

Senate Bill No. 75

Passed the Senate June 19, 2015

Secretary of the Senate

Passed the Assembly June 19, 2015

Chief Clerk of the Assembly

This bill was received by the Governor this _____ day
of _____, 2015, at _____ o'clock ____M.

Private Secretary of the Governor

CHAPTER _____

An act to amend Section 1220 of the Business and Professions Code, to amend Sections 100504 and 100505 of the Government Code, to amend Sections 1266, 1279.2, 1367.54, 1373.622, 1420, 1423, 104150, 104322, 110050, 120960, 120962, 124040, and 124977 of, to amend the heading of Chapter 17 (commencing with Section 121348) of Part 4 of Division 105 of, and to add Sections 120780.2, 121348.4, 122425, 122430, and 122435 to, the Health and Safety Code, to amend Sections 10123.184 and 10127.16 of the Insurance Code, to amend Section 19548.2 of the Revenue and Taxation Code, to amend Sections 4369, 4369.1, 4369.2, 4369.3, 4369.4, 4369.5, 14007.2, 14007.5, 14015.5, 14105.94, 14105.192, 14154, 14186, 14186.1, 14186.3, 15894, and 24005 of, to amend and repeal Section 14134 of, and to add Sections 14007.8 and 14127.7 to, the Welfare and Institutions Code, to amend Sections 70 and 71 of Chapter 23 of, and to amend Section 5 of Chapter 361 of, the Statutes of 2013, and to amend Section 1 of Chapter 551 of the Statutes of 2014, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

LEGISLATIVE COUNSEL'S DIGEST

SB 75, Committee on Budget and Fiscal Review. Health.

(1) Under existing law, the State Department of Public Health licenses and regulates clinical laboratories and certain clinical laboratory personnel performing clinical laboratory tests or examinations, subject to certain exceptions. Existing law requires a clinical laboratory to perform all clinical laboratory tests or examinations classified as waived under the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) in conformity with the manufacturer's instructions. Existing law requires a clinical laboratory that performs tests or examinations that are not classified as waived under CLIA to establish and maintain a quality control program that meets specified CLIA standards.

This bill would provide that the quality control program may include the clinical laboratory's use of an alternative quality testing

procedure recognized by the Centers for Medicare and Medicaid Services, including equivalent quality control procedures or an Individual Quality Control Plan, as specified.

(2) Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that took effect January 1, 2014. Among other things, PPACA requires each state, by January 1, 2014, to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. Existing state law establishes the California Health Benefit Exchange (the Exchange) within state government for the purpose of facilitating the enrollment of qualified individuals and qualified small employers in qualified health plans, and specifies the powers and duties of the board governing the Exchange. Among other things, existing law grants the board the authority to standardize products to be offered through the Exchange, and requires the board to establish and use a competitive process to select participating carriers and any other contractors, as specified.

This bill would require any product standardized by the board to be discussed by the board during at least one properly noticed board meeting prior to the board meeting at which the board adopts the standardized products. The bill would require the board to adopt a Health Benefit Exchange Contracting Manual incorporating procurement and contracting policies and procedures that shall be followed by the Exchange, as specified. The bill would also exempt any regulations adopted, amended, or repealed by the board to implement these provisions from the Administrative Procedure Act.

(3) Existing law authorizes the board of the Exchange to adopt emergency regulations until January 1, 2016. Existing law prohibits the Office of Administrative Law from repealing any emergency regulations adopted until revised or repealed by the board, except that existing law also requires any emergency regulation adopted by the board to be repealed by operation of law, except as specified. Existing law allows more than 2 readoptions of those emergency regulations until January 1, 2017, and allows the emergency regulations adopted by the board to remain in effect for 2 years, as specified.

This bill would extend the authority of the board of the Exchange to adopt emergency regulations until January 1, 2017. The bill would delete the prohibition against the office from repealing any emergency regulation of the board, but would continue to require any emergency regulation adopted by the board to be repealed by operation of law, except as specified. The bill would instead authorize the board to allow more than 2 readoptions of those emergency regulations until January 1, 2020, and would allow the emergency regulations adopted by the board to instead remain in effect for 3 years, as specified.

(4) Existing law provides for the licensure and regulation of health care facilities, including skilled nursing facilities and long-term health care facilities, as defined, by the State Department of Public Health. Existing law imposes specified fees for the licensure of skilled nursing facilities.

This bill would require the fees for the licensure of skilled nursing facilities to be increased in a specified manner to generate moneys for expenditure by the California Department of Aging for purposes of its Long-Term Care Ombudsman Program for work related to investigating complaints against skilled nursing facilities and increasing visits to those facilities.

(5) Existing law requires the State Department of Public Health to follow specified procedures when the department receives a written or oral complaint about a long-term health care facility, as specified, including investigation procedures. Existing law requires the issuance of a citation under specified provisions to be served upon a facility within 3 working days of a final determination, unless a licensee agrees to an extension of time.

This bill would make changes to those investigation procedures, as specified, including, but not limited to, changing the time period for investigation of a complaint and authorizing an extension of that time period under extenuating circumstances. The bill would instead require a citation issued under those provisions to be served within 30 days of a final determination or completion of a complaint investigation, as specified. The bill would make conforming changes to a reporting requirement.

Existing law requires the State Department of Public Health, when it receives a complaint or report involving a general acute care hospital, acute psychiatric hospital, or special hospital, that indicates an ongoing threat of imminent danger of death or serious

bodily harm, to complete an investigation of the complaint or report within 45 days.

If the department fails to meet those requirements, this bill would require the department to document the extenuating circumstances leading to the failure to meet the 45-day time period, and to provide written notice to the facility and the complainant of the extenuating circumstances and an anticipated completion date.

(6) Existing law requires the State Department of Health Care Services to perform various health functions, including providing for breast and cervical cancer screening and treatment for low-income individuals, prostate cancer screening and treatment for low-income and uninsured men, and specified family planning services.

This bill would require, with regard to the above health care programs, providers, or the enrolling entity, as applicable, to make available to all applicants and beneficiaries prior to, or concurrent with, enrollment, information on the manner in which to apply for insurance affordability programs, in a manner determined by the department. The information provided would be required to include the manner in which applications can be submitted for insurance affordability programs, information about the open enrollment periods for the Exchange, and the continuous enrollment aspect of the Medi-Cal program.

(7) Existing law creates the Food Safety Fund, as a special fund, and requires all moneys collected by the State Department of Public Health, pursuant to specified authority, to be deposited in the fund, for use by the department, upon appropriation by the Legislature, for the purposes of providing funds necessary to carry out and implement, among other things, inspection provisions relating to food, licensing, inspection, enforcement, and specified provisions relating to water.

This bill would require moneys awarded to the department pursuant to court orders or settlements for the use of food safety-related activities to be deposited in the fund for those same health and safety purposes.

(8) Existing law authorizes a public entity that receives General Fund money from the State Department of Public Health for HIV prevention and education to use that money to support clean needle and syringe exchange programs authorized pursuant to law. Existing law requires several conditions to be met for the use of

funds in this manner, such as the amount used not exceeding 7.5% of the total amount of General Fund money received for HIV prevention and education.

This bill would authorize the State Department of Public Health to purchase sterile hypodermic needles and syringes, and other supplies, for distribution to syringe exchange programs, for the purpose of reducing the spread of HIV, hepatitis C, and other potentially deadly blood-borne pathogens.

(9) Existing law requires the State Public Health Officer to establish, and authorizes him or her to administer, a program to provide drug treatments to persons infected with HIV, to the extent that state and federal funds are appropriated. Existing law makes a person financially eligible to receive services under this program if his or her adjusted gross income does not exceed \$50,000 per year, and as specified. Existing law establishes a payment schedule to determine the payment obligation of a person receiving drugs under the program, except as specified. Existing law requires the State Department of Public Health and the Franchise Tax Board to exchange prescribed information in order to verify financial eligibility under the program. Existing law provides that this information constitutes confidential public health records, as specified.

This bill would instead make a person financially eligible to receive services under the program if his or her modified adjusted gross income, as defined, does not exceed 500% of the federal poverty level, as defined, per year based on family size and household income, as defined. The bill would make conforming changes to the provisions that establish a payment schedule and that require the department and the board to exchange information for purposes of determining eligibility.

(10) Existing law establishes various programs relating to treatment of persons with the human immunodeficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS). Under existing law, the Office of AIDS, State Department of Public Health, is responsible for coordinating state programs, services, and activities relating to HIV and AIDS, and AIDS-related conditions.

This bill would require the State Department of Public Health, upon an appropriation in the annual Budget Act, to establish the Pre-Exposure Prophylaxis (PrEP) Navigator Services Program,

under which the department shall provide for specified activities relating to, among other things, oversight of the program and funding for community-based organizations and local health departments to provide outreach and education services to populations affected by HIV.

(11) Existing law requires the State Department of Public Health to make available protocols and guidelines developed by the National Institutes of Health, the University of California at San Francisco, and the California legislative advisory committees on hepatitis C for educating physicians and health professionals and training community service professionals and training community service providers on the most recent scientific and medical information on hepatitis C detection, transmission, diagnosis, treatment, and therapeutic decisionmaking.

This bill would establish a 3-year Hepatitis C Linkage to Care demonstration pilot project to allow for innovative, evidence-based approaches to provide outreach, hepatitis C screening, and linkage to, and retention in, quality health care for the most vulnerable and underserved individuals living with, or at high risk for, hepatitis C viral infection. The bill would, upon appropriation, require the department to award funding to community-based organizations or local health jurisdictions to operate demonstration pilot projects, as specified.

(12) Existing law requires the governing board of a county to establish a community child health and disability prevention program for the purpose of providing early and periodic evaluation of the health status of children in the county. The program plan is required to include screening and evaluation for each child, including referrals to a dentist participating in the Medi-Cal program for all children 3 years of age and older who are eligible for Medi-Cal.

This bill would, instead, require the program plan to include referrals to a dentist for all children eligible for the Medi-Cal program one year of age and older. Because the bill would require expansion of the county program plan, it would create a state-mandated local program.

(13) Existing law requires the State Department of Public Health to establish a program for the development, provision, and evaluation of genetic disease testing. Existing law requires the department to charge a fee to all payers for certain genetic disease

screening tests and activities. Existing law requires fees charged for prenatal screening and followup services provided to persons enrolled in the Medi-Cal program, health care service plan enrollees, or persons covered by health insurance policies, to be paid in full and deposited in the Genetic Disease Testing Fund or the Birth Defects Monitoring Program Fund, as prescribed, subject to all terms and conditions of each enrollee's or insured's health care service plan or insurance coverage, including, but not limited to, applicable copayments and deductibles.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, a group or individual health care service plan contract, with designated exceptions, or a health insurer is required to include coverage for the statewide Expanded Alpha Feto Protein (AFP) genetic testing program.

This bill would prohibit coverage by a health care service plan or health insurer for these genetic testing services from being subject to copayment, coinsurance, deductible, or any other form of cost sharing. The services would be paid according to the fee amounts set under the department's genetic disease testing programs and applicable regulations. The bill also would make various technical and conforming changes.

Because existing law makes a willful violation of the provisions relating to health care services plans a crime, by expanding the definition of this crime, the bill would impose a state-mandated local program.

(14) Under existing law, a health care service plan and a health insurer are required to offer a standard benefit plan, as specified, under which health care service plans and insurers are required to continue to provide coverage under the same terms and conditions prescribed under a previously authorized pilot program. Under existing law, the State Department of Health Care Services is responsible for paying the costs of the coverage, completing periodic reconciliation reports with health care service plans and insurers, and adopting appropriate regulations. Existing law requires the department to complete reconciliation with a health care service program or insurer for a given reporting period within 6 months after receiving the plan's or insurer's conciliation report.

Existing law establishes the California Major Risk Medical Insurance Program (MRMIP), which is administered by the department, operative July 1, 2014. Under existing law, MRMIP provides major risk medical coverage to certain categories of individuals who have been rejected for coverage by at least one private health plan, and meet other program requirements. Existing law specifies the powers and duties of the department with respect to MRMIP. Existing law creates the Major Risk Medical Insurance Fund as a continuously appropriated fund for purposes of funding services under MRMIP and the standard benefit plans described above.

This bill would extend the time within which the department is required to complete reconciliation with plans and insurers, to 18 months after receiving the conciliation report. The bill would authorize the department to implement these provisions in a specified manner.

The bill would also establish procedures that would apply under circumstances in which the department and a health care service plan or health insurer have not agreed to a final reconciliation of the amount to be expended from the Major Risk Medical Insurance Fund or to be reimbursed to the fund for the purposes described above, including provisions relating to the payment of interest or the negotiation of payment plans, as specified.

(15) Existing law establishes the Office of Problem and Pathological Gambling within the State Department of Public Health. Under existing law, the office is responsible for developing programs for problem gambling prevention and treatment services for California residents. Existing law defines the terms “pathological gambling disorder” and “problem gambling” for these purposes.

This bill would rename that office the Office of Problem Gambling and would substitute the term “gambling disorder,” as defined, for the terms “pathological gambling disorder” and “problem gambling.” The bill would, among other things, additionally authorize the gambling disorder prevention and treatment programs to provide services to an affected individual, which the bill would define as a person who experiences adverse psychiatric or physical impacts due to another person’s gambling disorder. The bill would also authorize the treatment program to include research and training components, as specified.

(16) 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.

The federal Medicaid Program provisions prohibit payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

This bill would extend eligibility for full-scope Medi-Cal benefits to individuals under 19 years of age who do not have, or are unable to establish, satisfactory immigration status. The bill would direct the State Department of Health Care Services to seek any necessary federal approvals to obtain federal financial participation for these services, and would require that these services be provided with state-only funds only if federal financial participation is not available. Because counties are required to make Medi-Cal eligibility determinations and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program.

(17) Existing law, until July 1, 2015, requires the State Department of Health Care Services to retain or delegate the authority to perform Medi-Cal eligibility determinations as set forth in specified provisions related to electronic determination of eligibility.

This bill would delete the repeal date, and would thereby extend the operation of those provisions indefinitely.

(18) Existing law authorizes certain ground emergency medical transportation providers to receive supplemental Medi-Cal reimbursement in addition to the rate of payment that the provider would otherwise receive for those services. Existing law specifies the manner in which the supplemental reimbursement is calculated, and requires the nonfederal share of the supplemental reimbursement to be paid only with funds from specified governmental entities.

This bill would require the State Department of Health Care Services to develop a modified supplemental reimbursement program that would seek to increase the reimbursement to an eligible provider, as specified. The bill would provide that the department shall not implement the modified program unless it determines that the modified program would likely result in an

overall increase to the supplemental reimbursement available under existing law, and the department receives all necessary federal approvals.

(19) Existing law requires, except as otherwise provided, Medi-Cal provider payments and payments for specified non-Medi-Cal programs to be reduced by 10% for dates of service on and after June 1, 2011, and requires payments to Medi-Cal managed health care plans to be reduced by the actuarial equivalent amount of the payment reductions for fee-for-service Medi-Cal benefits, as specified.

This bill would exempt from the application of those reductions dental services and applicable ancillary services for dates of service on or after July 1, 2015, or the effective date of any necessary federal approvals, whichever is later. The bill would also exempt from the application of those reductions payments to dental managed care plans for contract amendments or change orders effective on or after July 1, 2015, or the effective date of any necessary federal approvals, whichever is later.

(20) Existing law authorizes the State Department of Health Care Services, subject to federal approval, to create a Health Home Program for Medi-Cal enrollees with chronic conditions, as prescribed, as authorized under federal law.

This bill would create the Health Home Program Account in the Special Deposit Fund within the State Treasury in order to collect and allocate non-General Fund public or private grant funds, to be expended upon allocation by the Legislature, for the purposes of implementing the Health Home Program. The bill would appropriate \$50,000,000 from the Health Home Program Account to the State Department of Health Care Services for the purposes of implementing the Health Home Program.

(21) Existing law requires Medi-Cal beneficiaries to make set copayments for specified services and, upon federal approval, existing law revises these copayment rates and makes other related changes, as specified.

This bill would delete the revised copayment rate provisions and would make a conforming change.

(22) Under existing law, the Legislature finds and declares that linking appropriate funding for county Medi-Cal administrative operations, including annual cost-of-doing-business adjustments, with performance standards will give counties the incentive to

meet the performance standards and enable them to continue to do the work they do on behalf of the state. Existing law provides that it is the intent of the Legislature to provide appropriate funding to the counties for the effectual administration of the Medi-Cal program, except for specified fiscal years in regard to any cost-of-doing-business adjustment.

This bill would additionally provide that it is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2015–16 fiscal year.

(23) One of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care health plans. Existing federal law provides for the federal Medicare Program, which is a public health insurance program for persons who are 65 years of age or older and specified persons with disabilities who are under 65 years of age.

Existing law requires the State Department of Health Care Services to seek federal approval pursuant to a Medicare or Medicaid demonstration project or waiver, or a combination thereof, to establish a demonstration project, known as the Coordinated Care Initiative, that enables beneficiaries who are dually eligible for the Medi-Cal program and the Medicare Program to receive a continuum of services that maximizes access to, and coordination of, benefits between these programs. Existing law requires that Medi-Cal beneficiaries who have dual eligibility in the Medi-Cal program and Medicare Programs be assigned as mandatory enrollees into managed care health plans in counties participating in the demonstration project, and requires, beginning January 1, 2015, or 19 months after commencement of beneficiary enrollment into managed care, whichever is later, all Medi-Cal long-term services and supports, which includes Multipurpose Senior Services Program (MSSP) services, to be covered under managed care health contracts and only available through managed care health plans to beneficiaries residing in counties participating in the Coordinated Care Initiative.

This bill would extend the transition date MSSP services are required to be a Medi-Cal benefit only available through managed care health plans to no later than December 31, 2017, or on the date managed care health plans and MSSP providers jointly satisfy the readiness criteria developed by the department, and would make additional conforming changes. The bill would require the

department to notify the appropriate fiscal and policy committees of the Legislature of its intent to transition MSSP services to managed care health plans at least 30 days before this transition occurs. The bill would require the department and the California Department of Aging, in consultation with specified entities, to develop readiness criteria, as specified. The bill would require the department to evaluate the readiness of the managed care health plans and MSSP providers to commence the transition of MSSP services to managed care health plans.

(24) Existing law requires the State Department of Health Care Services to accept contributions by private foundations in the amount of at least \$14,000,000 for purposes of making Medi-Cal in-person enrollment assistance payments to eligible entities and persons, as specified, and in the amount of at least \$12,500,000 to provide allocations for the management and funding of Medi-Cal outreach and enrollment activities, as specified. Existing law requires the department to seek federal matching funds for those purposes. Existing law establishes the Healthcare Outreach and Medi-Cal Enrollment Account in the Special Deposit Fund within the State Treasury in order to collect and allocate these funds, as specified. Existing law appropriates specified funds to the department from this account for the purposes described above, which are available for encumbrance or expenditure until June 30, 2016, and until December 31, 2016, as specified.

