chapter 4 (commencing with Section 11370), and
37 Chapter 5 (commencing with Section 11500) of Part 1 of Division
38 3 of Title 2 of the Government Code), and shall not be subject to
39 the review and approval of the Office of Administrative Law.

1 *SEC. 7. Section 14105.86 of the Welfare and Institutions Code*
2 *is amended to read:*

3 14105.86. (a) For the purposes of this section, the following
4 definitions apply:

5 (1) (A) “Average sales price” means the price reported to the
6 federal Centers for Medicare and Medicaid Services by the
7 manufacturer pursuant to Section 1847A of the federal Social
8 Security Act (42 U.S.C. Sec. 1395w-3a).

9 (B) “Average manufacturer price” means the price reported to
10 the federal Centers for Medicare and Medicaid Services pursuant
11 to Section 1927 of the federal Social Security Act (42 U.S.C. Sec.
12 1396r-8).

13 (2) “Blood factors” means plasma protein therapies and their
14 recombinant analogs. Blood factors include, but are not limited
15 to, all of the following:

16 (A) Coagulation factors, including:

17 (i) Factor VIII, nonrecombinant.

18 (ii) Factor VIII, porcine.

19 (iii) Factor VIII, recombinant.

20 (iv) Factor IX, nonrecombinant.

21 (v) Factor IX, complex.

22 (vi) Factor IX, recombinant.

23 (vii) Antithrombin III.

24 (viii) Anti-inhibitor factor.

25 (ix) Von Willebrand factor.

26 (x) Factor VIIa, recombinant.

27 (B) Immune Globulin Intravenous.

28 (C) Alpha-1 Proteinase Inhibitor.

29 (b) The reimbursement for blood factors shall be by national
30 drug code number and shall not exceed 120 percent of the average
31 sales price of the last quarter reported.

32 (c) The average sales price for blood factors of manufacturers
33 or distributors that do not report an average sales price pursuant
34 to subdivision (a) shall be identical to the average manufacturer
35 price. The average sales price for new products that do not have
36 a calculable average sales price or average manufacturer price
37 shall be equal to a projected sales price, as reported by the
38 manufacturer to the department. Manufacturers reporting a
39 projected sales price for a new product shall report the first monthly
40 average manufacturer price reported to the federal Centers for

1 Medicare and Medicaid Services. The reporting of an average sales
2 price that does not meet the requirement of this subdivision shall
3 result in that blood factor no longer being considered a covered
4 benefit.

5 (d) The average sales price shall be reported at the national drug
6 code level to the department on a quarterly basis.

7 (e) (1) Effective July 1, 2008, the department shall collect a
8 state rebate, in addition to rebates pursuant to other provisions of
9 state or federal law, for blood factors reimbursed pursuant to this
10 section by programs that qualify for federal drug rebates pursuant
11 to Section 1927 of the federal Social Security Act (42 U.S.C. Sec.
12 1396r-8) or otherwise qualify for federal funds under Title XIX
13 of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.)
14 pursuant to the medicaid state plan or waivers and the programs
15 authorized by Article 5 (commencing with Section 123800) of
16 Chapter 3 of Part 2 of, and Article 1 (commencing with Section
17 125125) of Chapter 2 of Part 5 of, Division 106 of the Health and
18 Safety Code. ~~The~~

19 (2) *Paragraph (1) shall become inoperative when the department*
20 *implements paragraphs (4) and (5) of subdivision (b) of Section*
21 *14105.33. The department shall post on its Internet Web site a*
22 *notice that it has implemented paragraphs (4) and (5) of*
23 *subdivision (b) of Section 14105.33.*

24 (3) *The* state rebate shall be negotiated as necessary between
25 the department and the manufacturer. Manufacturers who do not
26 execute an agreement to pay additional rebates pursuant to this
27 section shall have their blood factors available only through an
28 approved treatment or service authorization request. All blood
29 factors that meet the definition of a covered outpatient drug
30 pursuant to Section 1927 of the federal Social Security Act (42
31 U.S.C. Sec. 1396r-8) shall remain a benefit subject to the utilization
32 controls provided for in this section.

33 ~~(2)~~

34 (4) In reviewing authorization requests, the department shall
35 approve the lowest net cost product that meets the beneficiary's
36 medical need. The review of medical need shall take into account
37 a beneficiary's clinical history or the use of the blood factor
38 pursuant to payment by another third party, or both.

39 (f) A beneficiary may obtain blood factors that require a
40 treatment or service authorization request pursuant to subdivision

1 (e) if the beneficiary qualifies for continuing care status. To be
2 eligible for continuing care status, a beneficiary must be taking
3 the blood factor and the department has reimbursed a claim for
4 the blood factor with a date of service that is within 100 days prior
5 to the date the blood factor was placed on treatment authorization
6 request status. A beneficiary may remain eligible for continuing
7 care status, provided that a claim is submitted for the blood factor
8 in question at least every 100 days and the date of service of the
9 claim is within 100 days of the date of service of the last claim
10 submitted for the same blood factor.

