

Assembly Bill No. 1107

Passed the Assembly June 16, 1999

Chief Clerk of the Assembly

Passed the Senate June 15, 1999

Secretary of the Senate

This bill was received by the Governor this _____ day
of _____, 1999, at _____ o'clock ____M.

Private Secretary of the Governor



CHAPTER _____

An act to amend Section 2815.1 of the Business and Professions Code, to repeal Section 95030 of the Government Code, to amend Sections 1179.3, 1276.5, 123870, 123900, 123940, 124250, and 128405 of, and to add Chapter 1.5 (commencing with Section 150) to Part 1 of Division 1 of, to add Chapter 1.5 (commencing with Section 120390) to Part 2 of Division 105 of, and to add and repeal Article 1.5 (commencing with Section 104160) to Chapter 2 of Part 1 of Division 103 of, the Health and Safety Code, to amend Sections 12693.02, 12693.06, 12693.21, 12693.41, 12693.43, 12693.62, 12693.70, 12693.73, and 12693.91 of, to amend and renumber Section 12963.96 of, and to add Sections 12393.17, 12693.69, and 12693.76 to, the Insurance Code, to amend Section 17273 of the Revenue and Taxation Code, and to amend Sections 4640.6, 4647, 4681.3, 14005.30, 14007.5, 14053, 14067, 14085.7, 14085.8, 14094.3, 14105.31, 14105.33, 14105.35, 14105.37, 14105.38, 14105.39, 14105.4, 14105.405, 14105.41, 14105.42, 14105.91, 14105.915, 14105.916, 14105.981, 14110.6, 14110.7, 14132, 14132.22, 14163, 16809, 18993.9, 24001, and 24005 of, to add Sections 4441.5, 5701.1, 6501, 14007.65, 14007.7, 14008.85, 14011.15, 14018.5, 14053.1, 14087.301, 14107.11, 24003.2, 24003.5, and 24007.5 to, to add Article 1.3 (commencing with Section 14043) to Chapter 7 of Part 3 of Division 9 of, and to repeal and add Section 24027 of, the Welfare and Institutions Code, relating to health care, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 1107, Cedillo. Health Care.

Existing law establishes the California Registered Nurse Education Program, within the Minority Health Education Professions Foundation, under which persons from demographically underrepresented groups or persons who agree in writing prior to graduation to serve



in an eligible county health facility or a health manpower shortage area, may apply for awards to assist students in completing nursing programs meeting specified standards.

Existing law creates the Registered Nurse Education Fund, to be used for the purposes of this program. This fund contains a \$5 assessment, which is collected by the Board of Registered Nursing at the time of the biennial registered nursing licensure renewal.

Under existing law, provisions establishing the California Registered Nurse Education Program and the licensure renewal assessment collected for that purpose would be repealed on January 1, 2000.

This bill would extend the duration of these provisions until January 1, 2003.

Under existing law, the California Early Intervention Services Act, various state departments provide coordinated services to infants and toddlers with disabilities and their families.

Under existing law, the act will repeal on January 1, 2000.

This bill would indefinitely extend the duration of these provisions.

Existing law establishes various programs administered by the State Department of Health Services to assist minority populations and underserved areas.

This bill would establish the Office of Multicultural Health in the department in order to perform specified functions.

Existing law establishes the Breast Cancer Control Program, which provides early breast cancer detection services for uninsured and underinsured women.

This bill would, until July 1, 2000, establish the Breast Cancer Treatment Program, to be administered by an eligible private nonprofit organization contracting with the State Department of Health Services, for the purpose of providing breast cancer treatment services to uninsured and underinsured women with incomes at or below 200% of the federal poverty level, to the extent funds are available for that purpose.



Existing law requires the Rural Health Policy Council to develop and administer a competitive grants program for health delivery projects in rural areas. Existing law requires the Office of Statewide Health Planning and Development to administer funds appropriated for this purpose by the Budget Act of 1998. Under existing law, these provisions become inoperative on July 1, 1999, and are repealed on January 1, 2000.

This bill would instead require the office to administer funds appropriated for this purpose by any act. This bill would provide that upon appropriation, the funds may be expended in the fiscal year of the appropriation or the subsequent fiscal year. This bill would delete the dates upon which these provisions would become inoperative and be repealed.

Existing law requires the Maternal and Child Health branch of the State Department of Health Services to administer a comprehensive shelter-based services grant program to battered women's shelters.

Existing law requires the department, in implementing this program, to consult with an advisory council which would remain in existence until January 1, 1998.

This bill would extend the date of the existence of this advisory council to January 1, 2003.

Under existing law, persons are required to be immunized against specified communicable diseases prior to admission to daycare institutions or schools. Existing law requires immunization against hepatitis B for all students unconditionally entering or unconditionally advancing to the 7th grade level on or after July 1, 1999.

This bill would require the State Department of Health Services, in consultation with, the Trustees of the California State University, and the Regents of the University of California, to adopt and enforce regulations relating to the immunization of first-time enrollees at the institutions against the hepatitis B virus.

The bill would require, with prescribed exceptions, the Trustees of the California State University, and the Regents of the University of California, to the extent the



regents act by resolution to make this bill applicable to the university, require that first-time enrollees who are 18 years of age or younger provide proof of full immunization against the hepatitis B virus, prior to enrollment.

Existing law creates the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health care services to children older than 12 months and less than 19 years of age who meet certain criteria, including having a gross household income equal to or less than 200% of the federal poverty level, and meeting the citizenship and immigration status requirements established by federal law. Existing law requires families with children participating in the program to pay specified family contribution amounts.

The bill would expand coverage to include families with an annual or monthly household income greater than 200% of the federal poverty level by use of an income disregard provision for income between 200 and 250%, inclusive, of the federal poverty level, and specified Medi-Cal income deductions for income over 250% of the federal poverty level. The bill would modify eligibility under the program to include children less than 12 months of age in a family. The bill would permit a minor to apply for coverage on behalf of his or her child, and on behalf of herself or himself if emancipated or not living with a natural or adoptive parent, legal guardian, or caretaker relative, foster parent, or stepparent. The bill would provide that a child who is a qualified alien, as defined in federal law and who is otherwise eligible for participation in the program, shall not be denied eligibility based on the child's date of entry into the United States. The bill would not require federal financial participation for qualified aliens in the 1999–2000 budget year, but would require that participation in subsequent fiscal years.

Existing law requires applicants for the Healthy Families Program who apply for the purchasing pool to pay the first month's family contribution to be eligible to



participate in the program. Existing law requires subscribers and purchase credit members of the Healthy Families Program to pay monthly contributions. Existing law provides a 4th consecutive month of coverage with no family contribution required if an applicant pays 3 months of required family contributions in advance.

This bill would permit a family contribution sponsor to pay all of the annual required family contributions at the time of application, but would not permit a family contribution sponsor to receive the free months of coverage provided to applicants. The bill would require the Managed Risk Medical Insurance Board to determine who may be family contribution sponsors and to provide a mechanism for sponsorship.

Existing law permits initial treatment, as specified, up to 30 days prior to the effective date of coverage under the Healthy Families Program.

This bill would permit initial treatment up to 90 days prior to the effective date of coverage.

Existing law continuously appropriates money from the Healthy Families Fund for purposes of implementation of the Healthy Families Program.

This bill, by liberalizing various eligibility criteria for participation within this program and thereby covering a new pool of participants, would make the moneys in this continuously appropriated fund available for a new or expanded purpose, and would thereby result in an appropriation.

Existing law, the Robert W. Crown California Children's Services Act, provides for treatment services for physically defective or handicapped persons under the age of 21 years. Existing law limits eligibility to families with an adjusted gross income of \$40,000 or less. Existing law requires a family to pay an annual enrollment fee for the California Children's Services program, except as specified. Existing law requires a county expenditure for services to handicapped children of the county, as specified.

This bill would permit children enrolled in the Healthy Families Program who have a California Children's



Services program (CCS program) eligible medical condition, and whose families do not meet the financial eligibility requirements of the CCS program, to receive CCS program benefits. The bill would exempt these families from the annual enrollment fee. The bill would waive county expenditures for services to these children, and would make corresponding changes in the Healthy Families Program to require the state to pay the expenditures from designated state and federal funds.

Under existing provisions of the Healthy Families Program, operative until July 1, 2003, the State Department of Health Services, in conjunction with the Managed Risk Medical Insurance Board, the County Medical Services Program board, and the Rural Health Policy Council, may develop and administer up to 5 demonstration projects in rural areas that are likely to contain a significant level of uninsured children, including seasonal and migratory worker dependents, to fund rural collaborative health care networks to alleviate unique problems of access to health care in rural areas through grants to entities that meet the criteria and standards for eligibility established by the State Department of Health Services, in conjunction with the Managed Risk Medical Insurance Board and Rural Health Policy Council.

This bill would require that, subject to appropriation by the Legislature, these grant funds be used for purchasing equipment, making capital expenditures, and providing infrastructure.

The Personal Income Tax Law, by reference to specified federal statutes, for taxable years beginning on or after January 1, 1999, allows a deduction for 40% of the amount paid or incurred during the taxable year by a self-employed individual for insurance that constitutes medical care for the taxpayer and his or her spouse and dependents. Existing federal law incrementally increases that deduction to certain percentage rates. Under federal law, a 60% deduction is allowed for taxable years beginning in calendar year 1999 through 2001, a 70% deduction is allowed for taxable years beginning in



calendar year 2002, and a 100% deduction is allowed for taxable years beginning in calendar year 2003 or thereafter.

This bill would conform the deduction allowed under the Personal Income Tax Law to the applicable federal percentage of the amount paid or incurred for taxable years beginning on or after January 1, 1999.

Under existing law, the State Department of Developmental Services contracts with regional centers for the provision of services and supports to persons with developmental disabilities.

Existing law requires the department, when approving regional center contracts, to ensure that regional center staffing patterns demonstrate that direct service coordination is the highest priority.

Existing law also requires that these contracts have consumer-to-staff ratios that reflect an overall average of 62 consumers to each staff member.

Existing law also requires that a regional center assign a service coordinator, who shall be responsible for implementing, overseeing, and monitoring each client's individual program plans.

This bill would enact specified regional center service coordinator-to-consumer ratios. It would require, by December 15, 1999, the department to make recommendations to the Legislature regarding the core staffing formula used to allocate operations funding to regional centers, and would require each regional center to provide the department with service coordinator caseload data.

The bill would also require that the regional centers provide the consumer, or where appropriate, his or her parents, legal guardian or conservator or authorized representative, with written notification of any permanent change in the assigned service coordinator within 10 business days.

Under existing law, certain persons with developmental disabilities are placed in state developmental centers operated by the State Department of Developmental Services.



This bill would require the department to develop policies and procedures, by no later than 30 days following the effective date of the Budget Act of 1999, at each developmental center, for the notification of appropriate law enforcement agencies in the event of a forensic client walkaway or escape.

Existing law contains provisions governing rates for community care facilities serving persons with developmental disabilities.

This bill would require that, for the 1999–2000 fiscal year, the rate schedule for these facilities be increased July 1, 1999, based upon the amount appropriated in the Budget Act of 1999 for that purpose, and that effective January 1, 2000, any funds available from cost-of-living adjustments in the Supplemental Security Income State Supplementary Payment for the 1999–2000 fiscal year be used to further increase these rates.

Existing law requires the State Department of Mental Health to identify, from mental health block grant funds provided by the federal government, the maximum amount that federal law and regulation permit to be allocated to cities and counties according to a specified formula.

This bill would authorize the department, in consultation with the California Mental Health Directors Association, to utilize funding from the Substance Abuse and Mental Health Services Administration Block Grant, awarded to the department, above the funding level provided in federal fiscal year 1998, for the development of innovative mental health programs for identified target populations, upon appropriation by the Legislature.

Existing law contains provisions governing placement of persons with developmental disabilities.

This bill would provide that when an individual charged with a violent felony has been committed to the State Department of Developmental Services, due to a finding of incompetency to stand trial, for placement in a secure treatment facility, the department shall give priority to placing the individual at Porterville



Developmental Center prior to placing him or her at any other developmental center which has been designated as a secure treatment facility.

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

Under existing law, a child is eligible to receive Medi-Cal benefits if the child meets certain deprivation requirements.

This bill would revise those requirements, effective March 1, 2000.

Existing law requires the department, not later than July 1, 1998, to create and implement a simplified application package for children, pregnant women, and infants.

This bill would require the department, by July 1, 2000, to create and implement a simplified application package for children, families, and adults applying for Medi-Cal. It would also require the department, by July 1, 2000, to revise the quarterly reporting form for Medi-Cal beneficiaries to be as simple as possible to complete.

Under existing law, counties are responsible for the implementation of eligibility determinations under the Medi-Cal program.

By extending the eligibility for benefits under the Medi-Cal program and modifying the eligibility determination process, this bill would increase the responsibilities of the counties in the administration of the Medi-Cal program, and would result in a state-mandated local program.

Existing law requires the State Department of Health Services to exercise its option under federal law authorizing states to use income and resource methodologies that are less restrictive than the methodologies used under the state plan meeting certain eligibility standards for families with dependent children to expand eligibility under the Medi-Cal program, to the extent federal financial participation is available.



This bill would specify that the department shall exercise that option by exempting all resources, commencing August 1, 1999, if federal financial participation is available.

Under existing California law, any alien who is otherwise eligible for Medi-Cal services, but who does not meet specified requirements relating to residency status, is only eligible for care and services that are necessary for the treatment of an emergency medical condition and medical care directly related to the emergency and for medically necessary pregnancy-related services. However, the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 makes any alien who is not a qualified alien, as defined, ineligible for federal public benefits, including medical assistance under the federal medicaid program for assistance other than care and services necessary for the treatment of an emergency medical condition. Federal law also prohibits a state from providing defined state public benefits to certain aliens, unless state legislation is enacted subsequent to the effective date of the act, August 22, 1996.

This bill would provide that any alien who is otherwise eligible for Medi-Cal services, but who does not meet specified requirements relating to residency status, is eligible for medically necessary pregnancy-related services.

Under existing law, counties are responsible for determining eligibility for Medi-Cal benefits. By making certain aliens eligible for Medi-Cal benefits, this bill would increase county responsibilities in making eligibility determinations, and would result in a state-mandated local program.

Under existing state law, certain aliens ineligible for the full scope of Medi-Cal benefits are eligible to receive long-term care benefits.

This bill would provide that any alien who is otherwise eligible for Medi-Cal services, but who does not meet the requirements to receive the full scope of Medi-Cal



benefits due to his or her alien status, shall be eligible for long-term care services.

Since the bill would affect the eligibility of persons for programs administered by local agencies and school districts, it would constitute a state-mandated local program.

Existing law, operative until July 1, 2000, provides for the State-Only Family Planning Program, in order to provide family planning comprehensive clinical services to eligible low-income persons.

This bill would indefinitely extend the duration of this program. The bill would also establish a program, within the Medi-Cal program, known as the Family Planning Access, Care, and Treatment (Family PACT) Waiver Program, to provide comprehensive clinical family planning services to any person whose family income is not in excess of 200% of the federal poverty level, to be operational only if a waiver is obtained from the federal government. It would repeal the provisions establishing this program on the first day of the month following 30 days after the date that a written notification is submitted to specified legislative committee chairpersons by the Department of Finance stating that the program is no longer cost-effective.

The bill would also, if this waiver is received for this program, add certain services to those provided under the State-Only Family Planning Program.

The bill would also appropriate \$5,000,000 to the State Department of Health Services for purposes of the Partnership for Responsible Parenting Program.

Under existing law, persons who are at least 21 years of age, but who have not attained the age of 65 years, and who are patients in an institution of mental diseases are eligible to receive outpatient services under the Medi-Cal program.

This bill would permit eligible persons to receive ancillary outpatient services regardless of whether federal financial participation is available.



Existing law requires the department to adopt regulations establishing payment rates for nursing facilities.

This bill would require the department, commencing August 1, 1999, to increase the Medi-Cal reimbursement for level A and level B nursing facilities to provide funds for salaries, wages, and benefits increases for direct care staff, as defined, and would require these facilities to provide these increases to their direct care staff.

Existing law also requires the department to adopt regulations setting forth the minimum number of equivalent nursing hours per patient day required in skilled nursing and intermediate care facilities.

The bill would require, commencing January 1, 2000, that the minimum number of actual nursing hours per patient required in skilled nursing facilities be 3.2 hours. It would also require that, commencing January 1, 2000, the minimum number of nursing hours per patient day in skilled nursing facilities be determined without regard to the doubling of nursing hours, as described.

Existing law provides that a party that incurs a forfeiture or a loss in the nature of a forfeiture by reason of failure to comply with an obligation may be relieved from the forfeiture by making full compensation to the other party, except in cases of grossly negligent, willful, or fraudulent breach of duty.

This bill would provide that this relief does not apply to Medi-Cal reimbursement or prior authorization.

Existing law permits the State Department of Health Services, in conjunction with the Managed Risk Medical Insurance Board, to conduct pilot outreach and education projects, through the allocation of grant funds or a competitive process, to entities with experience in serving uninsured children, Medi-Cal beneficiaries, or in providing services to low-income families.

This bill would, instead, require the department, in conjunction with the board, to award contracts to community-based organizations to help families learn about, and enroll in, the Medi-Cal program and the



Healthy Families Program, and other health care programs for low-income children.

Existing law establishes the California Children's Services Program, in order to provide services to qualified children with disabilities.

Existing law prohibits, with specified exceptions, and until August 1, 2000, services covered under that program from being incorporated into specified contracts entered into under the Medi-Cal program.

This bill would extend this date until August 1, 2005.

Existing law establishes the continuously appropriated Medi-Cal Medical Education Supplemental Payment Fund for allocation to university teaching hospitals and major nonuniversity teaching hospitals and the continuously appropriated Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund for allocation to large teaching emphasis hospitals and children's hospitals.

Existing law establishes that the funds are inoperative June 30, 1999, and repealed January 1, 2000.

This bill would extend those dates by a period of one year, and by extending the operative period of a continuously appropriated fund, this bill would make an appropriation.

Existing law provides that one of the services offered under the Medi-Cal program is dental services, subject to utilization controls.

This bill would provide that when entering into contracts with health care service plans that provide comprehensive dental benefits to Medi-Cal beneficiaries on an at-risk basis, the department may require that the health care service plans pay for the costs of the administrative and regulatory oversight required to monitor the contract compliance terms of the agreement with the department.

Existing law, until January 1, 2000, provides for the provision of drugs that are reimbursed through the Medi-Cal program without prior authorization when they are on an approved list of contract drugs.



This bill would extend until January 1, 2001, provisions for the use of a list of contract drugs for purposes of the Medi-Cal program.

Existing law, until January 1, 2000, authorizes the State Department of Health Services to enter into contracts with manufacturers of single-source and multiple-source drugs under the Medi-Cal program, and specifies procedures for the implementation of that authority.

This bill would extend that authority to January 1, 2001.

Under the Medi-Cal program, the State Department of Health Services is required, until January 1, 2000, to take all appropriate steps to ensure that transitional inpatient days are included in the payment adjustment program, as specified.

This bill would extend that requirement until January 1, 2001.

Existing law authorizes Medi-Cal reimbursement, until January 1, 2000, for transitional inpatient care, as defined, in general acute care hospitals and other specified health facilities.

This bill would extend that authorization until January 1, 2001.

Under existing law, the State Department of Health Services is required to evaluate and make recommendations regarding the effectiveness and safety of the transitional inpatient care program, by January 1, 1999.

This bill would instead require that evaluation be made by January 1, 2000.

Under the Medi-Cal program, the department is required to make supplemental payments to certain disproportionate share hospitals based on specified criteria. Payments are made from defined intergovernmental transfers that are paid into the Medi-Cal Inpatient Payment Adjustment Fund, as required, with this fund being continuously appropriated for specified purposes. Existing law authorizes moneys in the fund to be used for transfers to the Health Care Deposit Fund in the amount of \$114,757,690 for the 1998–99 fiscal year and each fiscal year thereafter.



This bill would authorize, instead, transfers to the Health Care Deposit Fund in the amount of \$84,757,690 for the 1999–2000 fiscal year and each fiscal year thereafter, and would require the department to implement this reduction in a specified manner. By changing the amount of moneys transferred for purposes of the Health Care Deposit Fund from the continuously appropriated Inpatient Payment Adjustment Fund, the bill would result in an appropriation.

Existing law provides that the board of supervisors of a county that contracted with the State Department of Health Services pursuant to a specified provision of law during the 1990–91 fiscal year and any county with a population under 300,000, as determined in accordance with the 1990 decennial census, by adopting a resolution to that effect, may elect to participate in the County Medical Services Program for state administration of health care services to eligible persons in the county.

Existing law provides for the State-Only Family Planning program, under which family planning services are provided to eligible individuals.

This bill would authorize the department, upon reliable evidence of fraud or willful misrepresentation by a provider under these programs, to collect any overpayment identified through an audit or examination from any provider or withhold payment for any goods or services owing to the provider.

The bill would also provide for disenrollment, in accordance with specified limitations, for providers and prohibit enrollment for applicants for provider status, found to have committed fraud or abuse.

Existing law provides that counties and the state shall share the risk for cost increases of the County Medical Services Program not funded through other sources according to specified parameters.

This bill would revise those risk-sharing requirements for the 1999–2000 fiscal year.

Existing law establishes the Community Challenge Grant Program, administered by the State Department of Health Services, in order to provide community



challenge grants to reduce the number of teenage and unwed pregnancies. The provisions of this program are operative until July 1, 1999, and would be repealed on January 1, 2000.

Existing law also establishes the State-Only Family Planning Program, in the department, to provide comprehensive clinical family planning services to low-income men and women.