This bill would require the department to make the in-person enrollment assistance payments described above for submitted applications received through June 30, 2015, that result in approved applications. Once all of those payments have been made, the bill would require the department to allocate any remaining funds accepted pursuant to the in-person enrollment assistance payment provisions to counties to be used for the Medi-Cal outreach and enrollment activities described above. The bill would require those remaining funds that are allocated to those counties to be distributed to community-based organizations providing enrollment assistance to prospective Medi-Cal enrollees, as specified. The bill would authorize those counties to retain a specified amount for administrative costs. The bill would require the department to make an initial allocation to counties for these funds no later than January 1, 2016, and the final allocation no later than June 30,

2016. The bill would make the in-person enrollment assistance provisions inoperative on a specified date.

This bill would make the requirement that the State Department of Health Care Services accept the private foundation funding for outreach and enrollment grants inoperative on June 30, 2018. The bill would extend the availability of amounts previously appropriated from the Healthcare Outreach and Medi-Cal Enrollment Account and the Federal Trust Fund to June 30, 2018, thereby making an appropriation.

(25) This bill would require, upon an appropriation of funds by the Legislature for this purpose, the State Department of Health Care Services to provide a grant to health benefit plans that meet certain criteria for purposes of funding health care coverage for agricultural employees and dependents, as specified.

(26) This bill, for the 2015–16 fiscal year and upon appropriation of funds by the Legislature for this purpose, would require the State Department of Health Care Services to provide a grant to LifeLong Medical Care, a federally qualified health center in Contra Costa County, to be used to support LifeLong Medical Care.

(27) Existing law, the Budget Act of 2013, appropriates \$142,000,000 to the California Health Facilities Financing Authority (CHFFA) for mental health wellness grants. Existing law, the Budget Act of 2013, authorizes these funds to be available for encumbrance or expenditure until June 30, 2016.

This bill would authorize CHFFA to use up to \$3,000,000 of these funds, if unencumbered, to develop peer respite sites. The bill would require any grant awards authorized by CHFFA for peer respite sites to be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase bed capacity for peer respite support services. The bill would authorize CHFFA to adopt emergency regulations relating to grants for peer respite sites in accordance with the Administrative Procedure Act.

(28) This bill would require the Office of System Integration to report to the Legislature by April 1, 2017, on the feasibility, benefits, costs, and risks of installing the Modified Adjusted Gross Income (MAGI) Eligibility Decision Engine in one, two, or all of the Statewide Automated Welfare System consortia systems.

(29) Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

(30) This bill would make legislative findings and declarations as to the necessity of a special statute for LifeLong Medical Care and Contra Costa County.

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

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

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

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

Appropriation: yes.

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

SECTION 1. It is the intent of the Legislature that, in enacting the amendments made to Section 1420 of the Health and Safety Code by the act that added this section, the State Department of Public Health continue to seek to reduce long-term care compliant investigation timelines to less than 60 days with a goal of meeting a 45-day timeline.

SEC. 2. Section 1220 of the Business and Professions Code is amended to read:

1220. (a) (1) Each clinical laboratory shall maintain records, equipment, and facilities that are adequate and appropriate for the services rendered.

(2) (A) Except for tests or examinations classified as waived under CLIA, each clinical laboratory shall enroll, and demonstrate successful participation, as defined under CLIA, for each specialty

and subspecialty in which it performs clinical laboratory tests or examinations, in a proficiency testing program approved by the department or by HCFA, to the same extent as required by CLIA in Subpart H (commencing with Section 493.801) of Title 42 of the Code of Federal Regulations. This requirement shall not be interpreted to prohibit a clinical laboratory from performing clinical laboratory tests or examinations in a specialty or subspecialty for which there is no department or HCFA approved proficiency testing program.

(B) Each clinical laboratory shall authorize its proficiency test results to be reported to the department in an electronic format that is compatible with the department's proficiency testing data monitoring system and shall authorize the release of proficiency tests results to the public to the same extent required by CLIA.

(b) Each clinical laboratory shall be conducted, maintained, and operated without injury to the public health.

(c) (1) The department shall conduct inspections of licensed clinical laboratories no less than once every two years. The department shall maintain a record of those inspections and shall ensure that every licensed clinical laboratory in California is inspected at least that often.

(2) Registered clinical laboratories shall not be routinely inspected by the department.

(3) The department shall conduct an investigation of complaints received concerning any clinical laboratory, which may include an inspection of the laboratory.

(4) Each licensed or registered clinical laboratory shall be subject to inspections by HCFA or HCFA agents, as defined by CLIA, as a condition of licensure or registration.

(d) (1) Each clinical laboratory shall perform all clinical laboratory tests or examinations classified as waived under CLIA in conformity with the manufacturer's instructions.

(2) Except for those clinical laboratories performing only tests or examinations classified as waived under CLIA, each clinical laboratory shall establish and maintain all of the following:

(A) A patient test management system that meets the standards of CLIA in Subpart J (commencing with Section 493.1100) of Title 42 of the Code of Federal Regulations.

(B) A quality control program that meets the requirements of CLIA in Subpart K (commencing with Section 493.1200) of Title

42 of the Code of Federal Regulations as in effect on January 1, 2015, and that may include the clinical laboratory's use of the following alternative quality control testing procedures recognized by the federal Centers for Medicare and Medicaid Services (CMS):

(i) Until December 31, 2015, equivalent quality control procedures.

(ii) Commencing January 1, 2016, an Individualized Quality Control Plan, as incorporated in Appendix C of the State Operations Manual adopted by CMS.

(C) A comprehensive quality assurance program that meets the standards of CLIA in Subpart P (commencing with Section 493.1701) of Title 42 of the Code of Federal Regulations.

SEC. 3. Section 100504 of the Government Code is amended to read:

100504. (a) The board may do the following:

(1) With respect to individual coverage made available in the Exchange, collect premiums and assist in the administration of subsidies.

(2) Enter into contracts.

(3) Sue and be sued.

(4) Receive and accept gifts, grants, or donations of moneys from any agency of the United States, any agency of the state, and any municipality, county, or other political subdivision of the state.

(5) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, and corporations, in compliance with the conflict of interest provisions to be adopted by the board at a public meeting.

(6) Adopt rules and regulations, as necessary. Until January 1, 2017, any necessary rules and regulations may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2). The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2, including subdivisions (e) and (h) of Section 11346.1, any emergency regulation adopted pursuant to this section shall be repealed by operation of law unless the adoption, amendment, or repeal of the regulation is promulgated by the board pursuant to Chapter 3.5

(commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code within three years of the initial adoption of the emergency regulation. Notwithstanding subdivision (h) of Section 11346.1, until January 1, 2020, the Office of Administrative Law may approve more than two readoptions of an emergency regulation adopted pursuant to this section. The amendments made to this paragraph by the act adding this sentence shall apply to any emergency regulation adopted pursuant to this section prior to the effective date of the Budget Act of 2015.

(7) Collaborate with the State Department of Health Care Services and the Managed Risk Medical Insurance Board, to the extent possible, to allow an individual the option to remain enrolled with his or her carrier and provider network in the event the individual experiences a loss of eligibility of premium tax credits and becomes eligible for the Medi-Cal program or the Healthy Families Program, or loses eligibility for the Medi-Cal program or the Healthy Families Program and becomes eligible for premium tax credits through the Exchange.

(8) Share information with relevant state departments, consistent with the confidentiality provisions in Section 1411 of the federal act, necessary for the administration of the Exchange.

(9) Require carriers participating in the Exchange to make available to the Exchange and regularly update an electronic directory of contracting health care providers so that individuals seeking coverage through the Exchange can search by health care provider name to determine which health plans in the Exchange include that health care provider in their network. The board may also require a carrier to provide regularly updated information to the Exchange as to whether a health care provider is accepting new patients for a particular health plan. The Exchange may provide an integrated and uniform consumer directory of health care providers indicating which carriers the providers contract with and whether the providers are currently accepting new patients. The Exchange may also establish methods by which health care providers may transmit relevant information directly to the Exchange, rather than through a carrier.

(10) Make available supplemental coverage for enrollees of the Exchange to the extent permitted by the federal act, provided that no General Fund money is used to pay the cost of that coverage. Any supplemental coverage offered in the Exchange shall be

subject to the charge imposed under subdivision (n) of Section 100503.

(b) The Exchange shall only collect information from individuals or designees of individuals necessary to administer the Exchange and consistent with the federal act.

(c) (1) The board shall have the authority to standardize products to be offered through the Exchange. Any products standardized by the board pursuant to this subdivision shall be discussed by the board during at least one properly noticed board meeting prior to the board meeting at which the board adopts the standardized products to be offered through the Exchange.

(2) The adoption, amendment, or repeal of a regulation by the board to implement this subdivision is exempt from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2).

SEC. 4. Section 100505 of the Government Code is amended to read:

100505. (a) The board shall establish and use a competitive process to select participating carriers and any other contractors under this title. Any contract entered into pursuant to this title shall be exempt from Chapter 1 (commencing with Section 10100) of Part 2 of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services. The board shall adopt a Health Benefit Exchange Contracting Manual incorporating procurement and contracting policies and procedures that shall be followed by the Exchange. The policies and procedures in the manual shall be substantially similar to the provisions contained in the State Contracting Manual.

(b) The adoption, amendment, or repeal of a regulation by the board to implement this section, including the adoption of a manual pursuant to subdivision (a) and any procurement process conducted by the Exchange in accordance with the manual, is exempt from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2).

SEC. 5. Section 1266 of the Health and Safety Code is amended to read:

1266. (a) The Licensing and Certification Division shall be supported entirely by federal funds and special funds by no earlier than the beginning of the 2009–10 fiscal year unless otherwise specified in statute, or unless funds are specifically appropriated from the General Fund in the annual Budget Act or other enacted legislation. For the 2007–08 fiscal year, General Fund support shall be provided to offset licensing and certification fees in an amount of not less than two million seven hundred eighty-two thousand dollars (\$2,782,000).

(b) (1) The Licensing and Certification Program fees for the 2006–07 fiscal year shall be as follows:

Type of Facility	Fee	
General Acute Care Hospitals	\$ 134.10	per bed
Acute Psychiatric Hospitals	\$ 134.10	per bed
Special Hospitals	\$ 134.10	per bed
Chemical Dependency Recovery Hospitals	\$ 123.52	per bed
Skilled Nursing Facilities	\$ 202.96	per bed
Intermediate Care Facilities	\$ 202.96	per bed
Intermediate Care Facilities- Developmentally Disabled	\$ 592.29	per bed
Intermediate Care Facilities- Developmentally Disabled-Habilitative	\$1,000.00	per facility
Intermediate Care Facilities- Developmentally Disabled-Nursing	\$1,000.00	per facility
Home Health Agencies	\$2,700.00	per facility
Referral Agencies	\$5,537.71	per facility
Adult Day Health Centers	\$4,650.02	per facility
Congregate Living Health Facilities	\$ 202.96	per bed
Psychology Clinics	\$ 600.00	per facility
Primary Clinics- Community and Free Specialty Clinics- Rehab Clinics	\$ 600.00	per facility
(For profit)	\$2,974.43	per facility
(Nonprofit)	\$ 500.00	per facility
Specialty Clinics- Surgical and Chronic Dialysis Clinics	\$1,500.00	per facility
Pediatric Day Health/Respite Care	\$ 142.43	per bed
Alternative Birthing Centers	\$2,437.86	per facility
Hospice	\$1,000.00	per provider
Correctional Treatment Centers	\$ 590.39	per bed

(2) (A) In the first year of licensure for intermediate care facility/developmentally disabled-continuous nursing (ICF/DD-CN) facilities, the licensure fee for those facilities shall be equivalent to the licensure fee for intermediate care facility/developmentally disabled-nursing facilities during the same year. Thereafter, the licensure fee for ICF/DD-CN facilities shall be established pursuant to the same procedures described in this section.

(B) In the first year of licensure for hospice facilities, the licensure fee shall be equivalent to the licensure fee for congregate living health facilities during the same year. Thereafter, the licensure fee for hospice facilities shall be established pursuant to the same procedures described in this section.

(c) Commencing in the 2015–16 fiscal year, the fees for skilled nursing facilities shall be increased so as to generate four hundred thousand dollars (\$400,000) for the California Department of Aging’s Long-Term Care Ombudsman Program for its work related to investigating complaints made against skilled nursing facilities and increasing visits to those facilities.

(d) Commencing February 1, 2007, and every February 1 thereafter, the department shall publish a list of estimated fees pursuant to this section. The calculation of estimated fees and the publication of the report and list of estimated fees shall not be subject to the rulemaking requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(e) Notwithstanding Section 10231.5 of the Government Code, by February 1 of each year, the department shall prepare the following reports and shall make those reports, and the list of estimated fees required to be published pursuant to subdivision (d), available to the public by submitting them to the Legislature and posting them on the department’s Internet Web site:

(1) A report of all costs for activities of the Licensing and Certification Program. At a minimum, this report shall include a narrative of all baseline adjustments and their calculations, a description of how each category of facility was calculated, descriptions of assumptions used in any calculations, and shall recommend Licensing and Certification Program fees in accordance with the following:

(A) Projected workload and costs shall be grouped for each fee category, including workload costs for facility categories that have

been established by statute and for which licensing regulations and procedures are under development.

(B) Cost estimates, and the estimated fees, shall be based on the appropriation amounts in the Governor's proposed budget for the next fiscal year, with and without policy adjustments to the fee methodology.

(C) The allocation of program, operational, and administrative overhead, and indirect costs to fee categories shall be based on generally accepted cost allocation methods. Significant items of costs shall be directly charged to fee categories if the expenses can be reasonably identified to the fee category that caused them. Indirect and overhead costs shall be allocated to all fee categories using a generally accepted cost allocation method.

(D) The amount of federal funds and General Fund moneys to be received in the budget year shall be estimated and allocated to each fee category based upon an appropriate metric.

(E) The fee for each category shall be determined by dividing the aggregate state share of all costs for the Licensing and Certification Program by the appropriate metric for the category of licensure. Amounts actually received for new licensure applications, including change of ownership applications, and late payment penalties, pursuant to Section 1266.5, during each fiscal year shall be calculated and 95 percent shall be applied to the appropriate fee categories in determining Licensing and Certification Program fees for the second fiscal year following receipt of those funds. The remaining 5 percent shall be retained in the fund as a reserve until appropriated.

(2) (A) A staffing and systems analysis to ensure efficient and effective utilization of fees collected, proper allocation of departmental resources to licensing and certification activities, survey schedules, complaint investigations, enforcement and appeal activities, data collection and dissemination, surveyor training, and policy development.

(B) The analysis under this paragraph shall be made available to interested persons and shall include all of the following:

(i) The number of surveyors and administrative support personnel devoted to the licensing and certification of health care facilities.

(ii) The percentage of time devoted to licensing and certification activities for the various types of health facilities.

(iii) The number of facilities receiving full surveys and the frequency and number of followup visits.

(iv) The number and timeliness of complaint investigations, including data on the department's compliance with the requirements of paragraphs (3), (4), and (5) of subdivision (a) of Section 1420.

(v) Data on deficiencies and citations issued, and numbers of citation review conferences and arbitration hearings.

(vi) Other applicable activities of the licensing and certification division.

(3) The annual program fee report described in subdivision (d) of Section 1416.36.

(f) The reports required pursuant to subdivision (e) shall be submitted in compliance with Section 9795 of the Government Code.

(g) (1) The department shall adjust the list of estimated fees published pursuant to subdivision(d) if the annual Budget Act or other enacted legislation includes an appropriation that differs from those proposed in the Governor's proposed budget for that fiscal year.

(2) The department shall publish a final fee list, with an explanation of any adjustment, by the issuance of an all facilities letter, by posting the list on the department's Internet Web site, and by including the final fee list as part of the licensing application package, within 14 days of the enactment of the annual Budget Act. The adjustment of fees and the publication of the final fee list shall not be subject to the rulemaking requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(h) (1) Fees shall not be assessed or collected pursuant to this section from any state department, authority, bureau, commission, or officer, unless federal financial participation would become available by doing so and an appropriation is included in the annual Budget Act for that state department, authority, bureau, commission, or officer for this purpose. Fees shall not be assessed or collected pursuant to this section from any clinic that is certified only by the federal government and is exempt from licensure under Section 1206, unless federal financial participation would become available by doing so.

(2) For the 2006–07 state fiscal year, a fee shall not be assessed or collected pursuant to this section from any general acute care hospital owned by a health care district with 100 beds or less.

(i) The Licensing and Certification Program may change annual license expiration renewal dates to provide for efficiencies in operational processes or to provide for sufficient cashflow to pay for expenditures. If an annual license expiration date is changed, the renewal fee shall be prorated accordingly. Facilities shall be provided with a 60-day notice of any change in their annual license renewal date.

(j) Commencing with the 2018–19 November Program estimate, the Licensing and Certification Program shall evaluate the feasibility of reducing investigation timelines based on experience with implementing paragraphs (3), (4), and (5) of subdivision (a) of Section 1420.

SEC. 6. Section 1279.2 of the Health and Safety Code is amended to read:

1279.2. (a) (1) In any case in which the department receives a report from a facility pursuant to Section 1279.1, or a written or oral complaint involving a health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250, that indicates an ongoing threat of imminent danger of death or serious bodily harm, the department shall make an onsite inspection or investigation within 48 hours or two business days, whichever is greater, of the receipt of the report or complaint and shall complete that investigation within 45 days.

(2) Until the department has determined by onsite inspection that the adverse event has been resolved, the department shall, not less than once a year, conduct an unannounced inspection of any health facility that has reported an adverse event pursuant to Section 1279.1.

(b) In any case in which the department is able to determine from the information available to it that there is no threat of imminent danger of death or serious bodily harm to that patient or other patients, the department shall complete an investigation of the report within 45 days.

(c) If the department does not meet the timeframes established in subdivision (a), the department shall document the extenuating circumstances explaining why it could not meet the timeframes. The department shall provide written notice to the facility and the

complainant, if any, of the basis for the extenuating circumstances and the anticipated completion date.

(d) The department shall notify the complainant and licensee in writing of the department's determination as a result of an inspection or report.

(e) For purposes of this section, "complaint" means any oral or written notice to the department, other than a report from the health facility, of an alleged violation of applicable requirements of state or federal law or an allegation of facts that might constitute a violation of applicable requirements of state or federal law.

(f) The costs of administering and implementing this section shall be paid from funds derived from existing licensing fees paid by general acute care hospitals, acute psychiatric hospitals, and special hospitals.

(g) In enforcing this section and Sections 1279 and 1279.1, the department shall take into account the special circumstances of small and rural hospitals, as defined in Section 124840, in order to protect the quality of patient care in those hospitals.

(h) In preparing the staffing and systems analysis required pursuant to Section 1266, the department shall also report regarding the number and timeliness of investigations of adverse events initiated in response to reports of adverse events.

SEC. 7. Section 1367.54 of the Health and Safety Code is amended to read:

1367.54. (a) Every group health care service plan contract that provides maternity benefits, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 1999, and every individual health care service plan contract of a type and form first offered for sale on or after January 1, 1999, that provides maternity benefits, except a specialized health care service plan contract, shall provide coverage for participation in the California Prenatal Screening Program, which is a statewide prenatal testing program administered by the State Department of Public Health, pursuant to Section 124977. Notwithstanding any other provision of law, a health care service plan that provides maternity benefits shall not require participation in the statewide prenatal testing program administered by the State Department of Public Health as a prerequisite to eligibility for, or receipt of, any other service.