11 (g) Changes made to the list of covered blood factors under this
12 or any other section shall be exempt from the requirements of the
13 Administrative Procedure Act (Chapter 3.5 (commencing with
14 Section 11340), Chapter 4 (commencing with Section 11370), and
15 Chapter 5 (commencing with Section 11500) of Part 1 of Division
16 3 of Title 2 of the Government Code), and shall not be subject to
17 the review and approval of the Office of Administrative Law.

18 *SEC. 8. Section 14132.56 is added to the Welfare and*
19 *Institutions Code, to read:*

20 *14132.56. (a) (1) Only to the extent required by the federal*
21 *government and effective no sooner than required by the federal*
22 *government, behavioral health treatment (BHT), as defined by*
23 *Section 1374.73 of the Health and Safety Code, shall be a covered*
24 *Medi-Cal service for individuals under 21 years of age.*

25 *(2) It is the intent of the Legislature that, to the extent the federal*
26 *government requires BHT to be a covered Medi-Cal service, the*
27 *department shall seek statutory authority to implement this new*
28 *benefit in Medi-Cal.*

29 *(b) The department shall implement, or continue to implement,*
30 *this section only after all of the following occurs or has occurred:*

31 *(1) The department receives all necessary federal approvals to*
32 *obtain federal funds for the service.*

33 *(2) The department seeks and obtains an appropriation that*
34 *would provide the necessary state funding estimated to be required*
35 *for the applicable fiscal year.*

36 *(3) The department consults with stakeholders.*

37 *(c) The department shall develop and define eligibility criteria,*
38 *provider participation criteria, utilization controls, and delivery*
39 *system structure for services under this section, subject to*

1 *limitations allowable under federal law, in consultation with*
2 *stakeholders.*

3 *(d) Notwithstanding Chapter 3.5 (commencing with Section*
4 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*
5 *the department, without taking any further regulatory action, shall*
6 *implement, interpret, or make specific this section by means of*
7 *all-county letters, plan letters, plan or provider bulletins, or similar*
8 *instructions until regulations are adopted. The department shall*
9 *adopt regulations by July 1, 2017, in accordance with the*
10 *requirements of Chapter 3.5 (commencing with Section 11340) of*
11 *Part 1 of Division 3 of Title 2 of the Government Code.*
12 *Notwithstanding Section 10231.5 of the Government Code,*
13 *beginning six months after the effective date of this section, the*
14 *department shall provide semiannual status reports to the*
15 *Legislature, in compliance with Section 9795 of the Government*
16 *Code, until regulations have been adopted.*

17 *(e) For the purposes of implementing this section, the*
18 *department may enter into exclusive or nonexclusive contracts on*
19 *a bid or negotiated basis, including contracts for the purpose of*
20 *obtaining subject matter expertise or other technical assistance.*
21 *Contracts may be statewide or on a more limited geographic basis.*
22 *Contracts entered into or amended under this subdivision shall*
23 *be exempt from Part 2 (commencing with Section 10100) of*
24 *Division 2 of the Public Contract Code and Chapter 6*
25 *(commencing with Section 14825) of Part 5.5 of Division 3 of the*
26 *Government Code, and shall be exempt from the review or*
27 *approval of any division of the Department of General Services.*

28 *(f) The department may seek approval of any necessary state*
29 *plan amendments or waivers to implement this section. The*
30 *department shall make any state plan amendments or waiver*
31 *requests public at least 30 days prior to submitting to the federal*
32 *Centers for Medicare and Medicaid Services, and the department*
33 *shall work with stakeholders to address the public comments in*
34 *the state plan amendment or waiver request.*

35 *(g) This section shall be implemented only to the extent that*
36 *federal financial participation is available and any necessary*
37 *federal approvals have been obtained.*

38 *SEC. 9. Section 14593 of the Welfare and Institutions Code is*
39 *amended to read:*

1 14593. (a) (1) The department may enter into contracts with
2 public or private nonprofit organizations for implementation of
3 the PACE program, and also may enter into separate contracts
4 with PACE organizations, to fully implement the single state
5 agency responsibilities assumed by the department in those
6 contracts, Section 14132.94, and any other state requirement found
7 necessary by the department to provide comprehensive
8 community-based, risk-based, and capitated long-term care services
9 to California's frail elderly.

10 (2) The department may enter into separate contracts as specified
11 in subdivision (a) with up to 15 PACE organizations.

