Assembly Bill No. 2877

CHAPTER 93

An act to add Section 49557.1 to, and to add Chapter 2.5 (commencing with Section 59150) to Part 32 of, the Education Code, to amend Section 14672.9 of, to add Section 13969.5 to, the Government Code, to amend Sections 1341.4, 1356, 1395, 1417.2, 1797.112, 101230, 104161, 104162, 104163, 104775, 104795, 124010, 124011, 124012, 124013, 124014, 124015, and 124900 of, to add Sections 1276.6, 1417.4, 1421.1, and 125285 to, to add and repeal Section 1421.2 of, to repeal Section 104164 of, to repeal and add Section 104160 of, to add Article 1.7 (commencing with Section 104170) to Chapter 2 of Part 1 of Division 103 of, to add Chapter 6.5 (commencing with Section 104316) and Chapter 7 (commencing with Section 104320) to Part 1 of Division 103 of, to add and repeal Division 109 (commencing with Section 130200) to, the Health and Safety Code, to amend Section 12693.76 of, to add Section 12693.326 to, and to add and repeal Section 12693.325 of, the Insurance Code, and to amend Sections 4689.7, 4791, 5675, 14005.30, 14011.15, 14021.4, 14053, 14053.1, 14085.7, 14085.8, 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, 14115, 14132.22, 14132.72, 14163, 14409, and 16809 of, to amend and renumber Section 14105.42 of, to add Sections 4094.1, 4094.2, 4107.1, 4598.5, 4639.5, 5600.8, 5614, 5614.5, 5618, 5675.1, 5676, 5676.5, 14005.28, 14005.40, 14067.5, 14085.81, 14105.17, 14132.05, 14132.88, 14132.91, 14133.05, and 14408.5 to, to add Article 2.5 (commencing with Section 5689) to Chapter 2.5 of Part 2 of Division 5 of, to add Chapter 5 (commencing with Section 4097) and Chapter 6 (commencing with Section 4098) to Part 1 of Division 4 of, to add Part 3.5 (commencing with Section 5830) to Division 5 of, and to add and repeal Chapter 4 (commencing with Section 4096.7) to Part 1 of Division 4 of, the Welfare and Institutions Code, relating to health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor July 6, 2000. Filed with Secretary of State July 7, 2000.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2877, Thomson. Public health programs: Budget Act implementation.

Existing law requires the governing board of a school district and the county superintendent of schools to make applications for free or reduced-price meals available to students at all times during the schoolday.

This bill would encourage school districts and county superintendents of schools, in making available these applications, to include information that parents may use to request information about the Medi-Cal program and the Healthy Families Program.

Existing law establishes two special schools for the deaf, and one special school for the blind.

This bill would require students attending these schools to be tested at least once every two years for tuberculosis, with the cost, if any, to be borne by the parent or guardian of the student.

Existing law provides for the indemnification of victims of specified types of crimes for specified types of expenses. Indemnification is made under these provisions from the Restitution Fund, which is continuously appropriated to the State Board of Control for these purposes.

This bill would declare the intent of the Legislature that funds be appropriated from the fund in the annual Budget Act to the State Department of Mental Health, according to a specified procedure, for specified types of programs and activities operated by the department, with respect to the needs of crime victims with disabilities.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Care and provides for the administration of the department to be supported from the Managed Care Fund. Existing law requires health care service plans each fiscal year to pay an assessment pursuant to a statutory schedule to the director of the Department of Managed Care to provide the department with sufficient revenues to support costs and expenses of the department. Existing law requires the director in determining the amount of the annual assessment to consider specified appropriations and reimbursements. Existing law permits the director to impose an additional assessment to provide the department with sufficient revenues to support costs and expenses, as specified, for the 2000–01 fiscal year.

This bill would limit the reserve in the Managed Care Fund in any fiscal year to a prudent 5% reserve unless otherwise determined by the Department of Finance. The bill would permit the Director of the Department of Managed Care to require health care service plans also to pay an additional assessment for the 2000–01, 2001–02, and 2002–03 fiscal years to provide the department with sufficient revenues to support costs and expenses, as specified, including maintaining a prudent reserve. The bill would permit the director on or after July 1, 2003, to adjust the amount of the annual assessment to incorporate annual expenditure levels.

Existing law permits health care service plans to advertise subject to specified conditions and limitations. Willful violation of health care service plan provisions is a crime.

Under existing law, one of the methods for procuring services under the Medi-Cal program is through contracts with prepaid health plans.

Existing law permits marketing activities by prepaid health plans to persuade Medi-Cal beneficiaries to enroll or accept an application in the prepaid health plan.

Existing law prohibits a prepaid health plan, marketing representative, or marketing organization from misrepresenting itself, the plans it represents, or the Medi-Cal program, and provides sanctions, including making it a misdemeanor for any marketing representative who misrepresents while engaged in door-to-door solicitation.

The Healthy Families Program prohibits a participating health, dental, or vision plan from directly, indirectly, or through their agents conducting in-person, door-to-door, mail, or phone solicitation of applicants for enrollment, except through employers with employees eligible to participate in the purchasing credit mechanism. The program does permit information approved by the Managed Risk Medical Insurance Board on the providers and plans available to prospective subscribers in their geographic areas to be distributed through any door-to-door activities for potentially eligible applicants and their children.

This bill would permit a participating health plan in the Healthy Families Program to provide application assistance directly to an applicant. The bill would subject any health care service plan representative, or representative of a subcontractor of the health care service plan who violates these provisions to a fine of $500 for each violation, thus creating a new crime and thereby imposing a state-mandated local program. The bill would permit participating health plans to solicit enrollment in or advertise the Healthy Families Program pursuant to applicable provisions of the Knox-Keene Health Care Service Plan Act of 1975 relating to the cost of subscription or enrollment, facilities and services rendered, thus broadening the act's coverage and thus changing the definition of a crime. Because it would change the definition of a crime, this bill would impose a state-mandated local program.

The bill would permit a subscriber in the Healthy Families Program to switch his or her choice of health plan for any reason once within the first 3 months of coverage.

The bill would permit prepaid health plans contracting with the Medi-Cal program or the Healthy Families Program to provide application assistance, as specified, during the Medi-Cal eligibility redetermination process in order to allow persons to retain health care coverage.

Existing law establishes the minimum number of nursing hours per patient day in skilled nursing and intermediate care facilities at 3.2 hours.

This bill would require each skilled nursing and intermediate care facility to certify, under penalty of perjury and to the best of their knowledge, on a form provided by the State Department of Health Services, that funds received pursuant to increasing the staffing ratio to 3.2 hours were expended for this purpose.

Under existing law, moneys collected as a result of civil penalties imposed against long-term health care facilities shall be deposited into the Health Facilities Citation Penalties Account in the Special Deposit Fund. The moneys in this account, upon appropriation by the Legislature, are used for the protection of health or property of residents of long-term health care facilities.

Under existing law, the balance in this account shall not exceed $1,000,000.

This bill would, instead, provide that the balance in this account is prohibited from exceeding $10,000,000.

The bill would also establish, under the administration of the State Department of Health Services, a quality awards program for nursing homes, under which monetary awards paid from federal funds and General Fund appropriations would be used for staff bonuses. This bill would also establish the Skilled Nursing Facility Financial Solvency Advisory Board in order to advise the Director of Health Services on matters of financial solvency affecting the delivery of services in skilled nursing facilities, including financial solvency licensing requirements.

The bill would require a skilled nursing facility to report to the department certain actions or events related to the financial and other resources of the facility, within 24 hours of their occurrence.

Existing law establishes the Emergency Medical Services Personnel Fund, the moneys in which, upon appropriation by the Legislature, are usable for the emergency medical services testing and personnel licensure program and for the purpose of making reimbursements to entities for the performance of functions for which fees are collected.

Existing law requires that the Emergency Medical Services Authority maintain a reserve balance in this fund equal to at least 3 months of the annual authorized expenditures for the personnel licensure program.

This bill would, instead, require this reserve to be 5%.

Existing law sets forth procedures under which a local health jurisdiction, as defined, may qualify for state financial assistance. Under these provisions, allocations, including a basic allotment, are made to administrative bodies of qualifying local jurisdictions in a specified manner.

This bill would change the formula used to make these basic allotments.

Existing law, which would be repealed on July 1, 2000, establishes the Breast Cancer Treatment Program, administered by the State

Department of Health Services. Under this program the department is required to award a contract for these services on a bid basis to an entity meeting specified requirements.

This bill would indefinitely extend the duration of this program. It would, however, permit the department to award one or more contracts to public or private nonprofit organizations, and would exempt these contracts from various state agency contract requirements.

The bill would also eliminate a requirement that funds appropriated for the purposes of this program be used to match other available funds, and would expand the services to be covered by the program.

Existing law establishes the Prostate Cancer Screening Program, administered by the department, in order to provide qualified uninsured men with prostate cancer screening services.

This bill would establish the Prostate Cancer Treatment Program, administered by the department, under which one or more contracts would be entered into in order to provide prostate cancer treatment services to low-income uninsured and underinsured men.

Existing law permits the State Department of Health Services to award grants to postsecondary higher educational institutions with a medical center for the establishment of diagnostic and treatment centers for Alzheimer's disease.

This bill would permit the department to provide, or contract for the provision of, public and professional education on Alzheimer's disease.

The bill would also provide that the balance of funds appropriated in the Budget Act of 2000 for Alzheimer's disease would be available for encumbrance and expenditure until June 30, 2003, thus constituting an appropriation.

This bill would require the State Department of Health Services to take specified actions relating to the establishment of a comprehensive state assessment, intervention, and evaluation program for the control of asthma, and would specify the components of that program.

This bill would establish the Human Leukocyte Antigen Testing Fund, to be administered by the State Department of Health Services, the moneys in which, upon appropriation by the Legislature, would be allocated to blood centers to pay the costs of blood collection and human leukocyte antigen typing for use in bone marrow transplantation.

Existing law authorizes the offering by a local sponsor, as defined, of a community dental disease prevention program for children in preschool through sixth grade and for children with special needs. Program services include preventive services, as defined.

This bill would include dental sealants within the meaning of preventive services.

Existing law authorizes the State Department of Health Services to reimburse local sponsors in the amount of $4.50 for each participating student per year.

This bill would, commencing July 1, 2001, increase this amount to $10 for each student per year.

The bill would also require that funds appropriated in the Budget Act of 2000 for improving the dental infrastructure of nonprofit, community-based clinics, shall be available for expenditure through June 30, 2002.

This bill would also require the State Department of Health Services to award a contract to establish a Parkinson's Disease Community Outreach, Diagnosis, and Treatment Center.

Existing law provides for the implementation of the Assistance to Children at Home Demonstration Project in order to assist medically fragile children, and requires the State Department of Health Services to award funding to a children's hospital meeting certain requirements, and requires the hospital to submit a report to the department that evaluates the project.

This bill would authorize the department to implement an unspecified number of demonstration projects, would expand the program to include medically fragile infants and adolescents, would revise the class of hospitals that may be funded under the program, would authorize the extension of the period of the existing projects, would extend the period for which a demonstration project may be operated, would revise the schedule of modes of providing services under the demonstration projects, would impose specified requirements on demonstration projects, and would revise the outcome measures to be used for the evaluation of the projects.

Existing law requires the State Department of Health Services to select primary care clinics to be reimbursed for delivery of primary care services to low-income persons. Rates for outpatient visits under this program are required to be not less than $65.

This bill would increase the minimum rate for an outpatient visit to $71.50.

Under existing law, community treatment facilities, which are residential facilities licensed by the State Department of Social Services and whose programs are certified by the State Department of Mental Health, provide mental health services to children.

This bill would require these departments to jointly develop protocols for the oversight of community treatment facilities. It would also require, for the 2000–01 fiscal year, that these departments undertake specified actions with respect to training and education of facility management and staff, facility inspections, and reporting requirements.

The bill would also provide for community treatment facility funding requirements, including the establishment of a system of supplemental reimbursement to community treatment facilities.

The bill would authorize both departments to adopt emergency regulations to implement these community treatment facility provisions.

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

Existing law requires the State Department of Developmental Services to make payments to providers of supported living services for adults with developmental disabilities. Under existing law, the department, by January 1, 2000, is required to establish, by regulation, an equitable and cost-effective methodology for the determination of supported living costs and a methodology of payment for these providers.

This bill would change this date to July 1, 2002.

Existing law, until July 1, 2000, requires that, in order to ensure services to eligible consumers of regional center services throughout the fiscal year, regional centers shall administer their contracts within the level of funding available within the annual Budget Act.

This bill would indefinitely extend this provision and other related provisions.

The bill would also require each regional center, by December 1 of each year, to provide to the State Department of Developmental Services a complete current salary schedule for all personnel classifications used by the regional center, as well as information on all prior year expenditures for all administrative services. Information provided to the department under this provision would be made available by the department to the public, upon request.

The bill would also require the department to establish a workgroup, composed as specified, to assist the department in examining options to meet the future needs of individuals currently served, or who will need services similar to those provided, in state developmental centers.

Existing law establishes the Developmental Disabilities Services Account, the moneys in which are derived from the lease of certain lands, including subleases thereof, by the Department of General Services for purposes of construction of a business development park. Moneys in this account are, upon appropriation by the Legislature, available for the benefit of persons with developmental disabilities.

This bill would require that moneys in this account be expended by the State Department of Developmental Services for projects that expand the availability of affordable housing for persons with developmental disabilities.

Existing law establishes the Organization of Area Boards on Developmental Disabilities for the purpose of engaging in activities to solve common problems, improve coordination, exchange information between areas, and provide advice and

recommendations to state agencies, the Legislature, and the State Council on Developmental Disabilities.

This bill would provide that if federal funds are not available for appropriation or transfer pursuant to the Budget Act of 2000, for purposes of the Organization of Area Boards on Developmental Disabilities based on a determination by the Department of Finance, the Department of Finance shall notify the appropriate fiscal and policy committees of the Legislature and the Joint Legislative Budget Committee of this determination within 10 calendar days. It would provide that this notification shall specify the dollar amount needed to fully continue operations of the Organization of Area Boards, and this amount would thereby be appropriated from the General Fund commencing 10 days after the receipt of the notification by the Legislature.

Existing law vests jurisdiction over Patton State Hospital with the State Department of Mental Health.

Existing law provides, however, that the security of certain patients in Patton State Hospital is the responsibility of the Department of Corrections.

This bill would require that, consistent with the existing authority of the State Department of Mental Health to maintain state hospitals under its jurisdiction, the State Department of Mental Health provide internal security for the patient population at Patton State Hospital, however, this provision would not be intended to affect the duties of the Department of Corrections with respect to patients at Patton State Hospital.

Existing law, the Bronzan-McCorquodale Act, requires the State Department of Mental Health to contract with counties for the provision of community mental health services.

This bill would require the department, in consultation with specified entities, to establish protocols for ensuring that local mental health departments meet statutory and regulatory requirements for the provision of mental health services and that quality indicators are established to measure the quality of care being provided.

The bill would make local mental health departments responsible for providing information to potential clients, family members, and caregivers regarding specialty mental health services offered by the local mental health department upon request of the individual.

The bill would also impose requirements upon counties which apply for funds to enhance their mental health service system.

The bill would establish, under the administration of the State Department of Mental Health, the Early Intervention Mental Health Program, to provide services to infants and toddlers and their families.

This bill would also permit the department to undertake various suicide prevention programs.

This bill would require the State Department of Mental Health to conduct a 3-year pilot project, under which local grantees would be selected to provide services to persons from culturally diverse populations who are dually diagnosed with both mental illness and substance abuse problems.

Existing law, which would be repealed on January 1, 2001, permits Placer County and up to 6 other counties to establish a pilot project to develop a shared mental health rehabilitation center for the provision of community care and treatment for persons with mental disorders who are placed in a state hospital or another health facility because no community placements are available to meet the needs of these patients.

This bill would extend the duration of this authority until July 1, 2001, and would increase to 15 the number of other counties that would be permitted to participate in the program.

This bill would require the State Department of Mental Health to establish and administer pilot projects, in accordance with prescribed criteria, to provide respite for eligible caregivers of seriously emotionally disturbed children and seriously mentally ill adults who reside in a caregiver's home, and would require that these projects be operated by a specified county and other counties submitting approved proposals. It would also permit the department to evaluate the pilot projects and to submit a report to the Legislature by March 30, 2001. By imposing the requirement on that specified county to operate a pilot project, this bill would create a state-mandated local program.

Under existing law, the Director of Mental Health is authorized to monitor and approve special treatment programs for persons with mental disorders in skilled nursing facilities.

This bill would require the State Department of Mental Health, in conjunction with the State Department of Health Services, to develop a state-level plan for a streamlined and consolidated evaluation and monitoring program for the review of mental health rehabilitation centers and special treatment programs in skilled nursing facilities.

The bill would also require the State Department of Mental Health to establish and administer an Older Adults System of Care Demonstration Project, under which grants would be made to selected counties to develop model systems of care to serve a target population of mentally ill adults.

The bill would also permit the State Department of Mental Health to impose sanctions against long-term care facilities licensed or certified by the department.

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

This bill would require the department, if, and to the extent that, all necessary federal approvals are obtained for federal financial participation, to implement a federal option to extend Medi-Cal benefits to independent foster care adolescents, as defined in federal law.

Existing law requires the provision of benefits under the Medi-Cal program to certain families with dependent children, and requires the department to adopt a procedure to disregard certain income in determining the eligibility of those persons for Medi-Cal benefits.

This bill would specify that increases in federal social security benefits provided under the Old Age, Survivors, and Disability Insurance program arising from cost-of-living adjustments shall be disregarded during certain time periods.

This bill would require the department to implement a federal option to reduce certain Medi-Cal income and resource eligibility requirements for aged, blind, and disabled persons.

Because each county is responsible for making eligibility determinations under the Medi-Cal program and because this bill would change eligibility requirements, the bill would constitute a state-mandated local program.

Under existing law, specified categories of Medi-Cal recipients are required to file annual reaffirmations of eligibility and at other times as required by the department. Pursuant to this authority the department requires the filing of quarterly status reports.

This bill would, commencing January 1, 2001, require the department to eliminate the requirement for the filing of quarterly status reports.

Because each county is responsible for making eligibility determinations under the Medi-Cal program and because this bill would change eligibility requirements, the bill would constitute a state-mandated local program.

Existing law provides that, until July 1, 2000, ancillary outpatient services shall be covered under the Medi-Cal program for a patient of an institute of mental disease who is at least 21 years of age, but who has not obtained the age of 65 years.

This bill would extend this date to July 1, 2001.

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 provides that this provision shall become inoperative June 30, 2000, and repealed January 1, 2001.

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. It would also specify that the Valley Medical Center, Fresno, is a major nonuniversity teaching hospital for purposes of these provisions.

Existing law permits certain hospitals to receive supplemental payments under the Medi-Cal program for inpatient hospital services.