(b) Coverage required by this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing.

(c) Reimbursement for services covered pursuant to this section shall be paid at the amount set pursuant to Section 124977 and regulations adopted thereunder.

SEC. 8. Section 1373.622 of the Health and Safety Code is amended to read:

1373.622. (a) (1) After the termination of the pilot program under Section 1373.62, a health care service plan shall continue to provide coverage under the same terms and conditions specified in Section 1376.62 as it existed on January 1, 2007, including the terms of the standard benefit plan and the subscriber payment amount, to each individual who was terminated from the program pursuant to subdivision (f) of Section 12725 of the Insurance Code during the term of the pilot program and who enrolled or applied to enroll in a standard benefit plan within 63 days of termination. The State Department of Health Care Services shall continue to pay the amount described in Section 1376.62 for each of those individuals. A health care service plan shall not be required to offer the coverage described in Section 1373.62 after the termination of the pilot program to individuals not already enrolled in the program.

(2) Notwithstanding paragraph (1) of this subdivision or Section 1373.62 as it existed on January 1, 2007, the following rules shall apply:

(A) (i) A health care service plan shall not be obligated to provide coverage to any individual pursuant to this section on or after January 1, 2014.

(ii) The State Department of Health Care Services shall not be obligated to provide any payment to any health care service plan under this section for (I) health care expenses incurred on or after January 1, 2014, or (II) the standard monthly administrative fee, as defined in Section 1373.62 as it existed on January 1, 2007, for any month after December 2013.

(B) Each health care service plan providing coverage pursuant to this section shall, on or before October 1, 2013, send a notice to each individual enrolled in a standard benefit plan that is in at least 12-point type and with, at minimum, the following information:

(i) Notice as to whether or not the plan will terminate as of January 1, 2014.

(ii) The availability of individual health coverage, including through Covered California, including at least all of the following:

(I) That, beginning on January 1, 2014, individuals seeking coverage may not be denied coverage based on health status.

(II) That the premium rates for coverage offered by a health care service plan or a health insurer cannot be based on an individual's health status.

(III) That individuals obtaining coverage through Covered California may, depending upon income, be eligible for premium subsidies and cost-sharing subsidies.

(IV) That individuals seeking coverage must obtain this coverage during an open or special enrollment period, and a description of the open and special enrollment periods that may apply.

(C) As a condition of receiving payment for a reporting period pursuant to this section, a health care service plan shall provide the State Department of Health Care Services with a complete, final annual reconciliation report by the earlier of December 31, 2014, or an earlier date as prescribed by Section 1373.62, as it existed on January 1, 2007, for that reporting period. To the extent that it receives a complete, final reconciliation report for a reporting period by the date required pursuant to this subparagraph, the State Department of Health Care Services shall complete reconciliation with the health care service plan for that reporting period within 18 months after receiving the report.

(b) If the state fails to expend, pursuant to this section, sufficient funds for the state's contribution amount to any health care service plan, the health care service plan may increase the monthly payments that its subscribers are required to pay for any standard benefit plan to the amount that the State Department of Health Care Services would charge without a state subsidy for the same plan issued to the same individual within the program.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

SEC. 9. Section 1420 of the Health and Safety Code is amended to read:

1420. (a) (1) Upon receipt of a written or oral complaint, the state department shall assign an inspector to make a preliminary review of the complaint and shall notify the complainant within two working days of the receipt of the complaint of the name of the inspector. Unless the state department determines that the complaint is willfully intended to harass a licensee or is without any reasonable basis, it shall make an onsite inspection or investigation within 10 working days of the receipt of the complaint. In any case in which the complaint involves a threat of imminent danger of death or serious bodily harm, the state department shall make an onsite inspection or investigation within 24 hours of the receipt of the complaint. In any event, the complainant shall be promptly informed of the state department's proposed course of action and of the opportunity to accompany the inspector on the inspection or investigation of the facility. Upon the request of either the complainant or the state department, the complainant or his or her representative, or both, may be allowed to accompany the inspector to the site of the alleged violations during his or her tour of the facility, unless the inspector determines that the privacy of any patient would be violated thereby.

(2) When conducting an onsite inspection or investigation pursuant to this section, the state department shall collect and evaluate all available evidence and may issue a citation based upon, but not limited to, all of the following:

- (A) Observed conditions.
- (B) Statements of witnesses.
- (C) Facility records.

(3) (A) For a complaint that involves a threat of imminent danger of death or serious bodily harm that is received on or after July 1, 2016, the state department shall complete an investigation of the complaint within 90 days of receipt of the complaint. At the completion of the complaint investigation, the state department shall notify the complainant and licensee in writing of the state department's determination as a result of the inspection or investigation.

(B) The time period described in subparagraph (A) may be extended up to an additional 60 days if the investigation cannot be completed due to extenuating circumstances. The state

department shall document these circumstances in its final determination and notify the facility and the complainant in writing of the basis for the extension and the estimated completion date.

(4) (A) For a complaint that does not involve a threat of imminent danger of death or serious bodily harm pursuant to paragraph (3) and that is received on or after July 1, 2017, and prior to July 1, 2018, the state department shall complete an investigation of the complaint within 90 days of receipt of the complaint. At the completion of the complaint investigation, the state department shall notify the complainant and licensee in writing of the state department's determination as a result of the inspection or investigation.

(B) The time period described in subparagraph (A) may be extended up to an additional 90 days if the investigation cannot be completed due to extenuating circumstances. The state department shall document these circumstances in its final determination and notify the facility and the complainant in writing of the basis for the extension and the estimated completion date.

(5) (A) For a complaint that is received on or after July 1, 2018, the state department shall complete an investigation of the complaint within 60 days of receipt of the complaint. At the completion of the complaint investigation, the state department shall notify the complainant and licensee in writing of the state department's determination as a result of the inspection or investigation.

(B) The time period described in subparagraph (A) may be extended up to an additional 60 days if the investigation cannot be completed due to extenuating circumstances. The state department shall document these circumstances in its final determination and notify the facility and the complainant in writing of the basis for the extension and the estimated completion date.

(b) Upon being notified of the state department's determination as a result of the inspection or investigation, a complainant who is dissatisfied with the state department's determination, regarding a matter which would pose a threat to the health, safety, security, welfare, or rights of a resident, shall be notified by the state department of the right to an informal conference, as set forth in this section. The complainant may, within five business days after receipt of the notice, notify the director in writing of his or her request for an informal conference. The informal conference shall

be held with the designee of the director for the county in which the long-term health care facility which is the subject of the complaint is located. The long-term health care facility may participate as a party in this informal conference. The director's designee shall notify the complainant and licensee of his or her determination within 10 working days after the informal conference and shall apprise the complainant and licensee in writing of the appeal rights provided in subdivision (c).

(c) If the complainant is dissatisfied with the determination of the director's designee in the county in which the facility is located, the complainant may, within 15 days after receipt of this determination, notify in writing the Deputy Director of the Licensing and Certification Division of the state department, who shall assign the request to a representative of the Complainant Appeals Unit for review of the facts that led to both determinations. As a part of the Complainant Appeals Unit's independent investigation, and at the request of the complainant, the representative shall interview the complainant in the district office where the complaint was initially referred. Based upon this review, the Deputy Director of the Licensing and Certification Division of the state department shall make his or her own determination and notify the complainant and the facility within 30 days.

(d) Any citation issued as a result of a conference or review provided for in subdivision (b) or (c) shall be issued and served upon the facility within 30 days of the final determination. Service shall be effected either personally or by registered or certified mail. A copy of the citation shall also be sent to each complainant by registered or certified mail.

(e) A miniexit conference shall be held with the administrator or his or her representative upon leaving the facility at the completion of the investigation to inform him or her of the status of the investigation. The state department shall also state the items of noncompliance and compliance found as a result of a complaint and those items found to be in compliance, provided the disclosure maintains the anonymity of the complainant. In any matter in which there is a reasonable probability that the identity of the complainant will not remain anonymous, the state department shall also notify the facility that it is unlawful to discriminate or seek retaliation against a resident, employee, or complainant.

(f) Any citation issued as a result of the complaint investigation provided for in paragraph (3), (4), or (5) of subdivision (a), and in compliance with Section 1423, shall be issued and served upon the facility within 30 days of the completion of the complaint investigation.

(g) For purposes of this section, “complaint” means any oral or written notice to the state department, other than a report from the facility of an alleged violation of applicable requirements of state or federal law or any alleged facts that might constitute such a violation.

(h) Nothing in this section shall be interpreted to diminish the state department’s authority and obligation to investigate any alleged violation of applicable requirements of state or federal law, or any alleged facts that might constitute a violation of applicable requirements of state or federal law, and to enforce applicable requirements of law.

SEC. 10. Section 1423 of the Health and Safety Code is amended to read:

1423. (a) If upon inspection or investigation the director determines that any nursing facility is in violation of any state or federal law or regulation relating to the operation or maintenance of the facility, or determines that any other long-term health care facility is in violation of any statutory provision or regulation relating to the operation or maintenance of the facility, the director shall promptly, but not later than 24 hours, excluding Saturday, Sunday, and holidays, after the director determines or has reasonable cause to determine that an alleged violation has occurred, issue a notice to correct the violation and of intent to issue a citation to the licensee. Before completing the investigation and making the final determination whether to issue a citation, the department shall hold an exit conference with the licensee to identify the potential for issuing a citation for any violation, discuss investigative findings, and allow the licensee to provide the department with additional information related to the violation. The department shall consider this additional information, in conjunction with information from the inspection or investigation, in determining whether to issue a citation, or whether other action would be appropriate. If the department determines that the violation warrants the issuing of a citation and an exit conference has been completed it shall either:

(1) Recommend the imposition of a federal enforcement remedy or remedies on a nursing facility in accordance with federal law; or

(2) Issue a citation pursuant to state licensing laws, and if the facility is a nursing facility, may recommend the imposition of a federal enforcement remedy.

A state citation shall be served upon the licensee within 30 days after completion of the investigation. Service shall be effected either personally or by registered or certified mail. A copy of the citation shall also be sent to each complainant. Each citation shall be in writing and shall describe with particularity the nature of the violation, including a reference to the statutory provision, standard, rule, or regulation alleged to have been violated, the particular place or area of the facility in which it occurred, as well as the amount of any proposed assessment of a civil penalty. The name of any patient jeopardized by the alleged violation shall not be specified in the citation in order to protect the privacy of the patient. However, at the time the licensee is served with the citation, the licensee shall also be served with a written list of each of the names of the patients alleged to have been jeopardized by the violation, that shall not be subject to disclosure as a public record. The citation shall fix the earliest feasible time for the elimination of the condition constituting the alleged violation, when appropriate.

(b) Where no harm to patients, residents, or guests has occurred, a single incident, event, or occurrence shall result in no more than one citation for each statute or regulation violated.

(c) No citation shall be issued for a violation that has been reported by the licensee to the state department, or its designee, as an “unusual occurrence,” if all of the following conditions are met:

(1) The violation has not caused harm to any patient, resident, or guest, or significantly contributed thereto.

(2) The licensee has promptly taken reasonable measures to correct the violation and to prevent a recurrence.

(3) The unusual occurrence report was the first source of information reported to the state department, or its designee, regarding the violation.

SEC. 11. Section 104150 of the Health and Safety Code is amended to read:

104150. (a) (1) A provider or entity that participates in the grant made to the department by the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program established under Title XV of the federal Public Health Service Act (42 U.S.C. Sec. 300k et seq.) in accordance with requirements of Section 1504 of that act (42 U.S.C. Sec. 300n) may only render screening services under the grant to an individual if the provider or entity determines that the individual's family income does not exceed 200 percent of the federal poverty level.

(2) Providers, or the enrolling entity, shall make available to all applicants and beneficiaries, prior to or concurrent with enrollment, information on the manner in which to apply for insurance affordability programs, in a manner determined by the State Department of Health Care Services. The information shall include the manner in which applications can be submitted for insurance affordability programs, information about the open enrollment periods for the California Health Benefit Exchange, and the continuous enrollment aspect of the Medi-Cal program.

(b) The department shall provide for breast cancer and cervical cancer screening services under the grant at the level of funding budgeted from state and other resources during the fiscal year in which the Legislature has appropriated funds to the department for this purpose. These screening services shall not be deemed to be an entitlement.

(c) To implement the federal breast and cervical cancer early detection program specified in this section, the department may contract, to the extent permitted by Section 19130 of the Government Code, with public and private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary. However, the Medi-Cal program's fiscal intermediary shall only be utilized if services provided under the program are specifically identified and reimbursed in a manner that does not claim federal financial reimbursement. Any contracts with, and the utilization of, the Medi-Cal program's fiscal intermediary shall not be subject to Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code. Contracts to implement the federal breast and cervical cancer early detection program entered into by the department with entities other than the Medi-Cal program's fiscal intermediary shall not be subject to Part 2

(commencing with Section 10100) of Division 2 of the Public Contract Code.

(d) The department shall enter into an interagency agreement with the State Department of Health Care Services to transfer that portion of the grant made to the department by the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program established under Title XV of the federal Public Health Service Act (42 U.S.C. Sec. 300k et seq.) to the State Department of Health Care Services. The department shall have no other liability to the State Department of Health Care Services under this article.

SEC. 12. Section 104322 of the Health and Safety Code is amended to read:

104322. (a) (1) The State Department of Health Care Services shall develop and implement a program to provide quality prostate cancer treatment for low-income and uninsured men.

(2) The State Department of Health Care Services shall award one or more contracts to provide prostate cancer treatment through private or public nonprofit organizations, including, but not limited to, community-based organizations, local health care providers, the University of California medical centers, and the Charles R. Drew University of Medicine and Science, an affiliate of the David Geffen School of Medicine at the University of California at Los Angeles. Contracts awarded, subsequent to the effective date of the amendments to this section made during the 2005 portion of the 2005–06 Regular Session, pursuant to this paragraph shall be consistent with both of the following:

(A) Eighty-seven percent of the total contract funding shall be used for direct patient care.

(B) No less than 70 percent of the total contract funding shall be expended on direct patient care treatment costs, which shall be defined as funding to fee-for-service providers for Medi-Cal eligible services.

(3) The contracts described in paragraph (2) shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code. Commencing July 1, 2006, those contracts shall be entered into on a competitive bid basis.

(4) It is the intent of the Legislature to support the prostate cancer treatment program provided for pursuant to this section, and that the program be cost-effective and maximize the number

of men served for the amount of funds appropriated. It is further the intent of the Legislature to ensure that the program has an adequate health care provider network to facilitate reasonable access to treatment.

(b) (1) Treatment provided under this chapter shall be provided to uninsured and underinsured men with incomes at or below 200 percent of the federal poverty level.

(2) The enrolling entity shall make available to all applicants and beneficiaries, prior to or concurrent with enrollment, information on the manner in which to apply for insurance affordability programs, in a manner determined by the State Department of Health Care Services. The information provided shall include the manner in which applications can be submitted for insurance affordability programs, information about the open enrollment periods for the California Health Benefit Exchange, and the continuous enrollment aspect of the Medi-Cal program.

(3) Covered services shall be limited to prostate cancer treatment and prostate cancer-related services. Eligible men shall be enrolled in a 12-month treatment regimen.

(c) The State Department of Health Care Services shall contract for prostate cancer treatment services only at the level of funding budgeted from state and other sources during a fiscal year in which the Legislature has appropriated funds to the department for this purpose.

(d) Notwithstanding subdivision (a) of Section 2.00 of the Budget Act of 2003 and any other law, commencing with the 2003–04 fiscal year and for each fiscal year thereafter, any amount appropriated to the State Department of Health Care Services for the prostate cancer treatment program implemented pursuant to this chapter shall be made available, for purposes of that program, for encumbrance for one fiscal year beyond the year of appropriation and for expenditure for two fiscal years beyond the year of encumbrance.

SEC. 13. Section 110050 of the Health and Safety Code is amended to read:

110050. The Food Safety Fund is hereby created as a special fund in the State Treasury. All moneys collected by the department under subdivision (c) of Section 110466 and Sections 110470, 110471, 110485, 114365, 114365.6, 111130, and 113717, and under Article 7 (commencing with Section 110810) of Chapter 5,

or awarded to the department pursuant to court orders or settlements for the use of food safety-related activities, shall be deposited in the fund, for use by the department, upon appropriation by the Legislature, for the purposes of providing funds necessary to carry out and implement the inspection provisions of this part relating to food, licensing, inspection, enforcement, and other provisions of Article 12 (commencing with Section 111070) of Chapter 5, relating to water, the provisions relating to education and training in the prevention of microbial contamination pursuant to Section 110485, and the registration provisions of Article 7 (commencing with Section 110810) of Chapter 5, and to carry out and implement the provisions of the California Retail Food Code (Part 7 (commencing with Section 113700) of Division 104).

SEC. 14. Section 120780.2 is added to the Health and Safety Code, to read:

120780.2. In order to reduce the spread of HIV, hepatitis C, and other potentially deadly blood-borne pathogens, the State Department of Public Health may purchase sterile hypodermic needles and syringes, and other supplies, for distribution to syringe exchange programs authorized pursuant to law. Supplies provided to programs, including those administered by local health departments, are not subject to the formulas and limits of Section 120780.1.

SEC. 15. Section 120960 of the Health and Safety Code is amended to read:

120960. (a) The department shall establish uniform standards of financial eligibility for the drugs under the program established under this chapter.

(b) Nothing in the financial eligibility standards shall prohibit drugs to an otherwise eligible person whose modified adjusted gross income does not exceed 500 percent of the federal poverty level per year based on family size and household income. However, the director may authorize drugs for persons with incomes higher than 500 percent of the federal poverty level per year based on family size and household income if the estimated cost of those drugs in one year is expected to exceed 20 percent of the person's modified adjusted gross income.

(c) The department shall establish and may administer a payment schedule to determine the payment obligation of a person receiving drugs. No person shall be obligated for payment whose modified

adjusted gross income is less than four times the federal poverty level based on family size and household income. The payment obligation shall be the lesser of the following:

(1) Two times the person's annual state income tax liability, less funds expended by the person for health insurance premiums.

(2) The cost of drugs.

(d) Persons who have been determined to have a payment obligation pursuant to subdivision (c) shall be advised by the department of their right to request a reconsideration of that determination to the department. Written notice of the right to request a reconsideration shall be provided to the person at the time that notification is given that he or she is subject to a payment obligation. The payment determination shall be reconsidered if one or more of the following apply:

(1) The determination was based on an incorrect calculation made pursuant to subdivision (b).

(2) There has been a substantial change in income since the previous eligibility determination that has resulted in a current income that is inadequate to meet the calculated payment obligation.

(3) Unavoidable family or medical expenses that reduce the disposable income and that result in current income that is inadequate to meet the payment obligation.

(4) Any other situation that imposes undue financial hardship on the person and would restrict his or her ability to meet the payment obligation.

(e) The department may exempt a person, who has been determined to have a payment obligation pursuant to subdivision (c), from the obligation if both of the following criteria are satisfied:

(1) One or more of the circumstances specified in subdivision (d) exist.

(2) The department has determined that the payment obligation will impose an undue financial hardship on the person.