12 (b) The requirements of the PACE model, as provided for
13 pursuant to Section 1894 (42 U.S.C. Sec. 1395eee) and Section
14 1934 (42 U.S.C. Sec. 1396u-4) of the federal Social Security Act,
15 shall not be waived or modified. The requirements that shall not
16 be waived or modified include all of the following:

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

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

21 (3) The interdisciplinary team approach to care management
22 and service delivery.

23 (4) Capitated, integrated financing that allows the provider to
24 pool payments received from public and private programs and
25 individuals.

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

27 (6) The provision of a PACE benefit package for all participants,
28 regardless of source of payment, that shall include all of the
29 following:

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

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

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

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

39 (d) Provisions governing the treatment of income and resources
40 of a married couple, for the purposes of determining the eligibility

1 of a nursing-facility certifiable or institutionalized spouse, shall
2 be established so as to qualify for federal financial participation.

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

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

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

16 (g) *This section shall remain in effect only until April 1, 2015,*
17 *and as of that date is repealed, unless a later enacted statute, that*
18 *is enacted before April 1, 2015, deletes or extends that date.*

19 *SEC. 10. Section 14593 is added to the Welfare and Institutions*
20 *Code, to read:*

21 *14593. (a) (1) The department may enter into contracts with*
22 *public or private nonprofit organizations for implementation of*
23 *the PACE program, and also may enter into separate contracts*
24 *with PACE organizations, to fully implement the single state agency*
25 *responsibilities assumed by the department in those contracts,*
26 *Section 14132.94, and any other state requirement found necessary*
27 *by the department to provide comprehensive community-based,*
28 *risk-based, and capitated long-term care services to California's*
29 *frail elderly.*

30 *(2) The department may enter into separate contracts as*
31 *specified in subdivision (a) with up to 15 PACE organizations.*

32 *(b) The requirements of the PACE model, as provided for*
33 *pursuant to Section 1894 (42 U.S.C. Sec. 1395eee) and Section*
34 *1934 (42 U.S.C. Sec. 1396u-4) of the federal Social Security Act,*
35 *shall not be waived or modified. The requirements that shall not*
36 *be waived or modified include all of the following:*

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

39 *(2) The delivery of comprehensive, integrated acute and*
40 *long-term care services.*

- 1 (3) *The interdisciplinary team approach to care management*
2 *and service delivery.*
- 3 (4) *Capitated, integrated financing that allows the provider to*
4 *pool payments received from public and private programs and*
5 *individuals.*
- 6 (5) *The assumption by the provider of full financial risk.*
- 7 (6) *The provision of a PACE benefit package for all participants,*
8 *regardless of source of payment, that shall include all of the*
9 *following:*
- 10 (A) *All Medicare-covered items and services.*
- 11 (B) *All Medicaid-covered items and services, as specified in the*
12 *state's Medicaid plan.*
- 13 (C) *Other services determined necessary by the interdisciplinary*
14 *team to improve and maintain the participant's overall health*
15 *status.*
- 16 (c) *Sections 14002, 14005.12, 14005.17, and 14006 shall apply*
17 *when determining the eligibility for Medi-Cal of a person receiving*
18 *the services from an organization providing services under this*
19 *chapter.*
- 20 (d) *Provisions governing the treatment of income and resources*
21 *of a married couple, for the purposes of determining the eligibility*
22 *of a nursing-facility certifiable or institutionalized spouse, shall*
23 *be established so as to qualify for federal financial participation.*
- 24 (e) (1) *The department shall establish capitation rates paid to*
25 *each PACE organization at no less than 95 percent of the*
26 *fee-for-service equivalent cost, including the department's cost of*
27 *administration, that the department estimates would be payable*
28 *for all services covered under the PACE organization contract if*
29 *all those services were to be furnished to Medi-Cal beneficiaries*
30 *under the fee-for-service Medi-Cal program provided for pursuant*
31 *to Chapter 7 (commencing with Section 14000).*
- 32 (2) *This subdivision shall be implemented only to the extent that*
33 *federal financial participation is available.*
- 34 (f) *Contracts under this chapter may be on a nonbid basis and*
35 *shall be exempt from Chapter 2 (commencing with Section 10290)*
36 *of Part 2 of Division 2 of the Public Contract Code.*
- 37 (g) *This section shall become operative on April 1, 2015.*
- 38 SEC. 11. (a) *With regard to Section 4 of this act, the*
39 *Legislature finds and declares all of the following:*

1 (1) *The County of Los Angeles has the largest number of school*
2 *districts in the state and a correspondingly large Medi-Cal*
3 *population with a lower than statewide average on utilization of*
4 *Medi-Cal vision services.*

5 (2) *The state contracts with two managed care health plans in*
6 *the County of Los Angeles, which results in the delivery of*
7 *Medi-Cal services to approximately 76 percent of the over 2.3*
8 *million Medi-Cal beneficiaries in that county.*