This bill would extend the duration of the Community Challenge Grant Program for one year, but would condition program implementation on receipt of federal financial participation pursuant to a federal waiver received under the State-Only Family Planning Services Program.

Existing law establishes various tobacco use prevention programs funded through moneys derived from the Cigarette and Tobacco Products Surtax Fund and administered by the State Department of Health Services and the State Department of Education.

This bill would make moneys appropriated for purposes of these programs by the Budget Act of 1999 available without regard to fiscal years until July 1, 2002.

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, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed \$1,000,000 statewide and other procedures for claims whose statewide costs exceed \$1,000,000.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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

Appropriation: yes.



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

SECTION 1. Section 2815.1 of the Business and Professions Code is amended to read:

2815.1. As provided in subdivision (d) of Section 2815, the Board of Registered Nursing shall collect an additional five dollar (\$5) assessment at the time of the biennial licensure renewal. This amount shall be credited to the Registered Nurse Education Fund. This assessment is separate from those fees prescribed in Section 2815.

This section shall remain in effect only until January 1, 2003, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2003, deletes or extends that date.

SEC. 2. Section 95030 of the Government Code is repealed.

SEC. 3. Chapter 1.5 (commencing with Section 150) is added to Part 1 of Division 1 of the Health and Safety Code, to read:

CHAPTER 1.5. MULTICULTURAL HEALTH

150. The Legislature finds and declares all of the following:

(a) The health status of California's racial and ethnic communities is poor relative to the health status of the white population.

(b) Of the estimated 24 percent of Californians without health insurance, approximately 81 percent are from racial and ethnic communities.

(c) Of the uninsured in California, an estimated 38 percent are Latino, 24 percent are Asian and Pacific Islander, and 19 percent are African-American.

(d) Racial and ethnic communities suffer from various infections and communicable diseases at higher rates than the white population, and experience increased mortality from more preventable disease relative to the white population. For example, the President's Racial and Ethnic Health Disparities Initiative recognized that infant mortality rates are 2.5 times higher for



African-Americans and 1.5 times higher for native Americans than for the white population. African men under 65 years of age suffer from prostate cancer at nearly five times the rate of white men and Vietnamese women suffer from cervical cancer at nearly five times the rate of white women. Latinos suffer from stomach cancer at two to three times the rate of the white population, and African-American men suffer from heart disease at nearly twice the rate of white men. Native Americans suffer from diabetes at nearly three times the average rate of the white population, while African-Americans suffer 70 percent higher rates of diabetes than the white population.

(e) Efforts to reduce and eliminate racial and ethnic disparities in health status have received scant attention, both in terms of funding for prevention and treatment services, as well as research.

(f) Program planning and implementation efforts to reduce these health disparities have been neither inclusive of racial and ethnic communities nor responsive to the needs of these communities.

151. (a) The Office of Multicultural Health is hereby established within the State Department of Health Services.

(b) For purposes of this chapter:

(1) “Department” means the State Department of Health Services.

(2) “Office” means the Office of Multicultural Health.

152. (a) The office shall do all of the following:

(1) Perform strategic planning within the department to develop departmentwide plans for implementation of goals and objectives to close the gaps in health status and access to care among the state’s diverse racial and ethnic communities.

(2) Conduct departmental policy analysis on specific issues related to multicultural health.

(3) Coordinate pilot projects and planning projects funded by the state that are related to improving the effectiveness of services to ethnic and racial communities.



(4) Identify the unnecessary duplication of services and future service needs.

(5) Communicate and disseminate information and perform a liaison function within the department and to providers of health, social, educational, and support services to racial and ethnic communities. The office shall consult regularly with representatives from diverse racial and ethnic communities, including health providers, advocates, and consumers.

(6) Perform internal staff training, an internal assessment of cultural competency, and training of health care professionals to ensure more linguistically and culturally competent care.

(7) Serve as a resource for ensuring that programs keep data and information regarding ethnic and racial health statistics, strategies and programs that address multicultural health issues, including, but not limited to, infant mortality, cancer, cardiovascular disease, diabetes, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), child and adult immunization, asthma, unintentional and intentional injury, and obesity, as well as issues that impact the health of racial and ethnic communities, including substance abuse, mental health, housing, teenage pregnancy, environmental disparities, immigrant and migrant health, and health insurance and delivery systems.

(8) Encourage innovative responses by public and private entities that are attempting to address multicultural health issues.

(9) Provide technical assistance to counties, other public entities, and private entities seeking to obtain funds for initiatives in multicultural health, including identification of funding sources and assistance with writing grants.

(b) Notwithstanding Section 7550.5 of the Government Code, the office shall biennially prepare and submit a report to the Legislature on the status of the activities required by this chapter.

SEC. 4. Section 1179.3 of the Health and Safety Code is amended to read:



1179.3. (a) (1) The Rural Health Policy Council shall develop and administer a competitive grants program for projects located in rural areas of California.

(2) The Rural Health Policy Council shall define “rural area” for the purposes of this section after receiving public input and upon recommendation of the Interdepartmental Rural Health Coordinating Committee and the Rural Health Programs Liaison.

(3) The purpose of the grants program shall be to fund innovative, collaborative, cost-effective, and efficient projects that pertain to the delivery of health and medical services in rural areas of the state.

(4) The Rural Health Policy Council shall develop and establish uses for the funds to fund special projects that alleviate problems of access to quality health care in rural areas and to compensate public and private health care providers associated with direct delivery of patient care. The funds shall be used for medical and hospital care and treatment of patients who cannot afford to pay for services and for whom payment will not be made through private or public programs.

(5) The Office of Statewide Health Planning and Development shall administer the funds appropriated by the Legislature for purposes of this section. Entities eligible for these funds shall include rural health providers served by the programs operated by the departments represented on the Rural Health Policy Council, which include the State Department of Alcohol and Drug Programs, the Emergency Medical Services Authority, the State Department of Health Services, the State Department of Mental Health, the Office of Statewide Health Planning and Development, and the Managed Risk Medical Insurance Board. The grant funds shall be used to expand existing services or establish new services and shall not be used to supplant existing levels of service. Funds appropriated by the Legislature for this purpose may be expended in the fiscal year of the appropriation or the subsequent fiscal year.

(b) The Rural Health Policy Council shall establish the criteria and standards for eligibility to be used in requests



for proposals or requests for application, the application review process, determining the maximum amount and number of grants to be awarded, preference and priority of projects, compliance monitoring, and the measurement of outcomes achieved after receiving comment from the public at a meeting held pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

(c) The Office of Statewide Health Planning and Development shall periodically report to the Rural Health Policy Council on the status of the funded projects. This information shall also be available at the public meetings.

SEC. 4.5. Section 1276.5 of the Health and Safety Code is amended to read:

1276.5. (a) The department shall adopt regulations setting forth the minimum number of equivalent nursing hours per patient required in skilled nursing and intermediate care facilities, subject to the specific requirements of Section 14110.7 of the Welfare and Institutions Code. However, notwithstanding Section 14110.7 or any other provision of law, commencing January 1, 2000, the minimum number of actual nursing hours per patient required in a skilled nursing facility shall be 3.2 hours.

(b) (1) For the purposes of this section, “nursing hours” means the number of hours of work performed per patient day by aides, nursing assistants, or orderlies plus two times the number of hours worked per patient day by registered nurses and licensed vocational nurses (except directors of nursing in facilities of 60 or larger capacity) and, in the distinct part of facilities and freestanding facilities providing care for the developmentally disabled or mentally disordered, by licensed psychiatric technicians who perform direct nursing services for patients in skilled nursing and intermediate care facilities, except when the skilled nursing and intermediate care facility is licensed as a part of a state hospital, and except that nursing hours for



skilled nursing facilities means the actual hours of work, without doubling the hours performed per patient day by registered nurses and licensed vocational nurses.

(2) Concurrent with implementation of the first year of rates established under the Medi-Cal Long Term Care Reimbursement Act of 1990 (Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code), for the purposes of this section, “nursing hours” means the number of hours of work performed per patient day by aides, nursing assistants, registered nurses, and licensed vocational nurses (except directors of nursing in facilities of 60 or larger capacity) and, in the distinct part of facilities and freestanding facilities providing care for the developmentally disabled or mentally disordered, by licensed psychiatric technicians who performed direct nursing services for patients in skilled nursing and intermediate care facilities, except when the skilled nursing and intermediate care facility is licensed as a part of a state hospital.

(c) Notwithstanding Section 1276, the department shall require the utilization of a registered nurse at all times if the department determines that the services of a skilled nursing and intermediate care facility require the utilization of a registered nurse.

(d) (1) Except as otherwise provided by law, the administrator of an intermediate care facility/developmentally disabled, intermediate care facility/developmentally disabled habilitative, or an intermediate care facility/developmentally disabled—nursing shall be either a licensed nursing home administrator or a qualified mental retardation professional as defined in Section 483.430 of Title 42 of the Code of Federal Regulations.

(2) To qualify as an administrator for an intermediate care facility for the developmentally disabled, a qualified mental retardation professional shall complete at least six months of administrative training or demonstrate six months of experience in an administrative capacity in a licensed health facility, as defined in Section 1250,



excluding those facilities specified in subdivisions (e), (h), and (i).

SEC. 5. Article 1.5 (commencing with Section 104160) is added to Chapter 2 of Part 1 of Division 103 of the Health and Safety Code, to read:

Article 1.5. Breast Cancer Treatment Program

104160. The department shall award a contract to provide breast cancer treatment to a bidder that is a nonprofit organization established under Section 501(c)(3) of the federal Internal Revenue Code and that meets the following additional eligibility criteria:

(a) The organization has at least two consecutive years of successful administration of a breast cancer treatment program, or the equivalent, operated on a statewide level, or servicing a population of at least 500 patients.

(b) The organization has experience operating a program dedicated to providing services to residents of California diagnosed with primary breast cancer, who are 18 years of age or older, at or below 200 percent of the federal poverty level, and who are uninsured or underinsured.

(c) The organization has operated the treatment program with administrative costs no higher than 10 percent of appropriated program funds, or can demonstrate the ability to do so.

(d) The organization has demonstrated ability to accomplish recruitment and commitment of breast cancer treatment providers to work with the program to provide care at or below established statewide Medi-Cal base rates of reimbursement.

104161. For purposes of this chapter, breast cancer treatment shall include, but shall not be limited to, lumpectomy, mastectomy, chemotherapy, hormone therapy, radiotherapy, reconstructive surgery, and breast implant surgery.

104162. Treatment under this chapter shall be provided to uninsured and underinsured women and



men with incomes at or below 200 percent of the federal poverty level.

104163. The department shall contract for breast 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. The funds appropriated shall be used to match any funding from non-General Fund sources, including, but not limited to, public nonprofit foundations.

104164. This article shall remain in effect only until July 1, 2000, and as of that date is repealed, unless a later enacted statute, that is enacted before July 1, 2000, deletes or extends that date.

SEC. 5.5. Chapter 1.5 (commencing with Section 120390) is added to Part 2 of Division 105 of the Health and Safety Code, to read:

CHAPTER 1.5. IMMUNIZATION OF COLLEGE-AGE STUDENTS

120390. The department, in consultation with the Trustees of the California State University, and the Regents of the University of California, shall adopt and enforce all regulations necessary to carry out this chapter.

120390.5. (a) Except as provided in subdivisions (b), (c), and (d), on or after January 1, 2000, the Trustees of the California State University, and the Regents of the University of California shall require the first-time enrollees at those institutions who are 18 years of age or younger to provide proof of full immunization against the hepatitis B virus prior to enrollment.

(b) A person who has not been fully immunized against the hepatitis B virus, as required by subdivision (a), may be admitted by the governing body of any of the institutions of higher education to which subdivision (a) is applicable on condition that, within a designated time period, the person will provide proof of full immunization against hepatitis B.

(c) Immunization of a person shall not be required for admission to an institution of higher education to which



subdivision (a) is applicable if any of the following persons files with the governing body of the educational institution a letter or affidavit stating that the immunization is contrary to the beliefs of either of the following:

(1) The parent, guardian, or adult who has assumed responsibility for the care and custody of the person seeking admission, if that applicant is a minor who is not emancipated or who is 17 years of age or younger.

(2) The person seeking admission, if that applicant is an emancipated minor or is 18 years of age.

(d) If a person seeking enrollment in an institution of higher education to which subdivision (a) is applicable, or the parent or guardian of a person seeking enrollment, files with the governing body a written statement by a physician and surgeon that the physical condition of the person or medical circumstances relating to the person are such that immunization is not considered safe, indicating the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization, that person shall be exempt from the requirements of subdivision (a).

120390.7. No provision of this chapter shall apply to the University of California except to the extent that the Regents of the University of California, by appropriate resolution, make that provision applicable.

SEC. 6. Section 123870 of the Health and Safety Code is amended to read:

123870. (a) The department shall establish standards of financial eligibility for treatment services under the California Children's Services Program (CCS program).

(1) Financial eligibility for treatment services under this program shall be limited to persons in families with an adjusted gross income of forty thousand dollars (\$40,000) or less in the most recent tax year, as calculated for California state income tax purposes. If a person is enrolled in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the financial documentation required for that program in Section 2699.6600 of Title 10 of the



California Code of Regulations may be used instead of the person's California state income tax return. However, the director may authorize treatment services for persons in families with higher incomes if the estimated cost of care to the family in one year is expected to exceed 20 percent of the family's adjusted gross income.

(2) Children enrolled in the Healthy Families Program who have a CCS program eligible medical condition under Section 123830, and whose families do not meet the financial eligibility requirements of paragraph (1), shall be deemed financially eligible for CCS program benefits.

(b) Necessary medical therapy treatment services under the California Children's Services Program rendered in the public schools shall be exempt from financial eligibility standards and enrollment fee requirements for the services when rendered to any handicapped child whose educational or physical development would be impeded without the services.

(c) All counties shall use the uniform standards for financial eligibility and enrollment fees established by the department. All enrollment fees shall be used in support of the California Children's Services Program.

(d) Annually, every family with a child eligible to receive services under this article shall pay a fee of twenty dollars (\$20), that shall be in addition to any other program fees for which the family is liable. This assessment shall not apply to any child who is eligible for full scope Medi-Cal benefits without a share of cost, for children receiving therapy through the California Children's Services Program as a related service in their individualized education plans, for children from families having incomes of less than 100 percent of the federal poverty level, or for children covered under the Healthy Families Program.

SEC. 7. Section 123900 of the Health and Safety Code is amended to read:

123900. (a) Beginning September 1, 1991, in addition to any other standards of eligibility pursuant to this article, each family with a child otherwise eligible to



receive services under this article shall pay an annual enrollment fee as a requirement for eligibility for services, except as specified in subdivision (f).

(b) The department shall determine the annual enrollment fee, that shall be a sliding fee scale based upon family size and income, and shall be adjusted by the department to reflect changes in the federal poverty level.

(c) “Family size” shall include the child, his or her natural or adoptive parents, siblings, and other family members who live together and whose expenses are dependent upon the family income.

(d) “Family income” for purposes of this article, shall include the total gross income, or their equivalents, of the child and his or her natural or adoptive parents.

(e) Payment of the enrollment fee is a condition of program participation. The enrollment fee is independent of any other financial obligation to the program.

(f) The enrollment fee shall not be charged in any of the following cases:

(1) The only services required are for diagnosis to determine eligibility for services, or are for medically necessary therapy pursuant to Section 123875.

(2) The child is otherwise eligible to receive services and is eligible for full Medi-Cal benefits at the time of application or reapplication.

(3) The family of the child otherwise eligible to receive services under this article has a gross annual income of less than 200 percent of the federal poverty level.

(4) The family of a child otherwise eligible to receive services under this article who is enrolled in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code).

(g) Failure to pay or to arrange for payment of the enrollment fee within 60 days of the due date shall result in disenrollment and ineligibility for coverage of treatment services 60 days after the due date of the required payment.



(h) The county shall apply the enrollment fee scale established by the department and shall collect the enrollment fee. The county may arrange with the family for periodic payment during the year if a lump-sum payment will be a hardship for the family. The agency director of California Children's Services may, on a case-by-case basis, waive or reduce the amount of a family's enrollment fee if, in the director's judgment, payment of the fee will result in undue hardship.

(i) By thirty days after the effective date of this section or August 1, 1991, whichever is later, the department shall advance to each county, as a one-time startup amount, five dollars and fifty cents (\$5.50) for each county child who was receiving services under this article on June 30, 1990, and who was not a Medi-Cal beneficiary. This one-time payment shall be in addition to the 4.1 percent of the gross total expenditures for diagnoses, treatment, and therapy by counties allowed under subdivision (c) of Section 123955.

(j) Each county shall submit to the state, as part of its quarterly claim for reimbursement, an accounting of all revenues due and revenues collected as enrollment fees.

SEC. 8. Section 123940 of the Health and Safety Code is amended to read:

123940. (a) (1) Annually, the board of supervisors shall appropriate a sum of money for services for handicapped children of the county, including diagnosis, treatment, and therapy services for physically handicapped children in public schools, equal to 25 percent of the actual expenditures for the county program under this article for the 1990-91 fiscal year, except as specified in paragraph (2).

(2) If the state certifies that a smaller amount is needed in order for the county to pay 25 percent of costs of the county's program from this source. The smaller amount certified by the state shall be the amount that the county shall appropriate.

(b) In addition to the amount required by subdivision (a), the county shall allocate an amount equal to the amount determined pursuant to subdivision (a) for



purposes of this article from revenues allocated to the county pursuant to Chapter 6 (commencing with Section 17600) of Division 9 of the Welfare and Institutions Code.

(c) (1) The state shall match county expenditures for this article from funding provided pursuant to subdivisions (a) and (b).

(2) County expenditures shall be waived for payment of services for children who are eligible pursuant to paragraph (2) of subdivision (a) of Section 123870.

(d) The county may appropriate and expend moneys in addition to those set forth in subdivision (a) and (b) and the state shall match the expenditures, on a dollar-for-dollar basis, to the extent that state funds are available for this article.

(e) Nothing in this section shall require the county to expend more than the amount set forth in subdivision (a) plus the amount set forth in subdivision (b) nor shall it require the state to expend more than the amount of the match set forth in subdivision (c).

SEC. 9. Section 124250 of the Health and Safety Code is amended to read:

124250. (a) The following definitions shall apply for purposes of this section:

(1) “Domestic violence” means the infliction or threat of physical harm against past or present adult or adolescent female intimate partners, and shall include physical, sexual, and psychological abuse against the woman, and is a part of a pattern of assaultive, coercive, and controlling behaviors directed at achieving compliance from or control over, that woman.

(2) “Shelter-based” means an established system of services where battered women and their children may be provided safe or confidential emergency housing on a 24-hour basis, including, but not limited to, hotel or motel arrangements, haven, and safe houses.

(3) “Emergency shelter” means a confidential or safe location that provides emergency housing on a 24-hour basis for battered women and their children.

(b) The Maternal and Child Health Branch of the State Department of Health Services shall administer a



comprehensive shelter-based services grant program to battered women's shelters pursuant to this section.

(c) The Maternal and Child Health Branch shall administer grants, awarded as the result of a request for application process, to battered women's shelters that propose to maintain shelters or services previously granted funding pursuant to this section, to expand existing services or create new services, and to establish new battered women's shelters to provide services, in any of the following four areas:

(1) Emergency shelter to women and their children escaping violent family situations.

(2) Transitional housing programs to help women and their children find housing and jobs so that they are not forced to choose between returning to a violent relationship or becoming homeless. The programs may offer up to 18 months of housing, case management, job training and placement, counseling, support groups, and classes in parenting and family budgeting.

(3) Legal and other types of advocacy and representation to help women and their children pursue the appropriate legal options.

(4) Other support services for battered women and their children.

(d) In implementing the grant program pursuant to this section, the State Department of Health Services shall consult with an advisory council, to remain in existence until January 1, 2003. The council shall be composed of not to exceed 13 voting members and two nonvoting members appointed as follows:

(1) Seven members appointed by the Governor.

(2) Three members appointed by the Speaker of the Assembly.

(3) Three members appointed by the Senate Committee on Rules.

(4) Two nonvoting ex officio members who shall be Members of the Legislature, one appointed by the Speaker of the Assembly and one appointed by the Senate Committee on Rules. Any Member of the Legislature appointed to the council shall meet with, and participate



in the activities of, the council to the extent that participation is not incompatible with his or her position as a Member of the Legislature.

The membership of the council shall consist of domestic violence advocates, battered women service providers, and representatives of women's organizations, law enforcement, and other groups involved with domestic violence. At least one-half of the council membership shall consist of domestic violence advocates or battered women service providers from organizations such as the California Alliance Against Domestic Violence.

It is the intent of the Legislature that the council membership reflect the ethnic, racial, cultural, and geographic diversity of the state.

(e) The department shall collaborate closely with the council in the development of funding priorities, the framing of the Request for Proposals, and the solicitation of proposals.

(f) (1) The Maternal and Child Health Branch of the State Department of Health Services shall administer grants, awarded as the result of a request for application process, to agencies to conduct demonstration projects to serve battered women, including, but not limited to, creative and innovative service approaches, such as community response teams and pilot projects to develop new interventions emphasizing prevention and education, and other support projects identified by the advisory council.

(2) For purposes of this subdivision, "agency" means a state agency, a local government, a community-based organization, or a nonprofit organization.

(g) It is the intent of the Legislature that services funded by this program include services in underserved and ethnic and racial communities. Therefore, the Maternal and Child Health Branch of the State Department of Health Services shall do all of the following:

(1) Fund shelters pursuant to this section that reflect the ethnic, racial, economic, cultural, and geographic diversity of the state.



