

Assembly Bill No. 1257

CHAPTER 537

An act to amend Sections 12302.3, 14132.44, and 14132.90 of, and to amend and repeal Section 14132.22 of, the Welfare and Institutions Code, to amend Section 23 of, and to amend and repeal Section 16 of, Chapter 305 of the Statutes of 1995, relating to health, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor October 4, 1995. Filed
with Secretary of State October 4, 1995.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1257, Vasconcellos. Human services.

Existing law establishes the In-Home Supportive Services (IHSS) program, under which services are provided to qualified aged, blind, and disabled individuals in order to permit them to remain in their own homes and avoid institutionalization.

Existing law permits each county, in administering its IHSS program, to utilize different options in determining the manner in which services will be provided.

Existing law specifically permits the City and County of San Francisco to make specified wage increases for its IHSS program providers for the 1995-96 fiscal year.

This bill would specify that this authority would be subject to federal approval and financial participation.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, under which qualified low-income persons are provided with health care services.

Existing law requires the department to establish transitional inpatient care services, to the extent that federal participation is available.

This bill would, among other things, make these provisions inoperative on July 1, 1999, and repeal them on January 1, 2000.

Existing law provides that targeted case management, as defined in federal law, is a covered Medi-Cal benefit, with a targeted case management provider being defined as a local governmental agency under contract with the department.

Existing law permits a local governmental entity to contract with a nongovernmental entity or the University of California to provide targeted case management services under specified conditions.

Existing law further specifies that to the extent that a federal audit disallowance and interest results from a claim or claims for which the local governmental agency has received reimbursement for targeted case management services performed by a nongovernmental entity,

the department shall be held harmless by the local governmental agency for the amount of the federal audit disallowance and interest, less specified amounts.

This bill would also apply this provision to services performed by the University of California.

Existing law provides that, as of September 1, 1995, day care habilitative services covered as part of Medi-Cal outpatient drug abuse services, shall be provided only to alcohol and drug exposed pregnant women and women in the postpartum period.

This bill would, instead, provide that, as of September 15, 1995, these services would be provided only to alcohol and drug exposed pregnant women and women in the postpartum period, or as required by federal law.

This bill would also declare that it is to take effect immediately as an urgency statute.

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

SECTION 1. Section 12302.3 of the Welfare and Institutions Code is amended to read:

12302.3. (a) Notwithstanding any other provision of this article, and in a manner consistent with the powers available to public authorities created under this article, the City and County of San Francisco may:

(1) Increase the wages of all in-home supportive services providers in the 1995–96 fiscal year.

(2) Subject to the requirements of federal law, use county-only funds to fund county and state shares to meet federal financial participation requirements necessary to obtain any available Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396, et seq.) (Medicaid) personal care services reimbursement.

(3) Provide in-home supportive services workers with any wage increase the city and county may appropriate, as long as this amount is in accordance with the provisions of the Medi-Cal State Plan Amendment 94-006, as approved by the federal Health Care Financing Administration. The county-only funds shall be used exclusively to increase workers wages and to pay any proportionate share of employer taxes and current benefits, and to pay for the cost of state and county administration of these activities as provided for in paragraph (5). Notwithstanding Section 12302.1, any wage increase for those workers employed under contract shall be passed through by the contractor to the workers, subject to the limitations specified in this paragraph. The state shall continue to provide payroll functions for all workers who are currently individual providers unless and until the in-home supportive services public authority is operational.



(4) Claim the administrative costs of the wage pass through in accordance with the department’s claiming requirements.

(5) In the event that federal financial participation is available for county-only payroll moneys, the following shall apply:

(A) If additional payroll costs will be incurred by the state due to the receipt and payment of federal funds, the department shall provide the city and county with a detailed estimate of the additional costs of the provision of payroll functions associated with the processing of federal funds. If the city and county elects to pay the additional costs, the department will provide these payroll functions. If the city and county does not elect to pay the additional costs, the department and the city and county may seek another, mutually satisfactory arrangement.

(B) In the event that federal financial participation is not available, the department shall continue to perform the existing payroll functions provided on July 28, 1995, at no additional cost to the city and county.

(b) (1) This section shall not be implemented with respect to any particular wage increase pursuant to subdivision (a) unless the department has obtained the approval of the State Department of Health Services for that wage increase prior to its execution to determine that it is consistent with federal law and to ensure federal financial participation for the services under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396, et seq.).