This bill would make critical care hospitals eligible for supplemental payments under the Medi-Cal program.

Under existing law, effective until January 1, 2001, certain telemedicine services are reimbursable under the Medi-Cal program.

This bill would indefinitely extend these provisions.

Existing law, until January 1, 2001, authorizes the department to enter into contracts with manufacturers of single-source and multiple-source drugs under the Medi-Cal program, and specifies procedures for implementation of that authority, thus authorizing the use of a Medi-Cal contract drug list for the procurement of prescription drugs under that program. On January 1, 2001, the provision of prescription drugs under the Medi-Cal program would be governed by existing provisions relating to the use of a Medi-Cal drug formulary.

This bill would extend these Medi-Cal contract drug list provisions until January 1, 2003.

Under existing law, skilled nursing and intermediate care facility services are covered under the Medi-Cal program.

This bill would, for the 2000–01 fiscal year, and subject to an appropriation in the Budget Act for this purpose, require the department to allocate funds to skilled nursing and certain intermediate care facilities for salary, wage, and benefit increases for direct care staff, as defined.

Existing law provides that a Medi-Cal provider shall not be reimbursed for claims submitted more than one year after the month of service.

This bill would, instead, provide that the director may establish, through regulations, exceptions for claims submitted beyond the one-year billing limitation, to the extent federal financial participation is available for services to a Medi-Cal beneficiary.

Existing law provides that, until January 1, 2001, transitional inpatient care services, as defined, are a covered benefit under the Medi-Cal program.

This bill would extend provisions relating to these services until January 1, 2002.

Existing law requires the department to seek a federal waiver to establish a Family Planning, Access, Care, and Treatment Waiver Program (Family Pact) in order to provide comprehensive clinical family planning services to qualified low-income persons.

This bill would require the department to provide the fiscal and appropriate policy committees of the Legislature with a copy of the submittal to the federal Health Care Financing Administration pertaining to any evaluation completed regarding the Family PACT federal waiver.

Existing law authorizes the provision of dental services, under the Medi-Cal program, with certain of these services being known as the Denti-Cal program.

This bill would require the department to allocate rate increases for Denti-Cal program services provided through the Budget Act of 2000 across procedure codes, as deemed appropriate by the department, after consultation with professional dental organizations.

This bill would also provide that 2 dental cleanings and 2 dental examinations per year would be covered benefits under the Medi-Cal program.

The bill would also require the department, subject to the availability of funds, to conduct a dental outreach and education program for Medi-Cal beneficiaries.

The bill would also require the department to provide the fiscal and appropriate policy committees of the Legislature with copies of certain hospital outpatient rate analyses.

Under existing law, various Medi-Cal benefits are provided subject to the use of utilization controls. One of the utilization controls used under the Medi-Cal program is the treatment authorization request process.

This bill would limit the department to reviewing a treatment authorization request only for medical necessity, and would permit a provider to appeal an adverse decision on the request.

Existing law provides for the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health care services to children.

Existing law provides that, for the 1999–2000 fiscal year, a child who is a qualified alien, as defined, 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.

This bill would extend this provision to apply to the 2000–01 fiscal year, and would allow these children to be eligible for a period of not less than 12 months from the date that eligibility is established or redetermined.

This bill would require the board and the State Department of Health Services to develop options for implementing streamlined processes for establishing Medi-Cal program and Healthy Families Program eligibility.

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 $84,757,690 for the 1999–2000 fiscal year and each fiscal year thereafter.

This bill would authorize, instead, transfers to the Health Care Deposit Fund in the amount of $29,757,690 for the 2000–01 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 make 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 contains state and county risk-sharing provisions applicable to the County Medical Services Program.

This bill would extend state-county risk sharing ratio provisions applicable only to the 1999–2000 fiscal year to the 2000–01 fiscal year.

Existing law requires the State Department of Health Services to award grants for projects directed at the prevention of tobacco-related diseases.

Existing law also requires the department to contract with one or more qualified agencies for production and implementation of an ongoing public awareness of tobacco-related diseases by developing an information campaign using a variety of media approaches.

Existing law also provides authority for other state and local tobacco products education programs.

This bill would provide that funds appropriated by the Budget Act of 2000 for these programs would be available for encumbrance and expenditure without regard to fiscal years, for 2 years beyond the date of appropriation.

The bill would authorize the State Department of Health Services to adopt emergency regulations in order to implement applicable provisions of the bill.

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 49557.1 is added to the Education Code, to read:

49557.1. In making available to pupils the application for participation in the free or reduced-price meal program provided for under subdivision (a) of Section 49557, each school district and county superintendent of schools is encouraged to include information that parents may use to request information concerning the Medi-Cal program administered pursuant to Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code, and the Healthy Families Program, administered pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code. School districts and county superintendents of schools are encouraged to perform this task in the most cost-beneficial manner.

SEC. 2. Chapter 2.5 (commencing with Section 59150) is added to Part 32 of the Education Code, to read:

CHAPTER 2.5. TUBERCULOSIS TESTING IN SPECIAL SCHOOLS

59150. Students attending the California School for the Deaf, Northern California, California School for the Deaf, Southern California, and California School for the Blind shall be tested for exposure to tuberculosis at least once every two years. The results of these tests shall be provided to the director of the appropriate special school. The parent or guardian of the student shall be responsible for the cost, if any, of the test.

SEC. 3. Section 14672.9 of the Government Code is amended to read:

14672.9. (a) Notwithstanding Section 14670, the Director of General Services, with the consent of the State Department of Developmental Services, may let in the best interests of the state to a nonprofit corporation, for the purposes specified in this section, real property not exceeding 45.3 acres located within the grounds of the Agnews State Hospital. Of this amount, up to 27 acres may be leased for a period not to exceed 79 years beginning in 1974 and ending July

1, 2053, for the purpose of constructing a business development park. In addition, no more than five acres, of the remaining acres, required by the local government agency for offsite improvements and roadways to support the business development park, may be leased for a period not to exceed 79 years beginning in 1974 and ending July 1, 2053. The remaining acres shall be leased for a period not to exceed 50 years beginning in 1974 and ending on July 1, 2024, for the purpose of conducting an educational and work program for developmentally disabled and other handicapped persons. In the event the nonprofit corporation fails to substantially commence construction of the business development park by July 1, 1988, the terms of the lease allowing construction of a business development park and roadways and offsite improvements shall be null and void, and the lease shall revert to a 50-year period terminating July 1, 2024.

The Department of General Services may provide a one-year extension to the deadline for commencement of construction if the department determines the nonprofit corporation has reasonable grounds for failure to commence construction.

(b) The lease authorized by this section shall be subject to periodic review every five years. The review shall require submission of a report every five years by the lessee. The report shall be reviewed by the Director of General Services, who shall assure the state that the original purposes of the lease are being carried out.

(c) Subject to the approval of the Director of General Services and the State Department of Developmental Services, a lease executed under subdivision (a) may be revised to provide any of the following:

(1) That the nonprofit corporation may assign its interest in the leased property, in whole or in part.

(2) That the nonprofit corporation may sublet all or any portion of the leased property.

(3) That the nonprofit corporation may enter into joint ventures with any other person, firm, partnership, or corporation to construct facilities or to conduct programs and activities on the leased property.

(d) Any revision of the nonprofit corporation’s lease pursuant to subdivision (c) shall be subject to the requirement that all activities, assignments, and subleases shall be in furtherance of the purposes specified in subdivision (a).

(e) Any sublease or partial assignment or transfer of the nonprofit corporation’s interest in the leased property, whether voluntary, involuntary, or by operation of law, shall not terminate the nonprofit corporation’s remaining interest in the leased property.

(f) In addition to rent paid by the nonprofit corporation to the state, the nonprofit corporation shall pay the state 50 percent of the gross rental income resulting from any subleases pursuant to subdivision (c) through June 30, 2024, and 75 percent of the gross rental income from July 1, 2024, to July 1, 2053. Any proceeds received

by the state shall be deposited in a special account within the General Fund to be known as the Developmental Disabilities Services Account. All funds within this account shall be held without regard to fiscal years and shall be available for appropriation by the Legislature for the benefit of persons with developmental disabilities. Any interest accruing to moneys deposited in the account also shall accrue to the account.

On or before April 15 of each year beginning in 1987, the State Department of Developmental Services shall submit a report to the Assembly Ways and Means Committee and the Senate Appropriations Committee. The report shall include, but not be limited to, the following information:

(1) The amount of funds in the Developmental Disabilities Services Account in the General Fund.

(2) The department's priorities for expenditure of those funds.

(g) Any profits to the nonprofit corporation from the proceeds of a sublease executed pursuant to paragraph (2) of subdivision (c) shall be directed into programs for persons with disabilities for the purpose of directly benefiting clients of the nonprofit corporation.

(h) A minimum of 15 percent of the total number of jobs created as a result of the sublease shall be reserved for handicapped employees and placed by the nonprofit corporation.

(i) (1) Moneys in the Developmental Disabilities Services Account shall be expended by the State Department of Developmental Services, through a request for proposals process, for projects that expand the availability of affordable housing for persons with developmental disabilities, including housing for funding developers in nonprofit housing development corporations or coalitions with expertise in the housing needs of persons with developmental disabilities.

(2) Prior to the expenditure of funds under this subdivision, the department shall consult with stakeholder groups, as designated by the State Department of Developmental Services, in ranking proposals and awarding funds. At least one project shall be located on the site previously known as the West Campus of Agnews Developmental Center. Funds shall not be awarded pursuant to this subdivision to a regional center for the development or management of housing projects or to fund regional center staff required in subdivision (c) of Section 4640.6 of the Welfare and Institutions Code.

(3) On or before April 15 of each year, the State Department of Developmental Services shall submit a report to the appropriate fiscal and policy committees of the Legislature on the implementation of this subdivision. The report shall include, but not be limited to, both of the following:

(1) A description of projects funded in the previous year.

(2) A description of the process used to select projects, including the criteria used in their selection and the stakeholder groups that were consulted as part of that process.

SEC. 4. The Legislature finds and declares as follows:

(a) Crimes against persons with substantial disabilities remain largely invisible and unapprised. Crimes against the disabled are frequently not reported to law enforcement and, when reported, may not be prosecuted. Furthermore, many of these victims are not aware of services provided by the program administered by the State Board of Control pursuant to Article 1 (commencing with Section 13959) of Chapter 5 of Part 4 of Division 3 of Title 2 of the Government Code.

(b) Under its existing authority, the State Department of Mental Health has initiated a program to prevent crime against disabled persons, increase the reporting of crime committed against disabled persons, assist law enforcement agencies in effectively investigating and prosecuting crimes committed against disabled persons, and make disabled victims aware of services available to them.

SEC. 5. Section 13969.5 is added to the Government Code, to read:

13969.5. (a) (1) The Governor's Budget shall specify the estimated amount in the Restitution Fund that is in excess of the amount needed to pay claims pursuant to this article, to pay administrative costs for increasing restitution funds, and to maintain a prudent reserve.

(2) It is the intent of the Legislature that, notwithstanding Section 13967, funds be appropriated in the annual Budget Act to the State Department of Mental Health from those funds that are determined to be in excess of the amount needed pursuant to paragraph (1), for the purposes of this section.

(b) Notwithstanding any other provision of law, moneys in the Restitution Fund appropriated in the annual Budget Act pursuant to subdivision (a) may be used to fund programs and activities operated by the State Department of Mental Health, that address the problem of unequal protection for, and unequal services to, crime victims with disabilities.

(c) Programs and activities that may be funded pursuant to this section include the following, as they relate to persons with disabilities:

(1) Identification of crime victims with disabilities.

(2) Crime and violence prevention.

(3) Improvement of access to victim's support and compensation.

(4) Planning and activities by service provider organizations to address the reduction of crime.

(5) Establishment of programs for personal safety, planning, and training.

(6) Public information efforts.

(7) Coordination with other federal and state agencies.

(8) Training of staff.

(9) Programs and activities that facilitate the building of partnerships between advocates and service providers and the criminal justice system to assist crime victims with disabilities to identify and report crime, and assist them in navigating the criminal justice system; secure victim assistance for victims with disabilities; and assist the criminal justice system in investigating, prosecuting, and trying those cases.

(10) Any other program or activity related to crime victims with disabilities.

(d) Moneys appropriated from the Restitution Fund may also be used for the evaluation of the effectiveness of the programs and activities funded pursuant to this section.

SEC. 6. Section 1276.6 is added to the Health and Safety Code, to read:

1276.6. Each facility shall certify, under penalty of perjury and to the best of their knowledge, on a form provided by the department, that funds received pursuant to increasing the staffing ratio to 3.2, as provided for in Section 1276.5, were expended for this purpose. The facility shall return the form to the department within 30 days of receipt by the facility.

SEC. 7. Section 1341.4 of the Health and Safety Code is amended to read:

1341.4. (a) In order to effectively support the Department of Managed Care in the administration of this law, there is hereby established in the State Treasury, the Managed Care Fund. The administration of the Department of Managed Care shall be supported from the Managed Care Fund.

(b) In any fiscal year, the Managed Care Fund shall maintain not more than a prudent 5 percent reserve unless otherwise determined by the Department of Finance.

SEC. 8. Section 1356 of the Health and Safety Code is amended to read:

1356. (a) Each plan applying for licensure under this chapter shall reimburse the director for the actual cost of processing the application, including overhead, up to an amount not to exceed twenty-five thousand dollars ($25,000). The cost shall be billed not more frequently than monthly and shall be remitted by the applicant to the director within 30 days of the date of billing. The director shall not issue a license to any applicant prior to receiving payment in full for all amounts charged pursuant to this subdivision.

(b) In addition to other fees and reimbursements required to be paid under this chapter, each licensed plan shall pay to the director an amount as estimated by the director for the ensuing fiscal year, as a reimbursement of its share of all costs and expenses, including, but not limited to, costs and expenses associated with routine financial

examinations, grievances and complaints including maintaining a toll-free number for consumer grievances and complaints, investigation and enforcement, medical surveys and reports, and overhead, reasonably incurred in the administration of this chapter and not otherwise recovered by the director under this chapter or from the Managed Care Fund. The amount may be paid in two equal installments. The first installment shall be paid on or before August 1 of each year, and the second installment shall be paid on or before December 15 of each year. The amount paid by each plan, except a plan offering only specialized health care service plan contracts, shall be twelve thousand five hundred dollars ($12,500), plus an amount up to, but not exceeding, an amount computed in accordance with the following schedule:

Plan Enrollment	Amount of Assessment
0 to 25,000	$0 + 65 cents for each enrollee
25,001 to 75,000	$16,250 + 53 cents for each enrollee in excess of 25,000
75,001 to 150,000	$42,750 + 50 cents for each enrollee in excess of 75,000
150,001 to 300,000	$80,250 + 47 cents for each enrollee in excess of 150,000
over 300,000	$150,750 + 45 cents for each enrollee in excess of 300,000

Plans offering only specialized health care service plan contracts shall pay seven thousand five hundred dollars ($7,500), plus an amount up to, but not exceeding, an amount computed in accordance with the following schedule:

Plan Enrollment	Amount of Assessment
0 to 25,000	$0 + 48 cents for each enrollee
25,001 to 75,000	$12,000 + 36 cents for each enrollee in excess of 25,000
75,001 to 150,000	$30,000 + 30 cents for each enrollee in excess of 75,000
150,001 to 300,000	$52,500 + 26 cents for each enrollee in excess of 150,000
over 300,000	$91,500 + 24 cents for each enrollee in excess of 300,000

The amount paid by each plan shall be for each enrollee enrolled in its plan in this state as of the preceding March 31, and shall be fixed

by the director by notice to all licensed plans on or before June 15 of each year. A plan that is unable to report the number of enrollees enrolled in the plan because it does not collect that data, shall provide the director with an estimate of the number of enrollees enrolled in the plan and the method used for determining the estimate. The director may, upon giving written notice to the plan, revise the estimate if the commissioner determines that the method used for determining the estimate was not reasonable.

In determining the amount assessed, the director shall consider all appropriations from the Managed Care Fund for the support of this chapter and all reimbursements provided for in this chapter.

(c) Each licensed plan shall also pay two thousand dollars ($2,000), plus an amount up to, but not exceeding, forty-eight hundredths of one cent ($0.0048) for each enrollee for the purpose of reimbursing its share of all costs and expenses, including overhead, reasonably anticipated to be incurred by the department in administering Sections 1394.7 and 1394.8 during the current fiscal year. The amount charged shall be remitted within 30 days of the date of billing.

(d) In no case shall the reimbursement, payment, or other fee authorized by this section exceed the cost, including overhead, reasonably incurred in the administration of this chapter.

(e) The director by notice to all licensed plans on or before September 15, 2000, may require health care service plans to pay an additional assessment to provide the department with sufficient revenues to support costs and expenses as set forth in this section and subdivision (b) of Section 1341.4 for the 2000–01, 2001–02, and 2002–03 fiscal years. The assessment pursuant to this subdivision is separate and independent of the assessment in subdivision (b), and may not be aggregated for the purposes of limitation or otherwise with the assessment in subdivision (b). The assessment pursuant to this subdivision is not subject to the limitations imposed on assessments pursuant to Section 1356.1. In imposing an assessment pursuant to this subdivision the director shall levy on each plan an amount determined by the director using the categories of plans in the schedules set forth in subdivision (b). The assessment shall be paid in full or in two equal installments, as determined by the department. On July 1, 2003, and thereafter, the director may raise the assessment limit pursuant to subdivision (b) to incorporate annual expenditure levels set forth in this subdivision.

(f) For the purpose of calculating the assessment under this section, an enrollee who is enrolled in one plan and who receives health care services under arrangements made by another plan or plans, whether pursuant to a contract, agreement, or otherwise, shall be considered to be enrolled in each of the plans.

SEC. 9. Section 1395 of the Health and Safety Code is amended to read:

1395. (a) Notwithstanding Article 6 (commencing with Section 650) of Chapter 1 of Division 2 of the Business and Professions Code, any health care service plan or specialized health care service plan may, except as limited by this subdivision, solicit or advertise with regard to the cost of subscription or enrollment, facilities and services rendered, provided, however, Article 5 (commencing with Section 600) of Chapter 1 of Division 2 of the Business and Professions Code remains in effect. Any price advertisement shall be exact, without the use of such phrases as ''as low as,'' ''and up,'' ''lowest prices'' or words or phrases of similar import. Any advertisement that refers to services, or costs for the services, and that uses words of comparison must be based on verifiable data substantiating the comparison. Any health care service plan or specialized health care service plan so advertising shall be prepared to provide information sufficient to establish the accuracy of the comparison. Price advertising shall not be fraudulent, deceitful, or misleading, nor contain any offers of discounts, premiums, gifts, or bait of similar nature. In connection with price advertising, the price for each product or service shall be clearly identifiable. The price advertised for products shall include charges for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.