(2) Target geographic areas and ethnic and racial communities of the state whereby, based on a needs assessment, it is determined that no shelter-based services exist or that additional resources are necessary.

(h) The director may award additional grants to shelter-based agencies when it is determined that there exists a critical need for shelter or shelter-based services.

(i) As a condition of receiving funding pursuant to this section, battered women’s shelters shall do all of the following:

(1) Provide matching funds or in-kind contributions equivalent to not less than 20 percent of the grant they would receive. The matching funds or in-kind contributions may come from other governmental or private sources.

(2) Ensure that appropriate staff and volunteers having client contact meet the definition of “domestic violence counselor” as specified in subdivision (a) of Section 1037.1 of the Evidence Code. The minimum training specified in paragraph (2) of subdivision (a) of Section 1037.1 of the Evidence Code shall be provided to those staff and volunteers who do not meet the requirements of paragraph (1) of subdivision (a) of Section 1037.1 of the Evidence Code.

SEC. 10. Section 128405 of the Health and Safety Code is amended to read:

128405. This article shall remain in effect only until January 1, 2003, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2003, deletes or extends that date.

SEC. 11. Section 12693.02 of the Insurance Code is amended to read:

12693.02. (a) “Applicant” means a person over the age of 18 years who is a natural or adoptive parent; a legal guardian; or a caretaker relative, foster parent, or stepparent with whom the child resides, who applies for coverage under the program on behalf of a child.

(b) “Applicant” also means any of the following:

(1) A person 18 years of age who is applying on his or her own behalf for coverage under the program.



(2) A person who is under 18 years of age and is an emancipated minor who is applying on his or her own behalf for coverage under the program.

(3) A minor who is not living in the home of a natural or adoptive parent, a legal guardian, or a caretaker relative, foster parent or stepparent, who is applying on his or her own behalf for coverage under the program.

(4) A minor who applies for coverage under the program on behalf of his or her child.

SEC. 12. Section 12693.06 of the Insurance Code is amended to read:

12693.06. “Family contribution” means the cost to an applicant to enable herself or himself or an eligible child or children to enroll in and participate in the program. Family contribution does not include copayments for insured services. The family contribution may be paid by a family contribution sponsor pursuant to Section 12693.17.

SEC. 13. Section 12693.17 is added to the Insurance Code, to read:

12693.17. “Family contribution sponsor” means a person or entity that pays the family contribution on behalf of an applicant for the period of 12 months from the month eligibility is established; and, notwithstanding Section 12693.70, the payment for 12 months is made with the application.

SEC. 14. Section 12693.21 of the Insurance Code is amended to read:

12693.21. The board may do all of the following consistent with the standards in this part:

- (a) Determine eligibility criteria for the program.
- (b) Determine the participation requirements of applicants, subscribers, purchasing credit members, and participating health, dental, and vision plans.
- (c) Determine when subscribers’ coverage begins and the extent and scope of coverage.
- (d) Determine family contribution amount schedules and collect the contributions.
- (e) Determine who may be a family contribution sponsor and provide a mechanism for sponsorship.



(f) Provide or make available subsidized coverage through participating health, dental, and vision plans, in a purchasing pool, which may include the use of a purchasing credit mechanism, through supplemental coverage, or through coordination with other state programs.

(g) Provide for the processing of applications, the enrollment of subscribers, and the distribution of purchasing credits.

(h) Determine and approve the benefit designs and copayments required by health, dental, or vision plans participating in the purchasing pool component program.

(i) Approve those health plans eligible to receive purchasing credits.

(j) Enter into contracts.

(k) Sue and be sued.

(l) Employ necessary staff.

(m) Authorize expenditures from the fund to pay program expenses that exceed subscriber contributions, and to administer the program as necessary.

(n) Maintain enrollment and expenditures to ensure that expenditures do not exceed amounts available in the Healthy Families Fund and if sufficient funds are not available to cover the estimated cost of program expenditures, the board shall institute appropriate measures to limit enrollment.

(o) Issue rules and regulations, as necessary. Until January 1, 2000, any rules and regulations issued pursuant to this subdivision 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 of the Government Code). The adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare. The regulations shall become effective immediately upon filing with the Secretary of State.



(p) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this part.

SEC. 15. Section 12693.41 of the Insurance Code is amended to read:

12693.41. (a) Upon the effective date of coverage of a child eligible for the program, the board shall arrange for payment of providers who participate in the Child Health and Disability Prevention Program pursuant to Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, for well-child health assessments, immunizations, and initial treatment provided up to 90 days prior to the effective date of coverage.

(b) The board shall pay only for those services that are eligible for federal financial participation under Section 2105 of Title XXI of the Social Security Act and that are approved in the required state plan under that title, except as specified in Section 12693.76.

(c) (1) Child Health and Disability Prevention Program providers shall submit charges for the services under subdivision (a) on the form or in the format specified by the department for the Child Health and Disability Prevention Program. Those providers shall be reimbursed at the rates established for these services by the Child Health and Disability Prevention Program once coverage under the program is established.

(2) Those providers shall submit charges for services reimbursable under Medi-Cal on the form or in the format specified by the department for Medi-Cal. Those providers shall be reimbursed at the rates established for these services by Medi-Cal once coverage under Medi-Cal is established.

(d) (1) The board may use the state fiscal intermediary for medicaid to process the payments authorized in subdivision (a).

(2) The board shall be exempt from the requirements of Chapter 7 (commencing with Section 11700) of Division 3 of Title 2 of the Government Code and Chapter 3 (commencing with Section 12100) of Part 2 of Division



2 of the Public Contract Code as those requirements apply to the use of contractual claims processing services by the state fiscal intermediary.

SEC. 16. Section 12693.43 of the Insurance Code is amended to read:

12693.43. (a) Applicants applying to the purchasing pool shall agree to pay family contributions, unless the applicant has a family contribution sponsor. Family contribution amounts consist of the following two components:

(1) The flat fees described in subdivision (b) or (d).

(2) Any amounts that are charged to the program by participating health, dental, and vision plans selected by the applicant that exceed the cost to the program of the highest cost Family Value Package in a given geographic area.

(b) In each geographic area the board shall designate one or more Family Value Packages for which the required total family contribution is:

(1) Seven dollars (\$7) per child with a maximum required contribution of fourteen dollars (\$14) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Nine dollars (\$9) per child with a maximum required contribution of twenty-seven dollars (\$27) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level.

(c) Combinations of health, dental, and vision plans that are more expensive to the program than the highest cost Family Value Package may be offered to and selected by applicants. However, the cost to the program of those combinations that exceeds the price to the program of the highest cost Family Value Package shall be paid by the applicant as part of the family contribution.

(d) The board shall provide a family contribution discount to those applicants who select the health plan in a geographic area which has been designated as the Community Provider Plan. The discount shall reduce the



portion of the family contribution described in subdivision (b) to the following:

(1) A family contribution of four dollars (\$4) per child with a maximum required contribution of eight dollars (\$8) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Six dollars (\$6) per child with a maximum required contribution of eighteen dollars (\$18) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level.

(e) Applicants, but not family contribution sponsors, who pay three months of required family contributions in advance shall receive the fourth consecutive month of coverage with no family contribution required.

(f) It is the intent of the Legislature that the family contribution amounts described in this section comply with the premium cost sharing limits contained in Section 2103 of Title XXI of the Social Security Act. If the amounts described in subdivision (a) are not approved by the federal government, the board may adjust these amounts to the extent required to achieve approval of the state plan.

SEC. 17. Section 12693.62 of the Insurance Code is amended to read:

12693.62. Notwithstanding any other provision of law, for a subscriber who is determined by the California Children's Services Program to be eligible for benefits under the program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, a participating plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. Participating plans shall refer a child who they reasonably suspect of having a medical condition that is eligible for services under the California Children's Services Program to the California



Children's Services Program. The California Children's Services Program shall provide case management and authorization of services if the child is found to be medically eligible for the California Children's Services Program. Diagnosis and treatment services that are authorized by the California Children's Services Program shall be performed by paneled providers for that program and approved special care centers of that program in accordance with treatment plans approved by the California Children's Services Program. All other services provided under the participating plan shall be available to the subscriber.

SEC. 18. Section 12693.69 is added to the Insurance Code, to read:

12693.69. A child enrolled in the Healthy Families Program who has a medical condition that is eligible for services pursuant to the California Children's Services Program, and whose family is not financially eligible for the California Children's Services Program, shall have the medically necessary treatment services for their California Children's Services Program eligible medical condition authorized and paid for by the California Children's Services Program. County expenditures for the payment of services for the child shall be waived and these expenditures shall be paid for by the state from Title XXI funds that are applicable and state general funds.

SEC. 19. Section 12693.70 of the Insurance Code is amended to read:

12693.70. To be eligible to participate in the program, an applicant shall meet all of the following requirements:

(a) Be an applicant applying on behalf of an eligible child, which means a child who is all of the following:

(1) Less than 19 years of age. An application may be made on behalf of a child not yet born up to three months prior to the expected date of delivery. Coverage shall begin as soon as administratively feasible, as determined by the board, after the board receives notification of the birth. However, no child less than 12 months of age shall be eligible for coverage until 90 days after the enactment of the Budget Act of 1999.



(2) Not eligible for no-cost full-scope Medi-Cal or Medicare at the time of application.

(3) In compliance with Sections 12693.71 and 12693.72.

(4) A child who meets citizenship and immigration status requirements that are applicable to persons participating in the program established by Title XXI of the Social Security Act, except as specified in Section 12693.76.

(5) A resident of the State of California pursuant to Section 244 of the Government Code; or, if not a resident pursuant to Section 244 of the Government Code, is physically present in California and entered the state with a job commitment or to seek employment, whether or not employed at the time of application to or after acceptance in, the program.

(6) (A) In a family with an annual or monthly household income equal to or less than 200 percent of the federal poverty level.

(B) All income over 200 percent of the federal poverty level but less than or equal to 250 percent of the federal poverty level shall be disregarded in calculating annual or monthly household income.

(C) In a family with an annual or monthly household income greater than 250 percent of the federal poverty level, any income deduction that is applicable to a child under Medi-Cal shall be applied in determining the annual or monthly household income. If the income deductions reduce the annual or monthly household income to 250 percent or less of the federal poverty level, subparagraph (B) shall be applied.

(b) If the applicant is applying for the purchasing pool, and does not have a family contribution sponsor the applicant shall pay the first month's family contribution and agree to remain in the program for six months, unless other coverage is obtained and proof of the coverage is provided to the program.

(c) An applicant shall enroll all of the applicant's eligible children in the program.

SEC. 20. Section 12693.73 of the Insurance Code is amended to read:



12693.73. Notwithstanding any other provision of law, children excluded from coverage under Title XXI of the Social Security Act are not eligible for coverage under the program, except as specified in Section 12693.76.

SEC. 21. Section 12693.76 is added to the Insurance Code, to read:

12693.76. Notwithstanding any other provision of law, a child who is a qualified alien as defined in Section 1641 of Title 8 of the United States Code Annotated shall not be determined ineligible solely on the basis of his or her date of entry into the United States. For the 1999–2000 fiscal year, these children shall be allowed to participate in the Healthy Families Program for a period of 12 months from the effective date that eligibility is established, whether or not federal financial participation is available for services provided to them. For subsequent fiscal years, these children may only participate in the Healthy Families Program upon the state receiving federal matching funds for them under the program.

SEC. 22. Section 12693.91 of the Insurance Code is amended to read:

12693.91. (a) The State Department of Health Services, in conjunction with the Managed Risk Medical Insurance Board, the County Medical Services Program board, and the Rural Health Policy Council, may develop and administer up to five demonstration projects in rural areas that are likely to contain a significant level of uninsured children, including seasonal and migratory worker dependents. In addition to any other funds provided pursuant to this section the grants for demonstration projects may include funds pursuant to subdivision (d).

(b) The purpose of the demonstration projects shall be to fund rural collaborative health care networks to alleviate unique problems of access to health care in rural areas.

(c) The State Department of Health Services, in conjunction with the Managed Risk Medical Insurance Board and Rural Health Policy Council, shall establish the criteria and standards for eligibility to be used in requests



for proposals or requests for application, the application review process, determining the maximum amount and number of grants to be awarded, preference and priority of projects, and compliance monitoring after receiving comment from the public.

(d) The grants may include funds for purchasing equipment, making capital expenditures, and providing infrastructure, including, but not limited to, salaries and payment of leaseholds. The funds under this subdivision may only be awarded to qualified eligible health care entities as determined by the State Department of Health Services. Title to any equipment or capital improvement purchased or acquired with grant funds shall vest in the grantee for the public good and not the state. Capital expenditures shall not include the acquisition of land. Notwithstanding subdivision (e), this subdivision shall be implemented only when funds are appropriated in the annual Budget Act or another statute to fund the cost of implementing this subdivision.

(e) This section shall only become operative upon federal approval of the state plan or subsequent amendments for the program and approval of federal financial participation.

(f) This section shall become inoperative on July 1, 2003.

SEC. 23. Section 12963.96 of the Insurance Code is amended and renumbered to read:

12693.96. (a) There is hereby created in the State Treasury the Healthy Families Fund which is, notwithstanding Section 13340 of the Government Code, continuously appropriated to the board for the purposes specified in this part.

(b) The board shall authorize the expenditure from the fund of any state funds, federal funds, or family contributions deposited into the fund. This shall include the authority for the board to authorize the State Department of Health Services to transfer funds appropriated to the department for the program to the Healthy Families Fund, and to also deposit those funds in,



and to disburse those funds from, the Healthy Families Fund.

(c) Notwithstanding any other provision of law, this part shall be implemented only if, and to the extent that, as provided under Title XXI of the Social Security Act, federal financial participation is available and state plan approval is obtained, except as specified in Section 12693.76.

(d) Nothing in this part is intended to establish an entitlement for individual coverage.

SEC. 23.5. Section 17273 of the Revenue and Taxation Code is amended to read:

17273. For each taxable year beginning on or after January 1, 1999, Section 162(l)(1) of the Internal Revenue Code, relating to applicable percentage, is modified to provide that Section 2002 of the Tax and Trade Relief Extension Act of 1998 (P.L. 105-277), relating to phase in of a 100-percent deduction for health insurance, shall apply.

SEC. 24. Section 4441.5 is added to the Welfare and Institutions Code, to read:

4441.5. The State Department of Developmental Services shall develop policies and procedures, by no later than 30 days following the effective date of the Budget Act of 1999, at each developmental center, to notify appropriate law enforcement agencies in the event of a forensic client walkaway or escape. Local law enforcement agencies, including local police and county sheriff's departments, shall review the policies and procedures prior to final implementation by the department.

SEC. 25. Section 4640.6 of the Welfare and Institutions Code is amended to read:

4640.6. (a) In approving regional center contracts, the department shall ensure that regional center staffing patterns demonstrate that direct service coordination are the highest priority.

(b) Contracts between the department and regional centers shall require that regional centers implement an emergency response system that ensures that a regional



center staff person will respond to a consumer, or individual acting on behalf of a consumer, within two hours of the time an emergency call is placed. This emergency response system shall be operational 24 hours per day, 365 days per year.

(c) Contracts between the department and regional centers shall require regional centers to have service coordinator-to-consumer ratios, as follows:

(1) An average service coordinator to consumer ratio of one to 62 for all consumers who have not moved from the developmental centers to the community since April 14, 1993. In no case shall a service coordinator for these consumers have an assigned caseload in excess of 79 consumers for more than 60 days.

(2) An average service coordinator-to-consumer ratio of one to 45 for all consumers who have moved from a developmental center to the community since April 14, 1993. In no case shall a service coordinator for these consumers have an assigned caseload in excess of 59 consumers for more than 60 days.

(d) For purposes of this section, “service coordinator” means a regional center employee whose primary responsibility includes preparing, implementing, and monitoring consumers’ individual program plans, securing and coordinating consumer services and supports, and providing placement and monitoring activities.

(e) By December 15, 1999, the department shall make recommendations to the Legislature and the Governor regarding the core staffing formula used to allocate operations funding to regional centers. These recommendations shall include consideration of, and public comments related to, the Regional Center Core Staffing Study, and shall include, but not be limited to, all of the following:

(1) Salary and wage levels for positions deemed necessary to retain and maintain qualified staff.

(2) Regional center staff positions that should be mandated.



(3) Staffing ratios necessary to meet the requirements of this chapter, including a service coordinator-to-consumer ratio necessary to appropriately meet the needs of consumers who are younger than three years of age and their families.

(4) Funding methodologies.

(5) Indicate the impact to staffing ratios implemented pursuant to subdivision (c).

(f) In order to ensure that caseload ratios are maintained pursuant to this section, each regional center shall provide service coordinator caseload data to the department in September and March of each fiscal year, commencing in the 1999-2000 fiscal year. The data shall be submitted in a format prescribed by the department. Within 30 days of receipt of data submitted pursuant to this subdivision, the department shall make a summary of the data available to the public upon request. The department shall verify the accuracy of the data when conducting regional center fiscal audits. Data submitted by regional centers pursuant to this subdivision shall:

(1) Only include data on service coordinator positions as defined in subdivision (d). Regional centers shall identify the number of positions that perform service coordinator duties on less than a fulltime basis. Staffing ratios reported pursuant to this subdivision shall reflect the appropriate proportionality of these staff to consumers served.

(2) Be reported separately for service coordinators whose caseload primarily includes any of the following:

(A) Consumers who are three years of age and older and who have not moved from the developmental center to the community since April 14, 1993.

(B) Consumers who have moved from a developmental center to the community since April 14, 1993.

(C) Consumers who are younger than three years of age.

(3) Not include positions that are vacant for more than 60 days.



(g) The department shall provide technical assistance and require a plan of correction for any regional center that, for two consecutive reporting periods, fails to maintain service coordinator caseload ratios required by this section or otherwise demonstrates an inability to maintain appropriate staffing patterns pursuant to this section. Plans of correction shall be developed following input from the local area board, local organizations representing consumers, family members, regional center employees, including recognized labor organizations, and service providers, and other interested parties.

(h) Contracts between the department and regional center shall require the regional center to have, or contract for, all of the following areas:

(1) Criminal justice expertise to assist the regional center in providing services and support to consumers involved in the criminal justice system as a victim, defendant, inmate, or parolee.

(2) Special education expertise to assist the regional center in providing advocacy and support to families seeking appropriate educational services from a school district.

(3) Family support expertise to assist the regional center in maximizing the effectiveness of support and services provided to families.

(4) Housing expertise to assist the regional center in accessing affordable housing for consumers in independent or supportive living arrangements.

(5) Community integration expertise to assist consumers and families in accessing integrated services and supports and improved opportunities to participate in community life.

(6) Quality assurance expertise, to assist the regional center to provide the necessary coordination and cooperation with the area board in conducting quality-of-life assessments and coordinate the regional center quality assurance efforts.



(7) Each regional center shall employ at least one consumer advocate who is a person with developmental disabilities.

(8) Other staffing arrangements related to the delivery of services that the department determines are necessary to ensure maximum cost-effectiveness and to ensure that the service needs of consumers and families are met.

(i) Any regional center proposing a staffing arrangement that substantially deviates from the requirements of this section shall request a waiver from the department. Prior to granting a waiver, the department shall require a detailed staffing proposal, including, but not limited to, how the proposed staffing arrangement will benefit consumers and families served, and shall demonstrate clear and convincing support for the proposed staffing arrangement from constituencies served and impacted, that include, but are not limited to, consumers, families, providers, advocates, and recognized labor organizations. In addition, the regional center shall submit to the department any written opposition to the proposal from organizations or individuals, including, but not limited to, consumers, families, providers, and advocates, including recognized labor organizations. The department may grant waivers to regional centers that sufficiently demonstrate that the proposed staffing arrangement is in the best interest of consumers and families served, complies with the requirements of this chapter, and does not violate any contractual requirements. A waiver shall be approved by the department for up to 12 months, at which time a regional center may submit a new request pursuant to this subdivision.

(j) The requirements of subdivisions (c), (g), and (i) shall not apply when a regional center is required to develop an expenditure plan pursuant to Section 4791, and when the expenditure plan addresses the specific impact of the budget reduction on staffing requirements and the expenditure plan is approved by the department.



SEC. 26. Section 4647 of the Welfare and Institutions Code is amended to read:

4647. (a) Pursuant to Section 4640.7, service coordination shall include those activities necessary to implement an individual program plan, including, but not limited to, participation in the individual program plan process; assurance that the planning team considers all appropriate options for meeting each individual program plan objective; securing, through purchasing or by obtaining from generic agencies or other resources, services and supports specified in the person's individual program plan; coordination of service and support programs; collection and dissemination of information; and monitoring implementation of the plan to ascertain that objectives have been fulfilled and to assist in revising the plan as necessary.

(b) The regional center shall assign a service coordinator who shall be responsible for implementing, overseeing, and monitoring each individual program plan. The service coordinator may be an employee of the regional center or may be a qualified individual or employee of an agency with whom the regional center has contracted to provide service coordination services, or persons described in Section 4647.2. The regional center shall provide the consumer or, where appropriate, his or her parents, legal guardian, or conservator or authorized representative, with written notification of any permanent change in the assigned service coordinator within 10 business days. No person shall continue to serve as a service coordinator for any individual program plan unless there is agreement by all parties that the person should continue to serve as service coordinator.

(c) Where appropriate, a consumer or the consumer's parents or other family members, legal guardian, or conservator, may perform all or part of the duties of the service coordinator described in this section if the regional center director agrees and it is feasible.

(d) If any person described in subdivision (c) is designated as the service coordinator, that person shall



not deviate from the agreed-upon program plan and shall provide any reasonable information and reports required by the regional center director.

