AMENDED IN SENATE JUNE 15, 2014

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 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. 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.

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

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

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

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

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

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

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

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

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

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

Chapter 13.6. Public Health Demonstration Projects

121287. (a) There are hereby established public health demonstration projects 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.

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

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

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

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

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

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

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

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

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

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

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

(i) Capacity to participate in evaluation activities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Capitation rate adjustments pursuant to this section shall be actuarially based and developed using projections of contingent events including targeted populations who will receive these

services, and shall otherwise be in accordance with requirements necessary to secure federal financial participation.

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

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

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

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

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

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

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

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

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

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

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

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

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

14105.33. (a) The department may 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, and shall maintain a list of those drugs for which contracts have been executed.

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

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

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

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

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

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

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

(4) Commencing July 1, 2014, utilization data used to determine the state rebate shall include data from all programs, including, but not limited to, fee-for-service Medi-Cal, and utilization data, as limited in paragraph (5), from health plans contracting with the department to provide services to beneficiaries pursuant to this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591), that qualify for federal

drug rebates pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8) or that otherwise qualify for federal funds under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) pursuant to the Medicaid state plan or waivers.

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

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

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

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

(7) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific paragraph (5) by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, until the time regulations are adopted. The department

shall adopt regulations by October 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Notwithstanding Section 10231.5 of the Government Code, beginning six months after the effective date of this section, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

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

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

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

(2) In the development of decisions by the department on the required number of single-source drugs in a therapeutic category or subcategory, and the relative therapeutic merits of each drug in a therapeutic category or subcategory, the department shall consult

with the Medi-Cal Contract Drug Advisory Committee. The committee members shall communicate their comments and recommendations to the department within 30 business days of a request for consultation, and shall disclose any associations with pharmaceutical manufacturers or any remuneration from pharmaceutical manufacturers.

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

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

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

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

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

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

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

(3) Following final resolution of any dispute pursuant to procedures established by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations regarding the amount of a rebate, any underpayment

by a manufacturer shall be paid with interest calculated pursuant to subdivisions (m) and (n), and any overpayment, together with interest at the rate calculated pursuant to subdivisions (m) and (n), shall be credited by the department against future rebates due.

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

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

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

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

(p) If the manufacturer provides payment or evidence of payment to the department at least 40 days prior to the proposed date the drug is to be made available only through prior

authorization pursuant to subdivision (o), the department shall terminate its actions to place the manufacturers' drug products on prior authorization.

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

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

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

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

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

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

14105.436. (a) Effective July 1, 2002, all pharmaceutical manufacturers shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Coagulation factors, including:

(i) Factor VIII, nonrecombinant.

(ii) Factor VIII, porcine.

(iii) Factor VIII, recombinant.

(iv) Factor IX, nonrecombinant.

(v) Factor IX, complex.

(vi) Factor IX, recombinant.

(vii) Antithrombin III.

(viii) Anti-inhibitor factor.

(ix) Von Willebrand factor.

(x) Factor VIIa, recombinant.

(B) Immune Globulin Intravenous.

(C) Alpha-1 Proteinase Inhibitor.

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

(c) The average sales price for blood factors of manufacturers or distributors that do not report an average sales price pursuant to subdivision (a) shall be identical to the average manufacturer price. The average sales price for new products that do not have a calculable average sales price or average manufacturer price shall be equal to a projected sales price, as reported by the manufacturer to the department. Manufacturers reporting a projected sales price for a new product shall report the first monthly average manufacturer price reported to the federal Centers for Medicare and Medicaid Services. The reporting of an average sales price that does not meet the requirement of this subdivision shall result in that blood factor no longer being considered a covered benefit.

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

(e) (1) Effective July 1, 2008, the department shall collect a state rebate, in addition to rebates pursuant to other provisions of state or federal law, for blood factors reimbursed pursuant to this section by programs that qualify for federal drug rebates pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8) or otherwise qualify for federal funds under Title XIX

of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) pursuant to the medicaid state plan or waivers and the programs authorized by Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of, and Article 1 (commencing with Section 125125) of Chapter 2 of Part 5 of, Division 106 of the Health and Safety Code.