(f) If a person requests reconsideration of the payment obligation determination, the person shall not be obligated to make any payment until the department has completed the reconsideration request pursuant to subdivision (d). If the department denies the exemption, the person shall be obligated to make payments for drugs received while the reconsideration request is pending.

(g) A county public health department administering this program pursuant to an agreement with the director pursuant to subdivision (b) of Section 120955 shall use no more than 5 percent of total payments it collects pursuant to this section to cover any administrative costs related to eligibility determinations, reporting requirements, and the collection of payments.

(h) A county public health department administering this program pursuant to subdivision (b) of Section 120955 shall provide all drugs added to the program pursuant to subdivision (a) of Section 120955 within 60 days of the action of the director, subject to the repayment obligations specified in subdivision (d) of Section 120965.

(i) For purposes of this section, the following terms shall have the following meanings:

(1) “Family size” has the meaning given to that term in Section 36B(d)(1) of the Internal Revenue Code of 1986, and shall include same or opposite sex married couples, registered domestic partners, and any tax dependents, as defined by Section 152 of the Internal Revenue Code of 1986, of either spouse or registered domestic partner.

(2) “Federal poverty level” refers to the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of Section 9902(2) of Title 42 of the United States Code.

(3) “Household income” means the sum of the applicant’s or recipient’s modified adjusted gross income, plus the modified adjusted gross income of the applicant’s or recipient’s spouse or registered domestic partner, and the modified adjusted gross incomes of all other individuals for whom the applicant or recipient, or the applicant’s or recipient’s spouse or registered domestic partner, is allowed a federal income tax deduction for the taxable year.

(4) “Internal Revenue Code of 1986” means Title 26 of the United States Code, including all amendments enacted to that code.

(5) “Modified adjusted gross income” has the meaning given to that term in Section 36B(d)(2)(B) of the Internal Revenue Code of 1986.

SEC. 16. Section 120962 of the Health and Safety Code is amended to read:

120962. (a) (1) For the purpose of verifying financial eligibility pursuant to Section 120960 and the federal Ryan White HIV/AIDS Treatment Extension Act of 2009 (42 U.S.C. Sec. 201 et seq.), the department shall verify the accuracy of the adjusted gross income reported on an AIDS Drug Assistance Program application submitted by an applicant or recipient with data, if available, from the Franchise Tax Board.

(2) Notwithstanding any other law, the department shall disclose the name and individual taxpayer identification number (ITIN) or social security number of an applicant for, or recipient of, services under this chapter to the Franchise Tax Board for the purpose of verifying the adjusted gross income of, any tax-exempt interest received by, any tax-exempt social security benefits received by, and any foreign earned income of an applicant or recipient pursuant to subdivision (b) of Section 120960.

(b) (1) The Franchise Tax Board, upon receipt of this information, shall inform the department of all of the following:

(A) The amount of the federal adjusted gross income as reported by the taxpayer to the Franchise Tax Board.

(B) The amount of the California adjusted gross income as reported by the taxpayer to the Franchise Tax Board or as adjusted by the Franchise Tax Board.

(C) The amount of any tax-exempt interest received by the taxpayer, as reported to the Franchise Tax Board.

(D) The amount of any tax-exempt social security benefits received by the taxpayer, as reported to the Franchise Tax Board.

(E) The amount of any foreign earned income of the taxpayer, as reported to the Franchise Tax Board.

(2) The Franchise Tax Board shall provide the information to the department for the most recent taxable year that the Franchise Tax Board has information available, and shall include the first and last name, date of birth, and the ITIN or social security number of the taxpayer.

(c) (1) Information provided by the department pursuant to this section shall constitute confidential public health records as defined in Section 121035, and shall remain subject to the confidentiality protections and restrictions on further disclosure by the recipient under subdivisions (d) and (e) of Section 121025.

(2) To the extent possible, verification of financial eligibility shall be done in a way to eliminate or minimize, by use of computer

programs or other electronic means, Franchise Tax Board staff and contractors' access to confidential public health records.

(3) Prior to accessing confidential HIV-related public health records, Franchise Tax Board staff and contractors shall be required to annually sign a confidentiality agreement developed by the department that includes information related to the penalties under Section 121025 for a breach of confidentiality and the procedures for reporting a breach of confidentiality under subdivision (h) of Section 121022. Those agreements shall be reviewed annually by the department.

(4) The Franchise Tax Board shall return or destroy all information received from the department after completing the exchange of information.

(d) For purposes of this section, "foreign earned income" also includes any deduction taken for the housing expenses of an individual while living abroad pursuant to Section 911 of Title 26 of the Internal Revenue Code.

SEC. 17. The heading of Chapter 17 (commencing with Section 121348) of Part 4 of Division 105 of the Health and Safety Code is amended to read:

CHAPTER 17. PRE- AND POST-EXPOSURE PROPHYLAXIS

SEC. 18. Section 121348.4 is added to the Health and Safety Code, to read:

121348.4. Upon an appropriation in the annual Budget Act, the State Department of Public Health shall establish the Pre-Exposure Prophylaxis (PrEP) Navigator Services Program, under which the department shall provide for the following activities:

(a) Oversight and evaluation of the PrEP Navigator Services Program.

(b) Implementation of a process to request applications, and award funding on a competitive basis, to community-based organizations or local health departments. An eligible entity shall collaborate with the Office of AIDS to conduct outcome and process evaluation of navigator services. An entity in any county shall be eligible to receive funding if it can demonstrate all of the following:

(1) Capacity to ensure access for and serve the most vulnerable and underserved Californians at high risk for HIV.

(2) Ability to develop protocols to conduct outreach to targeted populations, to provide PrEP education to clients and providers, and to assess and refer persons to appropriate clinical care and prevention services.

(c) Development and distribution of PrEP education materials statewide, including providing training for and support of any additional activity that is consistent with the goals of this chapter.

SEC. 19. Section 122425 is added to the Health and Safety Code, to read:

122425. There is hereby established a three-year Hepatitis C Linkage to Care demonstration pilot project to allow for innovative, evidence-based approaches to provide outreach, hepatitis C screening, and linkage to, and retention in, quality health care for the most vulnerable and underserved individuals living with, or at high risk for, hepatitis C viral infection (HCV). This demonstration pilot project is authorized for fiscal years 2015–16, 2016–17, and 2017–18.

SEC. 20. Section 122430 is added to the Health and Safety Code, to read:

122430. (a) Upon an appropriation for the purpose described in Section 122425 in the annual Budget Act for the 2015–16, 2016–17, and 2017–18 fiscal years, the department shall award funding, on a competitive basis, to community-based organizations or local health jurisdictions to operate demonstration pilot projects pursuant to this chapter. The department shall determine the funding levels of each demonstration project based on scope and geographic area. Funds may be used to support other activities consistent with the goals of this chapter, including the purchase of hepatitis C viral infection (HCV) test kits, syringe exchange supplies, or other HCV prevention and linkage to care materials and activities.

(b) An applicant for funding shall demonstrate each of the following qualifications:

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

(2) Experience with the target population or relationships with community-based organizations or nongovernmental organizations,

or both, that demonstrates expertise, history, and credibility working successfully in engaging the target population.

(3) Experience working with nontraditional collaborators who work within and beyond the field of HCV education and outreach, including homeless services, veterans' medical and service programs, substance use disorders treatment, syringe exchange programs, women's health, reproductive health, immigration, mental health, or human immunodeficiency virus (HIV) prevention and treatment.

(4) Strong relationships with community-based HCV health care providers that have the trust of the targeted population.

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

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

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

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

(9) Capacity to participate in evaluation activities.

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

SEC. 21. Section 122435 is added to the Health and Safety Code, to read:

122435. During the demonstration pilot project described in Section 122425, each demonstration pilot 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 living with hepatitis C viral infection (HCV) or at a high risk for HCV infection, for use by providers, the State Department of Public Health, including the Office of AIDS and the Office of Viral Hepatitis Prevention, federal departments and agencies, including the federal Department of Health and Human Services, and other national HIV/AIDS and viral hepatitis groups.

SEC. 22. Section 124040 of the Health and Safety Code is amended to read:

124040. (a) The governing body of each county or counties shall establish a community child health and disability prevention

program for the purpose of providing early and periodic assessments of the health status of children in the county or counties by July 1, 1974. However, this shall be the responsibility of the department for all counties that contract with the state for health services. Contract counties, at the option of the board of supervisors, may provide services pursuant to this article in the same manner as other county programs, if the option is exercised prior to the beginning of each fiscal year. Each plan shall include, but is not limited to, the following requirements:

- (1) Outreach and educational services.
- (2) Agreements with public and private facilities and practitioners to carry out the programs.
- (3) Health screening and evaluation services for all children, including a physical examination, immunizations appropriate for the child's age and health history, and laboratory procedures appropriate for the child's age and population group performed by, or under the supervision or responsibility of, a physician licensed to practice medicine in California or by a certified family nurse practitioner or a certified pediatric nurse practitioner.
- (4) Referral for diagnosis or treatment when needed, including, for all children eligible for Medi-Cal, referral for treatment by a provider participating in the Medi-Cal program of the conditions detected, and methods for assuring referral is carried out.
- (5) Recordkeeping and program evaluations.
- (6) The health screening and evaluation part of each community child health and disability prevention program plan shall include, but is not limited to, the following for each child:
 - (A) A health and development history.
 - (B) An assessment of physical growth.
 - (C) An examination for obvious physical defects.
 - (D) Ear, nose, mouth, and throat inspection, including inspection of teeth and gums, and for all children one year of age and older who are eligible for Medi-Cal, referral to a dentist participating in the Medi-Cal program.
 - (E) Screening tests for vision, hearing, anemia, tuberculosis, diabetes, and urinary tract conditions.
- (7) An assessment of nutritional status.
- (8) An assessment of immunization status.
- (9) If appropriate, testing for sickle-cell trait, lead poisoning, and other tests that may be necessary to the identification of

children with potential disabilities requiring diagnosis and possibly treatment.

(10) For all children eligible for Medi-Cal, necessary assistance with scheduling appointments for services and with transportation.

(b) Dentists receiving referrals of children eligible for Medi-Cal under this section shall employ procedures to advise the child's parent or parents of the need for and scheduling of annual appointments.

(c) Standards for procedures to carry out health screening and evaluation services and to establish the age at which particular tests should be carried out shall be established by the director. At the discretion of the department, these health screening and evaluation services may be provided at the frequency provided under the Healthy Families Program and permitted in managed care plans providing services under the Medi-Cal program, and shall be contingent upon appropriation in the annual Budget Act. Immunizations may be provided at the frequency recommended by the Committee on Infectious Disease of the American Academy of Pediatrics and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(d) Each community child health and disability prevention program shall, pursuant to standards set by the director, establish a record system that contains a health case history for each child so that costly and unnecessary repetition of screening, immunization and referral will not occur and appropriate health treatment will be facilitated as specified in Section 124085.

SEC. 23. Section 124977 of the Health and Safety Code is amended to read:

124977. (a) It is the intent of the Legislature that, unless otherwise specified, the genetic disease testing program carried out pursuant to this chapter be fully supported from fees collected for services provided by the program.

(b) (1) The department shall charge a fee to all payers for any tests or activities performed pursuant to this chapter. The amount of the fee shall be established by regulation and periodically adjusted by the director in order to meet the costs of this chapter. Notwithstanding any other law, any fees charged for prenatal screening and followup services provided to persons enrolled in the Medi-Cal program, health care service plan enrollees, or persons covered by health insurance policies, shall be paid in full

and deposited in the Genetic Disease Testing Fund or the Birth Defects Monitoring Program Fund consistent with this section.

(2) The department shall expeditiously undertake all steps necessary to implement the fee collection process, including personnel, contracts, and data processing, so as to initiate the fee collection process at the earliest opportunity.

(3) Effective for services provided on and after July 1, 2002, the department shall charge a fee to the hospital of birth, or, for births not occurring in a hospital, to families of the newborn, for newborn screening and followup services. The hospital of birth and families of newborns born outside the hospital shall make payment in full to the Genetic Disease Testing Fund. The department shall not charge or bill Medi-Cal beneficiaries for services provided under this chapter.

(4) (A) The department shall charge a fee for prenatal screening to support the pregnancy blood sample storage, testing, and research activities of the Birth Defects Monitoring Program.

(B) The prenatal screening fee for activities of the Birth Defects Monitoring Program shall be ten dollars (\$10).

(5) The department shall set guidelines for invoicing, charging, and collecting from approved researchers the amount necessary to cover all expenses associated with research application requests made under this section, data linkage, retrieval, data processing, data entry, reinventory, and shipping of blood samples or their components, and related data management.

(6) The only funds from the Genetic Disease Testing Fund that may be used for the purpose of supporting the pregnancy blood sample storage, testing, and research activities of the Birth Defects Monitoring Program are those prenatal screening fees assessed and collected prior to the creation of the Birth Defects Monitoring Program Fund specifically to support those Birth Defects Monitoring Program activities.

(7) The Birth Defects Monitoring Program Fund is hereby created as a special fund in the State Treasury. Fee revenues that are collected pursuant to paragraph (4) shall be deposited into the fund and shall be available upon appropriation by the Legislature to support the pregnancy blood sample storage, testing, and research activities of the Birth Defects Monitoring Program. Notwithstanding Section 16305.7 of the Government Code, interest earned on funds in the Birth Defects Monitoring Program Fund

shall be deposited as revenue into the fund to support the Birth Defects Monitoring Program.

(c) (1) The Legislature finds that timely implementation of changes in genetic screening programs and continuous maintenance of quality statewide services requires expeditious regulatory and administrative procedures to obtain the most cost-effective electronic data processing, hardware, software services, testing equipment, and testing and followup services.

(2) The expenditure of funds from the Genetic Disease Testing Fund for these purposes shall not be subject to Section 12102 of, and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of, the Public Contract Code, or to Division 25.2 (commencing with Section 38070). The department shall provide the Department of Finance with documentation that equipment and services have been obtained at the lowest cost consistent with technical requirements for a comprehensive high-quality program.

(3) The expenditure of funds from the Genetic Disease Testing Fund for implementation of the Tandem Mass Spectrometry screening for fatty acid oxidation, amino acid, and organic acid disorders, and screening for congenital adrenal hyperplasia may be implemented through the amendment of the Genetic Disease Branch Screening Information System contracts and shall not be subject to Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, and any policies, procedures, regulations, or manuals authorized by those laws.

(4) The expenditure of funds from the Genetic Disease Testing Fund for the expansion of the Genetic Disease Branch Screening Information System to include cystic fibrosis, biotinidase, severe combined immunodeficiency (SCID), and adrenoleukodystrophy (ALD) may be implemented through the amendment of the Genetic Disease Branch Screening Information System contracts, and shall not be subject to Chapter 2 (commencing with Section 10290) or Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, or Sections 4800 to 5180, inclusive, of the State Administrative Manual as they relate to approval of information technology projects or approval of increases in the

duration or costs of information technology projects. This paragraph shall apply to the design, development, and implementation of the expansion, and to the maintenance and operation of the Genetic Disease Branch Screening Information System, including change requests, once the expansion is implemented.

(d) (1) The department may adopt emergency regulations to implement and make specific this chapter in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the purposes of the Administrative Procedure Act, the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, these emergency regulations shall not be subject to the review and approval of the Office of Administrative Law. Notwithstanding Sections 11346.1 and 11349.6 of the Government Code, the department shall submit these regulations directly to the Secretary of State for filing. The regulations shall become effective immediately upon filing by the Secretary of State. Regulations shall be subject to public hearing within 120 days of filing with the Secretary of State and shall comply with Sections 11346.8 and 11346.9 of the Government Code or shall be repealed.

(2) The Office of Administrative Law shall provide for the printing and publication of these regulations in the California Code of Regulations. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the regulations adopted pursuant to this chapter shall not be repealed by the Office of Administrative Law and shall remain in effect until revised or repealed by the department.

(3) The Legislature finds and declares that the health and safety of California newborns is in part dependent on an effective and adequately staffed genetic disease program, the cost of which shall be supported by the fees generated by the program.

SEC. 24. Section 10123.184 of the Insurance Code is amended to read:

10123.184. (a) Every group policy of disability insurance that covers hospital, medical, or surgical expenses, and that provides maternity benefits, that is issued, amended, renewed, or delivered

on or after January 1, 1999, and every individual policy of disability insurance that covers hospital, medical, or surgical expenses, and that provides maternity benefits, that is of a type and form first offered for sale on or after January 1, 1999, shall provide coverage for participation in the California Prenatal Screening Program, which is a statewide prenatal testing program administered by the State Department of Public Health, pursuant to Section 124977 of the Health and Safety Code. Notwithstanding any other law, a disability insurer that provides coverage for maternity benefits shall not require participation in the statewide prenatal testing program administered by the State Department of Public Health as a prerequisite to eligibility for, or receipt of, any other service.

(b) Coverage required under this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing.

(c) Reimbursement for services covered pursuant to this section shall be paid at the amount set pursuant to Section 124977 of the Health and Safety Code and regulations adopted thereunder.

SEC. 25. Section 10127.16 of the Insurance Code is amended to read:

10127.16. (a) (1) After the termination of the pilot program under Section 10127.15, a health insurer shall continue to provide coverage under the same terms and conditions specified in Section 10127.15 as it existed on January 1, 2007, including the terms of the standard benefit plan and the subscriber payment amount, to each individual who was terminated from the program, pursuant to subdivision (f) of Section 12725 of the Insurance Code during the term of the pilot program and who enrolled or applied to enroll in a standard benefit plan within 63 days of termination. The State Department of Health Care Services shall continue to pay the amount described in Section 10127.15 for each of those individuals. A health insurer shall not be required to offer the coverage described in Section 10127.15 after the termination of the pilot program to individuals not already enrolled in the program.

(2) Notwithstanding paragraph (1) of this subdivision or Section 10127.15 as it existed on January 1, 2007, the following rules shall apply:

(A) (i) A health insurer shall not be obligated to provide coverage to any individual pursuant to this section on or after January 1, 2014.

(ii) The State Department of Health Care Services shall not be obligated to provide any payment to any health insurer under this section for (I) health care expenses incurred on or after January 1, 2014, or (II) the standard monthly administrative fee, as defined in Section 10127.15 as it existed on January 1, 2007, for any month after December 2013.

(B) Each health insurer providing coverage pursuant to this section shall, on or before October 1, 2013, send a notice to each individual enrolled in a standard benefit plan that is in at least 12-point type and with, at minimum, the following information:

(i) Notice as to whether or not the plan will terminate as of January 1, 2014.

(ii) The availability of individual health coverage, including through Covered California, including at least all of the following:

(I) That, beginning on January 1, 2014, individuals seeking coverage may not be denied coverage based on health status.

(II) That the premium rates for coverage offered by a health care service plan or a health insurer cannot be based on an individual's health status.

(III) That individuals obtaining coverage through Covered California may, depending upon income, be eligible for premium subsidies and cost-sharing subsidies.

(IV) That individuals seeking coverage must obtain this coverage during an open or special enrollment period, and a description of the open and special enrollment periods that may apply.

(C) As a condition of receiving payment for a reporting period pursuant to this section, a health insurer shall provide the State Department of Health Care Services with a complete, final annual reconciliation report by the earlier of December 31, 2014, or an earlier date as prescribed by Section 10127.15, as it existed on January 1, 2007, for that reporting period. To the extent that it receives a complete, final reconciliation report for a reporting period by the date required pursuant to this subparagraph, the State Department of Health Care Services shall complete reconciliation with the health insurer for that reporting period within 18 months after receiving the report.