(e) If any person described in subdivision (c) is designated as the service coordinator, the regional center shall provide ongoing information and support as necessary, to assist the person to perform all or part of the duties of service coordinator.

SEC. 27. Section 4681.3 of the Welfare and Institutions Code is amended to read:

4681.3. (a) Notwithstanding any other provision of this article, for the 1996–97 fiscal year, the rate schedule authorized by the department in operation June 30, 1996, shall be increased based upon the amount appropriated in the Budget Act of 1996 for that purpose. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

(b) Notwithstanding any other provision of this article, for the 1997–98 fiscal year, the rate schedule authorized by the department in operation on June 30, 1997, shall be increased based upon the amount appropriated in the Budget Act of 1997 for that purpose. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

(c) Notwithstanding any other provision of this article, for the 1998–99 fiscal year, the rate schedule authorized by the department in operation on June 30, 1998, shall be increased commencing July 1, 1998, based upon the amount appropriated in the Budget Act of 1998 for that purpose. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

(d) Notwithstanding any other provision of this article, for the 1998–99 fiscal year, the rate schedule authorized by the department in operation on December 31, 1998, shall be increased January 1, 1999, based upon the cost-of-living adjustments in the Supplemental Security Income/State Supplementary Program for the Aged, Blind, and Disabled appropriated in the Budget Act of 1998 for that purpose. The increase shall be applied as a



percentage and the percentage shall be the same for all providers.

(e) Notwithstanding any other provision of this article, for the 1999–2000 fiscal year, the rate schedule authorized by the department in operation on June 30, 1999, shall be increased July 1, 1999, based upon the amount appropriated in the Budget Act of 1999 for that purpose. The increase shall be applied as a percentage and the percentage shall be the same for all providers.

(f) In addition, commencing January 1, 2000, any funds available from cost-of-living adjustments in the Supplemental Security Income/State Supplementary Payment (SSI/SSP) for the 1999–2000 fiscal year shall be used to further increase the community care facility rate. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

SEC. 28. Section 5701.1 is added to the Welfare and Institutions Code, to read:

5701.1. Notwithstanding Section 5701, the State Department of Mental Health, in consultation with the California Mental Health Directors Association, may utilize funding from the Substance Abuse and Mental Health Services Administration Block Grant, awarded to the State Department of Mental Health, above the funding level provided in federal fiscal year 1998, for the development of innovative programs for identified target populations, upon appropriation by the Legislature.

SEC. 29. Section 6501 is added to the Welfare and Institutions Code, to read:

6501. If a person is charged with a violent felony, as described in Section 667.5 of the Penal Code, and the individual has been committed to the State Department of Developmental Services pursuant to Section 1370.1 of the Penal Code or Section 6500 for placement in a secure treatment facility, as described in subdivision (e) of Section 1370.1 of the Penal Code, the department shall give priority to placing the individual at Porterville Developmental Center prior to placing the individual at any other developmental center that has been designated as a secure treatment facility.



SEC. 30. Section 14005.30 of the Welfare and Institutions Code is amended to read:

14005.30. (a) (1) To the extent that federal financial participation is available, Medi-Cal benefits under this chapter shall be provided to individuals eligible for services under Section 1396u-1 of Title 42 of the United States Code, including any options under Section 1396u-1(b)(2)(C) made available to and exercised by the state.

(2) The department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt less restrictive income and resource eligibility standards and methodologies to the extent necessary to allow all recipients of benefits under Chapter 2 (commencing with Section 11200) to be eligible for Medi-Cal under paragraph (1).

(b) To the extent that federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary to expand eligibility for Medi-Cal under subdivision (a) by, commencing August 1, 1999, exempting all resources. If federal financial participation is not available to exempt all resources, then the department shall continue to establish the amount of countable resources individuals or families are allowed to retain at the same amount medically needy individuals and families are allowed to retain, except that a family of one shall be allowed to retain countable resources in the amount of three thousand dollars (\$3,000).

(c) To the extent federal financial participation is available, the department shall, commencing March 1, 2000, adopt an income disregard for applicants equal to the difference between the income standard under the program adopted pursuant to Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) and the amount equal to 100 percent of the federal poverty level applicable to the size of the family.

(d) Except for the exemption of resources effective as of August 1, 1999, as provided in subdivision (b),



subdivision (b) shall be applied retroactively to January 1, 1998.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement, without taking regulatory action, subdivisions (a) and (b) of this section by means of an all county letter or similar instruction. 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, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

SEC. 31. 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 Section 14007.7.

(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 (P.L. 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. 32. Section 14007.65 is added to the Welfare and Institutions Code, to read:

14007.65. (a) Any alien who is otherwise eligible for Medi-Cal services, but who does not meet the requirements under subdivision (b) or (c) of Section 14007.5, shall be eligible for long-term care services.

(b) Subdivision (a) is intended to reconfirm, and be declaratory of, existing law.

SEC. 33. Section 14007.7 is added to the Welfare and Institutions Code, to read:

14007.7. Any alien who is otherwise eligible for Medi-Cal services, but who does not meet the requirements under subdivision (b) or (c) of Section 14007.5, shall be eligible for medically necessary pregnancy-related services.

SEC. 34. Section 14008.85 is added to the Welfare and Institutions Code, to read:

14008.85. (a) To the extent federal financial participation is available, a parent who is the principal wage earner shall be considered an unemployed parent for purposes of establishing eligibility based upon deprivation of a child where any of the following applies:

(1) The parent works less than 100 hours per month as determined pursuant to the rules of the Aid to Families with Dependent Children program as it existed on July 16, 1996, including the rule allowing a temporary excess of hours due to intermittent work.

(2) The total net nonexempt earned income for the family is not more than 100 percent of the federal poverty level as most recently calculated by the federal government. The department may adopt additional deductions to be taken from a family's income.

(3) The parent is considered unemployed under the terms of an existing federal waiver of the 100-hour rule for recipients under the program established by Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1).



(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of an all county letter or similar instruction without taking regulatory action. 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.

(c) This section shall become operative March 1, 2000.

SEC. 35. Section 14011.15 is added to the Welfare and Institutions Code, to read:

14011.15. (a) The department shall, not later than July 1, 2000, create and implement a simplified application package for children, families, and adults applying for Medi-Cal benefits. This simplified application package shall include a simplified supplemental resource form.

(b) In developing the application package described in subdivision (a), the department shall seek input from persons with expertise, including beneficiary representatives, counties, and beneficiaries.

(c) The department shall allow an applicant to apply for benefits by mailing in the simplified application package.

(d) The simplified application package shall utilize at a minimum, all of the following documentation standards:

(1) Proof of income shall be documented by the most recent paystub or a copy of the last year's federal income tax return.

(2) Self-declaration of pregnancy.

(3) A simplified supplemental resource form, if applicable.

(e) The department shall not require an applicant who submits a simplified application pursuant to this section to complete a face-to-face interview, except for good cause, a suspicion of fraud, or in order to complete the application process. A county shall conduct random monitoring of the mail-in application process to ensure appropriate enrollment. Every application package shall



contain a notification of the applicant's right to complete a face-to-face interview.

(f) Not later than July 1, 2000, the department shall revise the quarterly reporting form to be as simple as possible to complete.

(g) The department shall implement this section only to the extent that its provisions are not in violation of the requirements of federal law, and only to the extent that federal financial participation is not jeopardized.

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of an all county letter or similar instruction without taking regulatory action. 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.

SEC. 36. Section 14018.5 is added to the Welfare and Institutions Code, to read:

14018.5. Notwithstanding any other provision of law, Section 3275 of the Civil Code does not apply to Medi-Cal reimbursement or prior authorization.

SEC. 37. Article 1.3 (commencing with Section 14043) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 1.3. Provider Enrollment

14043. In order to ensure the proper and efficient administration of the Medi-Cal program, every applicant, as defined in subdivision (b) of Section 14043.1, and every provider, as defined in subdivision (e) of Section 14043.1, shall be subject to the requirements of this article.

14043.1. As used in this article:

(a) "Abuse" means either of the following:

(1) Practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the Medicare program, the Medi-Cal program, another state's medicaid 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.

(2) Practices that are inconsistent with sound medical practices and result in reimbursement by the Medi-Cal 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, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

(b) “Applicant” means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, employees, or agents thereof, that applies to the department for enrollment as a provider in the Medi-Cal program.

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

(1) 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 posttrial motion or an appeal pending or the judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed.

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

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

(4) 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.

(d) “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.

(e) “Provider” means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, employees, or agents thereof, that



provides services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary and that has been enrolled in the Medi-Cal program.

(f) “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.

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

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

(2) 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:

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

(B) State or local licensing or certification authorities.

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

(D) State or local professional societies.

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

14043.15. The department may adopt regulations for certification of each applicant and each provider in the



Medi-Cal program. No certification shall be required for clinics licensed under Section 1204 of the Health and Safety Code, clinics exempt from licensure under Section 1206 of the Health and Safety Code, health facilities licensed under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, or natural persons licensed or certified under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act or the Chiropractic Initiative Act.

14043.2. (a) Whether or not regulations for certification are adopted under Section 14043.15, in order to be enrolled as a provider, or for enrollment as a provider to continue, an applicant or provider may be required to sign a provider agreement and shall disclose all information as required in federal medicaid regulations and any other information required by the department. The director may designate the form of a provider agreement by provider type. Failure to disclose the required information, or the disclosure of false information, shall, prior to any hearing, result in denial of the application for enrollment or shall make the provider subject to temporary suspension, which shall include temporary deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program.

(b) The director shall notify the provider of the temporary suspension and deactivation of the provider's Medi-Cal provider number or numbers and the effective date thereof. Notwithstanding Section 100171 of the Health and Safety Code and Section 14123, proceedings after the imposition of sanctions provided for in subdivision (a) shall be in accordance with Section 14043.65.

14043.25. (a) The application form for enrollment, the provider agreement, and all attachments or changes to either, shall be signed under penalty of perjury.

(b) The department may require that the application form for enrollment, the provider agreement, and all attachments or changes to either, submitted by an



applicant or provider licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, be notarized.

(c) Application forms for enrollment, provider agreements, and all attachments or changes to either, submitted by an applicant or provider not subject to subdivision (b) shall be notarized.

14043.3. A provider shall be required to reimburse those Medi-Cal funds received during any period for which material information was not reported, or reported falsely, to the department.

14043.35. Sections 14043.2, 14043.25, and 14043.3 shall not limit the authority granted the director and the rights granted providers in Section 14123. Action taken under the authority granted in Section 14123 shall be taken in accordance with that section.

14043.36. (a) The department shall not enroll any applicant that has been convicted of any felony or misdemeanor involving fraud or abuse in any government program, that has been found guilty of fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse, within the previous five years. In addition, the department may deny enrollment to any applicant that, at the time of application, is under investigation pursuant to Subpart A (commencing with Section 455.12) of Part 455 of Title 42 of the Code of Federal Regulations. 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 for fraud or abuse, that provider shall be subject to temporary suspension, which shall include temporary deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program.

(b) The director shall notify the provider of the temporary suspension and deactivation of the provider's Medi-Cal provider number or numbers and the effective



date thereof. Notwithstanding Section 100171 of the Health and Safety Code, proceedings after the imposition of sanctions provided for in subdivision (a) shall be in accordance with Section 14043.65.

14043.37. The department may complete a background check on applicants for the purpose of verifying the accuracy of the information provided in the application and in order to prevent fraud and abuse. The background check may include, but not be limited to, the following:

- (a) Onsite inspection prior to enrollment.
- (b) Review of business records.
- (c) Data searches.

14043.4. If discrepancies are found to exist during the preenrollment period, the department may conduct additional inspections prior to enrollment. Failure to remediate discrepancies as prescribed by the director may result in denial of the application for enrollment.

14043.45. Notwithstanding the adoption of the Standardized National Application form and the National Provider Identifier by the federal government, a provider may be issued a unique identification number or numbers, as prescribed by the director.

14043.5. Subject to Article 4 (commencing with Section 19130) of Chapter 5 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.

14043.55. The department may implement a 180-day moratorium on the enrollment of providers in a specific provider of service category, on a statewide basis or within a geographic area, except that no moratorium shall be implemented on the enrollment of providers who are licensed as clinics under Section 1204 of the Health and Safety Code, health facilities under Chapter 2 (commencing with Section 1250) of the Health and



Safety Code, clinics exempt from licensure under Section 1206 of the Health and Safety Code, or natural persons licensed or certified under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, when the director determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program. This moratorium may be extended or repeated when the director determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program. The authority granted in this section shall not be interpreted as a limitation on the authority granted to the department in Section 14105.3.

14043.6. The department shall automatically suspend, as a provider in the Medi-Cal program, 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 another state's licensing, certification, or approval authority, has otherwise lost that license, certificate, or approval, or has surrendered that license, certificate, or approval while a disciplinary hearing on that license, certificate, or approval was pending. The automatic suspension shall be effective on the date that the license, certificate, or approval was revoked, lost, or surrendered.

14043.65. Notwithstanding any other provision of law, any applicant whose application for enrollment as a provider or whose certification is denied, or any provider who is denied continued enrollment or certification, who has been temporarily suspended, or who has had payments withheld, who has had one or more provider numbers used to obtain reimbursement from the Medi-Cal program deactivated, pursuant to Section 14107.11, may appeal this action by submitting a written appeal, including any supporting evidence, to the director. Where the appeal is of a withholding of payment pursuant to Section 14107.11, the appeal to the director shall be limited to the issue of the reliability of the evidence supporting the withhold and shall not



encompass fraud or abuse. The appeal procedure shall not include a formal administrative hearing under the Administrative Procedure Act and shall not result in reactivation of any deactivated provider numbers during appeal. An applicant or provider that appeals an action taken pursuant to this article shall submit all pertinent documents and all other relevant evidence to the director or to the director's designee within 60 days of the date of notification of the department's action. The director or the director's designee shall review all of the relevant materials submitted and shall issue a decision within 90 days of the receipt of the evidence. The decision may provide that the action taken should be upheld, continued, or reversed, in whole or in part. The decision of the director or the director's designee shall be final. Any further appeal shall be required to be filed in accordance with Section 1085 of the Civil Code.

14043.7. (a) The department may make unannounced visits to any applicant or to any provider for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, or as necessary for the administration of the Medi-Cal program. At the time of the visit, the applicant or provider shall be required to demonstrate an established place of business appropriate and adequate for the services billed or claimed to the Medi-Cal program, as relevant to his or her scope of practice, as indicated by, but not limited to, the following:

- (1) Being open and available to the general public.
- (2) Having regularly established and posted business hours.
- (3) Having adequate supplies in stock on the premises.
- (4) Meeting all local laws and ordinances regarding business licensing and operations.
- (5) Having the necessary equipment and facilities to carry out day-to-day business for his or her practice.

(b) An unannounced visit pursuant to subdivision (a) shall be prohibited with respect to clinics licensed under Section 1204 of the Health and Safety Code, clinics exempt from licensure under Section 1206 of the Health



and Safety Code, health facilities licensed under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, and natural persons licensed or certified under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, unless the department has reason to believe that the provider will defraud or abuse the Medi-Cal program or lacks the organizational or administrative capacity to provide services under the program.

(c) Failure to remediate discrepancies that are discovered as a result of an unannounced visit to a provider shall, prior to hearing, make the provider subject to temporary suspension, which shall include temporary deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The director shall notify the provider of the temporary suspension and deactivation of provider numbers, and the effective date thereof. Notwithstanding Section 100171 of the Health and Safety Code, proceedings after the imposition of sanctions in this paragraph shall be in accordance with Section 14043.65.

14043.75. The director may, by regulation, adopt additional measures to prevent or curtail fraud and abuse.

SEC. 38. Section 14053 of the Welfare and Institutions Code is amended to read:

14053. The term “health care services” means the benefits set forth in Article 4 (commencing with Section 14131) of this chapter and in Section 14021. The term includes inpatient hospital services for any individual under 21 years of age in an institution for mental diseases. Any individual under 21 years of age receiving inpatient psychiatric hospital services immediately preceding the date on which he or she attains age 21 may continue to receive these services until he or she attains age 22. The term also includes early and periodic screening, diagnosis, and treatment for any individual under 21 years of age.



The term “health care services” does not include, except to the extent permitted by federal law, any of the following:

(a) Care or services for any individual who is an inmate of an institution (except as a patient in a medical institution).

(b) Care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis.

(c) Inpatient services provided to individuals 21 to 64 years of age, inclusive, in an institution for mental diseases operating under a consolidated license with a general acute care hospital pursuant to Section 1250.8 of the Health and Safety Code, unless federal financial participation is available for such inpatient services.

SEC. 39. Section 14053.1 is added to the Welfare and Institutions Code, to read:

14053.1. Notwithstanding Section 14053, ancillary outpatient services, pursuant to Section 14132, for any eligible individual who is 21 years of age or over, and has not attained 65 years of age and who is a patient in an institution for mental diseases shall be covered regardless of the availability of federal financial participation.

SEC. 40. Section 14067 of the Welfare and Institutions Code is amended to read:

14067. (a) The department, in conjunction with the Managed Risk Medical Insurance Board, shall develop and conduct a community outreach and education campaign to help families learn about, and apply for, Medi-Cal and the Healthy Families Program of the Managed Risk Medical Insurance Board, subject to the requirements of federal law. In conducting this campaign, the department may seek input from, and contract with, various entities and programs that serve children, including, but not limited to, the State Department of Education, counties, Women, Infants, and Children program agencies, Head Start and Healthy Start programs, and community-based organizations that deal with potentially eligible families and children to assist in



the outreach, education, and application completion process.

(b) The outreach and education campaign shall be established and implemented as of February 18, 1998. An annual outreach plan shall be submitted to the Legislature by April 1 for each fiscal year. The plan shall address both the Medi-Cal program for children and the Healthy Families Program and, at a minimum, shall include the following:

(1) Specific milestones and objectives to be completed for the upcoming year and their anticipated cost.

(2) A general description of each strategy or method to be used for outreach.

(3) Geographic areas and special populations to be targeted, if any, and why the special targeting is needed.

(4) Coordination with other state or county education and outreach efforts.

(5) The results of previous year outreach efforts.

(c) In implementing this section, the department may amend any existing or future media outreach campaign contract that it has entered into pursuant to Section 14148.5. Notwithstanding any other provision of law, any such contract entered into, or amended, as required to implement this section, shall be exempt from the approval of the Director of General Services and from the provisions of the Public Contract Code.

(d) (1) The department, in conjunction with the Managed Risk Medical Insurance Board, shall award contracts to community-based organizations to help families learn about, and enroll in, the Medi-Cal program and Healthy Families Program, and other health care programs for low-income children. Funding shall be contingent upon appropriation in the annual Budget Act.

(2) Contracts for these outreach and enrollment projects shall be awarded based on, but not limited to, all of the following criteria:

(A) Capacity to reach populations or geographic areas with disproportionately low enrollment rates. If it is not possible to estimate the number of uninsured children in a geographic area who are eligible for the Medi-Cal



program or the Healthy Families Program, proxy measures for rates of eligible children may be used. These measures may include, but are not limited to, the number of children in families with gross annual household incomes at or below the federal poverty levels pertinent to the programs.

(B) Organizational capacity and experience, including, but not limited to, any of the following:

(i) Organizational experience in serving low-income families.

(ii) Ability to work effectively with populations that have disproportionately low enrollment rates.

(iii) Organizational experiences in helping families learn about, and enroll in, the Medi-Cal program and Healthy Families Program. Organizations that do not have experience helping families learn about, and enroll in, the Medi-Cal program and Healthy Families Program shall be eligible only to the extent that they support and collaborate with the outreach and enrollment activities of entities with that experience.

(C) Effectiveness of the outreach and education plan, including, but not limited to, all of the following:

(i) Culturally and linguistically appropriate outreach and education strategies.

(ii) Strategies to identify and address barriers to enrollment, such as transportation limitations and community perceptions regarding the Medi-Cal program and Healthy Families Program.

(iii) Coordination with other outreach efforts in the community, including the statewide Healthy Families Program and Medi-Cal program outreach campaign, the state and federally funded county Medi-Cal outreach program, and any other Medi-Cal program and Healthy Families Program outreach projects in the target community.

(iv) Collaboration with other local organizations that serve families of eligible children.

(v) Strategies to ensure that children and families retain coverage and are informed of options for health



coverage and services when they lose eligibility for a particular program.

(vi) Plans to inform families about all available health care programs and services.

SEC. 41. Section 14085.7 of the Welfare and Institutions Code is amended to read:

14085.7. (a) The Medi-Cal Medical Education Supplemental Payment Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to, and under the administrative control of, the department for the purposes specified in this section. Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) All public moneys transferred by public agencies to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal medicaid laws.

(2) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal medicaid laws.

(3) Any amounts appropriated to the fund by the Legislature.

(4) Any interest that accrues on amounts in the fund.

(b) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(c) The department shall have the discretion to accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal matching funds to the full extent permitted by law. The department shall accept only those funds that are certified by the transferring or donating entity as qualifying for federal financial participation under the



terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable, and may return any funds transferred or donated in error.

(d) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under subdivision (e). Distributions from the fund shall be supplemental to any other amounts that hospitals receive under the contracting program.

(e) For purposes of recognizing medical education costs incurred for services rendered to Medi-Cal beneficiaries, payments from this fund shall be negotiated between the California Medical Assistance Commission and hospitals contracting under this article that meet the definition of university teaching hospitals or major (nonuniversity) teaching hospitals as set forth on page 51 and as listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping." Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(f) The state shall be held harmless from any federal disallowance resulting from this section. A hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the implementation of this section with respect to that hospital. The state may recoup any federal disallowance from the hospital.