9 (3) *These 2.3 million beneficiaries are 24 percent of the state's*
10 *total number of Medi-Cal beneficiaries. Approximately one-half*
11 *are under 21 years of age.*

12 (b) *It is therefore the intent of the Legislature, in an effort to*
13 *determine whether children's access to, and utilization of, vision*
14 *care services can be increased by providing vision care services*
15 *at schools, that the State Department of Health Care Services*
16 *establish a pilot program in the County of Los Angeles that enables*
17 *school districts to allow students enrolled in Medi-Cal managed*
18 *care plans to receive vision care services at the school site through*
19 *the use of a mobile vision service provider. It is the intent of the*
20 *Legislature that the vision care services available under this pilot*
21 *be limited to vision examinations and providing eyeglasses.*

22 SEC. 12. *It is the intent of the Legislature that the State*
23 *Department of Health Care Services shall continue to monitor*
24 *access to and utilization of Medi-Cal services in the fee-for-service*
25 *and managed care settings during the 2014–15 fiscal year, in*
26 *conjunction with the department's federally approved plan to*
27 *monitor health care access for Medi-Cal beneficiaries and any*
28 *other methods deemed appropriate by the director. The department*
29 *shall use this information to evaluate current reimbursement levels*
30 *for Medi-Cal providers and to make recommendations for targeted*
31 *changes to the reductions in reimbursement levels made pursuant*
32 *to Chapter 3 of the Statutes of 2011 to the extent the department*
33 *finds those changes appropriate.*

34 SEC. 13. *The balances of the reappropriations provided by*
35 *Item 4300-490 of Section 2.00 of the Budget Act of 2013, as added*
36 *by Chapters 20 and 354 of the Statutes of 2013, payable from the*
37 *General Fund (Item 4300-101-0001, Budget Act of 2009 (Ch. 1,*
38 *2009–10 3rd Ex. Sess., as revised by Ch. 1, 2009–10 4th Ex. Sess.)*
39 *and Item 4300-101-0001, Budget Act of 2010 (Ch. 712, Stats.*
40 *2010)), are hereby reappropriated for the purposes of, and subject*

1 to that Item 4300-490, and, notwithstanding any other law, shall
2 be available for liquidation until June 30, 2015.

3 SEC. 14. (a) For the 2014–15 fiscal year, the sum of three
4 million two hundred thousand dollars (\$3,200,000) is hereby
5 appropriated from the Major Risk Medical Insurance Fund to the
6 State Department of Health Care Services for allocation to health
7 benefit plans that meet all of the following requirements:

8 (1) The health benefit plan has a valid exemption letter from
9 the Internal Revenue Service pursuant to Section 501(c) (9) of the
10 Internal Revenue Code.

11 (2) The health benefit plan is a multiemployer plan, as defined
12 in Section 3(37) of the federal Employee Retirement Income
13 Security Act of 1974 (29 U.S.C. Sec. 1002(37)(A)).

14 (3) The health benefit plan is funded by contributions made by
15 agricultural employers, as defined in subdivision (c) of the Section
16 1140.4 of the Labor Code, where 85 percent or more of the plan's
17 eligible participants are agricultural employees, as defined in
18 subdivision (b) of Section 1140.4 of the Labor Code, for work
19 performed and covered under a collective bargaining agreement.

20 (b) On or before September 1, 2014, the State Department of
21 Health Care Services shall pay the funds allocated pursuant to
22 this section to the health plan that meets the criteria set forth in
23 this section. The funds shall be used to provide health care
24 coverage for agricultural employees and dependents.

25 (c) The payment set forth in subdivision (b) shall not require
26 the State Department of Health Care Services to contract with the
27 recipient of the funds nor shall the payment of funds be subject to
28 the requirements of Part 2 (commencing with Section 10100) of
29 Division 2 of the Public Contract Code.

30 SEC. 15. For the 2014–15 fiscal year, the sum of three million
31 seven hundred fifty thousand dollars (\$3,750,000) is hereby
32 appropriated from the Major Risk Medical Insurance Fund to the
33 State Department of Health Care Services for purposes of
34 electronic health records technical assistance in accordance with
35 the State Medicaid Health Information Technology Plan as
36 specified in Section 14046.1 of the Welfare and Institutions Code.

37 SEC. 16. This act is a bill providing for appropriations related
38 to the Budget Bill within the meaning of subdivision (e) of Section
39 12 of Article IV of the California Constitution, has been identified

- 1 *as related to the budget in the Budget Bill, and shall take effect*
- 2 *immediately.*
- 3 ~~SECTION 1. It is the intent of the Legislature to enact statutory~~
- 4 ~~changes relating to the Budget Act of 2014.~~

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