(b) Plans licensed under this chapter shall not be deemed to be engaged in the practice of a profession, and may employ, or contract with, any professional licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code to deliver professional services. Employment by or a contract with a plan as a provider of professional services shall not constitute a ground for disciplinary action against a health professional licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code by a licensing agency regulating a particular health care profession.

(c) A health care service plan licensed under this chapter may directly own, and may directly operate through its professional employees or contracted licensed professionals, offices and subsidiary corporations, including pharmacies that satisfy the requirements of subdivision (d) of Section 4080.5 of the Business and Professions Code, as are necessary to provide health care services to the plan's subscribers and enrollees.

(d) A professional licensed pursuant to the provisions of Division 2 (commencing with Section 500) of the Business and Professions Code who is employed by, or under contract to, a plan may not own or control offices or branch offices beyond those expressly permitted by the provisions of the Business and Professions Code.

(e) Nothing in this chapter shall be construed to repeal, abolish, or diminish the effect of Section 129450 of the Health and Safety Code.

(f) Except as specifically provided in this chapter, nothing in this chapter shall be construed to limit the effect of the laws governing professional corporations, as they appear in applicable provisions of the Business and Professions Code, upon specialized health care service plans.

(g) No representative of a participating health plan or its subcontractor representative shall in any manner use false or misleading claims to misrepresent itself, the plan, the subcontractor, or the Healthy Families or Medi-Cal program while engaging in application assistance activities that are subject to this section. Notwithstanding any other provision of this chapter, any representative of the health care plan or of the health care plan's subcontractor who violates any of the provisions of Section 12695.325 of the Insurance Code shall only be subject to a fine of five hundred dollars ($500) for each of those violations.

(h) A health care service plan shall comply with Section 12693.325 of the Insurance Code and Section 14409 of the Welfare and Institutions Code. In addition to any other disciplinary powers provided by this chapter, if a health care service plan violates any of the provisions of Section 12693.325 of the Insurance Code, the department may prohibit the health care service plan from providing application assistance and contacting applicants pursuant to Section 12693.325 of the Insurance Code.

SEC. 10. Section 1417.2 of the Health and Safety Code is amended to read:

1417.2. (a) Notwithstanding Section 1428, moneys collected as a result of civil penalties imposed under this chapter shall be deposited into an account which is hereby established in the Special Deposit Fund under the provisions of Section 16370 of the Government Code. This account is entitled the Health Facilities Citation Penalties Account and shall, upon appropriation by the Legislature, be used for the protection of health or property of residents of long-term health care facilities, including, but not limited to, the following:

(1) Relocation expenses incurred by the state department, in the event of a facility closure.

(2) Maintenance of facility operation pending correction of deficiencies or closure, such as temporary management or receivership, in the event that the revenues of the facility are insufficient.

(3) Reimbursing residents for personal funds lost. In the event that the loss is a result of the actions of a long-term health care facility or its employees, the revenues of the facility shall first be used.

(4) The costs associated with informational meetings required under Section 1327.2.

(b) Notwithstanding subdivision (a), the balance in the Health Facilities Citation Penalties Account shall not, at any time, exceed ten million dollars ($10,000,000).

SEC. 11. Section 1417.4 is added to the Health and Safety Code, to read:

1417.4. (a) There is hereby established in the State Department of Health Services a Quality Awards Program for nursing homes. The department shall establish criteria, after consultation with stakeholder groups, for recognizing all skilled nursing facilities that provide exemplary care to residents.

(b) Monetary awards shall be made to Quality Awards Program recipients that serve high proportions of Medi-Cal residents to the extent funds are appropriated each year in the Budget Act.

(c) Monetary awards presented under this section and paid for by funds appropriated from the General Fund shall be used for staff bonuses and distributed in accordance with criteria established by the department.

(d) Monetary awards presented under this section and paid for from funds from the Federal Citation Penalty Account shall be used to fund innovative facility grants to improve the quality of care and quality of life for residents in skilled nursing facilities.

(e) The department, in consultation with senior advocacy organizations, employee labor organizations representing facility employees, nursing home industry representatives, and other interested parties as deemed appropriate by the department, shall establish criteria for selecting facilities to receive the quality awards. The criteria established pursuant to this subdivision shall not be considered regulations within the meaning of Section 11342 of the Government Code, and shall not be subject to adoption as regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(f) The department shall publish an annual listing of the quality awards program recipients, including the dollar amount awarded, if applicable. The department shall also publish an annual listing of the quality award program recipients that receive innovative facility grants, including the purpose of the grant and its amount.

SEC. 12. Section 1421.1 is added to the Health and Safety Code, to read:

1421.1. (a) Within 24 hours of the occurrence of any of the events specified in subdivision (b), the licensee of a skilled nursing facility shall notify the department of the occurrence. This notification may be in written form if it is provided by telephone facsimile or by overnight mail, or by telephone with a written confirmation within five calendar days. The information provided pursuant to this subdivision may not be released to the public by the department unless its release is needed to justify an action taken by the department or it otherwise becomes a matter of public record. A violation of this section is a class ''B'' violation.

(b) All of the following occurrences shall require notification pursuant to this section:

(1) The licensee of a facility receives notice that a judgment lien has been levied against the facility or any of the assets of the facility or the licensee.

(2) A financial institution refuses to honor a check or other instrument issued by the licensee to its employee for a regular payroll.

(3) The supplies, including food items and other perishables, on hand in the facility fall below the minimum specified by any applicable statute or regulation.

(4) The financial resources of the licensee fall below the amount needed to operate the facility for a period of at least 45 days, based on the current occupancy level.

(5) The licensee fails to make timely payment of any premiums required to maintain required insurance policies or bonds in effect, or any tax lien levied by any government agency.

SEC. 13. Section 1421.2 is added to the Health and Safety Code, to read:

1421.2. (a) There is hereby established in the State Department of Health Services the Skilled Nursing Facility Financial Solvency Advisory Board, which shall be composed of eight members.

(b) The members shall consist of the director or the director's designee, and seven members appointed by the director.

(c) The seven members appointed by the director may be, but are not necessarily limited to, individuals with training and experience in the following areas or fields:

(1) Medical and health care economics.

(2) Accountancy.

(3) research or actuarial studies in the area of skilled nursing facilities.

(4) Management or administration of health care delivery systems.

(d) One of the members appointed by the director shall be a representative of a collective bargaining agent.

(e) The purpose of the board shall be to do all of the following:

(1) Advise the director on matters of financial solvency affecting the delivery of services in skilled nursing facilities.

(2) Develop and recommend to the director financial solvency licensing requirements and standards.

(3) Periodically monitor and report on the implementation and results of the financial solvency licensing requirements and standards.

(f) The board shall meet at least quarterly and at the call of the chair. In order to preserve the independence of the board, the director shall not serve as chair. The members of the board may establish their own rules and procedures. All members shall serve without compensation, but shall be reimbursed from department

funds for expenses actually and necessarily incurred in the performance of their duties.

(g) For purposes of this section, ‘‘board’’ means the Skilled Nursing Facility Financial Solvency Advisory Board.

(h) Financial solvency licensing requirements and standards recommended to the director by the board may, after a period of review and comment, not to exceed 45 days, and if adopted by the director, be noticed for adoption as regulations as proposed or modified under the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). During the director’s 45-day review and comment period, the director, in consultation with the board, may postpone the adoption of the licensing requirements and standards pending further review and comment.

(i) The board shall report to the director by July 1, 2002, on its recommendations.

(j) This section shall remain in effect only until January 1, 2004, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2004, deletes or extends that date.

SEC. 14. Section 1797.112 of the Health and Safety Code is amended to read:

1797.112. (a) The Emergency Medical Services Personnel Fund is hereby created in the State Treasury, the funds in which are to be held in trust for the benefit of the authority’s testing and personnel licensure program and for the purpose of making reimbursements to entities for the performance of functions for which fees are collected pursuant to Section 1797.172, for expenditure upon appropriation by the Legislature.

(b) The authority may transfer unused portions of the Emergency Medical Services Personnel Fund to the Surplus Money Investment Fund. Funds transferred to the Surplus Money Investment Fund shall be placed in a separate trust account, and shall be available for transfer to the Emergency Medical Services Personnel Fund, together with interest earned, when requested by the authority.

(c) The authority shall maintain a reserve balance in the Emergency Medical Services Personnel Fund of five percent. Any increase in the fees deposited in the Emergency Medical Services Personnel Fund shall be effective upon a determination by the authority that additional moneys are required to fund expenditures of the personnel licensure program, including, but not limited to, reimbursements to entities set forth in subdivision (a).

SEC. 15. Section 101230 of the Health and Safety Code is amended to read:

101230. From the appropriation made for the purposes of this article, allocation shall be made to the administrative bodies of qualifying local health jurisdictions described as public health

administrative organizations in Section 101185 in the following manner:

(a) A basic allotment as follows:

To the administrative bodies of local health jurisdictions a basic allotment of one hundred thousand dollars ($100,000) per local health jurisdiction or twenty-one and two-tenths cents ($0.212426630) per capita, whichever is greater. The population estimates used for the calculation of the per capita allotment shall be based on the Department of Finance's E-1 Report, ''City/County Population Estimates with Annual Percentage Changes'' as of January 1 of the previous fiscal year. However, if within a county there are one or more city health jurisdictions, the county shall subtract the population of the city or cities from the county total population for purposes of calculating the per capita total. If the amounts appropriated are insufficient to fully fund the allocations specified in this subdivision, the State Department of Health Services shall prorate and adjust each local health jurisdiction's allocation using the same percentage that each local health jurisdiction's allocation represents to the total appropriation under the allocation methodology specified in this subdivision.

(b) A per capita allotment, determined as follows:

After deducting the amounts allowed for the basic allotment as provided in subdivision (a), the balance of the appropriation, if any, shall be allotted on a per capita basis to the administrative body of each local health jurisdiction in the proportion that the population of that local health jurisdiction bears to the population of all qualified local health jurisdictions of the state.

(c) Beginning in the fiscal year 1998–99, funds appropriated for the purposes of this article shall be used to supplement existing levels of the services described in paragraphs (1) and (2) of subdivision (d) provided by qualifying participating local health jurisdictions. As part of a county's or city's annual realignment trust fund report to the Controller, a participating county or city shall annually certify to the Controller that it has deposited county or city funds equal to or exceeding the amount described in subdivisions (a) and (b) of Section 17608.10. The county or city shall not be required to submit any additional reports or modifications to existing reports to document compliance with this subdivision. Funds shall be disbursed quarterly in advance to local health jurisdictions beginning July 1, 1998. If a county or city does not accept its allocation, any unallocated funds provided under this section shall be redistributed according to subdivision (b) to the participating counties and cities that remain.

(d) Funds shall be used for the following:

(1) Communicable disease control activities. Communicable disease control activities shall include, but not be limited to, communicable disease prevention, epidemiologic services, public health laboratory identification, surveillance, immunizations,

followup care for sexually transmitted disease and tuberculosis control, and support services.

(2) Community and public health surveillance activities. These activities shall include, but not be limited to, epidemiological analyses, and monitoring and investigating communicable diseases and illnesses due to other untoward health events.

(e) Funds shall not be used for medical services, including jail medical treatment, except as provided in subdivision (d).

SEC. 16. Section 104160 of the Health and Safety Code is repealed.

SEC. 17. Section 104160 is added to the Health and Safety Code, to read:

104160. The State Department of Health Services shall utilize existing mechanisms to maintain, expand, and ensure quality breast cancer treatment for low-income, and uninsured persons who are diagnosed with breast cancer. The department shall award one or more contracts to provide breast cancer treatment through private or public nonprofit organizations, including, but not limited to, community-based organizations, local health care providers, and the University of California medical centers. The contracts shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

SEC. 18. Section 104161 of the Health and Safety Code is amended to read:

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

SEC. 19. Section 104162 of the Health and Safety Code is amended to read:

104162. Treatment under this chapter shall be provided to uninsured and underinsured persons with incomes at or below 200 percent of the federal poverty level.

SEC. 20. Section 104163 of the Health and Safety Code is amended to read:

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.

SEC. 21. Section 104164 of the Health and Safety Code is repealed.

SEC. 22. Article 1.7 (commencing with Section 104170) is added to Chapter 2 of Part 1 of Division 103 of the Health and Safety Code, to read:

Article 1.7. Human Leukocyte Antigen Testing Fund

104170. (a) The Human Leukocyte Antigen Testing Fund is hereby established in the State Treasury, to be administered by the State Department of Health Services. Moneys in the fund shall be subject to appropriation in the annual Budget Act, and shall be used to pay the costs of blood collection and human leukocyte antigen typing, also referred to as histocompatibility locus antigen (HLA) testing, for A, B, and DR antigens for use in bone marrow transplantation by California blood centers under contract with the federal National Marrow Donor Program provided for pursuant to Public Law 101-302.

(b) Moneys in the fund may only be expended if the individual being tested completes and signs a informed consent form authorizing the use of test results for participation in the federal program referred to in subdivision (a). The form shall require a declaration from the donor as to whether he or she has health plan benefits that would cover the cost of HLA testing. Moneys in the fund shall not be used to pay for the testing of a health plan enrollee if the health plan covers the cost of HLA testing for the enrollee.

SEC. 23. The Legislature finds and declares all of the following:

(a) Asthma is a chronic respiratory illness of enormous public health significance.

(b) Asthma is a disease that affects an estimated 2,000,000 Californians.

(c) Asthma is a leading cause of preventable hospitalization and absenteeism from school and work.

(d) In 1995, there were approximately 42,000 asthma-related hospital stays in California, including about 17,000 for children, costing over three hundred fifty million dollars ($350,000,000). Nearly 40 percent of those hospital stays were funded by the Medi-Cal program.

(e) Asthma is one of the most chronic conditions in children. It is a leading cause of school absences, and is one of the leading causes of hospital admissions for children in California.

(f) Although asthma is a major health problem, our scientific understanding of asthma has dramatically improved in recent years, and national guidelines for asthma diagnosis and management have been published to bridge the gap between the latest scientific-based evidence and actual practice.

(g) Researchers understand more about the environmental and social risk factors for asthma, and several asthma self-management programs have been developed allowing patients and their families to better understand and manage asthma.

(h) Despite this new understanding, asthma prevalence and death rates have increased over the last two decades.

(i) Asthma remains an especially severe health problem for certain populations, including African-Americans and those living in poverty. Asthma-related hospitalization and death rates for African-Americans are alarmingly high.

(j) New and innovative models for asthma management, which improve upon prior experience, must be developed and implemented. A successful asthma control program will continuously incorporate the latest scientific advances to improve the health of the state's population.

(k) In addition, factors that contribute to asthma morbidity, such as environmental and occupational exposures, must be evaluated and controlled. Allergens have been found to be an important trigger factor for asthma. These include pollen, fungi, mold, animal dander, cockroach allergens, and certain foods.

(*l*) Successful asthma control programs will require coordination of the efforts of individuals, families, health care providers, health care systems, school systems, employers, and state and local governments.

(m) Reducing the burden of asthma, especially among the most severely impacted populations, will require well-coordinated, long-term, multilevel programs.

SEC. 24. Chapter 6.5 (commencing with Section 104316) is added to Part 1 of Division 103 of the Health and Safety Code, to read:

CHAPTER 6.5. REDUCTION OF ASTHMA THROUGH ASSESSMENT, INTERVENTION, AND EVALUATION

104316. (a) Contingent upon appropriation in the annual Budget Act, the State Department of Health Services shall do all of the following:

(1) Regularly analyze asthma morbidity and mortality data, and shall periodically assess the burden of asthma on the state's medical and economic resources, and identify those populations most seriously affected by the disease.

(2) Survey factors known to worsen asthma, including allergy induced asthma, such as cockroach allergens and molds, in order to estimate the relative importance of these factors in California.

(3) Assess patterns of medical care and population-based health services, and the extent of ongoing local, regional, educational, environmental, and other asthma interventions and related activities.

(b) The information gained pursuant to subdivision (a) shall be used to guide the development of public health programs and asthma policy.

104317. (a) The department shall offer public and professional education to disseminate the most current information on asthma.

(b) The department shall assist health care organizations, such as managed care organizations, in identifying or developing effective asthma diagnosis and treatment protocols. The department shall improve clinical practice by working with experts, partnering with health care organizations, and conferring with interested constituencies.

(c) (1) Despite the necessity for increased information regarding asthma causation, there is also an urgent need to apply existing knowledge to reduce the burden on state resources due to asthma. Thus, the department shall administer available funds to organizations that propose promising, innovative asthma interventions that benefit persons with asthma and their families by increasing community awareness, improving patient education and asthma self-management skills, improving clinical practice, coordinating services, and developing local policies that support the prevention and control of asthma and environmental factors that can trigger asthma attacks.

(2) The department shall ensure that the projects are scientifically based and practical, and that a range of significant asthma prevention and control issues are addressed. The projects shall address both adult and pediatric asthma populations. Projects may include, but need not be limited to, the following:

(A) Clinical quality improvement.

(B) Disease management.

(C) Public and professional education, including information on asthma self-management skills and ways to reduce or eliminate allergens and irritants that exacerbate asthma, such as cockroaches, dust mites, and molds.

(D) Mobilization of communities including local health departments, community agencies, and other organizations.

(E) Unique exposure interventions for special or at-risk populations.

(F) Innovative collaborations between managed care organizations, local organizations, health systems, academic institutions, voluntary health organizations, and local governments.

(G) Reducing environmental factors that have been found to trigger asthma attacks.

(d) The department shall promote the utilization of evidence-based asthma guidelines, such as the National Institute of Health's National Asthma Education and Prevention Programs's asthma guidelines, to carry out the purposes of this chapter.

104318. The department shall do all of the following in connection with the administration of funds provided to implement this chapter:

(a) Draft and circulate requests for applications.

(b) Determine selection criteria, consult with applicants, and monitor the progress of projects.

(c) Require specific evaluations of projects, require plans for implementation of effective programs, and prepare a summary of findings from all projects conducted.

(d) Consult with community stakeholders for the development, implementation, and evaluation of asthma prevention and control programs.

104319. The department shall monitor the clinical and public interventions required by this chapter, and shall report successful and unsuccessful interventions in clinical and public health practice.

104320. The department shall establish and maintain a surveillance and intervention program for the prevention of asthma.

104321. The department shall implement this chapter contingent on the appropriation of funds in the annual Budget Act.

SEC. 25. Chapter 7 (commencing with Section 104320) is added to Part 1 of Division 103 of the Health and Safety Code, to read:

CHAPTER 7. PROSTATE CANCER TREATMENT PROGRAM

104320. (a) The State Department of Health Services shall develop, expand, and ensure quality prostate cancer treatment to low-income and uninsured men. The department shall award one or more contracts to provide prostate cancer treatment through private or public nonprofit organizations, including, but not limited to, community-based organizations, local health care providers, and the University of California medical centers. The contracts shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

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

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

SEC. 26. Section 104775 of the Health and Safety Code is amended to read:

104775. A community dental disease prevention program may be offered to school children in preschool through sixth grade, and in classes for individuals with exceptional needs, by a local sponsor. A local sponsor may be a city or county health department, county office of education, superintendent of schools office, school district or other public or private nonprofit agency approved by the department. The program shall include, but not be limited to, the following:

(a) Educational programs, focused on development of personal practices by pupils, that promote dental health. Emphasis shall include, but not be limited to, causes and prevention of dental

diseases, nutrition and dental health, and the need for regular dental examination with appropriate repair of existing defects.