(g) This section shall become inoperative on July 1, 2000, and, as of January 1, 2001, is repealed, unless a later enacted statute, that becomes effective on or before January 1, 2001, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 42. Section 14085.8 of the Welfare and Institutions Code is amended to read:



14085.8. (a) The Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund is hereby created in the State Treasury.

(b) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to, and under the administrative control of, the department for the purposes specified in this section.

(c) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) All public moneys transferred by public agencies to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal medicaid laws.

(2) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal medicaid laws.

(3) Any amounts appropriated to the fund by the Legislature.

(4) Any interest that accrues on amounts in the fund.

(d) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(e) The department may accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal matching funds to the full extent permitted by law. The department shall accept only those funds that are certified by the transferring or donating entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable, and may return any funds transferred or donated in error.



(f) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under subdivision (g). Distributions from the fund shall be supplemental to any other amounts that hospitals receive under the contracting program.

(g) (1) For purposes of recognizing medical education costs incurred for services rendered to Medi-Cal beneficiaries, contracts for payments from the fund may, at the discretion of the California Medical Assistance Commission, be negotiated between the commission and hospitals contracting under this article that are defined as either of the following:

(A) A large teaching emphasis hospital, as set forth on page 51 and listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," and meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(B) A children's hospital pursuant to Section 10727 and meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(2) Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(h) The state shall be held harmless from any federal disallowance resulting from this section. A hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the implementation of this section with respect to that hospital. The state may recoup any federal disallowance from the hospital.

(i) This section shall become inoperative on July 1, 2000, and, as of January 1, 2001, is repealed, unless a later enacted statute, that becomes effective on or before January 1, 2001, deletes or extends the dates on which it becomes inoperative and is repealed.



SEC. 43. Section 14087.301 is added to the Welfare and Institutions Code, to read:

14087.301. When entering into contracts with health care service plans that provide comprehensive dental benefits to Medi-Cal beneficiaries on an at-risk basis, the department may require that the health care service plans pay for the costs of the administrative and regulatory oversight required to monitor the contract compliance terms of the agreement with the department.

SEC. 44. Section 14094.3 of the Welfare and Institutions Code is amended to read:

14094.3. (a) Notwithstanding this article or Section 14093.05 or 14094.1, CCS covered services shall not be incorporated into any Medi-Cal managed care contract entered into after August 1, 1994, pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.9 (commencing with Section 14088), Article 2.91 (commencing with Section 14089), Article 2.95 (commencing with Section 14092); or either Article 2 (commencing with Section 14200), or Article 7 (commencing with Section 14490) of Chapter 8, until August 1, 2005, except for contracts entered into for county organized health systems in the Counties of San Mateo, Santa Barbara, Solano and Napa.

(b) Notwithstanding any other provision of this chapter, providers serving children under the CCS program who are enrolled with a Medi-Cal managed care contractor but who are not enrolled in a pilot project pursuant to subdivision (c) shall continue to submit billing for CCS covered services on a fee-for-service basis until CCS covered services are incorporated into the Medi-Cal managed care contracts described in subdivision (a).

(c) (1) The department may authorize a pilot project in Solano County in which reimbursement for conditions eligible under the CCS program may be reimbursed on a capitated basis pursuant to Section 14093.05, and provided all CCS program's guidelines, standards, and



regulations are adhered to, and CCS program's case management is utilized.

(2) During the time period described in subdivision (a), the department may approve, implement, and evaluate limited pilot projects under the CCS program to test alternative managed care models tailored to the special health care needs of children under the CCS program. The pilot projects may include, but need not be limited to, coverage of different geographic areas, focusing on certain subpopulations, and the employment of different payment and incentive models. Pilot project proposals from CCS program-approved providers shall be given preference. All pilot projects shall utilize CCS program-approved standards and providers pursuant to Section 14094.1.

(d) (1) The department shall submit to the appropriate committees of the Legislature an evaluation of pilot projects established pursuant to subdivision (c) based on at least one full year of operation.

(2) The evaluation required by paragraph (1) shall address the impact of the pilot projects on outcomes as set forth in paragraph (4) and, in addition, shall do both of the following:

(A) Examine the barriers, if any, to incorporating CCS covered services into the Medi-Cal managed care contracts described in subdivision (a).

(B) Compare different pilot project models with the fee-for-service system. The evaluation shall identify, to the extent possible, those factors that make pilot projects most effective in meeting the special needs of children with CCS eligible conditions.

(3) CCS covered services shall not be incorporated into the Medi-Cal managed care contracts described in subdivision (a) before the evaluation process has been completed.

(4) The pilot projects shall be evaluated to determine if:

(A) All children enrolled with a Medi-Cal managed care contractor described in subdivision (a) identified as



having a CCS eligible condition are referred in a timely fashion for appropriate health care.

(B) All children in the CCS program have access to coordinated care that includes primary care services in their own community.

(C) CCS program standards are adhered to.

(e) For purposes of this section, CCS covered services include all program benefits administered by the program specified in Section 123840 of the Health and Safety Code regardless of the funding source.

(f) Nothing in this section shall be construed to exclude or restrict CCS eligible children from enrollment with a managed care contractor or from receiving from the managed care contractor with which they are enrolled primary and other health care unrelated to the treatment of the CCS eligible condition.

SEC. 45. Section 14105.31 of the Welfare and Institutions Code is amended to read:

14105.31. For purposes of the Medi-Cal contract drug list, the following definitions shall apply:

(a) “Single-source drug” means a drug that is produced and distributed under an original New Drug Application approved by the federal Food and Drug Administration. This shall include a drug marketed by the innovator manufacturer and any cross-licensed producers or distributors operating under the New Drug Application, and shall also include a biological product, except for vaccines, marketed by the innovator manufacturer and any cross-licensed producers or distributors licensed by the federal Food and Drug Administration pursuant to Section 262 of Title 42 of the United States Code. A drug ceases to be a single-source drug when the same drug in the same dosage form and strength manufactured by another manufacturer is approved by the federal Food and Drug Administration under the provisions for an Abbreviated New Drug Application.

(b) “Best price” means the negotiated price, or the manufacturer’s lowest price available to any class of trade organization or entity, including, but not limited to,



wholesalers, retailers, hospitals, repackagers, providers, or governmental entities within the United States, that contracts with a manufacturer for a specified price for drugs, inclusive of cash discounts, free goods, volume discounts, rebates, and on- or off-invoice discounts or credits, shall be based upon the manufacturer's commonly used retail package sizes for the drug sold by wholesalers to retail pharmacies.

(c) "Equalization payment amount" means the amount negotiated between the manufacturer and the department for reimbursement by the manufacturer, as specified in the contract. The equalization payment amount shall be based on the difference between the manufacturer's direct catalog price charged to wholesalers and the manufacturer's best price, as defined in subdivision (b).

(d) "Manufacturer" means any person, partnership, corporation, or other institution or entity that is engaged in the production, preparation, propagation, compounding, conversion, or processing of drugs, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or in the packaging, repackaging, labeling, relabeling, and distribution of drugs.

(e) "Price escalator" means a mutually agreed upon price specified in the contract, to cover anticipated cost increases over the life of the contract.

(f) "Medi-Cal pharmacy costs" or "Medi-Cal drug costs" means all reimbursements to pharmacy providers for services or merchandise, including single-source or multiple-source prescription drugs, over-the-counter medications, and medical supplies, or any other costs billed by pharmacy providers under the Medi-Cal program.

(g) "Medicaid rebate" means the rebate payment made by drug manufacturers pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8).



(h) “State rebate” means any negotiated rebate under the Drug Discount Program in addition to the medicaid rebate.

(i) “Date of mailing” means the date that is evidenced by the postmark date by the United States Postal Service or other common mail carrier on the envelope.

(j) This section shall remain in effect only until January 1, 2001, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2001, deletes or extends that date.

SEC. 46. Section 14105.33 of the Welfare and Institutions Code is amended to read:

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

(b) (1) Contracts executed pursuant to this section shall be for the manufacturer’s best price, as defined in Section 14105.31, which shall be specified in the contract, and subject to agreed upon price escalators, as defined in that section. The contracts shall provide for an equalization payment amount, as defined in Section 14105.31, to be remitted to the department quarterly. The department shall submit an invoice to each manufacturer for the equalization payment amount, including supporting utilization data from the department’s prescription drug paid claims tapes within 30 days of receipt of the Health Care Financing Administration’s file of manufacturer rebate information. In lieu of paying the entire invoiced amount, a manufacturer may contest the invoiced amount pursuant to procedures established by the federal Health Care Financing Administration’s Medicaid Drug Rebate Program Releases or regulations by mailing a notice, that shall set forth its grounds for contesting the invoiced amount, to the department within 38 days of the department’s mailing of the state invoice and supporting utilization data. For purposes of state accounting practices only, the contested balance



shall not be considered an accounts receivable amount until final resolution of the dispute pursuant to procedures established by the federal Health Care Financing Administration's Medicaid Drug Rebate Program Releases or regulations that results in a finding of an underpayment by the manufacturer. Manufacturers may request, and the department shall timely provide, at cost, Medi-Cal provider level drug utilization data, and other Medi-Cal utilization data necessary to resolve a contested department-invoiced rebate amount.

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

(3) Utilization data used to determine an equalization payment amount shall exclude data from both of the following:

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

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

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



single-source and multiple-source drugs, as appropriate, in each major therapeutic category.

(d) (1) The department shall select the therapeutic categories to be included on the list of contract drugs, and the order in which it seeks contracts for those categories. The department may establish different contracting schedules for single-source and multiple-source drugs within a given therapeutic category.

(2) The department shall make every attempt to complete the initial contracting process for each major therapeutic category by January 1, 2001.

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

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



(3) In order to expedite implementation of paragraph (1), the requirements of Sections 14105.37, 14105.38, subdivisions (a), (c), (e), and (f) of Sections 14105.39, 14105.4, and 14105.405 are waived for the purposes of this section until January 1, 1994.

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

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

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

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

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

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

(2) For state rebate payments, manufacturers shall calculate and pay interest on late or unpaid rebates for



quarters that begin on or after the effective date of the act that added this subdivision.

(3) Following final resolution of any dispute pursuant to procedures established by the federal Health Care Financing Administration's Medicaid Drug Rebate Program Releases or regulations regarding the amount of a rebate, any underpayment by a manufacturer shall be paid with interest calculated pursuant to subdivisions (m) and (n), and any overpayment, together with interest at the rate calculated pursuant to subdivisions (m) and (n), shall be credited by the department against future rebates due.

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

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

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

(o) If the rebate payment is not received, the department shall send overdue notices to the manufacturer at 38, 68, and 98 days after the date of mailing of the invoice, and supporting utilization data. If the department has not received a rebate payment, including interest, within 180 days of the date of mailing of the invoice, including supporting utilization data, the



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

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

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

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

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



of the claim is within 100 days of the date of service of the last claim submitted for the same drug.

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

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

(v) This section shall remain in effect only until January 1, 2001, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2001, deletes or extends that date.

SEC. 47. Section 14105.35 of the Welfare and Institutions Code is amended to read:

14105.35. (a) (1) On and after July 1, 1990, drugs included on the Medi-Cal drug formulary shall be included on the list of contract drugs until the department and the manufacturer have concluded contract negotiations or the department suspends the drug from the list of contract drugs pursuant to the provisions of this subdivision.

The department shall, in writing, invite any manufacturer with single-source drug products on the formulary as of July 1, 1990, to enter into negotiations relative to the retention of its drug or drugs. As to the issue of cost, the department shall accept the manufacturer's best price as sufficient for purposes of entering into a contract to retain the drug or drugs on the list of contract drugs.

If the department and a manufacturer enter into a contract for retention of a drug or drugs on the list of contract drugs, the drug or drugs shall be retained on the



list of contract drugs for the effective term of the contract.

If a manufacturer refuses to enter into negotiations with the department pursuant to this subdivision, or if after 30 days of negotiation, the manufacturer has not agreed to execute a contract for a drug at the manufacturer's best price, the department may suspend from the list of contract drugs the manufacturer's single-source drug in question for a period of at least 180 days. The department shall lift the suspension upon execution of a contract for that drug. Consistent with the provisions of this section, the department shall delete the Medi-Cal drug formulary specified in paragraphs (b), (c), (d), and (e) of Section 59999 of Title 22 of the California Code of Regulations.

(2) On and after July 1, 1990, the director may retain a drug on the Medi-Cal list of contract drugs even if no contract is executed with a manufacturer, if the director determines that an essential need exists for that drug, and there are no other drugs currently on the formulary that meet that need.

(3) The director may delete a drug from the list of contract drugs if the director determines that the drug presents problems of safety or misuse. The director's decision as to safety shall be based upon published medical literature, and the director's decision as to misuse shall be based on published medical literature and claims data supplied by the fiscal intermediary.

(b) Any reference to the Medi-Cal drug formulary by statute or regulation shall be construed as referring to the list of contract drugs.

(c) (1) Any drug in the process of being added to the formulary by contract agreement pursuant to Section 14105.3, executed prior to the effective date of this section, shall be added to the list of contract drugs.

(2) Contracts pursuant to Section 14105.3 executed prior to January 1, 1991, shall be considered to be contracts executed pursuant to Section 14105.33, and the department shall exempt the drugs included in these



contracts from the initial therapeutic category review in which they would normally be considered.

(3) Nothing in this section shall be construed to require the department to discontinue negotiations into which it has entered with any manufacturer as of the effective date of this section. Contracts entered into as a result of these negotiations shall be exempt from the initial therapeutic category review in which they would normally be considered.

(d) This section shall remain in effect only until January 1, 2001, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2001, deletes or extends that date.

SEC. 48. Section 14105.37 of the Welfare and Institutions Code is amended to read:

14105.37. (a) The department shall notify each manufacturer of drugs in therapeutic categories selected pursuant to Section 14105.33 of the provisions of Sections 14105.31 to 14105.42, inclusive.

(b) If, within 45 days of notification, a manufacturer does not enter into negotiations for a contract pursuant to those sections, the department may suspend or delete from the list of contract drugs, or refuse to consider for addition, drugs of that manufacturer in the selected therapeutic categories.

(c) If, after 150 days from the initial notification, a contract is not executed for a drug currently on the list of contract drugs, the department may suspend or delete the drug from the list of contract drugs.

(d) If, within 150 days from the initial notification, a contract is executed for a drug currently on the list of contract drugs, the department shall retain the drug on the list of contract drugs.

(e) If, within 150 days from the date of the initial notification, a contract is executed for a drug not currently on the list of contract drugs, the department shall add the drug to the list of contract drugs.

(f) The department shall terminate all negotiations 150 days after the initial notification.



(g) The department may suspend or delete any drug from the list of contract drugs at the expiration of the contract term or when the contract between the department and the manufacturer of that drug is terminated.

(h) Any drug suspended from the list of contract drugs pursuant to this section or Section 14105.35 shall be subject to prior authorization, as if that drug were not on the list of contract drugs.

(i) Any drug suspended from the list of contract drugs pursuant to this section or Section 14105.35 for at least 12 months may be deleted from the list of contract drugs in accordance with the provisions of Section 14105.38.

(j) This section shall remain in effect only until January 1, 2001, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2001, deletes or extends that date.

SEC. 49. Section 14105.38 of the Welfare and Institutions Code is amended to read:

14105.38. (a) (1) In the event the department determines a drug should be deleted from the list of contract drugs, the department shall conduct a public hearing, as provided in this section, to receive comment on the impact of removing the drug.

(2) (A) The department shall provide written notice 30 days prior to the hearing.

(B) The department shall send the notice required by this subdivision to the manufacturer of the drug proposed to be deleted and to organizations representing Medi-Cal beneficiaries.

(b) (1) The hearing panel shall consist of the Chief, Medi-Cal Drug Discount Program, who shall serve as chair, and the Medi-Cal Contract Drug Advisory Committee.

(2) The hearing shall be recorded and transcribed, and the transcript available for public review.

(3) Subsequent to hearing all public comment, and within 30 days of the hearing, each panel member shall submit a recommendation regarding deletion of the drug and the reason for the recommendation to the director.



(c) The director shall consider public comments provided at the hearing and the recommendations of each panel member in determining whether to delete the drug.

(d) This section shall remain in effect only until January 1, 2001, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2001, deletes or extends that date.

SEC. 50. Section 14105.39 of the Welfare and Institutions Code is amended to read:

14105.39. (a) (1) A manufacturer of a new single-source drug may request inclusion of its drug on the list of contract drugs pursuant to Section 14105.33 provided all of the following conditions are met:

(A) The request is made within 12 months of approval for marketing by the federal Food and Drug Administration.

(B) The manufacturer agrees to negotiate a contract with the department to provide the drug at the manufacturer's best price.

(C) (i) The manufacturer provides the department with necessary information, as specified by the department, in the request.

(ii) Notwithstanding clause (i), either of the following may be submitted by the manufacturer in lieu of the Summary Basis of Approval prepared by the federal Food and Drug Administration for that drug:

(I) The federal Food and Drug Administration's approval or approvable letter for the drug and federal Food and Drug Administration's approved labeling.

(II) The federal Food and Drug Administration's medical officers' and pharmacologists' reviews and the federal Food and Drug Administration's approved labeling.

(D) The department had concluded contracting for the therapeutic category in which the drug is included prior to approval of the drug by the federal Food and Drug Administration.

(2) Within 90 days from receipt of the request, the department shall evaluate the request using the criteria



identified in subdivision (d), and shall submit the drug to the Medi-Cal Contract Drug Advisory Committee.

(b) Any petition for the addition to or deletion of a drug to the Medi-Cal drug formulary submitted prior to July 31, 1990, shall be deemed to be denied. A manufacturer who has submitted a petition deemed denied may request inclusion of that drug on the list of contract drugs provided all of the following conditions are met:

(1) The manufacturer agrees to negotiate for a contract with the department to provide the drug at the manufacturer's best price.

(2) The manufacturer provides the department with necessary information, as specified by the department, in the request.

(3) The manufacturer submits the request to the department prior to October 1, 1990.

(c) Any new drug designated as having an important therapeutic gain and approved for marketing by the federal Food and Drug Administration on or after July 31, 1990, shall immediately be included on the list of contract drugs for a period of three years provided that all of the following conditions are met:

(1) The manufacturer offers the department its best price.

(2) The drug is typically administered in an outpatient setting.

(3) The drug is prescribed only for the indications and usage specified in the federal Food and Drug Administration approved labeling.

(4) The drug is determined by the director to be safe, relative to other drugs in the same therapeutic category on the list of contract drugs.

(d) (1) To ensure that the health needs of Medi-Cal beneficiaries are met consistent with the intent of this chapter, the department shall, when evaluating a decision to execute a contract, and when evaluating drugs for retention on, addition to, or deletion from, the list of contract drugs, use all of the following criteria:

(A) The safety of the drug.



- (B) The effectiveness of the drug.
- (C) The essential need for the drug.
- (D) The potential for misuse of the drug.
- (E) The cost of the drug.

(2) The deficiency of a drug when measured by one of these criteria may be sufficient to support a decision that the drug should not be added or retained, or should be deleted from the list. However, the superiority of a drug under one criterion may be sufficient to warrant the addition or retention of the drug, notwithstanding a deficiency in another criterion.

(e) (1) A manufacturer of single-source drugs denied a contract pursuant to this section or Section 14105.33 or 14105.37, may file an appeal of that decision with the director within 30 calendar days of the department's written decision.

(2) Within 30 calendar days of the manufacturer's appeal, the director shall request a recommendation regarding the appeal from the Medi-Cal Contract Drug Advisory Committee. The committee shall provide its recommendation in writing, within 30 calendar days of the director's request.

(3) The director shall issue a final decision on the appeal within 30 calendar days of the recommendation.

(f) Deletions made to the list of contract drugs, including those made pursuant to Section 14105.37, shall become effective no sooner than 30 days after publication of the changes in provider bulletins.

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

(h) This section shall remain in effect only until January 1, 2001, and as of that date is repealed, unless a



later enacted statute, which is enacted before January 1, 2001, deletes or extends that date.

SEC. 51. Section 14105.4 of the Welfare and Institutions Code, as amended by Section 90 of Chapter 310 of the Statutes of 1998, is amended to read:

14105.4. (a) The director shall appoint a Medi-Cal Contract Drug Advisory Committee for the purpose of providing scientific and medical analysis on drugs contained on the list of contract drugs. The duties of the committee shall be as follows:

(1) To review drugs in the Medi-Cal list of contract drugs and make written recommendations to the director as to the addition of any drug or the deletion of any drug from the list. These recommendations shall be in accordance with subdivision (d) of Section 14105.39.

(2) To review and report in writing to the director as to the comparative therapeutic effect of drugs in accordance with Section 14053.5.

(3) To prepare a fair, impartial, and independent recommendation in writing, regarding appeals from manufacturers made pursuant to subdivision (e) of Section 14105.39.

(b) The committee shall consist of at least one representative from each of the following groups:

- (1) Physicians.
- (2) Pharmacists.
- (3) Schools of pharmacy or pharmacologists.
- (4) Medi-Cal beneficiaries.

(c) Members of the committee shall be reimbursed for necessary travel and other expenses incurred in the performance of official committee duties.

(d) In order to provide sufficient scientific information and analysis in the therapeutic categories under review, the director may replace a representative if required for specific expertise.

(e) The director shall notify the committee of the decisions made on the recommendations.

(f) This section shall remain in effect only until January 1, 2001, and as of that date is repealed, unless a



later enacted statute, which is enacted before January 1, 2001, deletes or extends that date.