(2) The Director of Health Services shall seek any federal waivers or approvals necessary for implementation of this section under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396, et seq.).

SEC. 2. Section 14132.22 of the Welfare and Institutions Code is amended to read:

14132.22. (a) (1) Transitional inpatient care services, as described in this section and provided by a qualified health facility, is a covered benefit under this chapter, subject to utilization controls and subject to the availability of federal financial participation. These services shall be available to individuals needing short-term medically complex or intensive rehabilitative services, or both.

(2) The department shall seek any necessary approvals from the federal Health Care Financing Administration to ensure that transitional inpatient care services, when provided by a general acute care hospital, will be considered for purposes of determining whether a hospital is deemed to be a disproportionate share hospital pursuant to Section 1396r-4(b) of Title 42 of the United States Code or any successor statute.

(3) Transitional inpatient care services shall be available to Medi-Cal beneficiaries who do not meet the criteria for eligibility for the subacute program provided for pursuant to Section 14132.25, but who need more medically complex and intensive rehabilitative services than are generally available in a skilled nursing facility, and



who are clinically stable and no longer need the level of diagnostic and ancillary services provided generally in an acute care facility.

(b) For purposes of this section, “transitional inpatient care” means the level of care needed by an individual who has suffered an illness, injury, or exacerbation of a disease, and whose medical condition has clinically stabilized so that daily physician services and the immediate availability of technically complex diagnostic and invasive procedures usually available only in the acute care hospital are not medically necessary, and when the physician assuming the responsibility of treatment management of the patient in transitional care has developed a definitive and time-limited course of treatment. The individual’s care needs may be medical, rehabilitative, or both. However, the individual shall fall within one of the two following patient groups:

(1) “Transitional medical patient,” which means a medically stable patient with short-term transitional care needs, whose primary barrier to discharge to a residential setting is medical status rather than functional status. These patients may require simple rehabilitation therapy, but not a rehabilitation program appropriate for multiple interrelated areas of functional disability.

(2) “Transitional rehabilitation patient,” which means a medically stable patient with short-term transitional care needs, whose primary barrier to discharge to a residential setting is functional status, rather than medical status, and who has the capacity to benefit from a rehabilitation program as determined by a physiatrist or physician otherwise skilled in rehabilitation medicine. These patients may have unresolved medical problems, but these problems must be sufficiently controlled to allow participation in the rehabilitation program.

(c) In implementing the transitional inpatient care program the department shall consider the differences between the two patient groups described in paragraphs (1) and (2) of subdivision (b) and shall assure that each group’s specific health care needs are met.

(d) For the initial two years following the implementation of this program, transitional inpatient care services shall be made available only to qualifying Medi-Cal beneficiaries who are 18 years of age or older.

(e) For the initial two years following implementation of this program, transitional inpatient care services shall not be available to patients in acute care hospitals defined as small and rural pursuant to Section 1188.855 of the Health and Safety Code.

(f) (1) Transitional inpatient care services may be provided by general acute care hospitals that are licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code. General acute care hospitals may provide transitional inpatient care services in the acute care hospital, an acute rehabilitation center, or the distinct part skilled nursing unit of the



acute care hospital. Licensed skilled nursing facilities, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, may also provide the services described in subdivision (b).

(2) Costs of providing transitional inpatient care services in nonsegregated parts of the distinct part skilled nursing unit of the acute care hospital shall be determinable, in the absence of distinct and separate cost centers established for this purpose. Costs of providing transitional inpatient care services in nondistinct parts of the acute care hospital shall be determinable, in the absence of distinct and separate cost centers established for this purpose. A separate and distinct cost center shall be maintained or established for each unit in freestanding skilled nursing facilities in which the services described in subdivision (b) are provided, in order to identify and segregate costs for transitional inpatient care patients from costs for other patients who may be served within the parent facility.

(g) In order to participate as a provider in the transitional inpatient care program, a facility shall meet all applicable standards necessary for participation in the Medi-Cal program and all of the following:

(1) If the health facility is a freestanding nursing facility, it shall be located in close proximity to a general acute care hospital with which the facility has a transfer agreement in order to support the capability to respond to medical emergencies.

(2) The health facility shall demonstrate, to the department, competency in providing high quality care to all patients for whom the facility provides care, experience in providing high quality care to the types of transitional inpatient care patients the facility proposes to serve, and the ability to provide transitional inpatient care to patients pursuant to this chapter.