(b) Preventive services including, but not limited to, ongoing plaque control, dental sealants, and supervised application of topical prophylactic agents for caries prevention, in accordance with this article or other preventive agents approved by the department. Services shall not include dental restoration, orthodontics, or extraction of teeth. Any acts performed, or services provided, under this article constituting the practice of dentistry shall be performed or provided by, or be subject to the supervision of, a licensed dentist in accordance with Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code.

SEC. 27. Section 104795 of the Health and Safety Code is amended to read:

104795. The department shall review the program proposals and approve programs that meet criteria established pursuant to Section 104785. The department shall, commencing July 1, 2000, through contractual arrangements, reimburse local sponsors with approved programs at an amount of ten dollars ($10.00), per participating child per year for administration and services, pursuant to Section 104775.

SEC. 28. Section 124010 of the Health and Safety Code is amended to read:

124010. (a) It is the intent of the Legislature to establish demonstration projects to assist medically fragile infants, children, and adolescents.

(b) It is further the intent of the Legislature that these demonstration projects serve as models for methods of providing primary care services and coordination of health care for medically fragile infants, children, and adolescents.

(c) The Legislature finds and declares that the use of care management services under these demonstration projects will lead to savings in medical costs through reduced emergency room visits, hospital admissions, and other medical indicators and measures.

SEC. 29. Section 124011 of the Health and Safety Code is amended to read:

124011. There is hereby established demonstration projects to provide a medical home and coordination of care model in order to reduce avoidable health problems of chronically, seriously ill infants, children, and adolescents. The demonstration projects may operate for a period of up to three years. Existing demonstration projects may be extended for up to two years, if outcome data display effectiveness as determined by the State Department of Health Services.

SEC. 30. Section 124012 of the Health and Safety Code is amended to read:

124012. The department shall award funding appropriated for purposes of this article, on a competitive basis, to any nonprofit children’s hospitals, as defined in Section 10727 of the Welfare and

Institutions Code, and other hospitals that operate at least 10 special care centers, as certified by the California Childrens' Services Program.

SEC. 31. Section 124013 of the Health and Safety Code is amended to read:

124013. The demonstration projects shall provide care management services to children enrolled in the demonstration projects pursuant to proposals accepted by the department.

Demonstration projects shall meet all of the following requirements:

(a) Establish and function as a medical home to a population of infants, children, and adolescents whose medical conditions requires multidisciplinary and multispecialty care.

(b) Provide care coordination between primary care and specialty health care providers and community agencies for project enrollees.

(c) Provide, or arrange for the provision of, health care services to maintain optimal health status. These services may include, but need not be limited to, physician office or home visits, psychosocial counseling, and medical nutrition evaluation and counseling.

(d) Establish a relationship with an enrollee's parent or guardian in order to enhance the understanding of the child's condition and the parent or guardian's participation in the enrollee's medical treatment plan and decisionmaking.

(e) Maximize the use of third-party reimbursement for the services provided to the population enrolled in the project.

SEC. 32. Section 124014 of the Health and Safety Code is amended to read:

124014. In order to most effectively assist children enrolled in the demonstration project, the demonstration project may employ the use of clinic visits, home visits, school visits, inpatient visits, and multidisciplinary conferences, as well as other innovative care management techniques.

SEC. 33. Section 124015 of the Health and Safety Code is amended to read:

124015. (a) The hospital receiving funding under this article shall submit a report to the department that evaluates the demonstration project and includes measures of medical costs and improved health outcomes of enrollees.

(b) The report shall address the following outcome measures as identified in the hospital's demonstration project submitted to the department for approval.

(c) The report required by subdivision (a) shall include a determination as to whether the demonstration project is deemed to be successful. Unless other outcome measures are used pursuant to subdivision (d), the demonstration project shall be deemed to be successful if all of the following have occurred:

(1) The average number of school days missed is decreased by 50 percent.

(2) The average number of emergency room visits is decreased by 50 percent.

(3) The average number of hospitalizations and hospital days is decreased by 50 percent.

(4) The number of children with up-to-date immunizations is increased by 50 percent.

(d) The demonstration project may use other outcome measures in lieu of those identified in subdivision (c), if deemed appropriate by the department, to measure success.

(e) The determinations made pursuant to this subdivision shall be based on a comparison of the preprogram utilization rates, which is data collected one year prior to enrollment in the program, with the utilization rates one year after enrollment.

SEC. 34. Section 124900 of the Health and Safety Code is amended to read:

124900. (a) (1) The State Department of Health Services shall select primary care clinics that are licensed under paragraph (1) or (2) of subdivision (a) of Section 1204, or are exempt from licensure under subdivision (c) of Section 1206, to be reimbursed for delivering medical services, including preventative health care, and smoking prevention and cessation health education, to program beneficiaries.

(2) Except as provided for in paragraph (3), in order to be eligible to receive funds under this article a clinic shall meet all of the following conditions, at a minimum:

(A) Provide medical diagnosis and treatment.

(B) Provide medical support services of patients in all stages of illness.

(C) Provide communication of information about diagnosis, treatment, prevention, and prognosis.

(D) Provide maintenance of patients with chronic illness.

(E) Provide prevention of disability and disease through detection, education, persuasion, and preventive treatment.

(F) Meet one or both of the following conditions:

(i) Are located in an area federally designated as a medically underserved area or medically underserved population.

(ii) Are clinics that are able to demonstrate that at least 50 percent of the patients served are persons with incomes at or below 200 percent of the federal poverty level.

(3) Notwithstanding the requirements of paragraph (2), all clinics that received funds under this article in the 1997–98 fiscal year shall continue to be eligible to receive funds under this article.

(b) As a part of the award process for funding pursuant to this article, the department shall take into account the availability of primary care services in the various geographic areas of the state. The department shall determine which areas within the state have

populations which have clear and compelling difficulty in obtaining access to primary care. The department shall consider proposals from new and existing eligible providers to extend clinic services to these populations.

(c) Each primary care clinic applying for funds pursuant to this article shall demonstrate that the funds shall be used to expand medical services, including preventative health care, and smoking prevention and cessation health education, for program beneficiaries above the level of services provided in the 1988 calendar year or in the year prior to the first year a clinic receives funds under this article if the clinic did not receive funds in the 1989 calendar year.

(d) (1) The department, in consultation with clinics funded under this article, shall develop a formula for allocation of funds available.

(2) The formula shall be based on both of the following:

(A) A hold harmless for clinics funded in the 1997–98 fiscal year to continue to reimburse them for some portion of their uncompensated care.

(B) Demonstrated unmet need by both new and existing clinics, as reflected in their levels of uncompensated care reported to the department. For purposes of this article, ''uncompensated care'' means clinic patient visits for persons with incomes at or below 200 percent of the federal poverty level for which there is no encounter-based third-party reimbursement which includes, but is not limited to, unpaid expanded access to primary care claims and other unreimbursed visits as verified by the department according to subparagraph (A) of paragraph (5).

(3) In the 1998–99 fiscal year, the department shall allocate funds for a three-year period as follows:

(A) If the funds available for the purposes of this article are equal to or less than the prior fiscal year, clinics that received funding in the prior fiscal year shall receive 90 percent of their prior fiscal year allocation, subject to available funds, provided that funding award is substantiated by the clinics' reported levels of uncompensated care. The remaining funds beyond 90 percent shall be awarded in the following order:

(i) First priority shall be given to clinics that participated in the program in prior fiscal years, withdrew from the program due to financial considerations, were subsequently categorized as ''new applicants'' when they reapplied to the program, and received a significantly reduced allocation as a result. These clinics shall be awarded 90 percent of their allocation prior to their withdrawal from the program, subject to available funds, provided that award level is substantiated by the clinic's reported levels of uncompensated care.

(ii) Second priority shall be given to those clinics that received program funds in the prior year and continue to meet the minimum requirements for funding under this article. In implementing this

priority, the department shall allocate funds to all eligible previously funded clinics on a proportionate basis, based on their reported levels of uncompensated care, which may include, but is not limited to, unpaid expanded access to primary care claims and other unreimbursed patient visits, as verified by the department according to subparagraph (A) of paragraph (5).

(B) If funds available for the purposes of this article are equal to or less than the prior fiscal year, only those clinics that received program funds in the prior fiscal year may be awarded funds. Funds shall be awarded in the same priority order as specified in clauses (i) and (ii) of subparagraph (A).

(C) If funds available for purposes of this article are greater than the prior fiscal year, clinics that received funds in the prior fiscal year shall be awarded 100 percent of their prior fiscal year allocation, provided that funding award level is substantiated by the clinic's reported levels of uncompensated care. Remaining funds shall be awarded in the following priority order:

(i) First priority shall be given to clinics that participated in the program in prior fiscal years, withdrew from the program due to financial considerations, were subsequently categorized as ''new applicants'' when they reapplied to the program, and received a significantly reduced allocation as a result. These clinics shall be awarded 100 percent of their allocation prior to their withdrawal from the program, provided that award level is substantiated by the clinic's reported levels of uncompensated care.

(ii) Second priority shall be given to new and existing applicants that meet the minimum requirements for funding under this article. In implementing this priority, the department shall allocate funds to all eligible previously funded clinics on a proportionate basis, based on their reported levels of uncompensated care, which may include, but is not limited to, unpaid expanded access to primary care claims and other unreimbursed patient visits, as verified by the department, according to subparagraph (A) of paragraph (5).

(4) In the 2001–02 fiscal year, and subsequent fiscal years thereafter, the department shall allocate available funds, for a three-year period, based on the clinics' reported levels of uncompensated care as verified by the department according to subparagraph (B) of paragraph (5).

(5) In assessing reported levels of uncompensated care, the department shall utilize the most recent data available from the Office of Statewide Health Planning and Development's (OSHPD) completed analysis of the ''Annual Report of Primary Care Clinics.''

(A) In the 1998–99 to 2000–01 fiscal years, inclusive, clinics shall submit updated data regarding the clinic's levels of uncompensated care to the department with their initial application, and for each of the two remaining years in the three-year application period. The department shall compare the clinic's updated uncompensated care

data to the OSHPD uncompensated care data for that clinic for the same reporting period. Discrepancies in uncompensated care data for any particular clinic shall be resolved to the satisfaction of the department prior to the award of funds to that clinic.

(B) In the 2001–02 fiscal year, and subsequent fiscal years thereafter, clinics may not submit updated data regarding the clinic's levels of uncompensated care. The department shall utilize the most recent data available from OSHPD's completed analysis of the ''Annual Report of Primary Care Clinics.''

(C) If the funds allocated to the program are less than the prior year, the department shall allocate available funds to existing program providers only.

(6) The department shall establish a base funding level, subject to available funds, of no less than thirty-five thousand dollars ($35,000) for frontier clinics and Native American reservation-based clinics. For purposes of this article, ''frontier clinics'' means clinics located in a medical services study area with a population of fewer than 11 persons per square mile.

(7) The department shall develop, in consultation with clinics funded pursuant to this article, a formula for reallocation of unused funds to other participating clinics to reimburse for uncompensated care. The department shall allocate the unused funds to other participating clinics to reimburse for uncompensated care.

(e) In applying for funds, eligible clinics shall submit a single application per clinic corporation. Applicants with multiple sites shall apply for all eligible clinics, and shall report to the department the allocation of funds among their corporate sites in the prior year. A corporation may only claim reimbursement for services provided at a program-eligible clinic site identified in the corporate entity's application for funds, and approved for funding by the department. A corporation may increase or decrease the number of its program-eligible clinic sites on an annual basis, at the time of the annual application update for the subsequent fiscal years of any multiple-year application period.

(f) Grant allocations pursuant to this article shall be based on the formula developed by the department, notwithstanding a merger of one of more licensed primary care clinics participating in the program.

(g) A clinic that is eligible for the program in every other respect, but that provides dental services only, rather than the full range of primary care medical services, shall only be eligible to receive funds under this article on an exception basis. A dental-only provider's application shall include a Memorandum of Understanding (MOU) with a primary care clinic funded under this article. The MOU shall include medical protocols for making referrals by the primary care clinic to the dental clinic and from the dental clinic to the primary care clinic, and ensure that case management services are provided

and that the patient is being provided comprehensive primary care as defined in subdivision (a).

(h) (1) For purposes of this article, an outpatient visit shall include diagnosis and medical treatment services, including the associated pharmacy, X-ray, and laboratory services, and prevention health and case management services that are needed as a result of the outpatient visit. For a new patient, an outpatient visit shall also include a health assessment encompassing an assessment of smoking behavior and the patient's need for appropriate health education specific to related tobacco use and exposure.

(2) ''Case management'' includes, for this purpose, the management of all physician services, both primary and specialty, and arrangements for hospitalization, postdischarge care, and followup care.

(i) (1) Payment shall be on a per visit basis at a rate that is determined by the department to be appropriate for an outpatient visit as defined in this section, and shall be not less than seventy-one dollars and fifty cents ($71.50).

(2) In developing a statewide uniform rate for an outpatient visit as defined in this article, the department shall consider existing rates of payments for comparable outpatient visits. The department shall review the outpatient visit rate on an annual basis.

(j) Not later than May 1 of each year, the department shall adopt and provide each licensed primary care clinic with a schedule for programs under this article, including the date for notification of availability of funds, the deadline for the submission of a completed application, and an anticipated contract award date for successful applicants.

(k) In administering the program created pursuant to this article, the department shall utilize the Medi-Cal program statutes and regulations pertaining to program participation standards, medical and administrative recordkeeping, the ability of the department to monitor and audit clinic records pertaining to program services rendered to program beneficiaries and take recoupments or recovery actions consistent with monitoring and audit findings, and the provider's appeal rights. Each primary care clinic applying for program participation shall certify that it will abide by these statutes and regulations and other program requirements set forth in this article.

SEC. 35. Section 125285 is added to the Health and Safety Code, to read:

125285. The department shall provide public and professional education on Alzheimer's disease to educate consumers, caregivers, and health care providers, and to increase public awareness. If the department determines that contracts are required to implement this section, the department may award these contracts on a sole source basis. The contracts shall not be subject to Part 2

(commencing with Section 10100) of Division 2 of the Public Contract Code. Notwithstanding any other provision of law, the balance of funds appropriated pursuant to the Budget Act of 2000 for Alzheimer's disease education shall be available for encumbrance and expenditure until June 30, 2003.

SEC. 36. Division 109 (commencing with Section 130200) is added to the Health and Safety Code, to read:

DIVISION 109. PARKINSON'S DISEASE COMMUNITY OUTREACH, DIAGNOSIS, AND TREATMENT PROJECT

130200. The department shall award a contract to establish a Parkinson's Disease Community Outreach, Diagnosis, and Treatment Project to a bidder that is a nonprofit medical education, diagnosis, and treatment organization established under Section 501(c)(3) of the federal Internal Revenue Code, affiliated with a licensed publicly funded medical center, and that meets the following eligibility criteria:

(a) The organization has an existing clinical research program for the diagnosis and treatment of Parkinson's disease.

(b) The organization is located in a geographic area that has direct access to an urban population with a high concentration of Parkinson's patients, with strategic access to other communities.

(c) The organization has an existing outreach program that includes ongoing relationships with Parkinson's Support Groups, and medical facilities.

(d) The organization has a demonstrated commitment to provide services to low-income and indigent Parkinson's patients.

130201. For purposes of this division, a Parkinson's disease outreach, diagnosis, and treatment program shall include, but not be limited to, diagnostic and clinical services provided by neurologists specializing in Parkinson's disease diagnosis and treatment, community physician and allied health professional Parkinson's disease and disease management training, patient and care giver educational services in Parkinson's disease and disease management outreach services targeting Parkinson's patients and caregivers that are from communities of color that would not otherwise have access to those services, family and other caregiver emotional support services, and nonmedical needs referral linkages staff.

130202. The department shall contract for Parkinson's disease 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, if available.

103203. This division shall become inoperative on July 1, 2004, and, as of January 1, 2005, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2005, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 37. Section 12693.325 is added to the Insurance Code, to read:

12693.325. (a) Notwithstanding any provision of this chapter, a participating health plan that is licensed and in good standing as required by subdivision (b) of Section 12693.36 may provide application assistance directly to an applicant acting on behalf of an eligible child who telephones, writes, or contacts the plan in person at the plan's place of business, or at a community public awareness event that is open to all participating plans in the county, or at any other site approved by the board, and who requests application assistance.

(b) A participating health plan may provide application assistance to an applicant who is acting on behalf of an eligible or potentially eligible child in any of the following situations:

(1) The child is enrolled in a Medi-Cal managed care plan and the participating health plan becomes aware that the child's eligibility status has or will change and that the child will no longer be eligible for Medi-Cal. In those instances, the plan shall inform the applicant of the differences in benefits and requirements between the Healthy Families Program and the Medi-Cal program.

(2) The child is enrolled in a Healthy Families Program managed care plan and the participating health plan becomes aware that the child's eligibility status has changed or will change and that the child will no longer be eligible for Healthy Families. When it appears a child may be eligible for Medi-Cal benefits, the plan shall inform the applicant of the differences in benefits and requirements between the Medi-Cal program and the Healthy Families Program.

(3) The participating health plan provides employer-sponsored coverage through an employer and an employee of that employer who is the parent or legal guardian of the eligible or potentially eligible child.

(4) The child and his or her family are participating through the participating health plan in COBRA continuation coverage or other group continuation coverage required by either state or federal law and the group continuation coverage will expire within 60 days, or has expired within the past 60 days.

(5) The child's family, but not the child, is participating through the participating health plan in COBRA continuation coverage or other group continuation coverage required by either state or federal law, and the group continuation coverage will expire within the past 60 days, or has expired within the past 60 days.

(c) A participating health plan employee or other representative that provides application assistance shall complete a certified

application assistant training class approved by the State Department of Health Services in consultation with the board. The employee or other representative shall in all cases inform an applicant verbally of his or her relationship with the participating health plan. In the case of an in-person contact, the employee or other representative shall provide in writing to the applicant the nature of his or her relationship with the participating health plan and obtain written acknowledgement from the applicant that the information was provided.

(d) A participating health plan that provides application assistance may not do any of the following:

(1) Directly, indirectly, or through its agents, conduct door-to-door marketing or phone solicitation.

(2) Directly, indirectly, or through its agents, select a health plan or provider for a potential applicant. Instead, the plan shall inform a potential applicant of the choice of plans available within the applicant's county of residence and specifically name those plans and provide the most recent version of the program handbook.