SEC. 52. Section 14105.4 of the Welfare and Institutions Code, as amended by Section 91 of Chapter 310 of the Statutes of 1998, is amended to read:

14105.4. (a) The department shall schedule and conduct a public regulatory hearing to consider the addition of a drug to, or the deletion of a drug from, the Medi-Cal drug formulary five working days subsequent to the Medical Therapeutic and Drug Advisory Committee meeting which shall meet at least every four months. The public hearing may consist of written testimony only, and the hearing record shall be closed at the end of the public hearing.

(b) The department shall make available 45 days prior to the public hearing the department's estimate of any anticipated costs or savings to the state from adding a drug product to, or deleting a drug product from, the Medi-Cal drug formulary.

(c) Whenever the department accepts a completed petition to add a drug product to the Medi-Cal drug formulary and it is not processed pursuant to Section 14105.9, it shall be scheduled for review at the next regularly scheduled Medical Therapeutic and Drug Advisory Committee meeting and public regulatory hearing, unless the meeting and hearing are scheduled to occur within 120 days, in which case the drug product may be scheduled for the following hearing.

(d) The director shall issue a final decision regarding the drug product and shall submit any regulation adding a drug product to, or deleting a drug product from, the Medi-Cal drug formulary to the Office of Administrative Law, along with the completed rulemaking record, within seven months after the hearing prescribed in subdivision (a). This section shall not, however, be construed in a manner which results in the disapproval or invalidation of a regulation for failure to comply with the timeframes prescribed in this subdivision and subdivisions (a) and (c).



(e) (1) Except as provided in paragraph (2), the criteria used by the department in deciding whether a drug product shall be added to or deleted from the formulary shall be limited to the criteria adopted as department regulations. The criteria shall be specific and unambiguous.

(2) Notwithstanding paragraph (1), either of the following may be submitted by the manufacturer in lieu of the Summary Basis of Approval prepared by the federal Food and Drug Administration for that drug:

(A) The federal Food and Drug Administration's approval or approvable letter for the drug and federal Food and Drug Administration's approved labeling.

(B) The federal Food and Drug Administration's medical officers' and pharmacologists' reviews and the federal Food and Drug Administration's approved labeling.

(f) Departmental requests for information from persons filing drug petitions to which this section applies shall be specific and unambiguous and shall be made solely for the purpose of addressing the criteria utilized in accordance with subdivision (e).

(g) All published studies received by the department pursuant to a drug petition prior to the close of the public regulatory hearing record shall be accepted and considered by the department.

(h) Whenever the director decides to reject a petition to add a drug product to, or delete a drug product from, the formulary, the director shall notify the petitioner directly and in writing indicating the reason and specifying the criteria utilized in reaching the decision.

(i) The department shall accept a petition for a drug that has been rejected by the director upon the submission of another complete petition containing substantial new information that addresses the reason or reasons for rejection stated by the director pursuant to subdivision (h). Any petition accepted pursuant to this subdivision shall be processed in accordance with subdivision (c), or Section 14105.9, whichever is applicable.



(j) This section shall become operative on January 1, 2001.

SEC. 53. Section 14105.405 of the Welfare and Institutions Code is amended to read:

14105.405. (a) A Medi-Cal beneficiary, within 90 days of receipt of the director's notice to beneficiaries pursuant to subdivision (g) of Section 14105.33, informing them of the decision to delete or suspend a drug from the list of contract drugs, may request a fair hearing pursuant to Chapter 7 (commencing with Section 10950) of Part 2.

(b) Any beneficiary filing a fair hearing request regarding the deletion or suspension of a drug from the formulary shall be granted a treatment authorization request for that drug until a final decision is adopted by the director. Should the beneficiary seek judicial review of the director's decision, a treatment authorization request shall be granted for that drug until a final decision is issued by the court.

(c) (1) Any Medi-Cal beneficiary, within one year of the director's decision pursuant to Section 10959, may file a petition with the superior court, under the provisions of Section 1094.5 of the Code of Civil Procedure, praying for a review of both the legal and factual basis for the director's decision.

(2) The director shall be the sole respondent in these proceedings.

(d) Any Medi-Cal beneficiary injured as a result of being denied a drug which is determined to be medically necessary may sue for injunctive or declaratory relief to review the director's decision to delete or suspend a drug from the list of contract drugs.

(e) This section shall remain in effect only until January 1, 2001, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2001, deletes or extends that date.

SEC. 54. Section 14105.41 of the Welfare and Institutions Code, as amended by Section 93 of Chapter 310 of the Statutes of 1998, is amended to read:

14105.41. (a) Moneys accruing to the department from contracts executed pursuant to Section 14105.33



shall be deposited in the Health Care Deposit Fund, and shall be subject to appropriation by the Legislature.

(b) This section shall remain in effect only until January 1, 2001, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2001, deletes or extends that date.

SEC. 55. Section 14105.41 of the Welfare and Institutions Code, as amended by Section 94 of Chapter 310 of the Statutes of 1998, is amended to read:

14105.41. (a) For the purpose of adding drugs to, or deleting drugs from, the Medi-Cal drug formulary as described in Section 14105.4, whether pursuant to a petition or by the department independent of a petition, all of the requirements of the Administrative Procedure Act contained in Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code shall be applicable except that the requirements of subdivision (a) of Section 11340.7 and subdivision (a) of Section 11346.9 of the Government Code shall be deemed to have been complied with if the department does all of the following:

(1) Upon receipt of a petition requesting the addition of a drug to, or the deletion of a drug from, the Medi-Cal drug formulary, the department shall notify the petitioner directly and in writing of the receipt of the petition and shall, within 30 days, either return the petition as incomplete or schedule the petition for public hearing, unless the public hearing is not required pursuant to Section 14105.9.

(2) Notifies each petitioner directly and in writing of its decision regarding the addition of a drug product to, or deletion of a drug product from, the formulary and shall state the reason or reasons for its decision and the specific regulatory criteria that are the basis of the department's decision.

(3) Prepares and submits to the Office of Administrative Law with the adopted regulation all of the following for each drug which the department has decided to add to, or delete from, the Medi-Cal drug formulary:



(A) A brief summary of the comments submitted. For the purpose of this section, “comments” shall mean the major points raised in testimony which specifically address the regulatory criteria upon which the department is authorized, pursuant to subdivision (e) of Section 14105.4, to base a decision to add or delete a drug from the formulary.

(B) The recommendation of the Medical Therapeutic and Drug Advisory Committee.

(C) The decision of the department.

(D) A statement of the reason and the specific regulatory criteria that are the basis of the department’s decision.

(b) Any additional information provided to the department during the posting of revisions to the proposed regulation shall be responded to by the department directly and in writing to the originator. That response shall notify the originator whether the additional information has resulted in a changed decision.

(c) For the purpose of review by the court, if any, and review and approval by the Office of Administrative Law of changes to the Medi-Cal drug formulary adopted by the department, each drug added to, or deleted from, the formulary shall be considered to be a separate regulation and shall be severable from all other additions or deletions of drugs contained in the rulemaking file.

(d) This section shall be applicable to any Medi-Cal drug formulary regulation package filed with the Office of Administrative Law on or after January 1, 2001.

(e) This section shall become operative on January 1, 2001.

SEC. 56. Section 14105.42 of the Welfare and Institutions Code, as amended by Section 95 of Chapter 310 of the Statutes of 1998, is amended to read:

14105.42. (a) The department shall report to the Legislature after the first three major therapeutic categories have been reviewed and contracts executed. The report shall include the estimated savings, number of manufacturers entering negotiations, number of



contracts executed, number of drugs added and deleted, and impact on Medi-Cal beneficiaries and providers.

(b) The department shall provide the following data to the Legislature and to the State Auditor by January 1, 1991, and every six months thereafter:

(1) The number of drug treatment authorization requests (TAR) received by facsimile, by secondary answering system and in person for each therapeutic category.

(2) The number of drug TARS requested, approved, denied, and returned.

(3) The length of time between the TAR request and the decision, specified by type of communication such as telephone or facsimile if available.

(4) For denied TARS, the number of fair hearings requested, approved, denied and pending.

(5) The numbers of providers who were unable to submit a request or made multiple attempts because of faulty or unavailable lines of communication, if available.

(6) The numbers of complaints made by beneficiaries and providers relating to difficulty or inability to obtain a TAR response.

(7) The status of the enhancements to the TAR process specified in Section 21 of Chapter 457 of the Statutes of 1990.

(8) The number of calls on the TAR line which are not getting through.

(c) Until January 1, 2001, or the date of the report specified in subdivision (e), whichever is earlier, the State Auditor shall prepare a report by February 1, 1991, and every six months thereafter providing a summary and analysis of the data specified in subdivision (b), and a comparative analysis of changes in the TAR process using June 1, 1990, as a base. The analysis shall include a measure of increased or decreased ability to contact the department and receive a response in a shorter or greater period of time.

(d) The department shall report to the Legislature, through the annual budget process, on the



cost-effectiveness of contracts executed pursuant to Section 14105.33.

(e) The Joint Legislative Audit Committee may review and report on the requirements imposed on the State Auditor by subdivision (c) on or before January 1, 2001.

(f) This section shall remain in effect only until January 1, 2001, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2001, deletes or extends that date.

SEC. 57. Section 14105.91 of the Welfare and Institutions Code is amended to read:

14105.91. The department may add a drug to the formulary which is a different dosage form, or strength of a drug product which is listed in the formulary without review by the Medical Therapeutics and Drug Advisory Committee and the addition shall be deemed to comply with the requirements of the California Administrative Procedure Act.

This section shall become operative on January 1, 2001.

SEC. 58. Section 14105.915 of the Welfare and Institutions Code is amended to read:

14105.915. The department may remove any drug from the formulary at the expiration of the contract term or when the contract between the department and the manufacturer of that drug is terminated.

This section shall become operative on January 1, 2001.

SEC. 59. Section 14105.916 of the Welfare and Institutions Code is amended to read:

14105.916. Notwithstanding any other provision of law, on and after January 1, 2001, drugs on the Medi-Cal list of contract drugs shall become the Medi-Cal drug formulary.

SEC. 60. Section 14105.981 of the Welfare and Institutions Code is amended to read:

14105.981. (a) In addition to the requirements of subdivision (t) of Section 14105.98:

(1) Except as provided in paragraph (2), the department shall take all appropriate steps permitted by



law and the Medi-Cal state plan to ensure the following for all years of the payment adjustment program.

(A) That transitional inpatient days are included in the payment adjustment program in the same fashion as all other Medi-Cal days of acute inpatient hospital service.

(B) That, to the same extent as any other Medi-Cal days of acute inpatient hospital service, transitional inpatient days are included as payable days under the payment adjustment program and in the total annualized Medi-Cal inpatient paid days.

(2) In no event shall paragraph (1) be implemented in a fashion that is inconsistent with federal medicaid law or the Medi-Cal state plan or any relevant amendments thereto.

(b) This section shall remain in effect only until January 1, 2001, and as of that date is repealed, unless a later enacted statute, that is enacted on or before January 1, 2001, deletes or extends that date.

SEC. 61. Section 14107.11 is added to the Welfare and Institutions Code, to read:

14107.11. (a) Upon receipt of reliable evidence of fraud or willful misrepresentation by a provider under the Medi-Cal program, the department may:

(1) Collect any Medi-Cal 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). 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 will 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 Medi-Cal 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 subdivision and that the withholding is for a temporary period and will not continue after it is determined that there is insufficient evidence of fraud or willful misrepresentation or when legal proceedings relating to the alleged fraud or willful misrepresentation are complete.

(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 for consideration by the department.

(3) Notwithstanding Section 100171 of the Health and Safety Code, a provider may appeal a withholding of payment 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.

(b) The director may adopt regulations to implement this section as necessary. These regulations may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) Part 1 of Division 3 of Title 2 of the Government Code) and 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 the adopted regulations, the rulemaking file, and the certification of compliance as required by subdivision (e) of Section 11346.1 of the Government Code.



(c) For purposes of this section, “provider” means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, employees, or agents thereof, that provide services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary, and that has been enrolled in the Medi-Cal program.

SEC. 62. Section 14110.6 of the Welfare and Institutions Code is amended to read:

14110.6. (a) The director shall adopt regulations, establishing payment rates for nursing facilities, intermediate care facilities/developmentally disabled, and intermediate care facilities/developmentally disabled-habilitative as defined in Section 1250 of the Health and Safety Code, which are sufficient to provide an increase of one dollar and ninety-six cents (\$1.96) per patient day for patients receiving skilled nursing services, one dollar and fifty-eight cents (\$1.58) per patient day, for patients receiving intermediate care services, two dollars and twenty-nine cents (\$2.29) per patient day for intermediate care facilities/developmentally disabled patients, to be used for wage increases and benefits to all employees, except a licensed nursing home administrator or an administrator-in-training and two dollars and thirty-five cents (\$2.35) per patient day for intermediate care facilities/developmentally disabled-habilitative patients in facilities with 4 to 6 beds, and one dollar and ninety-eight cents (\$1.98) per patient day for intermediate care facilities/developmentally disabled-habilitative patients in facilities with 7 to 15 beds, to be used for wage increases and benefits to all direct care staff. However, if either (1) the entry level wages of the lowest paid nonadministrative employee of a nursing facility, intermediate care facility/developmentally disabled, or intermediate care facility/developmentally disabled-habilitative, exceeds six dollars (\$6) per hour as of August 1, 1984; or (2) upon the election of a county board of supervisors, for any nursing facility, intermediate care facility/developmentally disabled, or intermediate care facility/developmentally



disabled-habilitative, which is operated by a county, the funds received pursuant to regulations adopted pursuant to this section shall be used solely for labor costs directly related to providing patient care services in order to meet patients' needs including the uses of funds provided for under subdivision (d) of Section 14110.7. Any increase in wages and benefits required by this section shall be in addition to any future mandatory increases required by federal or state law. The rate shall provide funding for the portion of additional costs necessary to implement the wage and benefit increase required by this section attributable to Medi-Cal patients. The portion of those additional costs shall be the same as the ratio of Medi-Cal patients to the total number of patients in the facility. These regulations shall be adopted, effective March 15, 1985, for skilled nursing facilities, intermediate care facilities, and intermediate care facilities/developmentally disabled, and by October 1, 1985, for intermediate care facilities/developmentally disabled-habilitative. Commencing October 1, 1990, these requirements shall become operative for nursing facilities.

(b) Each nursing facility or intermediate care facility/developmentally disabled, or, for the period prior to October 1, 1990, each skilled nursing facility or intermediate care facility, shall certify all of the following:

(1) All employees, except a licensed nursing home administrator or an administrator-in-training of a licensed nursing home, shall receive at least the prevailing federal or state minimum wage rate plus the average hourly wage increase established pursuant to Chapter 19 of the Statutes of 1978, and this section.

(2) All employees of the facility, except a licensed administrator or administrator-in-training, shall be paid not less than the sum of the employee's actual rate of pay as of the effective date of the Medi-Cal rate increase provided for under Section 14110.7 plus the amount of the adjustment specified pursuant to this section, or not less than the applicable agreed to rate plus the amount of the adjustment, whichever is greater.



(3) Any wage increase required pursuant to Section 1268.5 of the Health and Safety Code, is in addition to any minimum wages provided in this section.

(4) For purposes of determining the amount of Medi-Cal funds to be distributed for employee wages and benefits, the total Medi-Cal patient days recorded by the facility in the month of December 1983 shall be multiplied by the amount per patient day specified in subdivision (a) plus the amount provided by Chapter 19 of the Statutes of 1978. The new wage levels shall be determined by dividing the Medi-Cal funds received by the nonovertime hours worked by covered employees in December 1983, plus any adjustments due to additional employees as specified in Section 14110.7 and adjustments to reflect employee benefit allowances.

(c) Each intermediate care facility/developmentally disabled-habilitative shall certify all of the following:

(1) All direct care staff, as defined in the department's regulations developed pursuant to Section 1267.7 of the Health and Safety Code, shall receive at least the prevailing federal or state minimum wage plus the average hourly wage increase pursuant to this section.

(2) For purposes of determining the amount of Medi-Cal funds to be distributed for intermediate care facilities/developmentally disabled-habilitative for employee wages and benefits, the total Medi-Cal patient days in the month of December 1984, shall be multiplied by the amount per patient day specified in subdivision (a). The new wage level shall be determined by dividing the Medi-Cal funds received by the nonovertime hours by covered direct care employees in December 1984, and adjustments to reflect employee benefit allowances.

(d) The director shall order the inspection of relevant payroll and personnel records of facilities which are reimbursed for Medi-Cal patients under the rate of reimbursement established pursuant to subdivision (a) to ensure that the wage and benefit increases provided for have been implemented.

(e) The department shall, commencing August 1, 1999, increase the Medi-Cal reimbursement for level A



and level B nursing facilities solely to provide funds for salaries, wages, and benefits increases for direct care staff. For the purposes of this subdivision, “direct care staff” means registered nurses, licensed vocational nurses, and nurse assistants, who provide direct patient care. The amount of funds to be provided to each level A and level B facility pursuant to this subdivision shall be calculated on a per patient day basis, and shall be added to the per diem rate paid to each facility. The amount of funds provided under this subdivision to each nursing facility peer group shall be published in a Medi-Cal provider bulletin. Level A and level B facilities shall compensate their registered nurses, licensed vocational nurses, and nurse assistants that portion of the rate increase provided under this subdivision in the form of salaries, wages, and benefits increases for their direct care staff. The total amount to be passed through by each facility shall be the per diem amount received by the facility pursuant to this subdivision times the facility’s number of Medi-Cal patient days.

(f) Any facility which is paid under the rate provided for in subdivision (a) or (e) which the director finds has not made the wage and benefit increases provided for shall be liable for the amount of funds paid to the facility based upon the wage and benefit requirements provided for by this section but not distributed to employees for wages and benefits, plus a penalty equal to 10 percent of the funds not so distributed.

SEC. 63. Section 14110.7 of the Welfare and Institutions Code, as amended by Section 3 of Chapter 502 of the Statutes of 1990, is amended to read:

14110.7. (a) The director shall adopt regulations increasing the minimum number of equivalent nursing hours per patient required in skilled nursing facilities to 3.2, in skilled nursing facilities with special treatment programs to 2.3, in intermediate care facilities to 1.1, and in intermediate care facilities/developmentally disabled to 2.7.

(b) (1) The director shall adopt regulations which shall establish the minimum number of equivalent



nursing hours per patient required in the following, for the first year of implementation of the first year of rates established pursuant to this article:

(A) 2.6 hours for skilled nursing facilities.

(B) 1.9 hours for skilled nursing facilities with special treatment programs.

(C) 0.9 hours for intermediate care facilities.

(D) 2.2 hours for intermediate care facilities/developmentally disabled.

(2) The staffing standards established by paragraph (1) shall become effective concurrently with the establishment of the first reimbursement rates under this article.

(3) The director shall adopt regulations which establish the minimum number of equivalent nursing hours per patient required in skilled nursing facilities at 2.7 for the second year of implementation of rates established pursuant to this article.

(c) (1) The Legislature finds and declares all of the following:

(A) The one-year transition phase from 2.6 to 2.7 equivalent nursing hours allows ample time to restructure staffing.

(B) The 4 percent augmentation to reimburse for direct patient care, as defined in paragraph (2) of subdivision (b) of Section 14126.60, provides funds to cover additional expenses, if any, incurred by facilities to implement this staffing standard.

(2) Subject to the appropriation of sufficient funds, the department may adopt regulations to increase the minimum number of equivalent nursing hours required of facilities subject to this section per patient beyond 2.7 nursing hours per patient day.

(d) (1) The department shall identify those skilled nursing facilities that are in compliance with the 3.0 minimum double nursing hour standards, as defined in subdivision (a) of Section 1276.5 of the Health and Safety Code, but have actual staffing ratios below 2.5, as of July 1, 1990, and shall not enforce the 2.7 equivalent nursing hours with respect to those facilities until the third year



of implementation of the rates established under this article.

(2) The department shall periodically review facilities which have actual staffing ratios described in paragraph (1) to ensure that they are making sufficient progress toward 2.7 hours.

(e) Notwithstanding paragraph (1) of subdivision (d), commencing January 1, 2000, the minimum number of nursing hours per patient day required in skilled nursing facilities shall be 3.2, without regard to the doubling of nursing hours as described in Section 1276.5 of the Health and Safety Code.

SEC. 64. Section 14132 of the Welfare and Institutions Code is amended to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy and occupational therapy, are covered subject to utilization controls.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for the



developmentally disabled are covered subject to utilization controls.

(d) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetists services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and X-ray services are covered, subject to utilization controls. Nothing in this subdivision shall be construed to require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable X-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. The department's utilization controls shall not require X-rays as a condition of reimbursement for fillings for children under 18 years of age. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions which preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities



administered by the department's California Children Services Program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated, is covered



subject to utilization controls. When there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

(l) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(n) Family planning services are covered, subject to utilization controls.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, other prophylaxis treatment for children 17 years of age and under, are covered.

(2) All dental hygiene services provided by a registered dental hygienist in alternative practice pursuant to Sections 1768 and 1770 of the Business and Professions Code may be covered as long as they are



within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article.

(2) All providers enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, “in-home medical care service” includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

As used in this subdivision, in-home medical care services, include, but are not limited to:

- (1) Level of care and cost of care evaluations.
- (2) Expenses, directly attributable to home care activities, for materials.
- (3) Physician fees for home visits.
- (4) Expenses directly attributable to home care activities for shelter and modification to shelter.



(5) Expenses directly attributable to additional costs of special diets, including tube feeding.

(6) Medically related personal services.

(7) Home nursing education.

(8) Emergency maintenance repair.

(9) Home health agency personnel benefits which permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(11) Emergency and nonemergency medical transportation.

(12) Medical supplies.