(3) The health facility shall enter into a provider agreement with the department for the provision of transitional inpatient care. The provider agreement shall specify whether the facility is authorized to serve transitional medical patients or transitional rehabilitation patients or both, depending on the facility's demonstrated ability to meet standards specific to each patient group. Continuation of the provider agreement shall be contingent upon the facility's continued compliance with all the applicable requirements of this section and any other applicable laws or regulations.

(h) In determining a facility's qualifications for initial participation, an onsite review shall be conducted by the department. Subsequent review shall be conducted onsite as necessary, but not less frequently than annually. Initial and subsequent reviews shall be conducted by appropriate department personnel, which shall include a registered nurse and other health professionals where appropriate. The department shall develop written protocols for reviews.



(i) Transitional inpatient care services shall be available to patients receiving care in an acute care hospital. Under specified circumstances, as set forth in regulations, transitional inpatient care shall be available to patients transferring directly from a skilled nursing facility level of care, a physician's office, a clinic, or from the emergency room of a general acute care hospital, provided they have received a comprehensive medical assessment conducted by a physician, and the physician determines, and documents in the medical record, that the patient has been clinically stable for the 24 hours preceding admission to the transitional inpatient care program.

(j) A health facility providing transitional inpatient care shall accept and retain only those patients for whom it can provide adequate, safe, therapeutic, and effective care, and as identified in its application for participation as a transitional inpatient care provider. The facility's determination to accept a patient into the transitional inpatient care unit shall be based on its preadmission screening process conducted by appropriate facility personnel.

(k) The department shall establish a process for providing timely, concurrent authorization and coordination, as required, of all medically necessary services for transitional inpatient care.

(l) The department shall adopt regulations specifying admission criteria and an admission process appropriate to each of the transitional inpatient care patient groups specified in subdivision (b). Patient admission criteria to transitional inpatient care shall include, but not be limited to, the following:

(1) Prior to admission to transitional inpatient care, the patient shall be determined to have been clinically stable for the preceding 24 hours by the attending physician and the physician assuming the responsibility of treatment management of the patient in the transitional inpatient care program.

(2) The patient shall be admitted to transitional inpatient care on the order of the physician assuming the responsibility of the management of the patient, with an established diagnosis, and an explicit time-limited course of treatment of sufficient detail to allow the facility to initiate appropriate assessments and services. No patient shall be transferred from an acute care hospital to a transitional inpatient care program that is in a freestanding nursing facility if the patient's attending physician documents in the medical record that the transfer would cause physical or psychological harm to the patient.

(3) (A) Medical necessity for transitional care shall include, but not be limited to, one or more of the following:

- (i) Intravenous therapy.
- (ii) Rehabilitative services.
- (iii) Wound care.
- (iv) Respiratory therapy.



(v) Traction.

(B) The department shall develop regulations further defining the services to be provided pursuant to clauses (i) to (v), inclusive, and the circumstances under which these services shall be provided.

(m) Registered nurses shall be assigned to the transitional inpatient care unit at all times and in sufficient numbers to allow for the ongoing patient assessment, patient care, and supervision of licensed and unlicensed staff. Participating facilities shall assure that staffing is adequate in number and skill mix, at all times, to address reasonably anticipated admissions, discharges, transfers, patient emergencies, and temporary absences of staff from the transitional care unit including, but not limited to, absences to attend meetings or inservice training. All licensed and certified health care personnel shall hold valid, current licensure or certification.

(n) Continued medical assessments shall be of sufficient frequency as to adequately review, evaluate, and alter plans of care as needed in response to patients' medical progress.

(o) The department shall develop a rate of reimbursement for transitional inpatient care services for providers as specified in subdivision (f). Reimbursement rates shall be specified in regulation and in accordance with methodologies developed by the department and may include the following:

(1) All inclusive per diem rates.

(2) Individual patient specific rates according to the needs of the individual transitional care patient.

(3) Other rates subject to negotiation with the health facility.

(p) Reimbursement at transitional inpatient care rates shall only be implemented when funds are available for this purpose pursuant to the annual Budget Act. Funds expended to implement this section shall be used by providers to assure safe, therapeutic and effective patient care by staffing at levels which meet patients' needs, and to ensure that these providers have the needed resources and staff to provide quality care to transitional inpatient care patients.