(3) Directly, indirectly, or through its agents, conduct mail or in-person solicitation of applicants for enrollment, except as specified in subdivision (b), using materials approved by the board.

(e) A participating health plan that provides application assistance pursuant to this section is not eligible for an application assistance fee otherwise available pursuant to Section 12693.32, and may not sponsor a person eligible for the program by paying his or her family contribution amounts or copayments, and may not offer applicants any inducements to enroll, including, but not limited to, gifts or monetary payments.

(f) A participating health plan may assist applicants acting on behalf of subscribers who are enrolled with the participating plan in completing the program's annual eligibility review package in order to allow those applicants to retain health care coverage.

(g) Each participating health plan shall submit to the board a plan for application assistance. All scripts and materials to be used during application assistance sessions shall be approved by the board and the State Department of Health Services.

(h) Each participating health plan shall provide each applicant with the toll-free telephone number for the Healthy Families Program.

(i) When deemed appropriate by the board, the board may refer a participating health plan to the Department of Managed Care or the State Department of Health Services, as applicable, for the review or investigation of its application assistance practices.

(j) The board shall evaluate the impact of the changes required by this section, and shall provide a report to the Legislature on or before March 1, 2002. To prepare these reports, the State Department of Health Services, in cooperation with the board, shall code all the

application packets used by a managed care plan to record the number of applications received that originated from managed care plans. The number of applications received that originated from managed care plans shall also be reported on the board's website. In addition, the board shall periodically survey those families assisted by plans to determine if the plans are meeting the requirements of this section, and if families are being given ample information about the choice of health plans available to them. The report shall include any recommended changes to this section.

(k) Nothing in the section shall be seen as mitigating a participating health plan's responsibility to comply with all federal and state laws, including, but not limited to, Section 1320a-7b of Title 42 of the United States Code.

(*l*) 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 before January 1, 2003, deletes or extends that date.

SEC. 38. Section 12693.326 is added to the Insurance Code, to read:

12693.326. Notwithstanding any other provision of this part, a new subscriber in the program shall be allowed to switch his or her choice of health plan once within the first three months of coverage for any reason.

SEC. 39. Section 12693.76 of the Insurance Code is amended 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 and 2000–01 fiscal years, these children shall be allowed to participate in the Healthy Families Program for a period of not less than 12 months from the effective date that eligibility is established or redetermined, 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. 40. The Legislature finds and declares all of the following:

(a) The Legislature recognizes the need for community treatment facilities, as defined in paragraph (8) of subdivision (a) of Section 1502 of the Health and Safety Code, in California.

(b) These community treatment facilities will provide residential mental health treatment programs for seriously emotionally disturbed children and adolescents who need secure containment and a greater level of care than can be provided in a group home, but in a less restrictive program than those provided by a state or acute care institution.

(c) Community treatment facilities are licensed as community care facilities by the State Department of Social Services and their mental health programs will be certified by the State Department of Mental Health.

(d) The Legislature recognizes that the seriously emotionally disturbed children and adolescents placed in community treatment facilities may exhibit behaviors that are more serious and frequent than those exhibited by children in group homes and other community care facilities.

(e) In order to protect these children from themselves and to protect those around them, and to create a highly structured environment for effective mental health treatment, community treatment facilities are authorized by statute and regulations to lock their exterior doors and to utilize restraint and seclusion.

SEC. 41. Section 4094.1 is added to the Welfare and Institutions Code, to read:

4094.1. (a) (1) The department and the State Department of Social Services, in consultation with community treatment providers, local mental health departments, and county welfare departments, shall develop joint protocols for the oversight of community treatment facilities.

(2) Subject to subdivision (b), until the protocols and regulatory changes required by paragraph (1) are implemented, entities operating community treatment facilities shall comply with the current reporting requirements and other procedural and administrative mandates established in State Department of Mental Health regulations governing community treatment facilities.

(b) In accordance with all of the following, the State Department of Social Services shall modify existing regulations governing reporting requirements and other procedural and administrative mandates, to take into account the seriousness and frequency of behaviors that are likely to be exhibited by children placed in community treatment facilities. The modifications required by this subdivision shall apply for the entire 2000–01 fiscal year.

(1) Notwithstanding existing regulations, the State Department of Social Services shall issue alternative training and education requirements for community treatment facility managers and staff, which shall be developed in consultation with the State Department of Mental Health, patients' rights advocates, local mental health departments, county welfare offices, and providers.

(2) The department and the State Department of Social Services shall conduct joint bimonthly visits to licensed community treatment facilities to monitor operational progress and to provide technical assistance.

(3) The appropriate department shall centrally review any certification or licensure deficiency before notice of the citation is issued to the community care facility.

(4) A community treatment facility shall be exempt from reporting any occurrence of the use of restraint to the State Department of Social Services, unless physical injury is sustained or unconsciousness or other medical conditions arise from the restraint. All other reporting requirements shall apply.

SEC. 42. Section 4094.2 is added to the Welfare and Institutions Code, to read:

4094.2. (a) For the purpose of establishing payment rates for community treatment facility programs, the private nonprofit agencies selected to operate these programs shall prepare a budget that covers the total costs of providing residential care and supervision and mental health services for their proposed programs. These costs shall include categories that are allowable under California's Foster Care program and existing programs for mental health services. They shall not include educational, nonmental health medical and dental costs.

(b) Each agency operating a community treatment facility program shall negotiate a final budget with the local mental health department in the county in which its facility is located (the host county) and other local agencies as appropriate. This budget agreement shall specify the types and level of care and services to be provided by the community treatment facility program and a payment rate that fully covers the costs included in the negotiated budget. All counties that place children in a community treatment facility program shall make payments using the budget agreement negotiated by the community treatment facility provider and the host county.

(c) A foster care rate shall be established for each community treatment facility program by the State Department of Social Services. These rates shall be established using the existing foster care ratesetting system for group homes, with modifications designed as necessary. It is anticipated that all community treatment facility programs will offer the level of care and services required to receive the highest foster care rate provided for under the current group home ratesetting system.

(d) For the 2000–01 fiscal year, community treatment facility programs shall also be paid a community treatment facility supplemental rate of up to two thousand five hundred dollars ($2,500) per child per month on behalf of children eligible under the foster care program and children placed out of home pursuant to an individualized education program developed under Section 7572.5 of the Government Code. Subject to the availability of funds, the community treatment facility supplemental rate shall be funded by the state, and no county financial participation shall be required. The community treatment facility supplemental rate is intended to supplement, and not to supplant, the payments for which children placed in community treatment facilities are eligible to receive

under the foster care program and the existing programs for mental health services.

(e) For initial ratesetting purposes for community treatment facility funding, the cost of mental health services shall be determined by deducting the foster care rate and the community treatment facility supplemental rate from the total allowable cost of the community treatment facility program. Payments to certified providers for mental health services shall be based on eligible services provided to children who are Medi-Cal beneficiaries, up to the statewide maximum allowances for these services.

(f) Although there is statutory authorization for up to 400 community treatment facility beds statewide, it is anticipated that there will be a phased-in implementation of community treatment facilities, and that the average monthly community treatment facility caseload during the 2000–01 fiscal year will be approximately 100. Therefore, an augmentation of three million dollars ($3,000,000) from the state General Fund is being provided to fund community treatment facility supplemental rates for the 2000–01 fiscal year. In the event that, during the course of the 2000–01 fiscal year, it is determined that the implementation of community treatment facilities is proceeding faster than anticipated and the average monthly caseload will exceed 100, the department shall notify the Legislature, upon approval of the Department of Finance, and request a budget augmentation to pay for the additional costs of the community treatment facility supplemental rate.

(g) The department shall provide funding of community treatment facility supplemental rates to the counties for advanced payment to the community treatment facility providers.

(h) The department and the State Department of Social Services shall submit a joint report to the Legislature by April 1, 2001, on the status of their efforts to implement the community treatment facility payment system described in subdivisions (a) to (g), inclusive, and the joint protocols for the oversight of community treatment facility programs and regulatory changes that take into account the seriousness and frequency of behaviors that are likely to be exhibited by seriously emotionally disturbed children placed in community treatment facilities, as described in Section 4094.1.

(i) It is the intent of the Legislature that the department and the State Department of Social Services work to maximize federal financial participation in funding for children placed in community treatment facilities through funds available pursuant to Titles IV-E and XIX of the federal Social Security Act (Title 42 U.S.C. Sec. 670 and following and Sec. 1396 and following) and other appropriate federal programs.

(j) The department and the State Department of Social Services may adopt emergency regulations necessary to implement joint protocols for the oversight of community treatment facilities, to

modify existing licensing regulations governing reporting requirements and other procedural and administrative mandates to take into account the seriousness and frequency of behaviors that are likely to be exhibited by the seriously emotionally disturbed children placed in community treatment facility programs, to modify the existing foster care ratesetting regulations, and to pay the community treatment facility supplemental rate. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, and general welfare. The regulations shall become effective immediately upon filing with the Secretary of State. The regulations shall not remain in effect more than 180 days unless the adopting agency complies with all the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, as required by subdivision (e) of Section 11346.1 of the Government Code.

SEC. 43. Chapter 4 (commencing with Section 4096.7) is added to Part 1 of Division 4 of the Welfare and Institutions Code, to read:

CHAPTER 4. DUAL DIAGNOSIS PILOT PROJECT

4096.7. (a) Contingent upon the appropriation of funds in the annual Budget Act, commencing September 15, 2000, the State Department of Mental Health shall conduct a three-year pilot project under which funds shall be allocated to serve persons from culturally diverse, underserved populations, including clients from the Asian and Pacific Islander community and clients from the Latino community, who are dually diagnosed with both a mental illness and substance abuse problem.

(b) The department may develop and issue a request for proposals from county mental health departments and nonprofit organizations soliciting participation in the pilot project. System stakeholders shall be consulted in the development of the request for proposals and selection of each pilot area. At least two pilot areas shall be selected.

(c) Each eligible proposal shall, at a minimum, describe how the proposed pilot program will meet the following goals and objectives:

(1) Expand the continuum of culturally competent services and supports.

(2) Improve coordination of substance abuse and mental health services between programs or across counties in order to maximize the utilization of services and supports.

(3) Improve clinical standards in order to be able to provide culturally appropriate services and supports.

(4) Unify administrative policies between programs or across counties in order to provide more seamless services and supports and to better track and record utilization of services and supports.

(5) Develop long-term, cost-effective, multiprogram, or multicounty services to maximize the utilization of public dollars.

(d) Each eligible proposal shall include a description of specific activities to be accomplished by the pilot project, including, but not limited to:

(1) A needs assessment for the target populations.

(2) A description of the roles of community and local government partners under the pilot project.

(3) How service and support infrastructure will be developed to meet the needs of the target population, including the development of new services, enhancement of existing services, recruitment and training of culturally sensitive staff, and development and implementation of clinical policies and protocols.

(4) How outreach and enrollment will be accomplished.

(e) Each eligible proposal shall include an evaluation component, including, but not limited to:

(1) The extent to which goals and objectives have been met.

(2) Client satisfaction.

(3) Community satisfaction.

(4) Cost analysis.

(f) Each pilot project funded under this section shall submit to the department its evaluation, along with recommendations for the continuation or expansion of the program, by July 15, 2002.

(g) The department shall issue a report to the Legislature no later than September 1, 2002, on implementation of the pilot projects funded by this chapter and recommendations with respect to continuation and expansion.

(h) This chapter shall become inoperative on June 30, 2003, and, as of January 1, 2004, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2004, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 44. Chapter 5 (commencing with Section 4097) is added to Part 1 of Division 4 of the Welfare and Institutions Code, to read:

CHAPTER 5. EARLY INTERVENTION MENTAL HEALTH PROGRAM

4097. There is hereby established, under the administration of the State Department of Mental Health, an Early Intervention Mental Health Program. This program shall provide services to infants and toddlers, from birth to three years of age, and their families. To the extent funding is available through the annual Budget Act, and professional collaborative relationships have been established, the program may be expanded beyond the 1999–2000 pilot project focus on children who have been diagnosed with a developmental disability or delay or who are at risk of a developmental disability or delay.

4097.1. Up to three million dollars ($3,000,000) may be allocated on an annual basis for three years to the department for this program. No more than 5 percent of these funds may be used for state administrative costs.

4097.2. Program services shall be designed to facilitate a relationship-based approach that promotes optimal social and emotional development of the child in interactions between parent, or primary caregiver and child, and shall include both prevention and treatment aspects. A key component of the program shall include training of, and technical assistance to, public and private agencies that currently provide, or plan to provide, early intervention mental health services.

4097.3. The program shall be formally evaluated by the department and the results of the evaluation reported to the fiscal and policy committees of the Legislature before any additional state funding is authorized beyond June 30, 2003. The department shall provide interim annual progress reports to the Legislature by March 1, 2001, and 2002, which shall include data on the progress of implementation and findings to date.

SEC. 44.5. Chapter 6 (commencing with Section 4098) is added to Part 1 of Division 4 of the Welfare and Institutions Code, to read:

CHAPTER 6. SUICIDE PREVENTION PROGRAMS

4098. The Legislature finds and declares all of the following:

(a) The Surgeon General of the United States has described suicide prevention as a serious public health priority, and has called upon each state to develop a strategy for suicide prevention using a public health approach.

(b) In 1996, 3,401 Californians lost their lives to suicide, an average of nine residents per day. It is estimated that there are between 75,000 and 100,000 suicide attempts in California every year. 11 percent of all suicides in the nation take place in California.

(c) Adolescents are far more likely to attempt suicide than their older California counterparts. Data indicate that there are 100 attempts for every adolescent suicide completed. In 1996, 207 California youth died by suicide. Using this estimate, there were likely more than 20,000 suicide attempts made by California adolescents, and approximately 20 percent of all the estimated suicide attempts occurred in California.

(d) Of all of the violent deaths associated with schools nationwide since 1992, 14 percent were suicides.

(e) Homicide and suicide rank as the third and fifth leading causes of death for youth, respectively. Both are preventable. While the death rates for unintentional injuries decreased by more than 40 percent between 1979 and 1996, the death rates for homicide and suicide increased for youth. Evidence is growing in terms of the links

between suicide and other forms of violence. This provides compelling reasons for broadening the state's scope in identifying risk factors for self-harmful behavior. The number of estimated youth suicide attempts; and the growing concerns of youth violence can best be addressed through the implementation of successful gatekeeper training programs to identify and refer youth at risk for self-harmful behavior.

(f) The American Association of Suicidology (AAS) conservatively estimates that the lives of at least six persons related to or connected to individuals who attempt or complete suicide are impacted. Using these estimates, in 1996, more than 600,000 Californians, or 1,644 individuals per day, struggled to cope with the impact of suicide.

(g) Restriction of access to lethal means significantly reduces the number of successful suicides.

(h) Actual incidents of suicide attempts are expected to be higher than reported because attempts not requiring medical attention are less likely to be reported. The underreporting of suicide completion is also likely since suicide classification involves conclusions regarding the intent of the deceased. The stigma associated with suicide is also likely to contribute to underreporting.

(i) Without interagency collaboration and support for proven, community-based, culturally competent suicide prevention and intervention programs, occurrences of suicide are likely to rise.

4098.1. (a) This chapter shall be known and may be cited as the California Suicide Prevention Act of 2000.

4098.2. (a) The State Department of Mental Health, contingent upon appropriation in the annual Budget Act, may establish and implement a suicide prevention, education, and gatekeeper training program to reduce the severity, duration, and incidence of suicidal behaviors.

(b) In developing and implementing the components of this program, the department shall build upon the existing network of nonprofit suicide prevention programs in the state, and shall utilize the expertise of existing suicide prevention programs that meet any of the following criteria:

(1) Have been identified by a county as providing suicide prevention services for that county.

(2) Are certified by the American Association of Suicidology.

(3) Meet criteria for suicide prevention programs that may be established by the department.

(c) The program established by this section shall be consistent with the public health model proposed by the Surgeon General of the United States, and the system of care approach pursuant to the Bronzan-McCorquodale Act, Part 2 (commencing with Section 5600) of Division 5.

4098.3. The department may contract with an outside agency to establish and implement a targeted public awareness and education campaign on suicide prevention and treatment. Target populations shall include junior high and high school students, as well as other selected populations known to be at high risk of suicide.

4098.4. (a) The department may contract with local mental health organizations and professionals with expertise in the assessment and treatment of suicidal behaviors to develop an evidence-based assessment and prevention program for suicide that may be integrated with local mental health departments or replicated by public or private suicide treatment programs, or both.

(b) This component may include the creation of guidebooks and training protocols to improve the intervention capabilities of caregivers who work with individuals at risk of suicide. Applicants may reflect several gatekeeper training models that can be replicated in other communities.

4098.5. The department may establish and implement, or contract with an outside agency for the development of a multicounty, 24-hour, centralized suicide crisis line integrated network. Existing crisis lines that meet specifications of the department and the American Association of Suicidology may be included in this integrated network. The crisis line established under this section shall link persons at risk of committing suicide with local suicide prevention and treatment resources.

SEC. 45. Section 4107.1 is added to the Welfare and Institutions Code, to read:

4107.1. Consistent with the authority of the State Department of Mental Health to maintain and operate state hospitals under its jurisdiction, the State Department of Mental Health shall provide internal security for the patient population at Patton State Hospital. The State Department of Mental Health may employ hospital police at Patton State Hospital for this purpose.

This section is not intended to increase or decrease the duties and responsibilities of the Department of Corrections at Patton State Hospital.

SEC. 46. Section 4598.5 is added to the Welfare and Institutions Code, to read:

4598.5. If, in the unforeseen event that federal funds are not available for appropriation or transfer to Item 4110-001-0001 of Section 2.00 of the Budget Act of 2000 for support of the Organization of Area Boards on Developmental Disabilities, from Item 4100-001-0890 of Section 2.00 of the Budget Act of 2000 based on a determination by the Department of Finance, the Department of Finance shall notify the appropriate fiscal and policy committees of the Legislature and the Joint Legislative Budget Committee within 10 calendar days of this determination. This notification shall specify the dollar amount needed to fully continue operations of the

Organization of Area Boards on Developmental Disabilities, and this amount is hereby appropriated from the General Fund for those purposes, commencing 10 days after the receipt of the notification by the Legislature.

SEC. 47. Section 4639.5 is added to the Welfare and Institutions Code, to read:

4639.5. (a) By December 1 of each year, each regional center shall provide a listing to the State Department of Developmental Services a complete current salary schedule for all personnel classifications used by the regional center. The information shall be provided in a format prescribed by the department. The department shall provide this information to the public upon request.

(b) By December 1 of each year, each regional center shall report information to the State Department of Developmental Services on all prior fiscal year expenditures from the regional center operations budget for all administrative services, including managerial, consultant, accounting, personnel, labor relations, and legal services, whether procured under a written contract or otherwise. Expenditures for the maintenance, repair or purchase of equipment or property shall not be required to be reported for purposes of this subdivision. The report shall be prepared in a format prescribed by the department and shall include, at a minimum, for each recipient the amount of funds expended, the type of service, and purpose of the expenditure. The department shall provide this information to the public upon request.