(b) If the state fails to expend, pursuant to this section, sufficient funds for the state's contribution amount to any health insurer, the health insurer may increase the monthly payments that its subscribers are required to pay for any standard benefit plan to the amount that the State Department of Health Care Services would charge without a state subsidy for the same insurance product issued to the same individual within the program.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

SEC. 26. Section 19548.2 of the Revenue and Taxation Code is amended to read:

19548.2. (a) Notwithstanding any other law and in accordance with Section 120962 of the Health and Safety Code, the State Department of Public Health shall disclose the name and individual taxpayer identification number (ITIN) or social security number of an applicant for, or recipient of services pursuant to Chapter 6 (commencing with Section 120950) of Part 4 of Division 105 of the Health and Safety Code to the Franchise Tax Board for the purpose of verifying the adjusted gross income of, any tax-exempt interest received by, any tax-exempt social security benefits received by, and any foreign earned income of an applicant or recipient.

(b) (1) The Franchise Tax Board, upon receipt of this information, shall inform the State Department of Public Health of all of the following:

(A) The amounts of the federal adjusted gross income as reported by the taxpayer to the Franchise Tax Board.

(B) The amounts of the California adjusted gross income as reported by the taxpayer to the Franchise Tax Board or as adjusted by the Franchise Tax Board.

(C) The amount of any tax-exempt interest received by the taxpayer, as reported to the Franchise Tax Board.

(D) The amount of any tax-exempt social security benefits received by the taxpayer, as reported to the Franchise Tax Board.

(E) The amount of any foreign earned income of the taxpayer, as reported to the Franchise Tax Board.

(2) The Franchise Tax Board shall provide the information to the State Department of Public Health for the most recent taxable year that the Franchise Tax Board has information available, and shall include the first and last name, date of birth, and the ITIN or social security number of the taxpayer.

(c) (1) Information provided by the State Department of Public Health pursuant to this section shall constitute confidential public health records as defined in Section 121035 of the Health and Safety Code, and shall remain subject to the confidentiality protections and restrictions on further disclosure by the recipient under subdivisions (d) and (e) of Section 121025.

(2) Prior to accessing confidential HIV-related public health records, Franchise Tax Board staff and contractors shall be required to annually sign a confidentiality agreement developed by the State Department of Public Health that includes information related to the penalties under Section 121025 of the Health and Safety Code for a breach of confidentiality and the procedures for reporting a breach of confidentiality under subdivision (h) of Section 121022 of the Health and Safety Code. Those agreements shall be reviewed annually by the State Department of Public Health.

(3) The Franchise Tax Board shall return or destroy all information received from the State Department of Public Health after completing the exchange of information.

(d) For purposes of this section, “foreign earned income” also includes any deduction taken for the housing expenses of an individual while living abroad pursuant to Section 911 of Title 26 of the Internal Revenue Code.

SEC. 27. Section 4369 of the Welfare and Institutions Code is amended to read:

4369. There is within the State Department of Public Health, the Office of Problem Gambling.

SEC. 28. Section 4369.1 of the Welfare and Institutions Code is amended to read:

4369.1. As used in this chapter, the following definitions shall apply:

(a) “Affected individual” means a person who experiences adverse psychiatric or physical impacts due to another person’s gambling disorder.

(b) “Department” means the State Department of Public Health.

(c) “Gambling disorder” means a condition that causes the person to be unable to resist impulses to gamble, which can lead to harmful negative consequences, and that meets the diagnostic criteria set forth in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Gambling disorder includes both pathological and problem gambling behavior.

(d) “Office” means the Office of Problem Gambling.

(e) “Prevention program” means a program designed to reduce the prevalence of gambling disorders among California residents. The program shall include, but is not limited to, public education and awareness, outreach to high-risk populations, early identification and responsible gambling programs.

(f) “Treatment program” means a program designed to assist individuals who experience harmful negative consequences related to gambling disorders. This program shall include, but is not limited to, training and educating providers, establishing a provider network for the provision of treatment services, and conducting research to ensure the delivery of evidence-based practices.

SEC. 29. Section 4369.2 of the Welfare and Institutions Code is amended to read:

4369.2. (a) The office shall develop a gambling disorder prevention program, which shall consist of all of the following:

(1) A toll-free telephone service for immediate crisis management with subsequent referrals of gamblers and affected individuals to health providers at various levels of care who can provide treatment for gambling disorders and related problems and to self-help groups.

(2) Public awareness campaigns that focus on prevention and education among the general public including, for example, dissemination of youth oriented preventive literature, educational experiences, and public service announcements in the media.

(3) Empirically driven research programs focusing on epidemiology/prevalence, etiology/causation, and best practices in prevention and treatment.

(4) Training of health care professionals and educators, and training for law enforcement agencies and nonprofit organizations in the identification of gambling disorders and knowledge of referral services and treatment programs.

(5) Training of gambling industry personnel in identifying customers at risk for gambling disorders and knowledge of referral and treatment services.

(b) The office shall develop a treatment program for California residents who have a gambling disorder or who are affected individuals. The treatment program may consist of all of the following components:

(1) Training for licensed health providers, including screening and assessment of gambling disorders, the use of evidence-based treatment modalities, and the administrative practices for treatment services implemented under this chapter.

(2) A network of licensed health providers authorized to receive reimbursement from the state for the provision of treatment services. This network may be created through partnerships with established health or substance use disorder facilities or individuals in private practice that can provide treatment for gambling disorders. State funded treatment services may include, but are not limited to, the following: self-administered, home-based educational programs; telephone counseling; group treatment; outpatient treatment; and inpatient residential treatment when medically necessary.

(3) A research program to conduct studies and develop evidence-based tools for use in treating gambling disorders.

(4) A funding allocation methodology that ensures treatment services are delivered efficiently and effectively to areas of the state most in need.

(5) Appropriate review and monitoring of the treatment program by the director of the office or a designated institution, including grant oversight and monitoring of contracts, the standards for treatment, and outcome monitoring.

(6) Treatment efforts shall provide services that are relevant to the needs of a diverse multicultural population with attention to groups with unique needs, including female gamblers, underserved ethnic groups, the elderly, and the physically challenged.

(c) The office shall make information available as requested by the Governor and the Legislature with respect to the comprehensive program.

SEC. 30. Section 4369.3 of the Welfare and Institutions Code is amended to read:

4369.3. In designing and developing the overall program, the office shall do all of the following:

- (a) Develop a statewide plan to address gambling disorders.
- (b) Adopt any regulations necessary to administer the program.
- (c) Develop priorities for funding services and criteria for distributing program funds.
- (d) Monitor the expenditures of state funds by agencies and organizations receiving program funding.
- (e) Evaluate the effectiveness of services provided through the program. The department is authorized to contract with academic experts to perform these evaluations.
- (f) Notwithstanding any other provision of law, any contracts required to meet the requirements of this chapter are exempt from the requirements contained in the Public Contract Code and the State Administrative Manual, and are exempt from the approval of the Department of General Services.
- (g) Administrative costs for the program may not exceed 10 percent of the total funding budgeted for the program.

SEC. 31. Section 4369.4 of the Welfare and Institutions Code is amended to read:

4369.4. All state agencies, including, but not limited to, the California Horse Racing Board, the California Gambling Control Commission, the Department of Justice, and any other agency that regulates casino gambling or cardrooms within the state, and the Department of Corrections and Rehabilitation, the State Department of Public Health, the State Department of Health Care Services, and the California State Lottery, shall coordinate with the office to ensure that state programs take into account, as much as practicable, gambling disorders. The office shall also coordinate and work with other entities involved in gambling and the treatment of gambling disorders.

SEC. 32. Section 4369.5 of the Welfare and Institutions Code is amended to read:

4369.5. (a) It is the intent of the Legislature that the Office of Problem Gambling establish and maintain ongoing venues for system stakeholders to provide input into public policy issues related to gambling disorders, including, but not limited to, consumers of services and their families, providers of services and supports, and county representatives. It is further the intent of the Legislature that the Office of Problem Gambling shall have input

into policy discussions at the State Department of Public Health and at the California Health and Human Services Agency, when appropriate.

(b) It is the intent of the Legislature to ensure that the impacts of the transition of the Office of Problem Gambling from the State Department of Alcohol and Drug Programs to the State Department of Public Health are identified and evaluated, initially and over time. It is further the intent of the Legislature to establish a baseline for evaluating, on an ongoing basis, how and why services provided and overseen by the Office of Problem Gambling were improved, or otherwise changed, as a result of this transition.

(c) (1) By April 1, 2014, and March 1 annually thereafter, the State Department of Public Health shall report to the Joint Legislative Budget Committee and the appropriate budget subcommittees and policy committees of the Legislature, and publicly post a report on the Office of Problem Gambling on its Internet Web site.

(2) The report shall contain all of the following:

(A) A description of education and outreach activities related to the prevention program and how the Office of Problem Gambling establishes linkages with State Department of Public Health partners, including local health officers and other relevant entities, in order to increase awareness of, and provide input to, the Office of Problem Gambling, and how stakeholder involvement was changed, maintained, or enhanced after the transition.

(B) Beginning in the 2012–13 fiscal year, a description of year-over-year changes in the following: access to services, demographics of people served, the number of providers, and treatment program outcomes. The description of access to services shall include, but not be limited to, information regarding utilization of services and waiting lists for services. The description of providers shall include, but not be limited to, types and numbers of providers, including gambling disorder counselors, training protocols for providers, and workforce trends. The description of demographics of people served shall include, but not be limited to, age, sex, ethnicity, economic status, and geographic regions. The description of treatment program outcomes shall include, but not be limited to, participation levels in programs, recidivism rates, and quality of life measures.

(d) This section shall become inoperative on July 1, 2018, and, as of January 1, 2019, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2019, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 33. Section 14007.2 of the Welfare and Institutions Code is amended to read:

14007.2. (a) Any individual who is otherwise eligible for Medi-Cal services, but who does not meet the documentation requirements described in subdivision (e) of Section 14011.2, shall be eligible only for the scope of services made available to aliens under subdivision (d) of Section 14007.5, and Sections 14007.65, 14007.7, and 14007.8.

(b) To the extent that federal financial participation is available to fund services described under subdivision (a), the department shall file all necessary state plan amendments or waivers to obtain that funding.

SEC. 34. Section 14007.5 of the Welfare and Institutions Code is amended to read:

14007.5. (a) Aliens shall be eligible for Medi-Cal, whether federally funded or state-funded, only to the same extent as permitted under federal law and regulations for receipt of federal financial participation under Title XIX of the federal Social Security Act, except as otherwise provided in this section and elsewhere in this chapter.

(b) In accordance with Section 1903(v)(1) of the federal Social Security Act (42 U.S.C. Sec. 1396b(v)(1)), an alien shall only be eligible for the full scope of Medi-Cal benefits, if the alien has been lawfully admitted for permanent residence, or is otherwise permanently residing in the United States under color of law.

For purposes of this section, aliens “permanently residing in the United States under color of law” shall be interpreted to include all aliens residing in the United States with the knowledge and permission of the United States Immigration and Naturalization Service and whose departure the United States Immigration and Naturalization Service does not contemplate enforcing and with respect to whom federal financial participation is available under Title XIX of the federal Social Security Act.

(c) Any alien whose immigration status has been adjusted either to lawful temporary resident or lawful permanent resident in accordance with the provisions of Section 210, 210A, or 245A of

the federal Immigration and Nationality Act, and who meets all other eligibility requirements, shall be eligible only for care and services under Medi-Cal for which the alien is not disqualified pursuant to those sections of the federal act.

(d) Any alien who is otherwise eligible for Medi-Cal services, but who does not meet the requirements under subdivision (b) or (c), shall only be eligible for care and services that are necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law. For purposes of this section, the term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- (1) Placing the patient’s health in serious jeopardy.
- (2) Serious impairment to bodily functions.

(3) Serious dysfunction to any bodily organ or part. It is the intent of this section to entitle eligible individuals to inpatient and outpatient services that are necessary for the treatment of the emergency medical condition in the same manner as administered by the department through regulations and provisions of federal law.

(e) Pursuant to Section 14001.2, each county department shall require that each applicant for, or beneficiary of, Medi-Cal, including a child, shall provide his or her social security number account number, or numbers, if he or she has more than one social security number.

(f) (1) In order to be eligible for benefits under subdivision (b) or (c), an alien applicant or beneficiary shall present alien registration documentation or other proof of satisfactory immigration status from the United States Immigration and Naturalization Service.

(2) Any alien who meets all other program requirements but who lacks documentation of alien registration or other proof of satisfactory immigration status shall be provided a reasonable opportunity to submit the evidence. For purposes of this paragraph, “reasonable opportunity” means 30 days or the time it actually takes the county to process the Medi-Cal application, whichever is longer.

(3) During the reasonable opportunity period under paragraph (2), the county department shall process the applicant's application for medical assistance in a manner that conforms to its normal processing procedures and timeframes.

(g) (1) The county department shall grant only the Medi-Cal benefits set forth in subdivision (d) of this section or in Section 14007.7 to any individual who, after 30 calendar days or the time it actually takes the county to process the Medi-Cal application, whichever is longer, has failed to submit documents constituting reasonable evidence indicating a satisfactory immigration status for Medi-Cal purposes, or who is reported by the United States Immigration and Naturalization Service to lack a satisfactory immigration status for Medi-Cal purposes.

(2) If an alien has been receiving Medi-Cal benefits based on eligibility established prior to the effective date of this section and that individual, upon redetermination of eligibility for benefits, fails to submit documents constituting reasonable evidence indicating a satisfactory immigration status for Medi-Cal purposes, the county department shall discontinue the Medi-Cal benefits, except for the care and services set forth in subdivision (d) of this section or in Section 14007.7. The county department shall provide adequate notice to the individual of any adverse action and shall accord the individual an opportunity for a fair hearing if he or she requests one.

(h) To the extent permitted by federal law and regulations, an alien applying for services under subdivisions (b) and (c) shall be granted eligibility for the scope of services to which he or she would otherwise be entitled if, at the time the county department makes the determination about his or her eligibility, the alien meets either of the following requirements:

(1) He or she has not had a reasonable opportunity to submit documents constituting reasonable evidence indicating satisfactory immigration status.

(2) He or she has provided documents constituting reasonable evidence indicating a satisfactory immigration status, but the county department has not received timely verification of the alien's immigration status from the United States Immigration and Naturalization Service.

(3) The verification process shall protect the privacy of all participants. An alien's immigration status shall be subject to

verification by the United States Immigration and Naturalization Service, to the extent required for receipt of federal financial participation in the Medi-Cal program.

(i) If an alien does not declare status as a lawful permanent resident or alien permanently residing under color of law, or as an alien legalized under Section 210, 210A, or 245A of the federal Immigration and Nationality Act (Public Law 82-414), Medi-Cal coverage under subdivision (d) of this section or in Section 14007.7 shall be provided to the individual if he or she is otherwise eligible.

(j) If an alien subject to this section is not fluent in English, the county department shall provide an understandable explanation of the requirements of this section in a language in which the alien is fluent.

(k) Aliens who were receiving long-term care or renal dialysis services (1) on the day prior to the effective date of the amendment to paragraph (1) of subdivision (f) of Section 1 of Chapter 1441 of the Statutes of 1988 at the 1991–92 Regular Session of the Legislature and (2) under the authority of paragraph (1) of subdivision (f) of Section 1 of Chapter 1441 of the Statutes of 1988 as it read on June 30, 1992, shall continue to receive these services. The authority for continuation of long-term care or renal dialysis services in this subdivision shall not apply to any person whose long-term care or renal dialysis services end for any reason after the effective date of the amendment described in this subdivision.

SEC. 35. Section 14007.8 is added to the Welfare and Institutions Code, to read:

14007.8. (a) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this section, but no sooner than May 1, 2016, an individual who is under 19 years of age and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2 shall be eligible for the full scope of Medi-Cal benefits, if he or she is otherwise eligible for benefits under this chapter.

(b) To the extent permitted by state and federal law, an individual eligible under this section shall be required to enroll in a Medi-Cal managed care health plan in those counties in which a Medi-Cal managed care health plan is available.

(c) The department shall seek any necessary federal approvals to obtain federal financial participation in implementing this section. Benefits for services under this section shall be provided with state-only funds only if federal financial participation is not available for those services.

(d) The department shall maximize federal financial participation in implementing this section to the extent allowable.

(e) This section shall be implemented only to the extent it is in compliance with Section 1621(d) of Title 8 of the United States Code.

(f) (1) 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 the time any necessary regulations are adopted. Thereafter, the department shall adopt regulations 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.

(2) Commencing six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, 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.

(g) In implementing this section, the department may contract, as necessary, on a bid or nonbid basis. This subdivision establishes an accelerated process for issuing contracts pursuant to this section. Those contracts, and any other contracts entered into pursuant to this subdivision, may be on a noncompetitive bid basis and shall be exempt from the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures or regulations authorized by that part.

(2) Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code.

(3) Review or approval of contracts by the Department of General Services.

SEC. 36. Section 14015.5 of the Welfare and Institutions Code is amended to read:

14015.5. (a) Notwithstanding any other state law, the department shall retain or delegate the authority to perform Medi-Cal eligibility determinations as set forth in this section.

(b) If after an assessment and verification for potential eligibility for Medi-Cal benefits using the applicable MAGI-based income standard of all persons that apply through an electronic or a paper application processed by CalHEERS, which is jointly managed by the department and the Exchange, and to the extent required by federal law and regulation is completed, the Exchange and the department is able to electronically determine the applicant's eligibility for Medi-Cal benefits using only the information initially provided online, or through the written application submitted by, or on behalf of, the applicant, and without further staff review to verify the accuracy of the submitted information, the Exchange and the department shall determine that applicant's eligibility for the Medi-Cal program using the applicable MAGI-based income standard.

(c) Except as provided in subdivision (b) and Section 14015.7, the county of residence shall be responsible for eligibility determinations and ongoing case management for the Medi-Cal program.

(d) (1) Notwithstanding any other state law, the Exchange shall be authorized to provide information regarding available Medi-Cal managed health care plan selection options to applicants determined to be eligible for Medi-Cal benefits using the MAGI-based income standard and allow those applicants to choose an available managed health care plan.

(2) The Exchange is authorized to record an applicant's health plan selection into CalHEERS for reporting to the department. CalHEERS shall have the ability to report to the department the results of an applicant's health plan selection.

(e) 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 the time regulations are adopted. Thereafter, the department shall adopt regulations 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. Beginning

six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

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

(1) “ACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(2) “CalHEERS” means the California Healthcare Eligibility, Enrollment, and Retention System developed under Section 15926.

(3) “Exchange” means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(4) “MAGI-based income” means income calculated using the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code as added by ACA and any subsequent amendments.

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

(h) This section shall become operative on October 1, 2013.

SEC. 37. Section 14105.94 of the Welfare and Institutions Code is amended to read:

14105.94. (a) An eligible provider, as described in subdivision (b), may, in addition to the rate of payment that the provider would otherwise receive for Medi-Cal ground emergency medical transportation services, receive supplemental Medi-Cal reimbursement to the extent provided in this section.