(q) (1) The department shall reimburse physicians for all medically necessary care provided to transitional inpatient care patients and shall establish Medi-Cal physician reimbursement rates commensurate with those for visits to nontransitional acute care patients in acute care hospitals.

(2) It is the intent of this subdivision to cover physician costs not included in the per diem rate.

(r) No later than January 1, 1999, the department shall evaluate, and make recommendations regarding, the effectiveness and safety of the transitional inpatient care program. The evaluation shall be developed in consultation with representatives of providers, facility employees, and consumers. The department may contract for all or a portion of the evaluation. The evaluation shall be for the purpose of determining the impact of the transitional inpatient care program



on patient care, including functional outcomes, if applicable, on whether the care costs less than other alternatives, and whether it results in the deterioration of patient health and safety as compared to other placements. The evaluation shall also be for the purpose of determining the effect on patients other than those receiving transitional inpatient care in participating facilities. The evaluation shall include:

(1) Data on patient mortality, patients served, length of stay, and subsequent placement or discharge.

(2) Data on readmission to acute care and emergency room transfers.

(3) Staffing standards in the facilities.

(4) Other outcome measures and indicia of patient health and safety otherwise required to be reported by federal or state law.

(s) The department shall develop regulations to amend Sections 51540 to 51556, inclusive, of Title 22 of the California Code of Regulations, to exclude the cost of transitional inpatient care services rendered in general acute care hospitals from the hospital's inpatient services reimbursement.

(t) The department may adopt emergency regulations as necessary to implement this section in accordance with the Administrative Procedures Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The initial adoption of emergency regulations shall be deemed to be an emergency and considered by the Office of Administrative Law as necessary for the immediate preservation of public peace, health and safety, or general welfare. Emergency regulations adopted pursuant to this section shall remain in effect for no more than 180 days. If the department adopts emergency regulations to implement this section, the department shall obtain input from interested parties to address the unique needs of medically complex and intensive rehabilitative patients qualifying for transitional inpatient care. Notwithstanding the requirements of this section, the department shall, if it adopts emergency regulations to implement this section, address the following major subject areas:

(1) Patient selection and assessment criteria, including but not limited to, preadmission screening, patient assessments, physician services, and interdisciplinary teams.

(2) Facility participation criteria and agreements, including but not limited to, facility licensing and certification history, demonstration to the department of a preexisting history in providing care to medically complex or intensive rehabilitative patients, data reporting requirements, demonstration of continued ability to provide high quality of care to all patients, nurse staffing requirements, ancillary services, and staffing requirements.



(u) This section shall remain in effect only until January 1, 2000, and as of that date is repealed, unless a later enacted statute, that is enacted on or before January 1, 2000, deletes or extends that date.

SEC. 3. Section 14132.44 of the Welfare and Institutions Code is amended to read:

14132.44. (a) Targeted case management (TCM), pursuant to Section 1915(g) of the Social Security Act as amended by Public Law 99-272 (42 U.S.C. Sec. 1396n(g)), shall be covered as a benefit, effective January 1, 1995. Nothing in this section shall be construed to require any local governmental agency to implement TCM.

(b) A TCM provider furnishing TCM services shall be a local governmental agency under contract with the department to provide TCM services. Local educational agencies shall not be providers of case management services under this section.

(c) A TCM provider may contract with a nongovernmental entity or the University of California, or both, to provide TCM services on its behalf under the conditions specified by the department in regulations.

(d) Each TCM provider shall have all of the following:

(1) Established procedures for performance monitoring.

(2) A countywide system to prevent duplication of services and to ensure coordination and continuity of care among providers of case management services provided to beneficiaries who are eligible to receive case management services from two or more programs.

(3) A fee mechanism effective January 1, 1995, specific to TCM services provided, which may vary by program.

(e) A TCM service provider, a nongovernmental entity or the University of California, or both, under contract with a TCM provider may provide TCM services to one or all of the following groups of Medi-Cal beneficiaries, which shall be defined in regulation:

(1) High-risk persons.

(2) Persons who have language or other comprehension barriers.

(3) Persons on probation.

(4) Persons who have exhibited an inability to handle personal, medical, or other affairs.

(5) Persons abusing alcohol or drugs, or both.

(6) Adults at risk of institutionalization.

(7) Adults at risk of abuse or neglect.

(f) (1) A local governmental agency that elects to provide TCM services to the groups specified in subdivision (e) shall, for each fiscal year, for the purpose of obtaining federal medicaid matching funds, submit an annual cost report as prescribed by the department that certifies all of the following:

(A) The availability and expenditure of 100 percent of the nonfederal share for the provision of TCM services from the local governmental agency's general fund or from any other funds allowed under federal law and regulation.