SEC. 48. Section 4689.7 of the Welfare and Institutions Code is amended to read:

4689.7. (a) For the 1998–99 fiscal year, levels of payment for supported living service providers that are vendored pursuant to Section 4689 shall be increased based on the amount appropriated in this section for the purpose of increasing the salary, wage, and benefits for direct care workers providing supported living services.

(b) The sum of five million fifty-seven thousand dollars ($5,057,000) is hereby appropriated in augmentation of the appropriations made in the Budget Act of 1998 to implement this section as follows:

(1) The sum of two million four hundred five thousand dollars ($2,405,000) is hereby appropriated from the General Fund to the State Department of Health Services in augmentation of the appropriation made in Item 4260-101-0001.

(2) The sum of two million five hundred fifty-one thousand dollars ($2,551,000) is hereby appropriated from the Federal Trust Fund to the State Department of Health Services in augmentation of the appropriation made in Item 4260-101-0890.

(3) The sum of one hundred one thousand dollars ($101,000) is hereby appropriated from the General Fund to the Department of

Developmental Services in augmentation of the appropriation made in Item 4300-101-0001, scheduled as follows:

10.10—Regional Centers	
(b) 10.10.020 Purchase of Services	$5,057,000
(e) Reimbursements	–$4,956,000

(c) By July 1, 2002, in consultation with stakeholder organizations, the department shall establish by regulation, an equitable and cost-effective methodology for the determination of supported living costs and a methodology of payment for providers of supported living services. The methodology shall consider the special needs of persons with developmental disabilities and the quality of services to be provided.

SEC. 49. Section 4791 of the Welfare and Institutions Code is amended to read:

4791. (a) The Legislature finds that when the state faces an unprecedented fiscal crisis, the services set forth in this division are necessary to enable persons with developmental disabilities to live in the least restrictive setting.

(b) In order to ensure that services to eligible consumers are available throughout the fiscal year, regional centers shall administer their contracts within the level of funding available within the annual Budget Act.

(c) To carry out the intent of this provision, and notwithstanding Chapter 5 and Section 4643, each regional center contract shall include provisions which ensure the regional center will provide services to eligible consumers within the funds available in the contract throughout the fiscal year. Regional centers shall implement innovative, cost-effective methods of services delivery, which may include, but not be limited to, the use of vouchers, consumer or parent services coordinators, increased administrative efficiencies, and alternative sources of payment for services.

(d) In the event of an unallocated reduction, the Budget Act of each fiscal year shall determine the distribution of any unallocated reduction within the regional center budget item.

(e) In the event of an unallocated reduction in the regional center budget, or if an individual regional center notifies the department that the regional center will be unable to provide services and supports to eligible consumers throughout the fiscal year within the level of funding available in their contract, the following shall apply:

(1) The department shall provide the regional center or regional centers with guidelines, technical assistance, and a variety of options for reducing operations and purchase of service costs.

(2) Within 30 days of the enactment of the Budget Act or after the date a regional center notifies the department of a projected deficit

in its purchase of services budget, each impacted regional center shall develop and submit a plan to the department describing in detail how it intends to absorb any unallocated reduction and shall achieve savings necessary to provide services to eligible consumers throughout the fiscal year within the limitations of the funds allocated. Prior to adopting the plan, each regional center shall hold a public hearing in order to receive comment on the plan. The regional centers shall provide notice to the community at least 10 days in advance of the public hearing. The regional center shall summarize and respond to the public testimony in their plan.

(3) The plan submitted to the department may include, but not be limited to:

(A) Innovative and cost-effective methods of services delivery that include, but are not limited to, the use of vouchers; the use of consumers and parents as service coordinators; alternative methods of case management; the use of volunteer teams, made up of consumers, parents, other family members, and advocates, to conduct the monitoring activities described in Section 4648.1; increased administrative efficiencies; alternative sources of payment for services; use of available assessments in determining eligibility; and alternative nonresidential rate methodologies or service delivery models, or both. In addition, the regional center shall take into account, in identifying the consumer's service needs, the family's responsibility for providing similar services to a child without disabilities.

(B) The maximization of all alternative funding sources, including federal and generic funding sources.

(C) Assurances that all other operations expenditure reductions are considered before any reductions are made in nonsupervisory, service coordination staff.

(4) The regional centers shall implement components of their plans upon approval of the department. The department shall review and approve, or require modification of portions of the regional centers' plan, within 30 days of receipt of the plan. If the required modification is significant, the department shall require the regional center to hold an additional public hearing to review and comment on the modification.

(f) Notwithstanding any other provision of law, in any fiscal year in which an unallocated reduction is made in the regional center budget, the director may adopt, amend, repeal, or suspend regulations as necessary to permit program flexibility and allow regional centers to achieve cost savings or innovative approaches to service delivery, including, but not limited, to those specified in subparagraph (A) of paragraph (1) of subdivision (e) without adversely affecting consumer health and safety or placing persons with disabilities in a more restrictive environment. Furthermore, any such regulatory change shall not authorize categorical reductions;

changes in service delivery shall have an exemption process. It is the intent of the Legislature that any such action be deemed an emergency necessary for the immediate preservation of the public peace, health, and safety, or general welfare for purposes of subdivision (b) of Section 11346.1 of the Government Code.

(g) Notwithstanding any other provision of law, the State Director of the Department of Developmental Services may require one or more regional centers to take any actions he or she determines to be necessary to ensure reductions are made in the regional center operations budget, including, but not limited to, the following:

(1) Require a regional center to centralize billing and other fiscal and administrative functions.

(2) Require a regional center to reduce office space through the decentralization of service coordinators by allowing service coordinators to work in their homes and in community-based programs.

(3) Require a regional center to freeze or reduce levels of pay for administrative and managerial employees.

(4) Require a regional center to contract for specified functions currently conducted directly by the regional center.

(5) Require regional centers to seek Medi-Cal provider status for regional center staff performing reimbursable activities.

(h) Notwithstanding any other provisions of law, the director may terminate a regional center contract if he or she determines that the regional center is unable or unwilling to make the necessary reductions in its operations budget or if the action is necessary to avoid reductions in the purchase of services for regional center consumers.

(i) Notwithstanding any other provisions of law, the department may directly operate a regional center after the termination of a contract.

(j) If the director determines that regional centers cannot provide services throughout the fiscal year within the funds provided by the Budget Act, he or she shall immediately report to the Governor and the appropriate fiscal committees of the Legislature and recommend actions to secure additional funds or reduce expenditures, including any actions which require the suspension of the entitlement to service set forth in this division.

(k) Developing and implementing the plan shall be considered a contractual obligation pursuant to Section 4635 of the Welfare and Institutions Code. Accordingly, the department shall make reasonable efforts to assist regional centers in fulfilling their contractual obligations and provide technical assistance, as necessary. In addition, a regional center’s failure to develop and implement the plan may be considered grounds for contract termination or nonrenewal. If at any time the director of the department determines that a regional center’s plan does not

adequately address a funding deficiency during the fiscal year, the director may require the use of operational funds to reduce the deficiency in purchase of services funds.

(*l*) This section shall become inoperative on July 1, 2001, and, as of January 1, 2002, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2002, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 50. Section 5600.8 is added to the Welfare and Institutions Code, to read:

5600.8. (a) The department may allocate the funds appropriated in Schedule (b) of Item 4440-101-0001 of the Budget Act of 2000, to county mental health programs that meet programmatic goals and model adult system of care programs to the satisfaction of the department. The department shall audit and monitor the use of these funds to ensure they are used solely in support of Adult System of Care programming. If county programs receiving adult system of care funding do not comply with program and audit requirements determined by the department, funding shall be redistributed to other counties to implement, expand, or model adult systems of care.

(b) The department may allocate the funds appropriated in Schedule (c) of Item 4440-101-0001 of the Budget Act of 2000, to county mental health programs for Children's System of Care programming. These funds shall be utilized by counties only in support of a mental health system serving seriously emotionally disturbed children, in accordance with the principles and program requirements associated with the system of care model, as set forth in Part 4 (commencing with Section 5850). The department shall audit and monitor the use of these funds to ensure they are used solely in support of the Children's System of Care program. If county programs receiving children's system of care funding do not comply with program and audit requirements determined by the department, funds shall be redistributed to other counties to implement, expand, or model children's system of care programming.

SEC. 51. Section 5614 is added to the Welfare and Institutions Code, to read:

5614. (a) The department, in consultation with the Compliance Advisory Committee which shall have representatives from relevant stakeholders, including, but not limited to, local mental health departments, local mental health boards and commissions, private and community-based providers, consumers and family members of consumers, and advocates, shall establish a protocol for ensuring that local mental health departments meet statutory and regulatory requirements for the provision of publicly funded community mental health services provided under this part.

(b) The protocol shall include a procedure for review and assurance of compliance for all of the following elements, and any other elements required in law or regulation:

(1) Financial maintenance of effort requirements provided for under Section 17608.05.

(2) Each local mental health board has approved procedures that ensure citizen and professional involvement in the local mental health planning process.

(3) Children's services are funded pursuant to the requirements of Sections 5704.5 and 5704.6.

(4) The local mental health department complies with reporting requirements developed by the department.

(5) To the extent resources are available, the local mental health department maintains the program principles and the array of treatment options required under Sections 5600.2 to 5600.9, inclusive.

(7) The local mental health department meets the reporting required by the performance outcome systems for adults and children.

(c) The protocol developed pursuant to subdivision (a) shall focus on law and regulations and shall include, but not be limited to, the items specified in subdivision (b). The protocol shall include data collection procedures so that state review and reporting may occur. The protocol shall also include a procedure for the provision of technical assistance, and formal decision rules and procedures for enforcement consequences when the requirements of law and regulations are not met. These standards and decision rules shall be established through the consensual stakeholder process established by the department.

SEC. 52. Section 5614.5 is added to the Welfare and Institutions Code, to read:

5614.5. (a) The department, in consultation with the Quality Improvement Committee which shall include representatives of the California Mental Health Planning Council, local mental health departments, consumers and families of consumers, and other stakeholders, shall establish and measure indicators of access and quality to provide the information needed to continuously improve the care provided in California's public mental health system.

(b) The department in consultation with the Quality Improvement Committee shall include specific indicators in all of the following areas:

(1) Structure.

(2) Process, including access to care, appropriateness of care, and the cost effectiveness of care.

(3) Outcomes.

(c) Protocols for both compliance with law and regulations and for quality indicators shall include standards and formal decision rules for establishing when technical assistance, and enforcement in the

case of compliance, will occur. These standards and decision rules shall be established through the consensual stakeholder process established by the department.

(d) The department shall report to the legislative budget committees on the status of the efforts in Section 5614 and this section by March 1, 2001. The report shall include presentation of the protocols and indicators developed pursuant to this section or barriers encountered in their development.

SEC. 53. Section 5618 is added to the Welfare and Institutions Code, to read:

5618. Mental health plans shall be responsible for providing information to potential clients, family members, and caregivers regarding specialty Medi-Cal mental health services offered by the mental health plans upon request of the individual. This information shall be written in a manner that is easy to understand and is descriptive of the complete services offered.

SEC. 54. Section 5675 of the Welfare and Institutions Code is amended to read:

5675. (a) Subject to Section 5768, Placer County and up to 15 other counties may establish a pilot project for up to six years, to develop a shared mental health rehabilitation center for the provision of community care and treatment for persons with mental disorders who are placed in a state hospital or another health facility because no community placements are available to meet the needs of these patients. Participation in this pilot project by the counties shall be on a voluntary basis.

(b) (1) The department shall establish, by emergency regulation, the standards for the pilot project, and monitor the compliance of the counties with those standards. Participating counties, in consultation with the department, shall be responsible for program monitoring.

(2) The department, in conjunction with the county mental health directors, shall provide an interim report to the Legislature within three years of the commencement of operation of the facilities authorized pursuant to this section regarding the progress and cost effectiveness demonstrated by the pilot project. The department, in conjunction with the county mental health directors, shall report to the Legislature within five years of the commencement of operation of the facilities authorized pursuant to this section regarding the progress and cost effectiveness demonstrated by the pilot project. The report shall evaluate whether the pilot project is effective based on clinical indicators, and is successful in preventing future placement of its clients in state hospitals or other long-term health facilities, and shall report whether the cost of care in the pilot facilities is less than the cost of care in state hospitals or in other long-term health facility options. The evaluation report shall include, but not be limited to, an evaluation of the selected method and the effectiveness of the pilot project staffing, and an analysis of the

effectiveness of the pilot project at meeting all of the following objectives:

(A) That the clients placed in the facilities show improved global assessment scores, as measured by preadmission and postadmission tests.

(B) That the clients placed in the facilities demonstrate improved functional behavior as measured by preadmission and postadmission tests.

(C) That the clients placed in the facilities have reduced medication levels as determined by comparison of preadmission and postadmission records.

(3) The pilot project shall be deemed successful if it demonstrates both of the following:

(A) The costs of the program are no greater than public expenditures for providing alternative services to the clients served by the project.

(B) That the benefit to the clients, as described in this subdivision, is improved by the project.

(c) The project shall be subject to existing regulations of the State Department of Health Services applicable to health facilities that the State Department of Mental Health deems necessary for fire and life safety of persons with mental illness.

(d) The department shall consider projects proposed by other counties under Section 5768.

(e) (1) Clients served by the project shall have all of the protections and rights guaranteed to mental health patients pursuant to the following provisions of law:

(A) Part 1 (commencing with Section 5000) and this part.

(B) Article 5 (commencing with Section 835), Article 5.5 (commencing with Section 850), and Article 6 (commencing with Section 860) of Chapter 4 of Title 9 of the California Code of Regulations.

(2) Clients shall have access to the services of a county patients' rights advocates as provided in Chapter 6.2 (commencing with Section 5500) of Part 1.

(f) This section shall become inoperative on July 1, 2001, and as of January 1, 2002, is repealed unless a later enacted statute, that is enacted before January 1, 2002, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 55. Section 5675.1 is added to the Welfare and Institutions Code, to read:

5675.1. (a) In accordance with subdivision (b), the department may establish a system for the imposition of prompt and effective civil sanctions for long-term care facilities licensed or certified by the department, including facilities licensed under the provisions of Sections 5675 and 5768, and including facilities certified as providing

a special treatment program under Sections 72443 to 72474, inclusive, of Title 22 of the California Code of Regulations.

(b) If the department determines that there is or has been a failure, in a substantial manner, on the part of any such facility to comply with the applicable laws and regulations, the director may impose the following sanctions:

(1) A plan of corrective action that addresses all failure identified by the department and includes timelines for correction.

(2) A facility that is issued a plan of corrective action, and that fails to comply with the plan and repeats the deficiency, may be subject to immediate suspension of its license or certification, until the deficiency is corrected, when failure to comply with the plan of correction may cause a health or safety risk to residents.

(c) The department may also establish procedures for the appeal of an administrative action taken pursuant to this section, including a plan of corrective action or a suspension of license or certification.

SEC. 56. Section 5676 is added to the Welfare and Institutions Code, to read:

5676. (a) The department, in conjunction with the State Department of Health Services, shall develop a state-level plan for a streamlined and consolidated evaluation and monitoring program for the review of skilled nursing facilities with special treatment programs. The plan shall provide for consolidated reviews, reports, and penalties for these facilities. The plan shall include the cost of, and a timeline for implementing, the plan. The plan shall be developed in consultation with stakeholders, including county mental health programs, consumers, family members of persons residing in long-term care facilities who have serious mental illness, and long-term care providers. The plan shall review resident safety and quality programming, ensure that long-term care facilities engaged primarily in diagnosis, treatment, and care of persons with mental diseases are available and appropriately evaluated, and ensure that strong linkages are built to local communities and other treatment resources for residents and their families. The plan shall be submitted to the Legislature on or before March 1, 2001.

(b) The State Department of Health Services shall forward to the State Department of Mental Health copies of citations issued to a skilled nursing facility that has a special treatment program certified by the State Department of Mental Health.

SEC. 57. Section 5676.5 is added to the Welfare and Institutions Code, to read:

5676.5. (a) It is the intent of the Legislature to ensure that funds allocated to establish or enhance mental health programs are used to integrate the new or enhanced program into an existing system of care.

(b) Counties that apply for funds to establish or enhance their mental health service system shall document, in the application

process, how the new funds blend into an existing system of care and do not supplant existing expenditures.

(c) Applications shall include plans for services and supports, and shall specify how the new or enhanced program blends into an existing array of services. Applications shall demonstrate how a collaborative process involving clients, family members, and other system stakeholders was used to develop the proposal.

(d) Applications shall include a commitment to outcome reporting, as defined by the department, including client benefit outcomes, client and family member satisfaction, system of care access, cost savings, cost avoidance, and cost effectiveness outcomes that measure both short- and long-term cost savings.

(e) Applications shall demonstrate, when appropriate, how the county intends to continue the new or enhanced program when the grant funds have ended.

SEC. 58. Article 2.5 (commencing with Section 5689) is added to Chapter 2.5 of Part 2 of Division 5 of the Welfare and Institutions Code, to read:

Article 2.5. Older Adults System of Care Mental Health Demonstration Project

5689. (a) The State Department of Mental Health shall establish and administer an Older Adults System of Care Demonstration Project, subject to funds appropriated for this purpose, that provides support and funding to develop model systems of care to serve the target population specified in Section 5689.2. Funds appropriated for purposes of this article shall be used to support pilot projects that address the specific needs of older adults with mental illness by testing existing and new models for coordinated, comprehensive service delivery.

(b) The project shall be designed to encourage the development and testing of a coordinated, consumer-focused, comprehensive mental health system of care consistent with the recommendations contained in the California Mental Health Master Plans' Older Adult Chapter.

5689.1. The department shall establish a steering committee for the purposes of this article.

5689.2. (a) The target population to be served pursuant to this article shall be adults who are 60 years of age or older, diagnosed with a mental disorder, as defined by the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, who have a functional impairment, and who meet any of the following criteria:

(1) Are severely and persistently disabled.

(2) Are acutely disabled.

(3) Are impacted by disasters or local emergencies.

(b) For purposes of this article, ‘‘functional impairment’’ means a being substantially impaired in major life activities because of a mental disorder in at least two of the following areas on a continuing or intermittent basis:

(1) Independent living.
(2) Social and family relationships.
(3) Vocational skills, employment, or leisure activities.
(4) Basic living skills.
(5) Money management.
(6) Self-care capacities.
(7) Physical condition.

5689.3. The department shall seek proposals and competitively award grants to local mental health departments for a period of up to three years to implement this demonstration project. Grantees shall be representative of different geographic areas of the state to the extent resources are available. The department shall encourage multicounty collaboration.