(b) A provider shall be eligible for supplemental reimbursement only if the provider has all of the following characteristics continuously during a state fiscal year:

(1) Provides ground emergency medical transportation services to Medi-Cal beneficiaries.

(2) Is a provider that is enrolled as a Medi-Cal provider for the period being claimed.

(3) Is owned or operated by the state, a city, county, city and county, fire protection district organized pursuant to Part 2.7 (commencing with Section 13800) of Division 12 of the Health and Safety Code, special district organized pursuant to Chapter 1

(commencing with Section 58000) of Division 1 of Title 6 of the Government Code, community services district organized pursuant to Part 1 (commencing with Section 61000) of Division 3 of Title 6 of the Government Code, health care district organized pursuant to Chapter 1 (commencing with Section 32000) of Division 23 of the Health and Safety Code, or a federally recognized Indian tribe.

(c) An eligible provider's supplemental reimbursement pursuant to this section shall be calculated and paid as follows:

(1) The supplemental reimbursement to an eligible provider, as described in subdivision (b), shall be equal to the amount of federal financial participation received as a result of the claims submitted pursuant to paragraph (2) of subdivision (f).

(2) In no instance shall the amount certified pursuant to paragraph (1) of subdivision (e), when combined with the amount received from all other sources of reimbursement from the Medi-Cal program, exceed 100 percent of actual costs, as determined pursuant to the Medi-Cal State Plan, for ground emergency medical transportation services.

(3) The supplemental Medi-Cal reimbursement provided by this section shall be distributed exclusively to eligible providers under a payment methodology based on ground emergency medical transportation services provided to Medi-Cal beneficiaries by eligible providers on a per-transport basis or other federally permissible basis. The department shall obtain approval from the federal Centers for Medicare and Medicaid Services for the payment methodology to be utilized, and may not make any payment pursuant to this section prior to obtaining that approval.

(d) (1) It is the Legislature's intent in enacting this section to provide the supplemental reimbursement described in this section without any expenditure from the General Fund. An eligible provider, as a condition of receiving supplemental reimbursement pursuant to this section, shall enter into, and maintain, an agreement with the department for the purposes of implementing this section and reimbursing the department for the costs of administering this section.

(2) The nonfederal share of the supplemental reimbursement submitted to the federal Centers for Medicare and Medicaid Services for purposes of claiming federal financial participation shall be paid only with funds from the governmental entities

described in paragraph (3) of subdivision (b) and certified to the state as provided in subdivision (e).

(e) Participation in the program by an eligible provider described in this section is voluntary. If an applicable governmental entity elects to seek supplemental reimbursement pursuant to this section on behalf of an eligible provider owned or operated by the entity, as described in paragraph (3) of subdivision (b), the governmental entity shall do all of the following:

(1) Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for the ground emergency medical transportation services are eligible for federal financial participation.

(2) Provide evidence supporting the certification as specified by the department.

(3) Submit data as specified by the department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.

(4) Keep, maintain, and have readily retrievable, any records specified by the department to fully disclose reimbursement amounts to which the eligible provider is entitled, and any other records required by the federal Centers for Medicare and Medicaid Services.

(f) (1) The department shall promptly seek any necessary federal approvals for the implementation of this section. The department may limit the program to those costs that are allowable expenditures under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.). If federal approval is not obtained for implementation of this section, this section shall not be implemented.

(2) The department shall submit claims for federal financial participation for the expenditures for the services described in subdivision (e) that are allowable expenditures under federal law.

(3) The department shall, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

(g) (1) If either a final judicial determination is made by any court of appellate jurisdiction or a final determination is made by the administrator of the federal Centers for Medicare and Medicaid

Services that the supplemental reimbursement provided for in this section must be made to any provider not described in this section, the director shall execute a declaration stating that the determination has been made and on that date this section shall become inoperative.

(2) The declaration executed pursuant to this subdivision shall be retained by the director, provided to the fiscal and appropriate policy committees of the Legislature, the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and posted on the department's Internet Web site.

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

(i) (1) Upon the effective date of the act that added this subdivision, the department shall develop, in consultation with the providers described in subdivision (b), and seek any necessary federal approvals for, a modified program for the supplemental reimbursement authorized by this section that will seek to provide increased reimbursement to an eligible provider that participates in the program. The nonfederal share of any supplemental reimbursement provided under the modified program shall be derived from voluntary intergovernmental transfers of local funds. The department shall otherwise develop the modified program consistent with the requirements of this section, except for paragraph (2) of subdivision (c), and only to the extent that federal financial participation is available.

(2) The department shall be reimbursed for costs associated with administering the modified program described in paragraph (1) in accordance with subdivision (d). The department shall not otherwise assess a percentage fee in connection with any intergovernmental transfer of funds made pursuant to this subdivision.

(3) The department shall not implement the modified program described in paragraph (1) until it obtains all necessary federal approvals. Until those federal approvals are obtained, supplemental reimbursement shall continue to be available pursuant to the

provisions of this section that were operative prior to the effective date of the act that added this subdivision.

(j) The department shall not implement the modified program described in paragraph (1) of subdivision (i) unless it determines that the modified program will likely result in an overall increase to the supplemental reimbursement available pursuant to the provisions of this section that were operative prior to the effective date of the act that added this subdivision.

SEC. 38. Section 14105.192 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

(b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and consistent with federal and state law and policies, including any exemptions contained in the provisions of the act that added this section,

provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services and products.

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

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

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

(3) Payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after June 1, 2011. This paragraph shall not apply to inpatient hospital services provided in a hospital that is paid under contract pursuant to Article 2.6 (commencing with Section 14081).

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

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

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

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

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

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

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

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

(g) The department may enter into contracts with a vendor for the purposes of implementing this section on a bid or nonbid basis. In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this subdivision is necessary. Therefore, contracts entered into to implement this section and all contract amendments and change orders shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 Division 2 of the Public Contract Code.

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

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

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

(3) Rural health clinic services.

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

(5) Hospice services.

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

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

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

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

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

(11) (A) Effective for dates of service on or after July 1, 2015, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later, dental services and applicable ancillary services.

(B) For dental managed care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), payments pursuant to contract amendments or change orders effective on or after July 1, 2015, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later.

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

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

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

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

(3) Rural swing-bed facilities.

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

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

(6) Adult day health care centers.

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

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

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

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

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

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

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

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

(2) To the extent that federal approval is obtained for one or more of the payment reductions and adjustments in this section and Section 14105.07, the payment reductions and adjustments set forth in Section 14105.191 shall cease to be implemented for the same services provided by the same class of providers. In the event of a conflict between this section and Section 14105.191, other than the provisions setting forth a payment reduction or adjustment, this section shall govern.

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

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

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

SEC. 39. Section 14127.7 is added to the Welfare and Institutions Code, to read:

14127.7. (a) The Health Home Program Account is hereby created in the Special Deposit Fund within the State Treasury in order to collect and allocate non-General Fund public or private grant funds, to be expended, upon appropriation by the Legislature, for the purposes of implementing the Health Home Program established pursuant to this article.

(b) The department may accept funding from local governments, foundations, or other organizations to provide funding for the Health Home Program.

(c) Any unexpended funds within the Health Home Program Account, within the Special Deposit Fund, from a local government, foundation, or other organization, shall be returned to the contributing entity.

SEC. 40. Section 14134 of the Welfare and Institutions Code, as amended by Section 65 of Chapter 23 of the Statutes of 2013, is amended to read:

14134. (a) Except for any prescription, refill, visit, service, device, or item for which the program's payment is ten dollars (\$10) or less, in which case no copayment shall be required, a recipient of services under this chapter shall be required to make copayments not to exceed the maximum permitted under federal regulations or federal waivers, as follows:

(1) Copayment of five dollars (\$5) shall be made for nonemergency services received in an emergency department or emergency room when the services do not result in the treatment of an emergency medical condition or inpatient admittance. For the purposes of this section, "nonemergency services" means services not required to, as appropriate, medically screen, examine, evaluate, or stabilize an emergency medical condition that

manifests itself by acute symptoms of sufficient severity, including severe pain, so that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(A) Placing the individual's health, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(B) Serious impairment to bodily functions.

(C) Serious dysfunction of any bodily organ or part.

(2) Copayment of one dollar (\$1) shall be made for each drug prescription or refill.

(3) Copayment of one dollar (\$1) shall be made for each visit for services under subdivisions (a) and (h) of Section 14132.

(4) The copayment amounts set forth in paragraphs (1), (2), and (3) may be collected and retained, or waived by the provider.

(5) The department shall not reduce the reimbursement otherwise due to providers as a result of the copayment. The copayment amounts shall be in addition to any reimbursement otherwise due to the provider for services rendered under this program.

(6) This section does not apply to emergency services, family planning services, or to any services received by any of the following:

(A) A child in AFDC-Foster Care, as defined in Section 11400.

(B) A person who is an inpatient in a health facility, as defined in Section 1250 of the Health and Safety Code.

(C) A person 18 years of age or under.

(D) A woman receiving perinatal care.

(7) Paragraph (2) does not apply to a person 65 years of age or over.

(8) A provider of service shall not deny care or services to an individual solely because of that person's inability to copay under this section. However, an individual shall remain liable to the provider for any copayment amount owed.

(9) This section shall not apply to preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force provided by a physician or other licensed practitioner of the healing arts, or any approved adult vaccines and their administration recommended by the Advisory Committee on Immunization Practices. Pursuant to Section 1905(b) of the federal Social Security Act (42 U.S.C. Sec. 1396d(b)), these services shall be provided without any cost sharing by the beneficiary in order

for the state to receive an increased federal medical assistance percentage for these services.

(b) The department shall seek any federal waivers necessary to implement this section. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented, but provisions for which waivers are either obtained or found to be unnecessary shall be unaffected by the inability to obtain federal waivers for the other provisions.

(c) The director shall adopt regulations necessary to implement this section as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The director shall transmit these emergency regulations directly to the Secretary of State for filing and the regulations shall become effective immediately upon filing. Upon completion of the formal regulation adoption process and prior to the expiration of the 120 day duration period of emergency regulations, the director shall transmit directly to the Secretary of State for filing the adopted regulations, the rulemaking file, and the certification of compliance as required by subdivision (e) of Section 11346.1 of the Government Code.

SEC. 41. Section 14134 of the Welfare and Institutions Code, as amended by Section 66 of Chapter 23 of the Statutes of 2013, is repealed.

SEC. 42. Section 14154 of the Welfare and Institutions Code is amended to read:

14154. (a) (1) The department shall establish and maintain a plan whereby costs for county administration of the determination of eligibility for benefits under this chapter will be effectively controlled within the amounts annually appropriated for that administration. The plan, to be known as the County Administrative Cost Control Plan, shall establish standards and performance criteria, including workload, productivity, and support services standards, to which counties shall adhere. The plan shall include standards for controlling eligibility determination costs that are incurred by performing eligibility determinations at county hospitals, or that are incurred due to the outstationing of any other eligibility function. Except as provided in Section 14154.15,

reimbursement to a county for outstationed eligibility functions shall be based solely on productivity standards applied to that county's welfare department office.

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

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

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

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

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

(4) The department and county welfare departments shall develop procedures to ensure the data clarity, consistency, and reliability of information contained in the county budget survey document submitted by counties to the department. These procedures shall include the format of the county budget survey document and process, data submittal and its documentation, and the use of the county budget survey documents for the development of determining county administration costs. Communication between the department and the county welfare departments shall be ongoing as needed regarding the content of the county budget surveys and any potential issues to ensure the information is complete and well understood by involved parties. Any changes developed pursuant to this section shall be incorporated within the

state's annual budget process by no later than the 2011–12 fiscal year.

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

(6) Notwithstanding any other law, the department shall develop and implement, in consultation with county program and fiscal representatives, a new budgeting methodology for Medi-Cal county administrative costs that reflects the impact of PPACA implementation on county administrative work. The new budgeting methodology shall be used to reimburse counties for eligibility processing and case maintenance for applicants and beneficiaries.

(A) The budgeting methodology may include, but is not limited to, identification of the costs of eligibility determinations for applicants, and the costs of eligibility redeterminations and case maintenance activities for recipients, for different groupings of cases, based on variations in time and resources needed to conduct eligibility determinations. The calculation of time and resources shall be based on the following factors: complexity of eligibility rules, ongoing eligibility requirements, and other factors as determined appropriate by the department. The development of the new budgeting methodology may include, but is not limited to, county survey of costs, time and motion studies, in-person observations by department staff, data reporting, and other factors deemed appropriate by the department.

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

(C) The new budgeting methodology developed pursuant to this paragraph shall be implemented no sooner than the 2015–16 fiscal year. The department may develop a process for counties to phase in the requirements of the new budgeting methodology.

(D) The department shall provide the new budgeting methodology to the legislative fiscal committees by March 1 of

the fiscal year immediately preceding the first fiscal year of implementation of the new budgeting methodology.

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

(F) For purposes of this paragraph, “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(G) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this paragraph by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary 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. Beginning six months after the implementation of the new budgeting methodology pursuant to this paragraph, and notwithstanding Section 10231.5 of the Government Code, 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.

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

(c) (1) The Legislature finds and declares that in order for counties to do the work that is expected of them, it is necessary that they receive adequate funding, including adjustments for reasonable annual cost-of-doing-business increases. The Legislature further finds and declares that linking appropriate funding for county Medi-Cal administrative operations, including annual cost-of-doing-business adjustments, with performance standards will give counties the incentive to meet the performance standards

and enable them to continue to do the work they do on behalf of the state. It is therefore the Legislature's intent to provide appropriate funding to the counties for the effective administration of the Medi-Cal program at the local level to ensure that counties can reasonably meet the purposes of the performance measures as contained in this section.

(2) It is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2008–09, 2009–10, 2010–11, 2011–12, 2012–13, 2014–15, and 2015–16 fiscal years.

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

(1) Complete eligibility determinations as follows:

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

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

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

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

(3) Perform timely annual redeterminations, as follows:

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

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

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

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

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

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

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

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

(e) The department shall develop procedures in collaboration with the counties and stakeholder groups for determining county

review cycles, sampling methodology and procedures, and data reporting.

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

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

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

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

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

(j) No later than September 1, 2005, the department shall issue a revised annual redetermination form to allow a parent to indicate parental consent to forward the annual redetermination form to

the Healthy Families Program if the child is determined to have a share of cost.

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

(l) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and except as provided in subparagraph (G) of paragraph (6) of subdivision (a), the department shall, without taking any further regulatory action, implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters or similar instructions.

SEC. 43. Section 14186 of the Welfare and Institutions Code is amended to read:

14186. (a) It is the intent of the Legislature that long-term services and supports (LTSS) be covered through managed care health plans in Coordinated Care Initiative counties.

(b) It is further the intent of the Legislature that all of the following occur:

(1) Persons receiving health care services through Medi-Cal receive these services through a coordinated health care system that reduces the unnecessary use of emergency and hospital services.

(2) Coordinated health care services, including medical, long-term services and supports, and enhanced care management be covered through Medi-Cal managed care health plans in order to eliminate system inefficiencies and align incentives with positive health care outcomes.

(3) Managed care health plans shall, in coordination with LTSS care management providers, develop and expand care coordination practices in consultation with counties, nursing facilities, area agencies on aging, and other home- and community-based providers, and share best practices. Unless the consumer objects, managed care health plans may establish care coordination teams as needed. If the consumer is an IHSS recipient, his or her participation and the participation of his or her provider shall be subject to the consumer's consent. These care coordination teams

shall include the consumer, and his or her authorized representative, health plan, county social services agency, Community-Based Adult Services (CBAS) case manager for CBAS clients, Multipurpose Senior Services Program (MSSP) case manager for MSSP clients, and, if an IHSS recipient, may include others.

(4) To the extent possible, for Medi-Cal beneficiaries also enrolled in the Medicare Program, that the department work with the federal government to coordinate financing and incentives and permit managed care health plans to coordinate health care provided under both health care systems.

(5) The health care choices made by Medi-Cal beneficiaries be considered with regard to all of the following:

(A) Receiving care in a home- and community-based setting to maintain independence and quality of life.

(B) Selecting their health care providers in the managed care plan network.

(C) Controlling care planning, decisionmaking, and coordination with their health care providers.

(D) Gaining access to services that are culturally, linguistically, and operationally sensitive to meet their needs or limitations and that improve their health outcomes, enhance independence, and promote living in home- and community-based settings.

(E) Self-directing their care by being able to hire, fire, and supervise their IHSS provider.

(F) Being assured by the department and coordinating departments of their oversight of the quality of these coordinated health care services.

(6) (A) Counties continue to perform functions necessary for the administration of the IHSS program, including conducting assessments and determining authorized hours for recipients, pursuant to Article 7 (commencing with Section 12300) of Chapter 3. County agency assessments shall be shared with care coordination teams, when applicable. The county agency thereafter may receive and consider additional input from the care coordination team.

(B) Managed care health plans may authorize personal care services and related domestic services in addition to the hours authorized under Article 7 (commencing with Section 12300) of Chapter 3, which managed care health plans shall be responsible for paying at no share of cost to the county. The department, in

consultation with the State Department of Social Services, shall develop policies and procedures for these additional benefits, which managed care health plans may authorize. The grievance process for these benefits shall be the same process as used for other benefits authorized by managed care health plans, and shall comply with Section 14450, and Sections 1368 and 1368.1 of the Health and Safety Code.

(7) (A) No later than December 31, 2017, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of paragraph (4) of subdivision (b) of Section 14186.3, whichever is earlier, MSSP services shall transition from a federal waiver pursuant to Section 1915(c) under the federal Social Security Act (42 U.S.C. Sec. 1396n(c)) to a benefit administered and allocated by managed care health plans in Coordinated Care Initiative counties.

(B) Notwithstanding Chapter 8 (commencing with Section 9560) of Division 8.5, it is also the intent of the Legislature that the provisions of this article shall apply to dual eligible and Medi-Cal-only beneficiaries enrolled in MSSP. It is the further intent of the Legislature that managed care health plans shall work in collaboration with MSSP providers to begin development of an integrated, person-centered care management and care coordination model that works within the context of managed care, and explore which portions of the MSSP program model may be adapted to managed care while maintaining the integrity and efficacy of the MSSP model.

(C) At least 30 days before the MSSP services transition to a benefit administered and allocated by managed care health plans in Coordinated Care Initiative counties, the department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to transition the MSSP services to managed care health plans.

(8) In lieu of providing nursing facility services, managed care health plans may authorize home- and community-based services plan benefits, as defined in subdivision (d) of Section 14186.1, which managed care health plans shall be responsible for paying at no share of cost to the county.

(c) If the Coordinated Care Initiative becomes inoperative pursuant to Section 34 of Chapter 37 of the Statutes of 2013, MSSP

services shall be governed by the provisions of Chapter 8 (commencing with Section 9560) of Division 8.5.

SEC. 44. Section 14186.1 of the Welfare and Institutions Code is amended to read:

14186.1. For purposes of this article, the following definitions shall apply unless otherwise specified:

(a) “Coordinated Care Initiative counties” has the same meaning as that term is defined in paragraph (1) of subdivision (b) of Section 14182.16.