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

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

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

(f) A beneficiary may obtain blood factors that require a treatment or service authorization request pursuant to subdivision (e) if the beneficiary qualifies for continuing care status. To be eligible for continuing care status, a beneficiary must be taking the blood factor and the department has reimbursed a claim for the blood factor with a date of service that is within 100 days prior to the date the blood factor was placed on treatment authorization request status. A beneficiary may remain eligible for continuing care status, provided that a claim is submitted for the blood factor in question at least every 100 days and the date of service of the claim is within 100 days of the date of service of the last claim submitted for the same blood factor.

(g) Changes made to the list of covered blood factors under this or any other section shall be exempt from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with

Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law.

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

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

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

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

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

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

(3) The department consults with stakeholders.

(c) The department shall develop and define eligibility criteria, provider participation criteria, utilization controls, and delivery system structure for services under this section, subject to limitations allowable under federal law, in consultation with stakeholders.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Notwithstanding Section 10231.5 of the Government Code, beginning six months after the effective date of this section, the department shall provide semiannual status reports to the

Legislature, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

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

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

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

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

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

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

(b) The requirements of the PACE model, as provided for pursuant to Section 1894 (42 U.S.C. Sec. 1395eee) and Section 1934 (42 U.S.C. Sec. 1396u-4) of the federal Social Security Act,

shall not be waived or modified. The requirements that shall not be waived or modified include all of the following:

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

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

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

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

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

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

(A) All Medicare-covered items and services.

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

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

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

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

(e) (1) The department shall establish capitation rates paid to each PACE organization at no less than 90 percent 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 Medi-Cal program provided for pursuant to Chapter 7 (commencing with Section 14000).

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) All Medicare-covered items and services.

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

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

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

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

(e) (1) The department shall establish capitation rates paid to each PACE organization at no less than 95 percent 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 Medi-Cal program provided for pursuant to Chapter 7 (commencing with Section 14000).

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

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

(g) This section shall become operative on April 1, 2015.

SEC. 11. (a) With regard to Section 4 of this act, the Legislature finds and declares all of the following:

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

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

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

(b) It is therefore the intent of the Legislature, in an effort to determine whether children's access to, and utilization of, vision care services can be increased by providing vision care services

at schools, that the State Department of Health Care Services establish a pilot program in the County of Los Angeles that enables school districts to allow students enrolled in Medi-Cal managed care plans to receive vision care services at the school site through the use of a mobile vision service provider. It is the intent of the Legislature that the vision care services available under this pilot be limited to vision examinations and providing eyeglasses.

SEC. 12. It is the intent of the Legislature that the State Department of Health Care Services shall 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, in conjunction with the department's federally approved plan to monitor health care access for Medi-Cal beneficiaries and any other methods deemed appropriate by the director. The department shall use this information to evaluate current reimbursement levels for Medi-Cal providers and to make recommendations for targeted changes to the reductions in reimbursement levels made pursuant to Chapter 3 of the Statutes of 2011 to the extent the department finds those changes appropriate.

SEC. 13. The balances of the reappropriations provided by Item 4300-490 of Section 2.00 of the Budget Act of 2013, as added by Chapters 20 and 354 of the Statutes of 2013, payable from the General Fund (Item 4300-101-0001, Budget Act of 2009 (Ch. 1, 2009–10 3rd Ex. Sess., as revised by Ch. 1, 2009–10 4th Ex. Sess.) and Item 4300-101-0001, Budget Act of 2010 (Ch. 712, Stats. 2010)), are hereby reappropriated for the purposes of, and subject to that Item 4300-490, and, notwithstanding any other law, shall be available for liquidation until June 30, 2015.

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

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

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

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

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

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

SEC. 15. For the 2014–15 fiscal year, the sum of three million seven hundred fifty thousand dollars ($3,750,000) is hereby appropriated 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 in Section 14046.1 of the Welfare and Institutions Code.

SEC. 16. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

O