5689.4. Grantees shall establish or identify a Mental Health and Aging Advisory Coalition comprised of pilot project participants, public and private sector service providers, senior service consortiums, commissions, boards, and advisory councils, consumers and family members of consumers, mental health advocates, and other stakeholders. This coalition shall be advisory to the county mental health department. Coalition participants may include, but are not limited to, area agencies on aging, adult day and adult day health care programs, senior centers, public and private sector health programs, mental health, aging, social service, legal service, and public guardian programs, conservators, drug and alcohol programs, senior ombudsmen, residential care facility operators, family caregivers, family caregiver service providers, and other stakeholders.

5689.5. (a) Each grantee shall identify collaborative efforts it will undertake to link the Older Adult Mental Health System of Care with other related planning and implementation efforts occurring within the county, including, but not limited to, Long Term Care Integration Pilot Project activities pursuant to Article 4.3 (commencing with Section 14139.05) of Chapter 7 of Part 3 of Division 9.

(b) Each grantee shall define its project goals and establish client and system outcome measurements in collaboration with the department.

5689.6. The department, in collaboration with the California Mental Health Planning Council and the grantees, shall identify a set of common data elements that will be used to collect, analyze, and measure performance among grantees.

5689.7. (a) To the extent funds are available, evaluation shall be conducted both by the participating county evaluation staff of each

participating county and by an independent evaluator contracted for by the department.

(b) Evaluation at both the local and state levels shall assess the extent to which:

(1) The county system of care is serving the targeting population.

(2) Timely performance data related to client outcomes and cost avoidance is collected, analyzed, and reported.

(3) System of care components are implemented as intended.

(4) Information is collected that documents needs for future planning.

5689.8. The department shall provide periodic progress reports and recommendations on the status of the Demonstration Project provided for in this article to the Long Term Care Coordination Council pursuant to Section 12803.2 of the Government Code.

5689.9. The department shall provide periodic progress reports on the status of the demonstration projects to all Demonstration Project participants and mental health directors to increase statewide awareness about mental health service development for older adults. The department may provide copies of these reports to other individuals or entities.

SEC. 59. Part 3.5 (commencing with Section 5830) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 3.5. MENTAL HEALTH RESPITE CARE PILOT PROJECTS

CHAPTER 1. LEGISLATIVE DECLARATIONS AND DEFINITIONS

5830. The Legislature finds and declares all of the following:

(a) Family members are a primary source of care and support for children and adults with mental illness.

(b) As defined by the United States Surgeon General in a recent report on mental health, respite care is a concrete support service providing temporary relief to family members caring for individuals with mental illness.

(c) Respite care provided to families caring for a seriously emotionally disturbed child or seriously mentally ill adult is critical to assist them in keeping their family member in the home and maintaining the stability of the family.

(d) Respite care relieves the primary caregivers of providing constant care for a person with mental illness, and relieves chronic emotional stress that puts caregivers at risk of emotional and physical exhaustion, burnout, and related health disorders.

(e) When respite care is available, family members prefer in-home mental health care, rather than more costly out-of-home care.

5831. For purposes of this part, ‘‘department’’ means the State Department of Mental Health.

CHAPTER 2. PILOT PROJECTS

5832. (a) Contingent upon appropriation in the annual Budget Act, the department may establish and administer pilot projects providing respite for caregivers of seriously emotionally disturbed children and seriously mentally ill adults who reside in a caregiver’s home.

(b) A pilot project may be operated by the county mental health department which may utilize county personnel and may contract with organizations with expertise in serving persons with mental illness.

(c) A county electing to participate in a pilot project shall submit proposals for the operation of a project to the department that shall include, but shall not be limited to, plans for the implementation of respite care services and descriptions of how the respite project will be coordinated with children or adult systems of care to the extent those systems of care are operating in the county.

(d) Approval to operate a pilot project shall be made by the department.

5833. (a) Parents or other family members who provide care in their home for a seriously emotionally disturbed child or a seriously mentally ill adult family member shall be eligible for respite care provided by a pilot county when, as determined by the county, both of the following conditions are met:

(1) The caregiver is under significant stress as a result of the responsibility of providing care.

(2) Continued caretaking without respite may result in out-of-home placement or a breakdown in family stability.

(b) A county operating a pilot project shall consult with stakeholder organizations in determining priorities for services and approval of respite care hours. Stakeholder organizations include, but are not limited to, families caring for family members with mental illness, persons with mental illness, advocates for persons with mental illness, mental health treatment providers, and multicultural organizations.

5834. (a) The amount and type of respite care provided to an eligible individual caretaker shall be determined by the county mental health department, in consultation with the caretaker requesting the respite care. In the case of a caretaker of an adult with mental illness, both the adult and the caretaker shall be consulted and respite care shall not be provided if the adult objects.

(b) Approved respite care may be provided on an hourly or daily basis, up to a maximum of seven days a month, except in the case of an exceptional circumstance or emergency as determined by the

county. The county shall establish an annual maximum expenditure per case that shall not be exceeded except in the case of an exceptional circumstance or emergency as determined by the county.

5835. The caregiver shall be actively involved in the selection of the respite care provider. To the extent possible, the caregiver shall have flexibility in the timing of the use of the respite care hours that have been allocated. Respite care may be provided in the home of the caregiver or out-of-home locations including, but not limited to, another caregiver's home or other sites allowed by the county respite program and appropriate for the individual with mental illness. To the extent appropriate care is available, out-of-home respite care shall be provided within a reasonable proximity of the family's home.

5836. Entities operating pilot projects under this part shall do both of the following:

(a) Make reasonable efforts to recruit respite providers with skills in working with families from diverse ethnic and cultural groups and who are linguistically diverse.

(b) Conduct outreach to families from diverse ethnic and cultural groups to inform them of the availability of respite to prevent out-of-home placement or maintain family stability in times of significant caretaker stress.

5837. At county option, foster family home providers caring for a seriously emotionally disturbed child may be eligible for respite care under a pilot project if, as determined by the county mental health and county welfare departments, funding for the respite care is not available through the county foster care program and, without the respite care, the child's placement in the foster home is jeopardized. If the caregiver receiving respite care is a foster parent, the county and foster parent shall follow requirements of the foster care program in the selection of the respite care provider.

CHAPTER 3. EVALUATIONS

5838. The department may conduct an evaluation of the pilot projects, or contract for an evaluation, and shall submit a report to the Legislature by March 30, 2002. Up to one hundred thousand dollars ($100,000) may be used for this purpose. The report shall contain, at a minimum, all of the following:

(a) The total number of families receiving respite care.

(b) The amount of respite care provided to each family.

(c) A description of the results of the pilot projects, which may include, but shall not be limited to, an estimate of cost-savings and benefits to the caretaking families, individuals with mental illness, county mental health department programs, and other county programs as a result of the provision of respite care.

CHAPTER 4. REPEAL DATE

5839. This part shall remain in effect only until January 1, 2002, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2002, deletes or extends that date.

SEC. 60. Section 14005.28 is added to the Welfare and Institutions Code, to read:

14005.28. (a) To the extent federal financial participation is available pursuant to an approved state plan amendment, the department shall exercise its option under Section 1902(a)(10)(A)(XV) of the federal Social Security Act (Title 42 U.S.C. Section 1396a(a)(10)(A)(XV) to extend Medi-Cal benefits to independent foster care adolescents, as defined in Section 1905(v)(1) of the federal Social Security Act (Title 42 U.S.C. Section 1396d(v)(1).

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and if the state plan amendment described in subdivision (a) is approved by the federal Health Care Financing Administration, the department may implement subdivision (a) without taking any regulatory action and by means of all-county letters or similar instructions. 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) The department shall implement subdivision (a) on October 1, 2000, but only if, and to the extent that, the department has obtained all necessary federal approvals.

SEC. 61. 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 establishing 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. A recipient shall be entitled to the same disregard, but only to the extent it is more beneficial than, and is substituted for, the earned income disregard available to recipients.

(d) For purposes of calculating income under this section during any calendar year, increases in social security benefit payments under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 and following) arising from cost-of-living adjustments shall be disregarded commencing in the month that these social security benefit payments are increased by the cost-of-living adjustment through the month before the month in which a change in the federal poverty level requires the department to modify the income disregard pursuant to subdivision (c) and in which new income limits for the program established by this section are adopted by the department.

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

(f) 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. 62. Section 14005.40 is added to the Welfare and Institutions Code, to read:

14005.40. (a) To the extent federal financial participation is available, the department shall exercise its option under Section 1902(a)(10)(A)(ii)(X) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(X), to implement a program for aged and disabled persons as described in Section 1902(m) of the federal Social Security Act (42 U.S.C. Sec. 1396a(m)(1)).

(b) To the extent federal financial participation is available, the blind shall be included within the definition of disabled for the purposes of the program established in this section.

(c) An individual shall satisfy the financial eligibility requirement of this program if both of the following conditions are met:

(1) Countable income, as determined in accordance with Section 1902(m) of the federal Social Security Act (42 U.S.C. Sec. 1396a(m)), does not exceed an income standard equal to 100 percent of the applicable federal poverty level, plus two hundred thirty dollars ($230) for an individual or, in the case of a couple, three hundred ten dollars ($310), provided that the income standard so determined shall not be less than the SSI/SSP payment level for a disabled individual or, in the case of a couple, the SSI/SSP payment level for a disabled couple.

(2) Countable resources, as determined in accordance with Section 1902(m) of the federal Social Security Act (42 U.S.C. Sec. 1396a(m)), do not exceed the maximum levels established in that section.

(d) The financial eligibility requirements provided in subdivisions (c) may be adjusted upwards to reflect the cost of living in California, contingent upon appropriation in the annual Budget Act.

(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 this section by means of all-county letters or similar instructions, and 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.

(f) For purposes of calculating income under this section during any calendar year, increases in social security benefit payments under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 et seq.) arising from cost-of-living adjustments shall be disregarded commencing in the month that these social security benefit payments are increased by the cost-of-living adjustment through the month before the month in which a change in the federal poverty level requires the department to modify the income standard described in subdivision (c).

(g) Notwithstanding any other provision of law, the program provided for pursuant to this section shall be implemented only if, and to the extent that, the department determines that federal financial participation is available under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(h) Subject to subdivision (g), this section shall be implemented commencing January 1, 2001.

SEC. 63. Section 14011.15 of the Welfare and Institutions Code is amended 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) Commencing January 1, 2001, the department shall eliminate the requirement that recipients file quarterly status reports.

(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.

SECTION 63.5. Section 14021.4 of the Welfare and Institutions Code is amended to read:

14021.4. (a) The State Department of Mental Health shall prepare by January 15, 1991, amendments to California's plan for federal Medi-Cal grants for medical assistance programs, pursuant to Subchapter XIX (commencing with Section 1396) of Title 42 of the United States Code, to accomplish the following objectives:

(1) Expansion of the location and type of therapeutic services offered to the mentally ill under Medi-Cal by the category of ''other

diagnostic, screening, preventative, and rehabilitative services'' which is available to states under the Social Security Act (42 U.S.C. Sec. 1396d(a)(13); 42 C.F.R. 440.130).

(2) Expansion of federal financial participation in the costs of community mental health services provided by local Short-Doyle community mental health programs or under contract to local Short-Doyle community mental health programs.

(3) Expansion of the location where reimbursable Short-Doyle Medi-Cal mental health services can be provided, including home, school, and community based sites.

(4) Expansion of federal financial participation for services which meet the rehabilitation needs of severely mentally ill consumers, including, but not limited to, medication management, functional rehabilitation assessments of clients, and rehabilitative services which include remedial services directed at restoration to the highest possible functional level for persons with psychiatric disabilities and maximum reduction of symptoms of mental illness.

(5) Improvement of fiscal systems and accountability structures for Short-Doyle Medi-Cal and Short-Doyle costs and rates, with the goal of achieving federal fiscal requirements.

(b) This Short-Doyle Medi-Cal state plan revision shall be completed with review and comments by the California Conference of Local Mental Health Directors and other appropriate groups. The addition of the rehabilitative option shall be limited to Short-Doyle providers certified to provide Medi-Cal under this option.

(c) The State Department of Health Services shall review the state plan revision for medicaid services as recommended by the State Department of Mental Health. If the state plan amendment satisfies published federal requirements for these amendments and if the State Department of Health Services has approved and submitted to the Health Care Financing Administration a plan of correction for audit issues identified for the Short-Doyle Medi-Cal program, then the department shall promptly pursue federal adoption of the state plan revision. If the State Department of Health Services does not recommend adoption of the revision, it shall report on the financial and programmatic implications of the proposal and the reasons for the rejection to the Joint Legislative Budget Committee by July 1, 1991.

(d) The state and local funds required to match federal financial participation shall include, but not be limited to, Short-Doyle and county matching funds. Additional General Fund moneys for this purpose shall be subject to appropriation in the annual Budget Act.

(e) It is the intent of the Legislature that the rehabilitation option of the state medicaid plan be implemented to expand and provide flexibility to treatment services and to increase the federal participation without increasing the costs to the General Fund.

(f) It is the intent of the Legislature that addition of the rehabilitation option as a Short-Doyle Medi-Cal benefit shall become operative only after the Health Care Financing Administration has reviewed and approved the state plan revision submitted by the State Department of Health Services, a plan of correction approved by the department for audit issues identified for the Short-Doyle Medi-Cal program has been submitted, and the requirements of this section have been fully satisfied.

(g) If the Medi-Cal state plan revision required by this section is approved by the State Department of Health Services, and submitted for federal approval, the State Department of Mental Health shall review and revise the quality assurance standards and guidelines required by Article 5 (commencing with Section 4070) of Chapter 2 of Division 4 to meet the necessary standards to assure that quality services are delivered to the eligible population. This review shall include, but not be limited to, appropriate use of mental health professionals, including psychiatrists, in the treatment and rehabilitation of clients under this model. The existing quality assurance standards and guidelines shall remain in effect until the adoption of the new quality assurance standards and guidelines.

(h) Consistent with services offered to persons who are mentally ill under the Medi-Cal program, as required by this section, it is the intent of the Legislature for the State Department of Mental Health, working collaboratively with the department, to include care and treatment of persons with mental disorders who are eligible for the Medi-Cal program in facilities with a bed capacity of 16 beds or less.

SEC. 64. Section 14053 of the Welfare and Institutions Code is amended to read:

14053. (a) 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.

(b) The term ''health care services'' does not include, except to the extent permitted by federal law, any of the following:

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

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

(3) Care or services for any individual who is 21 years of age or over, except as provided in the first paragraph of this section, and has

not attained 65 years of age and who is a patient in an institution for mental disease.

(4) 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. 65. Section 14053.1 of the Welfare and Institutions Code is amended to read:

14053.1. (a) 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.

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

SEC. 66. Section 14067.5 is added to the Welfare and Institutions Code, to read:

14067.5. The department shall encourage counties to outstation additional Medi-Cal eligibility workers in nontraditional sites, such as schools, private hospitals, clinics, mental health centers, sites providing services under California Supplemental Food Program for Women, Infants, and Children sites, and community-based organizations. The department shall permit counties to redirect a portion of existing funding for Medi-Cal eligibility administration for this purpose. The department shall require counties that redirect funds to provide an annual report on the cost of the additional outstationed workers and their effectiveness in increasing or facilitating Medi-Cal enrollment. Expenditures under this section shall be subject to the availability of federal financial participation, and shall not cause an increase in the allocation of funds for the administration of the Medi-Cal program.

SEC. 67. 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, 2002, and, as of January 1, 2003, is repealed, unless a later enacted statute, that

becomes effective on or before January 1, 2003, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 68. 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, 2002, and, as of January 1, 2003, is repealed, unless a later enacted statute, that becomes effective on or before January 1, 2003, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 69. Section 14085.81 is added to the Welfare and Institutions Code, to read:

14085.81. Notwithstanding the requirement in subparagraph (A) of paragraph (1) of subdivision (3) of Section 14085.8 that a hospital must be listed on page 57 of the department's report dated May 1991, entitled ''Hospital Peer Grouping,'' any hospital whose license pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code was consolidated during the 1999 calendar year with a large teaching emphasis hospital that is listed on page 57 of the above described report shall be eligible to negotiate payments pursuant to paragraph (1) of subdivision (g) of Section 14085.8. All other requirements of Section 14085.8 shall continue to apply.

SEC. 70. Section 14105.17 is added to the Welfare and Institutions Code, to read:

14105.17. (a) Each hospital designated by the department as a critical access hospital, and certified as such by the Secretary of the United States Department of Health and Human Services under the federal Medicare rural hospital flexibility program, shall be eligible for supplemental payments for Medi-Cal covered outpatient services rendered to Medi-Cal eligible persons.

(b) Payments made pursuant to subdivision (a) shall be contingent upon receipt of federal financial participation, and shall

be limited by the appropriation in the annual Budget Act for the nonfederal share of these payments. Supplemental payments shall be apportioned among critical access hospitals based upon their number of Medi-Cal outpatient visits.

(c) Nothing in this section shall be interpreted as meaning that a critical access hospital is not a general acute care hospital.

(d) The department shall promptly seek any necessary federal approvals for the implementation of this section. If necessary to obtain federal approval, the department may, for federal purposes, limit implementation of this section to those payments that are allowable expenses under Title XIX of the federal Social Security Act (Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code). If federal approval is not obtained for implementation of this section, this section shall become inoperative.

(e) The department may adopt emergency regulations 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) to implement this section. One initial adoption of the 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. If the department adopts emergency regulations pursuant to this section, the department shall seek prior input from representatives of the hospital industry, including the California Healthcare Association.

SEC. 71. 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, 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. 72. 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, 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. 73. 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, 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. 74. 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, 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. 75. 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, 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. 76. 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, 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. 77. Section 14105.4 of the Welfare and Institutions Code, as amended by Section 51 of Chapter 146 of the Statutes of 1999, 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, 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. 78. Section 14105.4 of the Welfare and Institutions Code, as amended by Section 52 of Chapter 146 of the Statutes of 1999, 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, 2003.

SEC. 79. 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, 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. 80. Section 14105.41 of the Welfare and Institutions Code, as amended by Section 54 of Chapter 146 of the Statutes of 1999, 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, 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. 81. Section 14105.41 of the Welfare and Institutions Code, as amended by Section 55 of Chapter 146 of the Statutes of 1999, 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, 2003.

(e) This section shall become operative on January 1, 2003.

SEC. 82. Section 14105.42 of the Welfare and Institutions Code, as amended by Section 56 of Chapter 146 of the Statutes of 1999, 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 report to the Legislature, through the annual budget process, on the cost effectiveness of contracts executed pursuant to Section 14105.33.

(c) 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. 83. Section 14105.42 of the Welfare and Institutions Code, as amended by Section 13 of Chapter 723 of the Statutes of 1992, is amended and renumbered to read:

14105.425. The provisions of Sections 14105.4 to 14105.41, inclusive, and Section 14105.65 shall not preclude the department from taking emergency regulatory action as it deems appropriate.