(b) “Home- and community-based services” means services provided pursuant to paragraphs (1), (2), and (3) of subdivision (c).

(c) “Long-term services and supports” or “LTSS” means all of the following:

(1) In-home supportive services (IHSS) provided pursuant to Article 7 (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.

(2) Community-Based Adult Services (CBAS).

(3) Multipurpose Senior Services Program (MSSP) services, which include those services approved under a federal home- and community-based services waiver or, beginning January 1, 2018, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of paragraph (4) of subdivision (b) of Section 14186.3, whichever is earlier, equivalent services.

(4) Skilled nursing facility services and subacute care services established under subdivision (c) of Section 14132, including those services described in Sections 51511 and 51511.5 of Title 22 of the California Code of Regulations, regardless of whether the service is included in the basic daily rate or billed separately, and any leave of absence or bed hold provided consistent with Section 72520 of Title 22 of the California Code of Regulations or the state plan. However, services provided by any category of intermediate care facility for the developmentally disabled shall not be considered long-term services and supports.

(d) “Home- and community-based services (HCBS) plan benefits” may include in-home and out-of-home respite, nutritional assessment, counseling, and supplements, minor home or environmental adaptations, habilitation, and other services that may be deemed necessary by the managed care health plan,

including its care coordination team. The department, in consultation with stakeholders, may determine whether health plans shall be required to include these benefits in their scope of service, and may establish guidelines for the scope, duration, and intensity of these benefits. The grievance process for these benefits shall be the same process as used for other benefits authorized by managed care health plans, and shall comply with Section 14450, and Sections 1368 and 1368.1 of the Health and Safety Code.

(e) “Managed care health plan” means an individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), or Article 2.91 (commencing with Section 14089), of this chapter, or Chapter 8 (commencing with Section 14200). For purposes of this article, “managed care health plan” shall not include an individual, organization, or entity that enters into a contract with the department to provide services pursuant to Chapter 8.75 (commencing with Section 14591) or the Senior Care Action Network.

(f) “Other health coverage” means health coverage providing the same full or partial benefits as the Medi-Cal program, health coverage under another state or federal medical care program except for the Medicare Program (Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.)), or health coverage under a contractual or legal entitlement, including, but not limited to, a private group or indemnification insurance program.

(g) “Recipient” means a Medi-Cal beneficiary eligible for IHSS provided pursuant to Article 7 (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.

(h) “Stakeholder” shall include, but not be limited to, area agencies on aging and independent living centers.

SEC. 45. Section 14186.3 of the Welfare and Institutions Code is amended to read:

14186.3. (a) (1) No sooner than July 1, 2012, Community-Based Adult Services (CBAS) shall be a Medi-Cal benefit covered under every managed care health plan contract and available only through managed care health plans. Medi-Cal beneficiaries who are eligible for CBAS shall enroll in a managed care health plan in order to receive those services, except for

beneficiaries exempt under subdivision (c) of Section 14186.2 or in counties or geographic regions where Medi-Cal benefits are not covered through managed care health plans. Notwithstanding subdivision (a) of Section 14186.2 and pursuant to the provisions of an approved federal waiver or plan amendment, the provision of CBAS as a Medi-Cal benefit through a managed care health plan shall not be limited to Coordinated Care Initiative counties.

(2) Managed care health plans shall determine a member's medical need for CBAS using the assessment tool and eligibility criteria established pursuant to the provisions of an approved federal waiver or amendments and shall approve the number of days of attendance and monitor treatment plans of their members. Managed care health plans shall reauthorize CBAS in compliance with criteria established pursuant to the provisions of the approved federal waiver or amendment requirements.

(b) (1) Beginning in the 2012 calendar year, managed care health plans shall collaborate with MSSP providers to begin development of an integrated, person-centered care management and care coordination model and explore how the MSSP program model may be adapted to managed care while maintaining the efficacy of the MSSP model. The California Department of Aging and the department shall work with the MSSP site association and managed care health plans to develop a template contract to be used by managed care health plans contracting with MSSP sites in Coordinated Care Initiative counties.

(2) Notwithstanding the implementation date authorized in paragraph (1) of subdivision (a) of Section 14186.2, no later than December 31, 2017, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of paragraph (4), whichever is earlier:

(A) Multipurpose Senior Services Program (MSSP) services shall be a Medi-Cal benefit available only through managed care health plans, except for beneficiaries exempt under subdivision (c) of Section 14186.2 in Coordinated Care Initiative counties.

(B) Managed care health plans shall contract with all county and nonprofit organizations that are designated providers of MSSP services for the provision of MSSP case management and waiver services. These contracts shall provide for all of the following:

(i) Managed care health plans shall allocate to the MSSP providers the same level of funding they would have otherwise

received under their MSSP contract with the California Department of Aging.

(ii) MSSP providers shall continue to meet all existing federal waiver standards and program requirements, which include maintaining the contracted service levels.

(iii) Managed care plans and MSSP providers shall share confidential beneficiary data with one another, as necessary to implement the provisions of this section.

(C) The California Department of Aging shall continue to contract with all designated MSSP sites, including those in the counties participating in the demonstration project, and perform MSSP waiver oversight and monitoring.

(D) The California Department of Aging and the department, in consultation with MSSP providers, managed care health plans, and stakeholders, shall develop service fee structures, services, and person-centered care coordination models that shall be effective June 2013, for the provision of care coordination and home- and community-based services to beneficiaries who are enrolled in managed care health plans but not enrolled in MSSP, and who may have care coordination and service needs that are similar to MSSP participants. The service fees for MSSP providers and MSSP services for any additional beneficiaries and additional services for existing MSSP beneficiaries shall be based upon, and consistent with, the rates and services delivered in MSSP.

(3) In the 2014 calendar year, the provisions of paragraph (2) shall continue. In addition, managed care health plans shall work in collaboration with MSSP providers to begin development of an integrated, person-centered care management and care coordination model that works within the context of managed care and explore which portions of the MSSP program model may be adapted to managed care while maintaining the integrity and efficacy of the MSSP model.

(4) (A) No later than December 31, 2017, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of this paragraph, whichever is earlier, MSSP services in Coordinated Care Initiative counties shall transition from a federal waiver pursuant to Section 1915(c) under the federal Social Security Act (42 U.S.C. Sec. 1396n(c)) to a benefit administered and allocated by managed care health plans.

(B) No later than January 1, 2014, the department, in consultation with the California Department of Aging and the Department of Managed Health Care, and with stakeholder input, shall submit a transition plan to the Legislature to describe how subparagraph (A) shall be implemented. The plan shall incorporate the principles of the MSSP in the managed care benefit, and shall include provisions to ensure seamless transitions and continuity of care. Managed care health plans shall, in partnership with local MSSP providers, conduct a local stakeholder process to develop recommendations that the department shall consider when developing the transition plan.

(C) No later than 90 days prior to implementation of subparagraph (A), the department, in consultation with the California Department of Aging and the Department of Managed Health Care, and with stakeholder input, shall submit a transition plan to the Legislature that includes steps to address concerns, if any, raised by stakeholders subsequent to the plan developed pursuant to subparagraph (B).

(D) Before MSSP services transition to a benefit administered and allocated by managed care health plans pursuant to subparagraph (A) of paragraph (2), the California Department of Aging and the department, in consultation with MSSP providers, managed care health plans, and stakeholders, shall develop readiness criteria for the transition. The readiness criteria shall include, but are not limited to, the mutual agreement of the affected managed care health plans and MSSP providers to the transition date. The department shall evaluate the readiness of the managed care health plans and MSSP providers to commence the transition of MSSP services to managed care health plans.

(E) At least 30 days before the MSSP services transition to a benefit administered and allocated by managed care health plans in Coordinated Care Initiative counties, the department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to transition the MSSP services to managed care health plans.

(c) (1) Not sooner than March 1, 2013, or on the date that any necessary federal approvals or waivers are obtained, whichever is later, nursing facility services and subacute facility services shall be Medi-Cal benefits available only through managed care health plans.

(2) Managed care health plans shall authorize utilization of nursing facility services or subacute facility services for their members when medically necessary. The managed care health plan shall maintain the standards for determining levels of care and authorization of services for both Medicare and Medi-Cal services that are consistent with policies established by the federal Centers for Medicare and Medicaid Services and consistent with the criteria for authorization of Medi-Cal services specified in Section 51003 of Title 22 of the California Code of Regulations, which includes utilization of the “Manual of Criteria for Medi-Cal Authorization,” published by the department in January 1982, last revised April 11, 2011.

(3) The managed care health plan shall maintain continuity of care for beneficiaries by recognizing any prior treatment authorization made by the department for not less than six months following enrollment of a beneficiary into the health plan.

(4) When a managed care health plan has authorized services in a facility and there is a change in the beneficiary’s condition under which the facility determines that the facility may no longer meet the needs of the beneficiary, the beneficiary’s health has improved sufficiently so the resident no longer needs the services provided by the facility, or the health or safety of individuals in the facility is endangered by the beneficiary, the managed care health plan shall arrange and coordinate a discharge of the beneficiary and continue to pay the facility the applicable rate until the beneficiary is successfully discharged and transitioned into an appropriate setting.

(5) The managed care health plan shall pay providers, including institutional providers, in accordance with the prompt payment provisions contained in each health plan’s contracts with the department, including the ability to accept and pay electronic claims.

SEC. 46. Section 15894 of the Welfare and Institutions Code is amended to read:

15894. (a) Except as provided in Section 15894.5, the department shall authorize the expenditure of money in the fund to cover program expenses, including program expenses that exceed subscriber contributions, and to cover expenses relating to Section 10127.16 of the Insurance Code, or to Section 1373.622 of the Health and Safety Code. The department shall determine the

amount of funds expended for each of these purposes, taking into consideration the requirements of this chapter, Section 10127.16 of the Insurance Code, and Section 1373.622 of the Health and Safety Code.

(b) Following consultation with a health care service plan or health insurer, if the department and the health care service plan or health insurer have not agreed to a final reconciliation of the amount to be expended from the fund or to be reimbursed to the fund, the department shall give written notice of its determination to the health care service plan or health insurer of the final reconciliation amount, as determined by the department. The health care service plan or health insurer shall remit payment to the department within 60 days of the date of notice from the department. If payment is not received, interest shall accrue in the amount of 7 percent per annum. The department may offset the amount to be reimbursed to the fund against any other payments owed to the health care service plan or health insurer by the department, or may negotiate a payment plan with the health care service plan or health insurer for full payment, and in that case may waive interest accrual as long as payment from the health care service plan or health insurer is made in accordance with the payment plan. This subdivision shall control over any conflict or ambiguity between this subdivision and the provisions of Section 1373.622 of the Health and Safety Code, Section 10127.16 of the Insurance Code, Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code, or this chapter.

SEC. 47. Section 24005 of the Welfare and Institutions Code is amended to read:

24005. (a) This section shall apply to the Family Planning, Access, Care, and Treatment Program identified in subdivision (aa) of Section 14132 and this program.

(b) Only licensed medical personnel with family planning skills, knowledge, and competency may provide the full range of family planning medical services covered in this program.

(c) Medi-Cal enrolled providers, as determined by the department, shall be eligible to provide family planning services under the program when these services are within their scope of practice and licensure. Those clinical providers electing to participate in the program and approved by the department shall provide the full scope of family planning education, counseling,

and medical services specified for the program, either directly or by referral, consistent with standards of care issued by the department.

(d) The department shall require providers to enter into clinical agreements with the department to ensure compliance with standards and requirements to maintain the fiscal integrity of the program. Provider applicants, providers, and persons with an ownership or control interest, as defined in federal Medicaid regulations, shall be required to submit to the department their social security numbers to the full extent allowed under federal law. All state and federal statutes and regulations pertaining to the audit or examination of Medi-Cal providers shall apply to this program.

(e) Clinical provider agreements shall be signed by the provider under penalty of perjury. The department may screen applicants at the initial application and at any reapplication pursuant to requirements developed by the department to determine provider suitability for the program.

(f) The department may complete a background check on clinical provider applicants for the purpose of verifying the accuracy of information provided to the department for purposes of enrolling in the program and in order to prevent fraud and abuse. The background check may include, but not be limited to, unannounced onsite inspection prior to enrollment, review of business records, and data searches. If discrepancies are found to exist during the preenrollment period, the department may conduct additional inspections prior to enrollment. Failure to remediate significant discrepancies as prescribed by the director may result in denial of the application for enrollment. Providers that do not provide services consistent with the standards of care or that do not comply with the department's rules related to the fiscal integrity of the program may be disenrolled as a provider from the program at the sole discretion of the department.

(g) The department shall not enroll any applicant who, within the previous 10 years:

(1) Has been convicted of any felony or misdemeanor that involves fraud or abuse in any government program, that relates to neglect or abuse of a patient in connection with the delivery of a health care item or service, or that is in connection with the

interference with, or obstruction of, any investigation into health care related fraud or abuse.

(2) Has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program.

(h) In addition, the department may deny enrollment to any applicant that, at the time of application, is under investigation by the department or any local, state, or federal government law enforcement agency for fraud or abuse. The department shall not deny enrollment to an otherwise qualified applicant whose felony or misdemeanor charges did not result in a conviction solely on the basis of the prior charges. If it is discovered that a provider is under investigation by the department or any local, state, or federal government law enforcement agency for fraud or abuse, that provider shall be subject to immediate disenrollment from the program.

(i) (1) The program shall disenroll as a program provider any individual who, or any entity that, has a license, certificate, or other approval to provide health care, which is revoked or suspended by a federal, California, or other state's licensing, certification, or other approval authority, has otherwise lost that license, certificate, or approval, or has surrendered that license, certificate, or approval while a disciplinary hearing on the license, certificate, or approval was pending. The disenrollment shall be effective on the date the license, certificate, or approval is revoked, lost, or surrendered.

(2) A provider shall be subject to disenrollment if the provider submits claims for payment for the services, goods, supplies, or merchandise provided, directly or indirectly, to a program beneficiary, by an individual or entity that has been previously suspended, excluded, or otherwise made ineligible to receive, directly or indirectly, reimbursement from the program or from the Medi-Cal program and the individual has previously been listed on either the Suspended and Ineligible Provider List, which is published by the department, to identify suspended and otherwise ineligible providers or any list published by the federal Office of the Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and Medicaid programs, to identify suspended, excluded, or otherwise ineligible providers.

(3) The department shall deactivate, immediately and without prior notice, the provider numbers used by a provider to obtain reimbursement from the program when warrants or documents mailed to a provider’s mailing address, its pay to address, or its service address, if any, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the program for one year. Prior to taking this action, the department shall use due diligence in attempting to contact the provider at its last known telephone number and to ascertain if the return by the United States Postal Service is by mistake and shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in regulation.

(4) For purposes of this subdivision:

(A) “Mailing address” means the address that the provider has identified to the department in its application for enrollment as the address at which it wishes to receive general program correspondence.

(B) “Pay to address” means the address that the provider has identified to the department in its application for enrollment as the address at which it wishes to receive warrants.

(C) “Service address” means the address that the provider has identified to the department in its application for enrollment as the address at which the provider will provide services to program beneficiaries.

(j) Subject to Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, the department may enter into contracts to secure consultant services or information technology including, but not limited to, software, data, or analytical techniques or methodologies for the purpose of fraud or abuse detection and prevention. Contracts under this section shall be exempt from the Public Contract Code.

(k) Enrolled providers shall attend specific orientation approved by the department in comprehensive family planning services. Enrolled providers who insert IUDs or contraceptive implants shall have received prior clinical training specific to these procedures.

(l) Upon receipt of reliable evidence that would be admissible under the administrative adjudication provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, of fraud or willful misrepresentation by a provider under the program or commencement of a suspension under Section 14123, the department may do any of the following:

(1) Collect any State-Only Family Planning program or Family Planning, Access, Care, and Treatment Program overpayment identified through an audit or examination, or any portion thereof from any provider. Notwithstanding Section 100171 of the Health and Safety Code, a provider may appeal the collection of overpayments under this section pursuant to procedures established in Article 5.3 (commencing with Section 14170) of Chapter 7 of Part 3 of Division 9. Overpayments collected under this section shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings, if the findings are against the provider. Overpayments shall be returned to a provider with interest if findings are in favor of the provider.

(2) Withhold payment for any goods or services, or any portion thereof, from any State-Only Family Planning program or Family Planning, Access, Care, and Treatment Program provider. The department shall notify the provider within five days of any withholding of payment under this section. The notice shall do all of the following:

(A) State that payments are being withheld in accordance with this paragraph and that the withholding is for a temporary period and will not continue after it is determined that the evidence of fraud or willful misrepresentation is insufficient or when legal proceedings relating to the alleged fraud or willful misrepresentation are completed.

(B) Cite the circumstances under which the withholding of the payments will be terminated.

(C) Specify, when appropriate, the type or types of claimed payments being withheld.

(D) Inform the provider of the right to submit written evidence that is evidence that would be admissible under the administrative adjudication provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, for consideration by the department.

(3) Notwithstanding Section 100171 of the Health and Safety Code, a provider may appeal a withholding of payment under this section pursuant to Section 14043.65. Payments withheld under this section shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings.

(m) As used in this section:

(1) “Abuse” means either of the following:

(A) Practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the Medicaid program, the Medicare program, the Medi-Cal program, including the Family Planning, Access, Care, and Treatment Program, identified in subdivision (aa) of Section 14132, another state’s Medicaid program, or the State-Only Family Planning program, or other health care programs operated, or financed in whole or in part, by the federal government or any state or local agency in this state or any other state.

(B) Practices that are inconsistent with sound medical practices and result in reimbursement, by any of the programs referred to in subparagraph (A) or other health care programs operated, or financed in whole or in part, by the federal government or any state or local agency in this state or any other state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

(2) “Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(3) “Provider” means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of any partnership, group, association, corporation, institution, or entity, that provides services, goods, supplies, or merchandise, directly or indirectly, to a beneficiary and that has been enrolled in the program.

(4) “Convicted” means any of the following:

(A) A judgment of conviction has been entered against an individual or entity by a federal, state, or local court, regardless of whether there is a post-trial motion or an appeal pending or the

judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed.

(B) A federal, state, or local court has made a finding of guilt against an individual or entity.

(C) A federal, state, or local court has accepted a plea of guilty or nolo contendere by an individual or entity.

(D) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgment of conviction has been withheld.

(5) “Professionally recognized standards of health care” means statewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is an issue, recognize as applying to those peers practicing or providing care within a state. When the United States Department of Health and Human Services has declared a treatment modality not to be safe and effective, practitioners that employ that treatment modality shall be deemed not to meet professionally recognized standards of health care. This definition shall not be construed to mean that all other treatments meet professionally recognized standards of care.

(6) “Unnecessary or substandard items or services” means those that are either of the following:

(A) Substantially in excess of the provider’s usual charges or costs for the items or services.

(B) Furnished, or caused to be furnished, to patients, whether or not covered by Medicare, Medicaid, or any of the state health care programs to which the definitions of applicant and provider apply, and which are substantially in excess of the patient’s needs, or of a quality that fails to meet professionally recognized standards of health care. The department’s determination that the items or services furnished were excessive or of unacceptable quality shall be made on the basis of information, including sanction reports, from the following sources:

(i) The professional review organization for the area served by the individual or entity.