(13) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(14) Utility use directly attributable to the requirements of home care activities which are in addition to normal utility use.

(15) Special drugs and medications.

(16) Home health agency supervision of visiting staff which is medically necessary, but not included in the home health agency rate.

(17) Therapy services.

(18) Household appliances and household utensil costs directly attributable to home care activities.

(19) Modification of medical equipment for home use.

(20) Training and orientation for use of life support systems, including, but not limited to, support of respiratory functions.

(21) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

Beneficiaries receiving in-home medical care services are entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent



that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services may be covered to the extent that federal financial participation is available for those services under waivers granted in accordance with Section 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

The department shall submit a report, as provided in Section 28 of the 1982 Budget Act, 30 days prior to providing these services as Medi-Cal benefits. The report shall be submitted to the Joint Legislative Budget Committee and the fiscal committees and shall address the cost effectiveness of services provided pursuant to this subdivision.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter



XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service which is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services which are authorized and reimbursable under this chapter, and services which are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for beneficiaries with a diagnosis of AIDS or ARC, who require intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to individual beneficiaries in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible beneficiaries. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).



(aa) (1) There is hereby established in the department, a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program.

(2) The department shall seek a waiver for a program to provide comprehensive clinical family planning services as described in paragraph (8). The program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. The services shall be provided under the program only if the waiver is approved by the federal Health Care Financing Administration in accordance with Section 1396n of Title 42 of the United States Code and only to the extent that federal financial participation is available for the services.

(3) Solely for the purposes of the waiver and notwithstanding any other provision of law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other provision of law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) 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, without taking regulatory action, the provisions of the waiver after its approval by the federal Health Care Financing Administration and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the



approved waiver 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 the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) In the event that the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) is no longer cost-effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, “comprehensive clinical family planning services” means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies,



natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

- (i) Psychosocial and medical aspects of contraception.
- (ii) Sexuality.
- (iii) Fertility.
- (iv) Pregnancy.
- (v) Parenthood.
- (vi) Infertility.



(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

SEC. 65. 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) Transitional inpatient care services shall be made available only to qualifying Medi-Cal beneficiaries who are 18 years of age or older.

(e) Transitional inpatient care services shall not be available to patients in acute care hospitals defined as small and rural pursuant to Section 124840 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 that are certified to participate as a nursing facility in the Medicare and medicaid programs, pursuant to Titles XVIII and XIX of the federal Social Security Act, and licensed congregate living health facilities, as defined in Section 1265.7 of the Health and Safety Code, that are certified to participate as a nursing facility in the Medicare and medicaid programs pursuant to Titles XVIII and XIX of the federal Social Security Act, 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 certified 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 certified 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 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 certified 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, 2000, 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 Procedure 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, 2001, and as of that date is repealed, unless a later enacted statute, that is enacted on or before January 1, 2001, deletes or extends that date.

SEC. 67. Section 14163 of the Welfare and Institutions Code is amended to read:

14163. (a) For purposes of this section, the following definitions shall apply:

(1) "Public entity" means a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state.

(2) "Hospital" means a health facility that is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code to provide acute inpatient hospital services, and includes all components of the facility.

(3) "Disproportionate share hospital" means a hospital providing acute inpatient services to Medi-Cal beneficiaries that meets the criteria for disproportionate share status relating to acute inpatient services set forth in Section 14105.98.

(4) "Disproportionate share list" means the annual list of disproportionate share hospitals for acute inpatient services issued by the department pursuant to Section 14105.98.

(5) "Fund" means the Medi-Cal Inpatient Payment Adjustment Fund.



(6) “Eligible hospital” means, for a particular state fiscal year, a hospital on the disproportionate share list that is eligible to receive payment adjustment amounts under Section 14105.98 with respect to that state fiscal year.

(7) “Transfer year” means the particular state fiscal year during which, or with respect to which, public entities are required by this section to make an intergovernmental transfer of funds to the Controller.

(8) “Transferor entity” means a public entity that, with respect to a particular transfer year, is required by this section to make an intergovernmental transfer of funds to the Controller.

(9) “Transfer amount” means an amount of intergovernmental transfer of funds that this section requires for a particular transferor entity with respect to a particular transfer year.

(10) “Intergovernmental transfer” means a transfer of funds from a public entity to the state, that is local government financial participation in Medi-Cal pursuant to the terms of this section.

(11) “Licensee” means an entity that has been issued a license to operate a hospital by the department.

(12) “Annualized Medi-Cal inpatient paid days” means the total number of Medi-Cal acute inpatient hospital days, regardless of dates of service, for which payment was made by or on behalf of the department to a hospital, under present or previous ownership, during the most recent calendar year ending prior to the beginning of a particular transfer year, including all Medi-Cal acute inpatient covered days of care for hospitals that are paid on a different basis than per diem payments.

(13) “Medi-Cal acute inpatient hospital day” means any acute inpatient day of service attributable to patients who, for those days, were eligible for medical assistance under the California state plan, including any day of service that is reimbursed on a basis other than per diem payments.



(14) “OBRA 1993 payment limitation” means the hospital-specific limitation on the total annual amount of payment adjustments to each eligible hospital under the payment adjustment program that can be made with federal financial participation under Section 1396r-4(g) of Title 42 of the United States Code as implemented pursuant to the Medi-Cal State Plan.

(b) The Medi-Cal Inpatient Payment Adjustment Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to, and under the administrative control of, the department for the purposes specified in subdivision (d). The fund shall consist of the following:

(1) Transfer amounts collected by the Controller under this section, whether submitted by transferor entities pursuant to applicable provisions of this section or obtained by offset pursuant to subdivision (j).

(2) Any other intergovernmental transfers deposited in the fund, as permitted by Section 14164.

(3) Any interest that accrues with respect to amounts in the fund.

(c) Moneys in the fund, which shall not consist of any state general funds, shall be used as the source for the nonfederal share of payments to hospitals pursuant to Section 14105.98. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures, and used to make payments pursuant to Section 14105.98.

(d) Except as otherwise provided in Section 14105.98 or in any provision of law appropriating a specified sum of money to the department for administering this section and Section 14105.98, moneys in the fund shall be used only for the following:

(1) Payments to hospitals pursuant to Section 14105.98.

(2) Transfers to the Health Care Deposit Fund as follows:

(A) In the amount of two hundred thirty-nine million seven hundred fifty-seven thousand six hundred ninety



dollars (\$239,757,690) for the 1994–95 and 1995–96 fiscal years.

(B) In the amount of two hundred twenty-nine million seven hundred fifty-seven thousand six hundred ninety dollars (\$229,757,690) for the 1996–97 fiscal year.

(C) In the amount of one hundred fifty-four million seven hundred fifty-seven thousand six hundred ninety dollars (\$154,757,690) for the 1997–98 fiscal year.

(D) In the amount of one hundred fourteen million seven hundred fifty-seven thousand six hundred ninety dollars (\$114,757,690) for the 1998–99 fiscal year.

(E) (i) In the amount of eighty-four million seven hundred fifty-seven thousand six hundred ninety dollars (\$84,757,690) for the 1999–2000 fiscal year and each fiscal year thereafter.

(ii) It is the intent of the Legislature that the economic benefit of any reduction in the amount transferred, or to be transferred, to the Health Care Deposit Fund pursuant to this subdivision for the 1999-2000 fiscal year, as compared to the amount so transferred for the 1998-99 fiscal year, be allocated equally between public and nonpublic disproportionate share hospitals. To implement the reduction in clause (i) the department shall, by June 30, 2000, adjust the calculations in Section 14105.98 in order to allocate the funds in accordance with this clause.

(F) The transfers from the fund shall be made in six equal monthly installments to the Medi-Cal local assistance appropriation item (Item 4260-101-001 of the annual Budget Act) in support of Medi-Cal expenditures. The first installment shall accrue in October of each transfer year, and all other installments shall accrue monthly thereafter from November through March.

(e) For the 1991–92 state fiscal year, the department shall determine, no later than 70 days after the enactment of this section, the transferor entities for the 1991–92 transfer year. To make this determination, the department shall utilize the disproportionate share list for the 1991–92 fiscal year issued by the department pursuant to paragraph (1) of subdivision (f) of Section



14105.98. The department shall identify each eligible hospital on the list for which a public entity is the licensee as of July 1, 1991. The public entity that is the licensee of each identified eligible hospital shall be a transferor entity for the 1991–92 transfer year.

(f) The department shall determine, no later than 70 days after the enactment of this section, the transfer amounts for the 1991–92 transfer year.

The transfer amounts shall be determined as follows:

(1) The eligible hospitals for 1991–92 shall be identified. For each hospital, the applicable total per diem payment adjustment amount under Section 14105.98 for the 1991–92 transfer year shall be computed. This amount shall be multiplied by 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days as determined from all Medi-Cal paid claims records available through April 1, 1991. The products of these calculations for all eligible hospitals shall be added together to determine an aggregate sum for the 1991–92 transfer year.

(2) The eligible hospitals for 1991–92 involving transferor entities as licensees shall be identified. For each hospital, the applicable total per diem payment adjustment amount under Section 14105.98 for the 1991–92 transfer year shall be computed. This amount shall be multiplied by 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days as determined from all Medi-Cal paid claims records available through April 1, 1991. The products of these calculations for all eligible hospitals with transferor entities as licensees shall be added together to determine an aggregate sum for the 1991–92 transfer year.

(3) The aggregate sum determined under paragraph (1) shall be divided by the aggregate sum determined under paragraph (2), yielding a factor to be utilized in paragraph (4).

(4) The factor determined in paragraph (3) shall be multiplied by the amount determined for each hospital under paragraph (2). The product of this calculation for each hospital in paragraph (2) shall be divided by 1.771,



yielding a transfer amount for the particular transferor entity for the transfer year.

(g) For the 1991–92 transfer year, the department shall notify each transferor entity in writing of its applicable transfer amount or amounts.

(h) For the 1992–93 transfer year and subsequent transfer years, transfer amounts shall be determined in the same procedural manner as set forth in subdivision (f), except:

(1) The department shall use all of the following:

(A) The disproportionate share list applicable to the particular transfer year to determine the eligible hospitals.

(B) The payment adjustment amounts calculated under Section 14105.98 for the particular transfer year. These amounts shall take into account any projected or actual increases or decreases in the size of the payment adjustment program as are required under Section 14105.98 for the particular year in question, including any decreases resulting from the application of the OBRA 1993 payment limitation. The department may issue interim, revised, and supplemental transfer requests as necessary and appropriate to address changes in payment adjustment levels that occur under Section 14105.98. All transfer requests, or adjustments thereto, issued to transferor entities by the department shall meet the requirements set forth in subdivision (i).

(C) Data regarding annualized Medi-Cal inpatient paid days for the most recent calendar year ending prior to the beginning of the particular transfer year, as determined from all Medi-Cal paid claims records available through April 1 preceding the particular transfer year.

(D) The status of public entities as licensees of eligible hospitals as of July 1 of the particular transfer year.

(E) For the 1993–94 transfer year and subsequent transfer years, the divisor to be used for purposes of the calculation referred to in paragraph (4) of subdivision (f) shall be determined by the department. The divisor shall be calculated to ensure that the appropriate amount of



transfers from transferor entities are received into the fund to satisfy the requirements of Section 14105.98, exclusive of the amounts described in paragraph (2) of this subdivision, and to satisfy the requirements of paragraph (2) of subdivision (d), for the particular transfer year. For the 1993–94 transfer year, the divisor shall be 1.742.

(F) The following provisions shall apply for certain transfer amounts relating to nonsupplemental payments under Section 14105.98:

(i) For the 1998–99 transfer year, transfer amounts shall be determined as though the payment adjustment amounts arising pursuant to subdivision (ag) of Section 14105.98 were increased by the amounts paid or payable pursuant to subdivision (af) of Section 14105.98.

(ii) Any transfer amounts paid by a transferor entity pursuant to subparagraph (C) of paragraph (2) shall serve as credit for the particular transferor entity against an equal amount of its transfer obligation for the 1998–99 transfer year.

(iii) For the 1999–2000 transfer year, transfer amounts shall be determined as though the amount to be transferred to the Health Care Deposit Fund, as referred to in paragraph (2) of subdivision (d), were reduced by 28 percent.

(2) (A) Except as provided in subparagraphs (B), (C), and (D), for the 1993–94 transfer year and subsequent transfer years, transfer amounts shall be increased for the particular transfer year in the amounts necessary to fund the nonfederal share of the total supplemental payment adjustment amounts of all types that arise under Section 14105.98. These increases shall be paid only by those transferor entities that are licensees of hospitals that are projected to receive some or all of the particular supplemental payments, and the increases shall be paid by the transferor entities on a pro rata basis in connection with the particular supplemental payments. For purposes of this paragraph, supplemental payment adjustment amounts shall be deemed to arise for the particular transfer year as of the date specified in



Section 14105.98. Transfer amounts to fund the nonfederal share of the payments shall be paid for the particular transfer year within 20 days after the department notifies the transferor entity in writing of the additional transfer amount to be paid.

(B) For the 1995–96 transfer year, the nonfederal share of the secondary supplemental payment adjustments described in paragraph (9) of subdivision (y) of Section 14105.96 shall be funded as follows:

(i) Ninety-nine percent of the nonfederal share shall be funded by a transfer from the University of California.

(ii) One percent of the nonfederal share shall be funded by transfers from those public entities that are the licensees of the hospitals included in the “other public hospitals” group referred to in clauses (ii) and (iii) of subparagraph (B) of paragraph (9) of subdivision (y) of Section 14105.98. The transfer responsibilities for this 1 percent shall be allocated to the particular public entities on a pro rata basis, based on a formula or formulae customarily used by the department for allocating transfer amounts under this section. The formula or formulae shall take into account, through reallocation of transfer amounts as appropriate, the situation of hospitals whose secondary supplemental payment adjustments are restricted due to the application of the limitation set forth in clause (v) of subparagraph (B) of paragraph (9) of subdivision (y) of Section 14105.98.

(iii) All transfer amounts under this subparagraph shall be paid by the particular transferor entities within 30 days after the department notifies the transferor entity in writing of the transfer amount to be paid.

(C) For the 1997–98 transfer year, transfer amounts to fund the nonfederal share of the supplemental payment adjustments described in subdivision (af) of Section 14105.98 shall be funded by a transfer from the County of Los Angeles.

(D) (i) For the 1998–99 transfer year, transfer amounts to fund the nonfederal share of the supplemental payment adjustment amounts arising



under subdivision (ah) of Section 14105.98 shall be increased as set forth in clause (ii).

(ii) The transfer amounts otherwise calculated to fund the supplemental payment adjustments referred to in clause (i) shall be increased on a pro rata basis by an amount equal to 28 percent of the amount to be transferred to the Health Care Deposit Fund for the 1999–2000 fiscal year, as referred to in paragraph (2) of subdivision (d).

(3) The department shall prepare preliminary analyses and calculations regarding potential transfer amounts, and potential transferor entities shall be notified by the department of estimated transfer amounts as soon as reasonably feasible regarding any particular transfer year. Written notices of transfer amounts shall be issued by the department as soon as possible with respect to each transfer year. All state agencies shall take all necessary steps in order to supply applicable data to the department to accomplish these tasks. The Office of Statewide Health Planning and Development shall provide to the department quarterly access to the edited and unedited confidential patient discharge data files for all Medi-Cal eligible patients. The department shall maintain the confidentiality of that data to the same extent as is required of the Office of Statewide Health Planning and Development. In addition, the Office of Statewide Health Planning and Development shall provide to the department, not later than March 1 of each year, the data specified by the department, as the data existed on the statewide data base file as of February 1 of each year, from all of the following:

(A) Hospital annual disclosure reports, filed with the Office of Statewide Health Planning and Development pursuant to Section 443.31 or 128735 of the Health and Safety Code, for hospital fiscal years that ended during the calendar year ending 13 months prior to the applicable February 1.

(B) Annual reports of hospitals, filed with the Office of Statewide Health Planning and Development pursuant to Section 439.2 or 127285 of the Health and Safety Code,



for the calendar year ending 13 months prior to the applicable February 1.

(C) Hospital patient discharge data reports, filed with the Office of Statewide Health Planning and Development pursuant to subdivision (g) of Section 443.31 or 128735 of the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

(D) Any other materials on file with the Office of Statewide Health Planning and Development.

(4) Transfer amounts calculated by the department may be increased or decreased by a percentage amount consistent with the Medi-Cal state plan.

(5) For the 1993–94 fiscal year, the transfer amount that would otherwise be required from the University of California shall be increased by fifteen million dollars (\$15,000,000).

(6) Notwithstanding any other provision of law, except for subparagraph (D) of paragraph (2), the total amount of transfers required from the transferor entities for any particular transfer year shall not exceed the sum of the following:

(A) The amount needed to fund the nonfederal share of all payment adjustment amounts applicable to the particular payment adjustment year as calculated under Section 14105.98. Included in the calculations for this purpose shall be any decreases in the program as a whole, and for individual hospitals, that arise due to the provisions of Section 1396r-4(f) or (g) of Title 42 of the United States Code.

(B) The amount needed to fund the transfers to the Health Care Deposit Fund, as referred to in subdivision (d).

(7) (A) Except as provided in subparagraphs (B) and (C) and in paragraph (2) of subdivision (j), and except for a prudent reserve not to exceed two million dollars (\$2,000,000) in the Medi-Cal Inpatient Payment Adjustment Fund, any amounts in the fund, including interest that accrues with respect to the amounts in the fund, that are not expended, or estimated to be required



for expenditure, under Section 14105.98 with respect to a particular transfer year shall be returned on a pro rata basis to the transferor entities for the particular transfer year within 120 days after the department determines that the funds are not needed for an expenditure in connection with the particular transfer year.

(B) The department shall determine the interest amounts that have accrued in the fund from its inception through June 30, 1995, and, no later than January 1, 1996, shall distribute these interest amounts to transferor entities:

(C) With respect to those particular amounts in the fund resulting solely from the provisions of subparagraph (D) of paragraph (2), the department shall determine by September 30, 1999, whether these particular amounts exceed 28 percent of the amount to be transferred to the Health Care Deposit Fund for the 1999–2000 fiscal year, as referred to in paragraph (2) of subdivision (d). Any excess amount so determined shall be returned to the particular transferor entities on a pro rata basis no later than October 31, 1999.

(D) Regarding any funds returned to a transferor entity under subparagraph (A) or (C), or interest amounts distributed to a transferor entity under subparagraph (B), the department shall provide to the transferor entity a written statement that explains the basis for the particular return or distribution of funds and contains the general calculations used by the department in determining the amount of the particular return or distribution of funds.

(i) (1) For the 1991–92 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in eight equal installments.

(2) (A) Except as provided in subparagraphs (B) and (C), for the 1992–93 transfer year and subsequent transfer years, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in eight equal installments. However, for the 1997–98 and subsequent transfer years, each transferor entity shall pay



its transfer amount or amounts to the Controller, for deposit in the fund, in the form of periodic installments according to a timetable established by the department. The timetable shall be structured to effectuate, on a reasonable basis, the prompt distribution of all nonsupplemental payment adjustments under Section 14105.98, and transfers to the Health Care Deposit Fund under subdivision (d).

(B) For the 1994–95 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in five equal installments.

(C) For the 1995–96 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in five equal installments.

(D) Except as otherwise specifically provided, subparagraphs (A) to (C), inclusive, shall not apply to increases in transfer amounts described in paragraph (2) of subdivision (h) or to additional transfer amounts described in subdivision (o).

(E) All requests for transfer payments, or adjustments thereto, issued by the department shall be in writing and shall include (i) an explanation of the basis for the particular transfer request or transfer activity, (ii) a summary description of program funding status for the particular transfer year, and (iii) the general calculations used by the department in connection with the particular transfer request or transfer activity.

(3) A transferor entity may use any of the following funds for purposes of meeting its transfer obligations under this section:

(A) General funds of the transferor entity.

(B) Any other funds permitted by law to be used for these purposes, except that a transferor entity shall not submit to the Controller any federal funds unless those federal funds are authorized by federal law to be used to match other federal funds. In addition, no private donated funds from any health care provider, or from any person or organization affiliated with the health care



provider, shall be channeled through a transferor entity or any other public entity to the fund, unless the donated funds will qualify under federal rules as a valid component of the nonfederal share of the Medi-Cal program and will be matched by federal funds. The transferor entity shall be responsible for determining that funds transferred meet the requirements of this subparagraph.

(j) (1) If a transferor entity does not submit any transfer amount within the time period specified in this section, the Controller shall offset immediately the amount owed against any funds which otherwise would be payable by the state to the transferor entity. The Controller, however, shall not impose an offset against any particular funds payable to the transferor entity where the offset would violate state or federal law.

(2) Where a withhold or a recoupment occurs pursuant to the provisions of paragraph (2) of subdivision (r) of Section 14105.98, the nonfederal portion of the amount in question shall remain in the fund, or shall be redeposited in the fund by the department, as applicable. The department shall then proceed as follows:

(A) If the withhold or recoupment was imposed with respect to a hospital whose licensee was a transferor entity for the particular state fiscal year to which the withhold or recoupment related, the nonfederal portion of the amount withheld or recouped shall serve as a credit for the particular transferor entity against an equal amount of transfer obligations under this section, to be applied whenever the transfer obligations next arise. Should no such transfer obligation arise within 180 days, the department shall return the funds in question to the particular transferor entity within 30 days thereafter.

(B) For other situations, the withheld or recouped nonfederal portion shall be subject to paragraph (7) of subdivision (h).

(k) All transfer amounts received by the Controller or amounts offset by the Controller shall immediately be deposited in the fund.