(B) The amount of funds expended on allowable TCM services.

(C) Its expenditures represent costs that are eligible for federal financial participation.

(D) The costs reflected in the annual cost reports used to determine TCM rates are developed in compliance with the definitions contained in the Office of Management and Budget (OMB) Circular A-87.

(E) Case management services provided in accordance with Section 1396n(g) of Title 42 of the United States Code will not duplicate case management services provided under any home- and community-based services waiver.

(F) Claims for providing case management services pursuant to this section will not duplicate claims made to public agencies or private entities under other program authorities for the same purposes.

(G) The requirements of subdivision (d) have been met.

(2) The department shall deny any claim if it determines that any certification required by this subdivision is not adequately supported for purposes of federal financial participation.

(g) Only a local governmental agency may submit TCM service claims to the department for the performance of TCM services.

(h) During the period from January 1, 1995, through June 30, 1995, TCM services shall be reimbursed according to the interim mechanism developed by the state and the Health Care Financing Administration, which is reflected in the document entitled "Agreement Between the Health Care Financing Administration and the State of California, Department of Health Services." For the 1995-96 fiscal year, the department shall establish an initial rate of reimbursement. Effective July 1, 1996, and thereafter, TCM services shall be reimbursed in accordance with regulations that shall be adopted by the department.

(i) The department, in consultation with local governmental agencies, and consistent with federal regulations, and the State Medicaid Manual of the Department of Health and Human Services, Health Care Financing Administration, shall adopt regulations that define TCM services, establish the standards under which TCM services qualify as a Medi-Cal reimbursable service, prescribe the methodology for determining the rate of reimbursement, and establish a claims submission and processing system and method to certify local matching expenditures.

(j) (1) Notwithstanding any other provision of this section, the state shall be held harmless, in accordance with paragraphs (2) and (3) from any federal audit disallowance and interest resulting from payments made by the federal medicaid program as reimbursement for claims for providing TCM services pursuant to this section, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim.



(2) To the extent that a federal audit disallowance and interest results from a claim or claims for which any local governmental agency has received reimbursement for TCM services, the department shall recoup from the local governmental agency that submitted that disallowed claim, through offsets or by a direct billing, amounts equal to the amount of the disallowance and interest, in that fiscal year, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim. All subsequent claims submitted to the department applicable to any previously disallowed claim, may be held in abeyance, with no payment made, until the federal disallowance issue is resolved.

(3) Notwithstanding paragraphs (1) and (2), to the extent that a federal audit disallowance and interest results from a claim or claims for which the local governmental agency has received reimbursement for TCM services performed by a nongovernmental entity or the University of California, or both, under contract with, and on behalf of, the participating local governmental agency, the department shall be held harmless by that particular local governmental agency for 100 percent of the amount of any such federal audit disallowance and interest, less the amounts already remitted to the state pursuant to subdivision (m) for the disallowed claim.

(k) The use of local matching funds required by this section shall not create, lead to, or expand the health care funding obligations or service obligations for current or future years for each local governmental agency, except as required by this section or as may be required by federal law.

(l) TCM services are services which assist beneficiaries to gain access to needed medical, social, educational, and other services. Services provided by TCM providers, and their subcontractors, shall be defined in regulation, and shall include at least one of the following:

- (1) Assessment.
- (2) Plan development.
- (3) Linkage and consultation.
- (4) Assistance in accessing services.
- (5) Periodic review.
- (6) Crisis assistance planning.

(m) (1) Each local government agency shall contribute to the department a portion of the agency's general fund that has been made available due to the coverage of services described in this section under the Medi-Cal program. For both the 1994-95 and 1995-96 fiscal years, this contribution shall not exceed twenty million dollars (\$20,000,000) in each fiscal year less the amount contributed pursuant to subdivision (m) of Section 14132.47. The contributed funds shall be reinvested in health services through the Medi-Cal program. The total contribution amount shall be equal to $33\frac{1}{3}$



percent of the amounts that have been made available under this section. Beginning with the 1994–95 fiscal year, each local governmental agency's share of the total contribution shall be determined by claims submitted and approved for payment through January 1 of the following calendar year. Claims received and approved for payment after January 1 for dates of service in the previous fiscal year shall be included in the following year's calculation. Each local governmental agency's share of the contribution for the previous fiscal year shall be determined no later than February 15 and shall be remitted to the state no later than April 1 of each year. The contribution amount shall be paid from nonfederal, general fund revenues, and shall be deposited in the Targeted Case Management Claiming Fund, which is hereby created, for transfer to the Health Care Deposit Fund.