This section shall become operative on January 1, 1997.

SEC. 84. 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, 2003.

SEC. 85. 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, 2003.

SEC. 86. 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, 2003, drugs on the Medi-Cal list of contract drugs shall become the Medi-Cal drug formulary.

SEC. 87. Section 14105.981 of the Welfare and Institutions Code is amended to read:

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

(a) 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.

(1) 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.

(2) 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.

(b) 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.

(c) 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. 88. 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) Subject to an appropriation for this purpose in the Budget Act of 2000, in addition to the increase specified in subdivision (e), the department shall, commencing August 1, 2000, increase the Medi-Cal reimbursement rate for nursing facilities, intermediate care facilities/developmentally disabled, intermediate care facilities/developmentally disabled-habilitative, and intermediate care facilities/developmentally disabled-nursing solely to provide funds for salaries, wages, and benefits increases for direct care staff and other staff, subject to all of the following:

(1) For purposes of this subdivision ''direct care staff in nursing facilities'' means the following:

(A) Registered nurses and licensed vocational nurses, when employed in the performance of direct care to patients.

(B) Employees in the nurse assistant classification employed in the performance of direct care to patients at a freestanding or distinct-part nursing facility, including job titles such as nursing aide, aide, practical nurse, orderly, nurse assistant, and certified nurse assistant.

(C) Employees performing respiratory therapy services for Medi-Cal pediatric subacute patients, including job titles such as respiratory care practitioner, respiratory technician, respiratory therapist inhalation technician, and inhalation therapist.

(2) For purposes of this subdivision, ''direct care staff in intermediate care facilities/developmentally disabled, intermediate care facilities/developmentally disabled-habilitative, and intermediate care facilities/developmentally disabled-nursing'' means all of the following:

(A) Qualified mental retardation professionals employed in the performance of direct care to patients.

(B) Lead personnel employed in the performance of direct care to patients. Lead personnel described in this subparagraph shall not be considered to be supervisory.

(C) Employees in the nurse assistant classification employed in the performance of direct care to patients at a freestanding or distinct-part nursing facility, including job titles such as nurse assistants and aides.

(D) Other nonsupervisory staff providing direct patient care.

(E) Registered nurses and licensed vocational nurses, if employed in the performance of direct care to patients.

(3) For purposes of paragraphs (1) and (2), ''direct care staff'' shall not include registered nurses or other personnel performing supervisory functions or housekeeping or maintenance staff in any facility.

(4) For purposes of this subdivision, ''other staff'' means all of the following personnel:

(A) Linen and laundry staff.

(B) Plant operations and maintenance staff.

(C) Housekeeping staff.

(D) Dietary staff.

(5) (A) The amount of funds to be provided to each facility pursuant to this subdivision shall be added to the per diem rate paid to each facility on a per patient day basis.

(B) The per diem amount of funds provided to each facility type and peer group pursuant to this subdivision shall be published in a Medi-Cal provider bulletin. Nursing facilities that are part of an acute care hospital and subacute facilities shall be notified of their per diem amount provided pursuant to this subdivision in a separate letter to each facility.

(6) (A) Facilities receiving funds pursuant to this subdivision shall compensate staff that portion of the rate increase provided pursuant to this subdivision in the form of salaries, wages, and benefits increases. The total amount to be passed through pursuant to this subdivision by each facility shall be the per diem amount received by the facility pursuant to this subdivision multiplied by the facility's number of Medi-Cal patient days.

(B) Each direct care and other staff employee classification shall receive a portion of the rate increase provided pursuant to this subdivision in the form of an increase in salary, wage, and benefits. The facility may allocate the amounts that each classification may receive, but the amount shall not be nominal or zero.

(C) Funds passed through pursuant to this subdivision for purposes of salary, wages, or benefits increases may not be used for any salary, wage, or benefit increase that were committed to by a facility prior to August 1, 2000, nor may these funds be used for any salaries, wages, or benefits that the facility would have paid in the absence of this subdivision.

(D) Funds passed through pursuant to this subdivision for purposes of salary, wages, or benefits increases may not be distributed to direct care and other staff in the form of bonuses. These funds may, however, be used to provide retroactive pay increases if those wage increases also increase the employee's base salary rate.

(7) The base from which direct care and other staff salaries, wages, and benefits shall be increased shall be the aggregate per hour salaries, wages, and benefits for the period of August 1, 1999, to July 31, 2000, inclusive.

(8) The department may inspect relevant payroll and personnel records of facilities receiving funds pursuant to this subdivision in order to ensure that the salary, wage, and benefit increases provided for pursuant to this subdivision have been implemented.

(9) Each facility receiving funds from the department, or from a county organized health system described in paragraph (10) pursuant to this subdivision shall certify on the form provided by the department that these funds were expended for increased direct care and other staff salary, wages, and benefits increases in accordance

with this subdivision. The facility shall return the form to the department by October 1, 2001. The facility shall submit a copy of the completed form to all collective bargaining agents with whom the facility has collective bargaining agreements for direct care and other staff at the facility.

(10) County organized health systems contracting with the department pursuant to Article 2.8 (commencing with Section 14087.5) and Article 7 (commencing with Section 14490) of Chapter 8 shall certify to the department, in a manner to be specified by the department, that the August 1, 2000, wage pass-through funds, received pursuant to this section in the form of capitated rate payments, were passed through to the facilities described in this subdivision.

(g) Any facility which is paid under the rate provided for in subdivision (a), (e), or (f) 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. The facility shall be subject to Section 14107.

SEC. 89. Section 14115 of the Welfare and Institutions Code is amended to read:

14115. (a) Bills for service under this chapter shall be submitted not more than six months after the month in which the service is rendered, and shall be in the form prescribed by the director, except that in the event the patient does not identify himself or herself to the provider as a Medi-Cal beneficiary within four months after the month in which the service was rendered, the provider shall be entitled to submit his or her statement at any time within 60 days after that date certified by the provider as the date the patient was first identified as a Medi-Cal beneficiary. However, the date certified by the provider as the date the patient was first so identified shall not be later than one year after the month in which the service was rendered. Whenever a provider has submitted a claim to a liable third party, the provider shall have one year after the month in which the service is rendered for submission of the bill. Whenever a legal proceeding has been commenced with either an administrative or judicial tribunal concerning a bill for which the provider is attempting to obtain payment from a liable third party, the provider shall have one year in which to submit the bill after the month in which the services have been rendered. A copy of the pleadings shall be conclusively presumed to be sufficient evidence of commencement of a legal proceeding.

(b) The director may, where he or she finds that delay in the submission of bills was caused by circumstances beyond the control

of the provider, extend the period for submission of bills for a period not to exceed one year.

(c) (1) Reimbursement for an original claim, submitted for payment between six and 12 months after the month of service, that does not meet any of the exceptions allowing billing after six months as specified in subdivisions (a) and (b), or the exception specified in subdivision (f), shall be reduced as follows:

(A) The amount otherwise payable by Medi-Cal shall be reduced by 25 percent for claims submitted during the seventh through the ninth month after the month of service.

(B) The amount otherwise payable by Medi-Cal shall be reduced by 50 percent for claims submitted during the 10th through the 12th month after the month of service.

(2) The director may establish exceptions through regulations, for claims submitted beyond the one-year billing limitation, to the extent full federal participation is available.

(d) For the purposes of this section, identification of a patient as a Medi-Cal beneficiary shall mean presentation to the provider of the patient's Medi-Cal card.

(e) No further followup shall be required, after the provider receives acknowledgment of a claim inquiry from the fiscal intermediary, until the claim is paid or denied, except that this period shall not exceed one year from the date of acknowledgment. Within one year from the date of acknowledgment the next level of appeal shall be utilized by the provider.

(f) To the extent permitted by federal law, when a state of emergency has been declared by either the President of the United States or the Governor, the director, in order to ensure continued access to health care services, may remit payment for services without the submission of required documentation, to any provider in good standing under the Medi-Cal program who, due to destruction, loss, or inaccessibility of data as a result of the emergency situation, is unable to submit claims. Emergency payments may be made for a period of up to six months from the date of the emergency declaration. All requests for emergency payment shall include adequate justification for payment, as required by the director, and shall be paid based on the previous claims history of the requesting provider held by the department.

SEC. 90. Section 14132.05 is added to the Welfare and Institutions Code, to read:

14132.05. The department shall provide the fiscal and appropriate policy committees of the Legislature with a copy of their submittal to the federal Health Care Financing Administration pertaining to any evaluation completed regarding the Family PACT federal waiver required by subdivision (aa) of Section 14132.

SEC. 91. 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 psychiatrist 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, 2002, and as of that date is repealed, unless a later enacted statute, that is enacted on or before January 1, 2002, deletes or extends that date.

SEC. 92. Section 14132.72 of the Welfare and Institutions Code is amended to read:

14132.72. (a) It is the intent of the Legislature to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.

(b) For the purposes of this section, ''telemedicine'' and ''interactive'' are defined as those terms are defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.

(c) (1) Commencing July 1, 1997, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telemedicine, subject to reimbursement policies developed by the Medi-Cal program to compensate licensed health care providers who provide health care services, that are otherwise covered by the Medi-Cal program, through telemedicine. The audio and visual telemedicine system used shall, at a minimum, have the capability of meeting the procedural definition of the Current Procedural Terminology Fourth Edition (CPT-4) codes which represent the service provided through telemedicine. The telecommunications equipment shall be of a level of quality to adequately complete all necessary components to document the level of service for the CPT-4

code billed. If a peripheral diagnostic scope is required to assess the patient, it shall provide adequate resolution or audio quality for decisionmaking.

(2) The department shall report to the appropriate committees of the Legislature, by January 1, 2000, on the application of telemedicine to provide home health care; emergency care; critical and intensive care, including neonatal care; psychiatric evaluation; psychotherapy; and medical management as potential Medi-Cal benefits.

(d) The Medi-Cal program shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.

(e) The Medi-Cal program shall pursue private or federal funding to conduct an evaluation of the cost-effectiveness and quality of health care provided through telemedicine by those providers who are reimbursed for telemedicine services by the program.

SEC. 93. Section 14132.88 is added to the Welfare and Institutions Code, to read:

14132.88. Notwithstanding subdivision (h) of Section 14132 and to the extent funds are made available in the annual Budget Act for this purpose, the following are covered benefits under this chapter:

(a) Two basic dental cleanings per year.

(b) Two dental examinations per year.

SEC. 94. Section 14132.91 is added to the Welfare and Institutions Code, to read:

14132.91. (a) Subject to the availability of funding, the department shall conduct a dental outreach and education program for Medi-Cal beneficiaries. The program shall inform Medi-Cal beneficiaries of the availability of dental care and provide information regarding recommended frequencies for regular and preventive dental care, how to obtain Medi-Cal dental care, how to avoid inappropriate care or fraudulent providers, and how to obtain assistance in getting care or resolving problems with dental care.

(b) The program shall particularly target underserved populations and parents of young and adolescent children, and it shall include the following components:

(1) Incorporation of dental themes and information in ongoing outreach and advertising efforts, including those for Medi-Cal and the Healthy Families program.

(2) Education and outreach materials for inclusion in mailings to beneficiaries.

(3) Education and consumer protection materials for display and distribution at sites providing Medi-Cal dental care, clinics, and other health care facilities and sites.

(c) The department shall consult with dental professional groups and experts, community organizations, advertising and media experts, and other parties, as the department deems appropriate, in

order to develop and structure the program in an effective and efficient manner.

SEC. 95. Section 14133.05 is added to the Welfare and Institutions Code, to read:

14133.05. (a) Notwithstanding any other provision of law, a request for a treatment authorization received by the department shall be reviewed for medical necessity only.

(b) Any claim for a service that is authorized pursuant to a treatment authorization request that qualifies for approval under the requirements established by the department in regulations shall be reduced in accordance with Section 14115.

(c) If a provider does not agree with the decision on a treatment authorization request, the provider may appeal the decision pursuant to procedures set forth in regulations adopted by the department.

(d) Providers shall comply with the administrative remedies available to them prior to seeking a judicial remedy with respect to a decision of the department on a treatment authorization request.

SEC. 96. 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.

(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) In the amount of twenty-nine million seven hundred fifty-seven thousand six hundred ninety dollars ($29,757,690) for the 2000–01 fiscal year and each fiscal year thereafter.

(G) 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. 97. Section 14408.5 is added to the Welfare and Institutions Code, to read:

14408.5. A prepaid health plan that contracts with Medi-Cal managed care or contracts with the Healthy Families Program may provide application assistance pursuant to Section 12693.325 of the Insurance Code during the eligibility redetermination process in order to allow persons to retain coverage.

SEC. 98. Section 14409 of the Welfare and Institutions Code is amended to read:

14409. (a) No prepaid health plan, marketing representative, or marketing organization shall in any manner misrepresent itself, the plans it represents, or the Medi-Cal program or Healthy Families Program. Violations of this section shall include, but are not limited to:

(1) False or misleading claims that marketing representatives are employees or representatives of the state, county, or anyone other than the prepaid health plan or the organization by whom they are reimbursed.

(2) False or misleading claims that the prepaid health plan is recommended or endorsed by any state or county agency, or by any other organization which has not certified its endorsement in writing to the prepaid health plan.

(3) False or misleading claims that the state or county recommends that a Medi-Cal beneficiary enroll in a prepaid health plan.

(4) Claims that a Medi-Cal beneficiary will lose his benefits under the Medi-Cal program or any other health or welfare benefits to which he is legally entitled, if he does not enroll in a prepaid health plan.

(b) Violations of this article or regulations adopted by the department pursuant to this article shall result in one or more of the following sanctions that are appropriate to the specific violation, considering the nature of the offense and frequency of occurrence within the prepaid health plan:

(1) Revocation of one or more permitted methods of marketing.

(2) Termination of authorization for a plan to provide application assistance.

(3) Refusal of the department to accept new enrollments for a period specified by the department.

(4) Refusal of the department to accept enrollments submitted by a marketing representative or organization.

(5) Forfeiture by the plan of all or part of the capitation payments for persons enrolled as a result of such violations.

(6) Requirement that the prepaid health plan in violation of this article personally contact each enrollee enrolled to explain the nature of the violation and inform the enrollee of his right to disenroll.

(7) Application of sanctions as provided in Section 14304.

(8) Temporarily withhold capitation payments for beneficiaries enrolled in violation of this article, or regulations adopted thereunder, until the prepaid health plan is in substantial compliance with the statutory and regulatory provisions.

(c) Any marketing representative who violates subdivision (a) while engaged in door-to-door solicitation is guilty of a misdemeanor, and shall be subject to a fine of five hundred dollars ($500) or imprisonment in the county jail for six months, or both.

SEC. 99. Section 16809 of the Welfare and Institutions Code, as amended by Section 68 of Chapter 146 of the Statutes of 1999, 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 and 2000–01 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 and 2000-01 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 and 2000–01 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 and 2000-01 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. 100. Funds appropriated in the Budget Act of 2000 for the purpose of improving the dental infrastructure of nonprofit, community-based clinics, as determined by the State Department of Health Services, shall be available for expenditure through June 30, 2002.

SEC. 101. Notwithstanding any other provision of law, the funds appropriated by the Budget Act of 2000 for the tobacco use competitive grants program provided for in Section 104385 of the Health and Safety Code, the tobacco prevention media campaign provided for in subdivision (e) of Section 104375 of the Health and Safety Code, the evaluation of the tobacco use prevention and education program set forth in subdivision (b) and (c) of Section 104375 of the Health and Safety Code, school-based tobacco use prevention pursuant to Sections 104420, 104425, 104430, and 104435 of the Health and Safety Code, and local tobacco use prevention programs set forth in Section 104400 of the Health and Safety Code, shall be available for encumbrance and expenditure without regard to fiscal years for two years beyond the date of appropriation.

SEC. 102. The State Department of Health Services shall provide the fiscal and policy committees of the Legislature with a copy of any hospital outpatient rate analysis submitted to the court regarding the case of Orthopedic Hospital and California Hospital Association v. Belshe', once the analysis is considered to be part of the public record as defined by the California Public Records Act.

SEC. 103. (a) The State Department of Health Services shall allocate any rate increases for Denti-Cal Program services provided through the Budget Act of 2000 across procedure codes as deemed appropriate by the department after consultation with professional dental organizations.

(b) It is the intent of the Legislature for rate increases for Denti-Cal Program services provided through the Budget Act of 2000 to be provided to dental plans operating under a managed care environment, as defined by the department, on an equitable basis in order to ensure recipient access to services.

SEC. 104. (a) The State Department of Developmental Services shall identify a range of options to meet the future needs of individuals currently served, or who will need services similar to those provided, in state developmental centers.

(b) The department shall establish a workgroup consisting of system stakeholders to assist in examining the various options including, but not limited to, renovation of existing developmental centers, smaller state owned and operated facilities, state operated leased facilities, privately owned and operated facilities, and services and supports provided in consumer owned or leased homes.

(c) Options shall be evaluated for their appropriateness in meeting consumers' needs, compliance with requirements of federal and state laws, and efficient use of state and federal funds.

(d) The department shall report on these options and the recommendations of the workgroup to the Legislature by March 1, 2001.

SEC. 105. (a) The Legislature finds and declares all of the following:

(1) Lack of insurance coverage for children results in reduced access to medical services, resulting in restricted access to primary and preventive care and increased reliance on emergency rooms and hospitals for treatment.

(2) Almost 50 percent of uninsured children eligible for the Medi-Cal program, or the Healthy Families programs are already enrolled in the California Supplemental Food Program for Women, Infants and Children, the School Lunch program, or the Food Stamps program. Not only have these families been certified as income-eligible for these programs, they have also already provided extensive information to enroll in the programs.

(3) It is the intent of the Legislature, therefore, to make the Medi-Cal and Healthy Families enrollment process more user-friendly and efficient for children currently enrolled in programs with income eligibility guidelines similar to Medi-Cal and the Healthy Families program, and thus make the process more accessible for those in need of care.

(b) The State Department of Health Services and the Managed Risk Medical Insurance Board shall develop options for implementing streamlined processes for establishing Medi-Cal program and Healthy Families program eligibility, as applicable, for a child enrolled in or applying to certain public programs, such as the School Lunch program, the Food Stamp program, and the California Supplemental Food Program for Women, Infants and Children, or other programs as determined by the department. The department shall be designated as the lead entity in this effort. Other state departments, such as the State Department of Social Services and the State Department of Education, shall respond to inquiries from the State Department of Health Services on an as needed basis regarding the programs they administer.

(c) The department shall provide these options to the chairs of the policy and fiscal committees of the Legislature by no later than February 1, 2001.

SEC. 106. The State Department of Health Services may adopt emergency regulations to implement the applicable provisions of this act in accordance with the Administrative Procedures Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The initial adoption of emergency regulations 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. 107. 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. 108. 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 2000–01 fiscal year, it is necessary that this act go into immediate effect.

O