(l) For purposes of this section, the disproportionate share list utilized by the department for a particular transfer year shall be identical to the disproportionate share list utilized by the department for the same state fiscal year for purposes of Section 14105.98. Nothing on a disproportionate share list, once issued by the department, shall be modified for any reason other than mathematical or typographical errors or omissions on the part of the department or the Office of Statewide Health Planning and Development in preparation of the list.

(m) Neither the intergovernmental transfers required by this section, nor any elective transfer made pursuant to Section 14164, shall create, lead to, or expand the health care funding or service obligations for current or future years for any transferor entity, except as required of the state by this section or as may be required by federal law, in which case the state shall be held harmless by the transferor entities on a pro rata basis.

(n) Except as otherwise permitted by state and federal law, no transfer amount submitted to the Controller under this section, and no offset by the Controller pursuant to subdivision (j), shall be claimed or recognized as an allowable element of cost in Medi-Cal cost reports submitted to the department.

(o) Whenever additional transfer amounts are required to fund the nonfederal share of payment adjustment amounts under Section 14105.98 that are distributed after the close of the particular payment adjustment year to which the payment adjustment amounts apply, the additional transfer amounts shall be paid by the parties who were the transferor entities for the particular transfer year that was concurrent with the particular payment adjustment year. The additional transfer amounts shall be calculated under the formula that was in effect during the particular transfer year. For transfer years prior to the 1993–94 transfer year, the percentage of the additional transfer amounts available for transfer to the Health Care Deposit Fund under subdivision (d) shall be the percentage that was in effect during the particular transfer year. These additional



transfer amounts shall be paid by transferor entities within 20 days after the department notifies the transferor entity in writing of the additional transfer amount to be paid.

(p) (1) Ten million dollars (\$10,000,000) of the amount transferred from the Medi-Cal Inpatient Payment Adjustment Fund to the Health Care Deposit Fund due to amounts transferred attributable to years prior to the 1993–94 fiscal year is hereby appropriated without regard to fiscal years to the State Department of Health Services to be used to support the development of managed care programs under the department’s plan to expand Medi-Cal managed care.

(2) These funds shall be used by the department for both of the following purposes: (A) distributions to counties or other local entities that contract with the department to receive those funds to offset a portion of the costs of forming the local initiative entity, and (B) distributions to local initiative entities that contract with the department to receive those funds to offset a portion of the costs of developing the local initiative health delivery system in accordance with the department’s plan to expand Medi-Cal managed care.

(3) Entities contracting with the department for any portion of the ten million dollars (\$10,000,000) shall meet the objectives of the department’s plan to expand Medi-Cal managed care with regard to traditional and safety net providers.

(4) Entities contracting with the department for any portion of the ten million dollars (\$10,000,000) may be authorized under those contracts to utilize their funds to provide for reimbursement of the costs of local organizations and entities incurred in participating in the development and operation of a local initiative.

(5) To the full extent permitted by state and federal law, these funds shall be distributed by the department for expenditure at the local level in a manner that qualifies for federal financial participation under the medicaid program.



(q) (1) Any local initiative entity that has performed unanticipated additional work for the purposes identified in subparagraph (B) of paragraph (2) of subdivision (p) resulting in additional costs attributable to the development of its local initiative health delivery system, may file a claim for reimbursement with the department for the additional costs incurred due to delays in start dates through the 1996–97 fiscal year. The claim shall be filed by the local initiative entity not later than 90 days after the effective date of the act adding this subdivision, and shall not seek extra compensation for any sum that is or could have been asserted pursuant to the contract disputes and appeals resolution provisions of the local initiative entity’s respective two-plan model contract. All claims for unanticipated additional incurred costs shall be submitted with adequate supporting documentation including, but not limited to, all of the following:

(A) Invoices, receipts, job descriptions, payroll records, work plans, and other materials that identify the unanticipated additional claimed and incurred costs.

(B) Documents reflecting mitigation of costs.

(C) To the extent lost profits are included in the claim, documentation identifying those profits and the manner of calculation.

(D) Documents reflecting the anticipated start date, the actual start date, and reasons for the delay between the dates, if any.

(2) In determining any amount to be paid, the department shall do all of the following:

(A) Conduct a fiscal analysis of the local initiative entity’s claimed costs.

(B) Determine the appropriate amount of payment, after taking into consideration the supporting documentation and the results of any audit.

(C) Provide funding for any such payment, as approved by the Department of Finance through the deficiency process.

(D) Complete the determination required in subparagraph (B) within six months after receipt of a local initiative entity’s completed claim and supporting



documentation. Prior to final determination, there shall be a review and comment period for that local initiative entity.

(E) Make reasonable efforts to obtain federal financial participation. In the event federal financial participation is not allowed for this payment, the state's payment shall be 50 percent of the total amount determined to be payable.

SEC. 68. Section 16809 of the Welfare and Institutions Code, as amended by Section 1 of Chapter 669 of the Statutes of 1998, is amended to read:

16809. (a) (1) The board of supervisors of a county which contracted with the department pursuant to Section 16709 during the 1990–91 fiscal year and any county with a population under 300,000, as determined in accordance with the 1990 decennial census, by adopting a resolution to that effect, may elect to participate in the County Medical Services Program. The County Medical Services Program shall have responsibilities for specified health services to county residents certified eligible for those services by the county.

(2) If the County Medical Services Program Governing Board contracts with the department to administer the County Medical Services Program, that contract shall include, but need not be limited to, all of the following:

(A) Provisions for the payment to participating counties for making eligibility determinations based on the formula used by the County Medical Services Program for the 1993–94 fiscal year.

(B) Provisions for payment of expenses of the County Medical Services Program Governing Board.

(C) Provisions relating to the flow of funds from counties' vehicle license fees, sales taxes, and participation fees and the procedures to be followed if a county does not pay those funds to the program.

(D) Those provisions, as applicable, contained in the 1993–94 fiscal year contract with counties under the County Medical Services Program.



(3) The contract between the department and the County Medical Services Program Governing Board shall require that the state maintain at least the level of administrative support provided to the County Medical Services Program for the 1993–94 fiscal year. The department may decline to implement decisions made by the governing board that would require a greater level of administrative support than that for the 1993–94 fiscal year. The department may implement decisions upon compensation by the governing board to cover that increased level of support.

(4) The department shall administer the County Medical Services Program pursuant to the provisions of the 1993–94 fiscal year contract with the counties and regulations relating to the administration of the program until the County Medical Services Program Governing Board executes a contract for the administration of the County Medical Services Program and adopts regulations for that purpose.

(5) The department shall not be liable for any costs related to decisions of the County Medical Services Program Governing Board that are in excess of those set forth in the contract between the department and the County Medical Services Program Governing Board.

(b) Each county intending to participate in the County Medical Services Program pursuant to this section shall submit to the Governing Board of the County Medical Services Program a notice of intent to contract adopted by the board of supervisors no later than April 1 of the fiscal year preceding the fiscal year in which the county will participate in the County Medical Services Program.

(c) A county participating in the County Medical Services Program pursuant to this section shall not be relieved of its indigent health care obligation under Section 17000.

(d) (1) The County Medical Services Program Account is established in the County Health Services Fund. The following amounts may be deposited in the account:



(A) Any interest earned upon money deposited in the account.

(B) Moneys provided by participating counties or appropriated by the Legislature to the account.

(C) Moneys loaned pursuant to subdivision (q).

(2) The methods and procedures used to deposit funds into the account shall be consistent with the methods used by the program during the 1993–94 fiscal year.

(e) Moneys in the program account shall be used by the department, pursuant to its contract with the County Medical Services Program Governing Board, to pay for health care services provided to the persons meeting the eligibility criteria established pursuant to subdivision (j) and to pay for the expense of the governing board as set forth in the contract between the board and the department.

(f) (1) Moneys in this account shall be administered on an accrual basis and notwithstanding any other provision of law, except as provided in this section, shall not be transferred to any other fund or account in the State Treasury except for purposes of investment as provided in Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code.

(2) (A) All interest or other increment resulting from the investment shall be deposited in the program account, at the end of the 1982–83 fiscal year and every six months thereafter, notwithstanding Section 16305.7 of the Government Code.

(B) All interest deposited pursuant to subparagraph (A) shall be available to reimburse program-covered services, County Medical Services Program Governing Board expenses, or for expenditures to augment the program's rates, benefits, or eligibility criteria pursuant to subdivision (j).

(g) A separate County Medical Services Program Reserve Account is established in the County Health Services Fund. Six months after the end of each fiscal year, any projected savings in the program account shall be transferred to the reserve account, with final



settlement occurring no more than 12 months later. Moneys in this account shall be utilized when expenditures for health services made pursuant to subdivision (j) for a fiscal year exceed the amount of funds available in the program account for that fiscal year. When funds in the reserve account are estimated to exceed 10 percent of the budget for health services for all counties electing to participate in the County Medical Services Program under this section for the fiscal year, the additional funds shall be available for expenditure to augment the rates, benefits, or eligibility criteria pursuant to subdivision (j) or for reducing the participation fees as determined by the County Medical Services Program Governing Board pursuant to subdivision (i). Nothing in this section shall preclude the CMSP Governing Board from establishing other reserves.

(h) Moneys in the program account and the reserve account, except for moneys provided by the state in excess of the amount required to fund the state risk specified in subdivision (j), and any funds loaned pursuant to subdivision (p) shall not be transferred to any other fund or account in the State Treasury except for purposes of investment as provided in Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code. All interest or other increment resulting from investment shall be deposited in the program account, notwithstanding Section 16705.7 of the Government Code.

(i) (1) Counties shall pay participation fees as established by the County Medical Services Program Governing Board and their jurisdictional risk amount in a method that is consistent with that established in the 1993–94 fiscal year.

(2) A county may request, due to financial hardship, the payments under paragraph (1) be delayed. The request shall be subject to approval by the CMSP Governing Board.

(3) Payments made pursuant to this subdivision shall be deposited in the program account.



(4) Payments may be made as part of the deposits authorized by the county pursuant to Sections 17603.05 and 17604.05.

(j) (1) (A) For the 1991–92 fiscal year and all preceding fiscal years, the state shall be at risk for any costs in excess of the amounts deposited in the reserve fund.

(B) (i) Beginning in the 1992–93 fiscal year and for each fiscal year thereafter, counties and the state shall share the risk for cost increases of the County Medical Services Program not funded through other sources. The state shall be at risk for any cost that exceeds the cumulative annual growth in dedicated sales tax and vehicle license fee revenue, up to the amount of twenty million two hundred thirty-seven thousand four hundred sixty dollars (\$20,237,460) per fiscal year, except for the 1999–2000 fiscal year. Counties shall be at risk up to the cumulative annual growth in the Local Revenue Fund created by Section 17600, according to the table specified in paragraph (2), to the County Medical Services Program, plus the additional cost increases in excess of twenty million two hundred thirty-seven thousand four hundred sixty dollars (\$20,237,460) per fiscal year, except for the 1999–2000 fiscal year. In the 1994–95 fiscal year, the amount of the state risk shall be twenty million two hundred thirty-seven thousand four hundred sixty dollars (\$20,237,460) per fiscal year, in addition to the cost of administrative support pursuant to paragraph (3) of subdivision (a).

(ii) For the 1999–2000 fiscal year, the state shall not be at risk for any cost that exceeds the cumulative annual growth in dedicated sales tax and vehicle license fee revenue. Counties shall be at risk up to the cumulative annual growth in the Local Revenue Fund created by Section 17600, according to the table specified in paragraph (2), to the County Medical Services Program, plus any additional cost increases for the 1999–2000 fiscal year.

(C) The CMSP Governing Board, after consultation with the department, shall establish uniform eligibility



criteria and benefits for the County Medical Services Program.

(2) For the 1991–92 fiscal year, jurisdictional risk limitations shall be as follows:

Jurisdiction	Amount
Alpine	\$ 13,150
Amador	620,264
Butte	5,950,593
Calaveras	913,959
Colusa	799,988
Del Norte	781,358
El Dorado	3,535,288
Glenn	787,933
Humboldt	6,883,182
Imperial	6,394,422
Inyo	1,100,257
Kings	2,832,833
Lassen	687,113
Madera	2,882,147
Marin	7,725,909
Mariposa	435,062
Modoc	469,034
Mono	369,309
Napa	3,062,967
Nevada	1,860,793
Plumas	905,192
San Benito	1,086,011
Shasta	5,361,013
Sierra	135,888
Siskiyou	1,372,034
Solano	6,871,127
Sonoma	13,183,359
Sutter	2,996,118
Tehama	1,912,299
Trinity	611,497
Tuolumne	1,455,320
Yuba	2,395,580



(3) Beginning in the 1991–92 fiscal year and in subsequent fiscal years, the jurisdictional risk limitation for the counties that did not contract with the department pursuant to Section 16709 during the 1990–91 fiscal year shall be the amount specified in paragraph (A) plus the amount determined pursuant to paragraph (B), minus the amount specified by the County Medical Services Program Governing Board as participation fees.

(A)

Jurisdiction	Amount
Lake	\$1,022,963
Mendocino	1,654,999
Merced	2,033,729
Placer	1,338,330
San Luis Obispo	2,000,491
Santa Cruz	3,037,783
Yolo	1,475,620

(B) The amount of funds necessary to fully fund the anticipated costs for the county shall be determined by the CMSP Governing Board before a county is permitted to participate in the County Medical Services Program.

(4) For the 1994–95 and 1995–96 fiscal years, the specific amounts and method of apportioning risk to each participating county may be adjusted by the CMSP Governing Board.

(k) The Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Contracts under this section shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code. Contracts of the department pursuant to this section shall have no force or effect unless they are approved by the Department of Finance.

(l) The state shall not incur any liability except as specified in this section.

(m) Third-party recoveries for services provided under this section pursuant to Article 3.5 (commencing



with Section 14124.70) of Chapter 7 of Part 3 may be pursued.

(n) Under the program provided for in this section, the department may reimburse hospitals for inpatient services at the rates negotiated for the Medi-Cal program by the California Medical Assistance Commission, pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3, if the California Medical Assistance Commission determines that reimbursement to the hospital at the contracted rate will not have a detrimental fiscal impact on either the Medi-Cal program or the program provided for in this section. In negotiating and renegotiating contracts with hospitals, the commission may seek terms which allow reimbursement for patients receiving services under this section at contracted Medi-Cal rates.

(o) Any hospital which has a contract with the state for inpatient services under the Medi-Cal program and which has been approved by the commission to be reimbursed for patients receiving services under this section shall not deny services to these patients.

(p) Participating counties may conduct an independent program review to identify ways through which program savings may be generated. The counties and the department may collectively pursue identified options for the realization of program savings.

(q) The Department of Finance may authorize a loan of up to thirty million dollars (\$30,000,000) for deposit into the program account to ensure that there are sufficient funds available to reimburse providers and counties pursuant to this section.

(r) Regulations adopted by the department pursuant to this section shall remain operative and shall be used to operate the County Medical Services Program until a contract with the County Medical Services Program Governing Board is executed and regulations, as appropriate, are adopted by the County Medical Services Program Governing Board. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, those regulations



adopted under the County Medical Services Program shall become inoperative until January 1, 1998, except those regulations that the department, in consultation with the County Medical Services Program Governing Board, determines are needed to continue to administer the County Medical Services Program. The department shall notify the Office of Administrative Law as to those regulations the department will continue to use in the implementation of the County Medical Services Program.

(s) Moneys appropriated from the General Fund to meet the state risk as set forth in subparagraph (B) of paragraph (1) of subdivision (j) shall not be available for those counties electing to disenroll from the County Medical Services Program.

(t) This section shall remain in effect only until January 1, 2003, and as of that date is repealed, unless a later enacted statute, that is enacted on or before January 1, 2003, deletes or extends that date.

SEC. 69. Section 18993.9 of the Welfare and Institutions Code is amended to read:

18993.9. (a) This chapter shall remain operative until July 1, 2000, and shall remain in effect only until January 1, 2001, and as of that date is repealed, unless a later enacted statute, which is effective on or before January 1, 2001, deletes or extends that date.

(b) Commencing July 1, 1999, this chapter shall only be implemented if the department receives federal financial participation for its implementation pursuant to a federal waiver for family planning services provided under the State-Only Family Planning Program (Division 24 (commencing with Section 24000)).

SEC. 70. Section 24001 of the Welfare and Institutions Code is amended to read:

24001. (a) (1) For purposes of this division, “family planning” means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility,



including contraceptive methods, natural family planning, abstinence methods and basic, limited fertility management. Family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Family planning shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, not including contraceptives, or pregnancy care that is not incident to the diagnosis of pregnancy.

(2) Family planning services for males shall be expanded to include laboratory tests for sexually transmitted infections and comprehensive physical examinations. Within 60 days of approval of the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program, provided for pursuant to subdivision (aa) of Section 14132, the department shall seek to amend the waiver to add this expansion. The implementation of this paragraph shall be dependent upon federal approval and receipt of federal financial participation.

(b) For purposes of this division, “department” means the State Department of Health Services.

SEC. 71. Section 24003.2 is added to the Welfare and Institutions Code, to read:

24003.2. The basic preventive health services covered under this program shall include measles, mumps, and rubella vaccines for women of reproductive age. Within 60 days of approval of the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program, provided for pursuant to subdivision (aa) of Section 14132, the department shall seek to amend the waiver to add this expansion. The implementation of this section shall be dependent upon federal approval and receipt of federal financial participation.



SEC. 72. Section 24003.5 is added to the Welfare and Institutions Code, to read:

24003.5. Any male or female of reproductive age who is not at risk for pregnancy and is eligible for the program shall have available the scope of benefits provided by the program. Within 60 days of approval of the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program, provided for pursuant to subdivision (aa) of Section 14132, the department shall seek to amend the waiver to add this expansion. The implementation of this section shall be dependent upon federal approval and receipt of federal financial participation.

SEC. 73. Section 24005 of the Welfare and Institutions Code is amended to read:

24005. (a) 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.

(b) The following requirements shall apply to the Family Planning Access Care and Treatment Waiver program identified in subdivision (aa) of Section 14132 and this program:

(1) 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.

(2) 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. All state and federal statutes and regulations pertaining to the audit or examination of Medi-Cal providers shall apply to this program.



(3) 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.

(c) The department may complete a background check on clinical provider applicants for the purpose of verifying the accuracy of information provided in the application 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 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.

(d) The department shall not enroll any applicant that has been convicted of any felony or misdemeanor involving fraud or abuse in any government program, that has been found guilty of fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse, within the previous five years. In addition, the department may deny enrollment to any applicant that, at the time of application, is under investigation. 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 for fraud or abuse, that provider shall be subject to immediate disenrollment from the program.

(e) 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.

(f) Subject to Article 4 (commencing with Section 19130) of Chapter 5 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.

(g) 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.

(h) Upon receipt of reliable evidence of fraud or willful misrepresentation by a provider under the program, the department may:

(1) Collect any State-Only Family Planning program or Family Planning Access Care and Treatment Waiver 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 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 Waiver 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 there is insufficient evidence of fraud or willful misrepresentation 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 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.

(i) 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 Medicare program, the Medi-Cal program, including the Family Planning Access Care and Treatment Waiver 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, employees, or agents thereof, 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.

SEC. 74. Section 24007.5 is added to the Welfare and Institutions Code, to read:

24007.5. The program formulary shall include all federal Food and Drug Administration approved contraceptive drugs, devices, and supplies that are authorized by the Medi-Cal program.



SEC. 75. Section 24027 of the Welfare and Institutions Code is repealed.

SEC. 76. Section 24027 is added to the Welfare and Institutions Code, to read:

24027. The State-Only Family Planning Program established under this division is hereby reenacted and continued in existence in order to continue to provide comprehensive, clinical family planning services to those persons who are not eligible to receive these services under the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program established pursuant to subdivision (aa) of Section 14132, and to those persons who are not eligible to receive family planning services pursuant to subdivision (n) of Section 14132 without a share of cost.

SEC. 77. (a) Notwithstanding any other provision of law, funds appropriated pursuant to the Budget Act of 1999 for the tobacco use competitive grants program set forth in Section 104385 of the Health and Safety Code and the tobacco prevention media campaign set forth in subdivision (e) of Section 104375 of the Health and Safety Code shall be available for expenditure without regard to fiscal years until July 1, 2002.

(b) Notwithstanding any other provision of law, funds appropriated pursuant to the Budget Act of 1999 for the evaluation of the State Department of Education's tobacco use prevention education program pursuant to subdivisions (b) and (c) of Section 104375 of the Health and Safety Code, for the State Department of Education's allocation of funds for school-based tobacco use prevention pursuant to Sections 104425 and 104430 of the Health and Safety Code, and for the tobacco use prevention program set forth in Sections 104400 and 104440 of the Health and Safety Code, shall be available for expenditure without regard to fiscal year until July 1, 2002.

SEC. 78. The State Department of Health Services may adopt emergency regulations to implement the applicable provisions of this act in accordance with the Administrative Procedure Act (Chapter 3.5



(commencing with Section 11340) of Part 1 of Division 1 of Title 2 of the Government Code). The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations, and shall remain in effect for no more than 180 days.

SEC. 79. There is hereby appropriated the sum of five million dollars (\$5,000,000) from the General Fund to the State Department of Health Services, in augmentation of Item 4260-111-0001 of the Budget Act of 1999, for purposes of the Partnership for Responsible Parenting Program.

SEC. 80. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains 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. If the statewide cost of the claim for reimbursement does not exceed one million dollars (\$1,000,000), reimbursement shall be made from the State Mandates Claims Fund.

SEC. 81. 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 provide for the administration of this act relating to health care for the entire 1999–2000 fiscal year, it is necessary that this act go into immediate effect.



Approved _____, 1999

Governor