(2) Moneys received by the department pursuant to this subdivision are hereby continuously appropriated, notwithstanding Section 13340 of the Government Code, to the department for the support of the Medi-Cal program, and the funds shall be administered in accordance with procedures prescribed by the Department of Finance. If not paid as provided in this section, the department may offset payments due to each local governmental agency from the state, not related to payments required to be made pursuant to this section, in order to recoup these funds for the Targeted Case Management Claiming Fund.

(n) As a condition of participation and in consideration of the joint effort of the local governmental agencies and the department in implementing this section and the ongoing need of local governmental agencies to receive technical support from the department, as well as assistance in claims processing and program monitoring, the local governmental agencies shall cover the costs of the administrative activities performed by the department. Each local governmental agency shall annually pay a portion of the total costs of administrative activities performed by the department through a mechanism agreed to by the department and the local governmental agencies, or if no agreement is reached by August 1 of each year, directly to the state. The department shall determine and report the staffing requirements upon which projected costs will be based. Projected costs shall include the anticipated salaries, benefits, and operating expenses necessary to administer targeted case management.

(o) For the purposes of this section a "local governmental agency" means a county or chartered city.

SEC. 4. Section 14132.90 of the Welfare and Institutions Code is amended to read:

14132.90. (a) As of September 15, 1995, day care habilitative services, pursuant to subdivision (c) of Section 14021 shall be



provided only to alcohol and drug exposed pregnant women and women in the postpartum period, or as required by federal law.

(b) (1) Notwithstanding any other provision of law, except to the extent required by federal law, outpatient drug abuse services, as described in Section 14021, shall not be benefits under this chapter as of July 1, 1996, if the projected costs for those outpatient drug abuse services for the 1995–96 fiscal year as of May 15, 1996, exceed sixty million dollars (\$60,000,000) in state General Fund moneys.

(2) Notwithstanding paragraph (1), outpatient methadone maintenance and Naltrexone shall remain benefits under this chapter.

(3) Notwithstanding paragraph (1), residential care, outpatient drug free services, and day care habilitative services, for alcohol and drug exposed pregnant women and women in the postpartum period shall remain benefits under this chapter.

SEC. 5. Section 16 of Chapter 305 of the Statutes of 1995 is amended to read:

SEC. 16. The Legislature finds and declares all of the following:

(a) It is in the best interest of the state to ensure that Medi-Cal patients receive high quality health care in settings that are consistent with their medical needs, rehabilitative needs, or both, and that are as cost-effective as possible.

(b) Health care facilities, in addition to general acute care hospitals, are available that can provide high quality inpatient medical or rehabilitative care of short-term duration to clinically stable Medi-Cal patients.

(c) It is in the best interest of the state for the State Department of Health Services to establish a cost-effective, transitional inpatient care program for Medi-Cal patients meeting criteria to be specified in regulation, that can be provided in various settings, meeting criteria specified in regulation, that will be coordinated with any other medically necessary services, and that will be reimbursed at the transitional inpatient care rate.

(d) It is the intent of the Legislature in establishing a cost-effective transitional inpatient care program for Medi-Cal patients, that this program ensure quality patient care and adequate patient protections directed toward maximizing patients’ potential for good health, independence, and productivity.

(e) This section shall remain in effect only until January 1, 2000, and as of that date is repealed, unless a later enacted statute, that is enacted on or before January 1, 2000, deletes or extends that date.

SEC. 6. Section 23 of Chapter 305 of the Statute of 1995 is amended to read:

SEC. 23. (a) Subject to the requirements of Section 14132.06 of the Welfare and Institutions Code, the State Department of Health Services shall adopt emergency regulations to authorize local educational agencies to bill the Medi-Cal Program for services



provided by credentialed professionals, under the supervision of a licensed health professional to eligible special education pupils pursuant to an approved individualized education plan.

(b) Subdivision (a) shall not be implemented unless matching funds from Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) are available.

SEC. 7. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to ensure that essential changes are made in health services programs, at the earliest possible time, it is necessary that this act go into immediate effect.