(ii) State or local licensing or certification authorities.

(iii) Fiscal agents or contractors, or private insurance companies.

(iv) State or local professional societies.

(v) Any other sources deemed appropriate by the department.

(7) “Enrolled or enrollment in the program” means authorized under any and all processes by the department or its agents or contractors to receive, directly or indirectly, reimbursement for the provision of services, goods, supplies, or merchandise to a program beneficiary.

(n) In lieu of, or in addition to, the imposition of any other sanctions available, including the imposition of a civil penalty under Sections 14123.2 or 14171.6, the program may impose on providers any or all of the penalties pursuant to Section 14123.25, in accordance with the provisions of that section. In addition, program providers shall be subject to the penalties contained in Section 14107.

(o) (1) Notwithstanding any other provision of law, every primary supplier of pharmaceuticals, medical equipment, or supplies shall maintain accounting records to demonstrate the manufacture, assembly, purchase, or acquisition and subsequent sale, of any pharmaceuticals, medical equipment, or supplies, to providers. Accounting records shall include, but not be limited to, inventory records, general ledgers, financial statements, purchase and sales journals, and invoices, prescription records, bills of lading, and delivery records.

(2) For purposes of this subdivision, the term “primary supplier” means any manufacturer, principal labeler, assembler, wholesaler, or retailer.

(3) Accounting records maintained pursuant to paragraph (1) shall be subject to audit or examination by the department or its agents. The audit or examination may include, but is not limited to, verification of what was claimed by the provider. These accounting records shall be maintained for three years from the date of sale or the date of service.

(p) Each provider of health care services rendered to any program beneficiary shall keep and maintain records of each service rendered, the beneficiary to whom rendered, the date, and such additional information as the department may by regulation require. Records required to be kept and maintained pursuant to this subdivision shall be retained by the provider for a period of three years from the date the service was rendered.

(q) A program provider applicant or a program provider shall furnish information or copies of records and documentation requested by the department. Failure to comply with the

department's request shall be grounds for denial of the application or automatic disenrollment of the provider.

(r) A program provider may assign signature authority for transmission of claims to a billing agent subject to Sections 14040, 14040.1, and 14040.5.

(s) Moneys payable or rights existing under this division shall be subject to any claim, lien, or offset of the State of California, and any claim of the United States of America made pursuant to federal statute, but shall not otherwise be subject to enforcement of a money judgment or other legal process, and no transfer or assignment, at law or in equity, of any right of a provider of health care to any payment shall be enforceable against the state, a fiscal intermediary, or carrier.

(t) (1) Notwithstanding any other law, within 30 calendar days of receiving a complete application for enrollment into the Family PACT Program from an affiliate primary care clinic licensed under Section 1218.1 of the Health and Safety Code, the department shall do one of the following:

(A) Approve the provider's Family PACT Program application, provided the applicant meets the Family PACT Program provider enrollment requirements set forth in this section.

(B) If the provider is an enrolled Medi-Cal provider in good standing, notify the applicant in writing of any discrepancies in the Family PACT Program enrollment application. The applicant shall have 30 days from the date of written notice to correct any identified discrepancies. Upon receipt of all requested corrections, the department shall approve the application within 30 calendar days.

(C) If the provider is not an enrolled Medi-Cal provider in good standing, the department shall not proceed with the actions described in this subdivision until the department receives confirmation of good standing and enrollment as a Medi-Cal provider.

(2) The effective date of enrollment into the Family PACT Program shall be the later of the date the department receives confirmation of enrollment as a Medi-Cal provider, or the date the applicant meets all Family PACT Program provider enrollment requirements set forth in this section.

(u) Providers, or the enrolling entity, shall make available to all applicants and beneficiaries prior to, or concurrent with,

enrollment, information on the manner in which to apply for insurance affordability programs, in a manner determined by the State Department of Health Care Services. The information provided shall include the manner in which applications can be submitted for insurance affordability programs, information about the open enrollment periods for the California Health Benefit Exchange, and the continuous enrollment aspect of the Medi-Cal program.

SEC. 48. Section 70 of Chapter 23 of the Statutes of 2013 is amended to read:

Sec. 70. (a) The State Department of Health Care Services shall accept contributions by private foundations in the amount of at least fourteen million dollars (\$14,000,000) for the purpose of this section and shall immediately seek an equal amount of federal matching funds.

(b) Entities and persons that are eligible for Medi-Cal in-person enrollment assistance payments of fifty-eight dollars (\$58) per approved Medi-Cal application and payment processing costs shall be those trained and eligible for in-person enrollment assistance payments by the California Health Benefit Exchange. The payments may be made by the State Department of Health Care Services or through the California Health Benefit Exchange in-person assistance payment system.

(c) Enrollment assistance payments shall be made only for Medi-Cal applicants newly eligible for coverage pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), or those who have not been enrolled in the Medi-Cal program during the previous 12 months prior to making the application.

(d) The commencement of enrollment assistance payments shall be consistent with those of the California Health Benefit Exchange.

(e) The State Department of Health Care Services or the California Health Benefit Exchange shall provide monthly and cumulative payment updates and number of persons enrolled through in-person assistance payments on its Internet Web site.

(f) The State Department of Health Care Services shall make enrollment assistance payments pursuant to this section for submitted applications received through June 30, 2015, that result in approved applications. Once all of those payments have been

made, any remaining funds described in subdivision (a) shall be allocated to the county outreach and enrollment grants under Section 71 of Chapter 23 of the Statutes of 2013. Any of those remaining funds that are allocated to those grants shall be distributed to community-based organizations providing enrollment assistance to prospective Medi-Cal enrollees pursuant to Section 71 of Chapter 23 of the Statutes of 2013. The State Department of Health Care Services shall make authorized payments to counties for distribution to community-based organizations. Counties that receive money pursuant to this subdivision may retain an amount for administrative costs not to exceed 10 percent of grants approved by the State Department of Health Care Services. The State Department of Health Care Services shall require progress reports, in a manner as determined by the department, from those receiving allocations under this subdivision. The State Department of Health Care Services shall make an initial allocation to the counties for these funds no later than January 1, 2016, and the final allocation no later than June 30, 2016.

(g) This section shall be inoperative and cease to be implemented on the date that all of the private contributions accepted pursuant to subdivision (a) and any federal matching funds have been exhausted.

SEC. 49. Section 71 of Chapter 23 of the Statutes of 2013, as amended by Section 4 of Chapter 361 of the Statutes of 2013, is amended to read:

Sec. 71. (a) (1) The State Department of Health Care Services shall accept funding from private foundations in the amount of at least twelve million five hundred thousand dollars (\$12,500,000) to provide allocations for the management and funding of Medi-Cal outreach and enrollment plans specific to the provisions contained in this section.

(2) The department shall seek necessary federal approval for purposes of obtaining federal funding for activities conducted under this section.

(3) Notwithstanding any other law, and in a manner that the Director of Health Care Services shall provide, the department may make allocations to fund Medi-Cal outreach and enrollment activities as described in this section.

(b) (1) Funds appropriated by the Legislature to the department for the purposes of this section shall be made available to selected

counties, counties acting jointly, and the County Medical Services Program Governing Board pursuant to Section 16809 of the Welfare and Institutions Code.

(2) Selected counties, counties acting jointly, and the County Medical Services Program Governing Board may partner with community-based organizations as applicable to conduct outreach and enrollment to the target population as contained in subdivision (d).

(3) The director may, at his or her discretion, also give consideration to community-based organizations in an area or region of the state if a county, or counties acting jointly do not seek an allocation or funds are made available.

(4) For purposes of this section only, “county” shall be defined as county, city and county, a consortium of counties serving a region consisting of more than one county, the County Medical Services Program Governing Board, or a health authority.

(c) (1) The allocations shall be apportioned geographically, by the entities identified in subdivision (b), according to the estimated number of persons who are eligible but not enrolled in Medi-Cal and who will be newly Medi-Cal eligible as of January 1, 2014.

(2) The department may determine the number of allocations and the application process. The director may consult or obtain technical assistance from private foundations in implementation of the application and allocation process.

(3) The department shall coordinate and partner with the California Health Benefit Exchange on certified application assister and outreach, enrollment, and marketing activities related to the federal Patient Protection and Affordable Care Act.

(d) Notwithstanding any other law, the department shall develop selection criteria to allocate funds for the Medi-Cal outreach and enrollment activities with special emphasis targeting all of the following populations:

- (1) Persons with mental health disorder needs.
- (2) Persons with substance use disorder needs.
- (3) Persons who are homeless.
- (4) Young men of color.
- (5) Persons who are in county jail, in state prison, on state parole, on county probation, or under postrelease community supervision.
- (6) Families of mixed-immigration status.

(7) Persons with limited English proficiency.

(e) (1) The funds allocated under this section shall be used only for the Medi-Cal outreach and enrollment activities and may supplement, but shall not supplant, existing local, state, and foundation funding of county outreach and enrollment activities.

(2) Notwithstanding Section 10744 of the Welfare and Institutions Code, the department may recoup or withhold all or part of an allocation for failure to comply with any requirements or standards set forth by the department for the purposes of this section.

(f) The department shall begin the payment for the outreach and enrollment allocation program no later than February 1, 2014.

(g) Under the terms of the approved allocation for the outreach and enrollment program, funded entities under this section shall not receive payment for in-person assister payments for assisting potential Medi-Cal enrollees.

(h) The department shall require progress reports, in a manner as determined by the department, from those receiving allocations under this section.

(i) To the extent federal funding is received for the services specified in this section, reimbursements for costs incurred under the approved allocations shall be made in compliance with federal law.

(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 by means of all-county letters, provider bulletins, or similar instructions.

(k) This section shall become inoperative on June 30, 2018.

SEC. 50. Section 5 of Chapter 361 of the Statutes of 2013 is amended to read:

Sec. 5. (a) The Healthcare Outreach and Medi-Cal Enrollment Account is hereby created in the Special Deposit Fund within the State Treasury in order to collect and allocate non-General Fund public or private grant funds, to be expended upon appropriation by the Legislature, for the purposes of outreach to and enrollment of targeted Medi-Cal populations and to compensate Medi-Cal in-person assisters, as specified in Sections 70 and 71 of Chapter 23 of the Statutes of 2013.

(b) There is hereby appropriated to the State Department of Health Care Services the following sums to compensate eligible Medi-Cal in-person assisters as specified in Section 70 of Chapter 23 of the Statutes of 2013:

(1) The sum of fourteen million dollars (\$14,000,000) from the Healthcare Outreach and Medi-Cal Enrollment Account, to be available for encumbrance or expenditure until June 30, 2018.

(2) The sum of fourteen million dollars (\$14,000,000) from the Federal Trust Fund, to be available for encumbrance or expenditure until June 30, 2018.

(3) After June 30, 2015, the State Department of Health Care Services is authorized to expend all or any portion of the remaining funds targeted for payment of enrollment assistance for Medi-Cal applications in the Healthcare Outreach and Medi-Cal Enrollment Account that has been created within the Special Deposit Fund within the State Treasury and any matching federal funds, as specified in paragraph (2), for the funding of allocations for Medi-Cal Outreach And Enrollment plans, as specified in Section 71 of Chapter 23 of the Statutes of 2013, as amended by the act the added this paragraph.

(c) There is hereby appropriated to the State Department of Health Care Services the following sums to provide allocations for outreach and enrollment grants to eligible entities as specified in Section 71 of Chapter 23 of the Statutes of 2013:

(1) The sum of twelve million five hundred thousand dollars (\$12,500,000) from the Healthcare Outreach and Medi-Cal Enrollment Account, to be available for encumbrance or expenditure until June 30, 2018.

(2) The sum of twelve million five hundred thousand dollars (\$12,500,000) from the Federal Trust Fund, to be available for encumbrance or expenditure until June 30, 2018.

(d) Of the amounts appropriated in subdivisions (b) and (c), the State Department of Health Care Services may expend in aggregate up to five hundred thousand dollars (\$500,000) annually in fiscal years 2013–14, 2014–15, and 2015–16, inclusive, to administer the activities described in Sections 70 and 71 of Chapter 23 of the Statutes of 2013, including funding for four three-year limited-term positions, which are hereby authorized to be established. Any private foundation funding expended by the department to administer the activities under Sections 70 and 71 of Chapter 23

of the Statutes of 2013 shall be expended only for filled positions and administrative expenses directly related to these sections.

(e) The State Department of Health Care Services may expend, in aggregate, up to five hundred thousand dollars (\$500,000) annually for the 2016–17 and 2017–18 fiscal years, to administer the activities described in Sections 70 and 71 of Chapter 23 of the Statutes of 2013, and Section 1 of Chapter 551 of the Statutes of 2014, as amended by that act that added this subdivision. Any private foundation funding expended by the department for administration shall be expended only for the administrative expenses directly related to Sections 70 and 71 of Chapter 23 of the Statutes of 2013, and Section 1 of Chapter 551 of the Statutes of 2014.

(f) This section shall become inoperative on June 30, 2020, and, as of January 1, 2021, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2021, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 51. Section 1 of Chapter 551 of the Statutes of 2014 is amended to read:

Section 1. (a) (1) The State Department of Health Care Services shall accept contributions by private foundations in the amount of at least six million dollars (\$6,000,000) for the purpose of providing Medi-Cal renewal assistance payments starting January 1, 2015. These contributions shall be deposited in the Healthcare Outreach and Medi-Cal Enrollment Account that has been created in the Special Deposit Fund within the State Treasury for the purposes specified in this section.

(2) There is hereby appropriated to the State Department of Health Care Services the following sums for the purposes specified in this section:

(A) The sum of six million dollars (\$6,000,000) from the Healthcare Outreach and Medi-Cal Enrollment Account, to be available for encumbrance or expenditure until June 30, 2018.

(B) The sum of six million dollars (\$6,000,000) from the Federal Trust Fund, to be available for encumbrance or expenditure until June 30, 2018.

(3) The department may expend a portion of the five hundred thousand dollars (\$500,000) authorized for expenditure in subdivision (d) of Section 5 of Chapter 361 of the Statutes of 2013

to administer the activities described in this section. Private foundation funding expended by the department to administer the activities described in this section shall be expended only for filled positions and administrative expenses directly related to this section.

(b) (1) Notwithstanding any other law, and in a manner that the Director of the State Department of Health Care Services shall provide, the department may make allocations to fund Medi-Cal renewal assistance activities as described in this section.

(2) The department may determine the number of allocations and the application process. The director may consult or obtain technical assistance from private foundations in implementation of the application and allocation process.

(3) The director may, at his or her discretion, give consideration to distributing funds to community-based organizations in an area or region of the state if a county or counties, acting jointly, do not seek an allocation or if funds are made available.

(c) Renewal assistance payments shall be distributed to community-based organizations providing renewal assistance to Medi-Cal beneficiaries. Authorized payments shall be made to counties by the department for distribution of funds to community-based organizations. Counties may retain an amount for administrative costs that have been approved by the department.

(d) The department, in collaboration with the County Welfare Directors Association and legal services organizations, shall develop renewal assistance training for employees of community-based organizations that shall be consistent with the counties' human services agencies Medi-Cal redetermination timeframes and process. In order to be eligible for renewal assistance payments under this section, the community-based organization's employees providing the assistance shall have completed the renewal assistance training developed under this subdivision.

(e) (1) The funds allocated under this section shall be used only for the Medi-Cal renewal assistance activities and may supplement, but shall not supplant, existing local, state, and foundation funding of county renewal assistance activities.

(2) Notwithstanding Section 10744 of the Welfare and Institutions Code, the department may recoup or withhold all or part of an allocation for failure to comply with any requirements

or standards set forth by the department for the purposes of this section.

(f) The department shall require progress reports, in a manner as determined by the department, from those receiving allocations under this section.

(g) The department shall seek federal matching funds for the contributions to the extent permissible for training, testing, certifying, supporting, and compensating persons and entities providing renewal assistance and for any other permissible renewal assistance related activities and shall seek all necessary federal approvals for purposes of obtaining federal funding for activities conducted under this section.

(h) To the extent federal funding is received for the services specified in this section, reimbursements for costs incurred under the approved allocations shall be made in compliance with federal law.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, provider bulletins, or similar instructions.

(j) This section shall cease to be implemented when all of the private contributions and any federal matching funds have been exhausted.

SEC. 52. The sum of fifty million dollars (\$50,000,000) is hereby appropriated from the Health Home Program Account to the State Department of Health Care Services for the purposes of implementing the Health Home Program established pursuant to Article 3.9 (commencing with Section 14127) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code. Notwithstanding Section 16304 of the Government Code, this appropriation shall be available for encumbrance or expenditure until June 30, 2020.

SEC. 53. (a) For the 2015–16 fiscal year, and upon an appropriation of funds by the Legislature for this purpose, the State Department of Health Care Services shall provide a grant 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, 2015, 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. 54. (a) For the 2015–16 fiscal year, and upon an appropriation of funds by the Legislature for this purpose, the State Department of Health Care Services shall provide a grant to LifeLong Medical Care, a federally qualified health center in Contra Costa County.

(b) On or before September 1, 2015, the State Department of Health Care Services shall pay the funds allocated pursuant to this section to LifeLong Medical Care. The funds shall be considered a grant to be used to support LifeLong Medical Care and are not a payment for services.

(c) To the extent allowable by federal law, the grant received pursuant to subdivision (b) is not income for the purposes of the prospective payment system rate setting or rate reconciliations that are conducted by the State Department of Health Care Services for LifeLong Medical Care.

(d) The grant made pursuant to subdivision (b) does not require the State Department of Health Care Services to contract with the recipient of the funds, nor is the grant subject to the requirements of Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

SEC. 55. (a) For the 2015–16 fiscal year, the California Health Facilities Financing Authority (CHFFA) may authorize up to three million dollars (\$3,000,000) in unencumbered funds, as appropriated in Item 0977-101-0001 for Mental Health Wellness Grants, of Section 2.00 of the Budget Act of 2013, to develop peer respite sites.

(b) Any grant awards authorized by CHFFA for peer respite sites shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase bed capacity for peer respite support services. This may include, but not be limited to, the purchase of property, purchase of equipment, and the remodeling or construction of housing for the purposes of operating a peer respite site.

(c) Any recipient of a grant to develop peer respite sites shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

(d) CHFFA may adopt emergency regulations relating to grants for peer respite sites, including emergency regulations that define eligible costs, and determine minimum and maximum grant amounts. The adoption, amendments, or repeal of these regulations shall be in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) and shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.

SEC. 56. The Office of System Integration shall report to the Legislature by April 1, 2017, on the feasibility, benefits, costs, and risks of installing the Modified Adjusted Gross Income (MAGI) Eligibility Decision Engine in one, two, or all of the Statewide Automated Welfare System consortia systems.

SEC. 57. The Legislature finds and declares that the sections of this act that amend Section 120962 of the Health and Safety Code and Section 19548.2 of the Revenue and Taxation Code impose a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to continue to protect the confidentiality of public health records under specified provisions of this act, the limitations on the public's right of access imposed under this act are necessary.

SEC. 58. The Legislature finds and declares that a special law is necessary and that a general law cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique circumstances regarding providing urgent care to the citizens of Contra Costa County.

SEC. 59. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 60. 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.

Approved _____, 2015

Governor