Assembly Bill No. 97

CHAPTER 3

An act to amend Sections 12693.43, 12693.60, 12693.615, and 12693.65 of the Insurance Code, and to amend Sections 4474.5, 14007.9, 14091.3, 14105.31, 14105.33, 14105.332, 14105.34, 14126.033, 14132, and 14154 of, to amend and repeal Sections 14105.191 and 14134.1 of, to amend, repeal, and add Section 14134 of, to add Sections 14105.07, 14105.192, 14105.451, 14126.036, 14131.05, and 14131.07 to, and to add Article 6 (commencing with Section 14589) to Chapter 8.7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health care services, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately, bill related to the budget.

[Approved by Governor March 24, 2011. Filed with Secretary of State March 24, 2011.]

LEGISLATIVE COUNSEL'S DIGEST

AB 97, Committee on Budget. Health care services.

(1) Existing law creates the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health, vision, and dental benefits to children less than 19 years of age who meet certain criteria, including having a limited household income. Existing law requires families with children participating in the program to pay specified family contribution amounts. Existing law continuously appropriates funds, including family contributions, to the board from the Healthy Families Fund for the program.

This bill would, commencing on a specified date, increase those family contribution amounts, subject to federal authorization and any lesser increase in family contribution as authorized by the federal Department of Health and Human Services. By increasing moneys deposited into a continuously appropriated fund, the bill would make an appropriation.

(2) Existing law requires the board to establish the required copayment levels for specific benefits and prohibits copayments from exceeding the copayment level established for state employees under the Public Employees' Retirement System (PERS) as of January 1, 1998, and from exceeding $250 annually per family. Existing law also requires covered health benefits provided under the program to be equivalent to those provided to state employees under PERS as of January 1, 1998.

This bill would require the board to set copayments for outpatient emergency room and inpatient hospital services at specified amounts, contingent upon federal approval and implementation of the same copayments under Medi-Cal, as specified. The bill would also modify the health benefit and copayment provisions to prohibit copayments from

exceeding those charged, and require covered health benefits to be equivalent to those provided, to state employees under PERS in the year prior to the program plan year, except as otherwise provided. The bill would deem regulations of the board to implement these provisions to be emergency regulations.

(3) Existing law provides, except as specified, that vision benefits under the Healthy Families Program shall be equivalent to, and subscriber copayment levels shall reflect, those provided to state employees through the Department of Personnel Administration on July 1, 1997.

This bill would delete the specified date of July 1, 1997, from these provisions.

(4) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified, low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions.

Existing law requires the establishment of protocols to ensure appropriate services are provided for persons transitioning as a result of the planned closure of the Agnews Developmental Center and the Lanterman Developmental Center. For persons transitioning under a plan for the closure of these developmental centers who have service needs for coordinated medical and specialty care identified in their individual program plans that cannot be met using the traditional Medi-Cal fee-for-service system, existing law establishes a structure requiring provision of those services under Medi-Cal managed care health plans that are currently operational in prescribed counties as a county organized health system or a local initiative, if consumers choose to enroll, and authorizes prescribed supplemental payments, including payments for administrative services.

This bill would recast those provisions to require, for consumers transitioning from the Lanterman Developmental Center, that the Medi-Cal managed care health plan be any plan operating in the various counties if the consumers choose to enroll, or as mandated by prescribed statutory provisions; to delete consultation with the Lanterman Developmental Center staff as an administrative service eligible for supplemental reimbursement; and to require that plans be paid a full-risk capitation payment.

(5) Existing law, operative 30 days after the date that the increase in the state's federal medical assistance percentage (FMAP) pursuant to the federal American Recovery and Reinvestment Act of 2009 (ARRA) is no longer available, requires, no later than 90 days after this operative date, each individual to pay a monthly premium that is equal to 5% of his or her individual or spousal countable income, as described, except that the premium cannot fall below or exceed a specified minimum and maximum premium payment, as provided.

This bill would, instead, make these provisions operative 30 days after the execution of a declaration by the Director of Health Care Services that states that implementation of these provisions will not jeopardize the state's ability to receive certain federal funds, as specified.

(6) Existing law, until January 1, 2012, requires the State Department of Health Care Services, subject to any necessary federal approval, to take all appropriate steps to amend the Medicaid state plan, to implement a requirement that any hospital that does not have in effect a contract with a Medi-Cal managed health care plan that establishes payment amounts for services furnished to a beneficiary enrolled in that plan shall accept, as payment in full, prescribed payment amounts.

This bill would extend the duration of these provisions until January 1, 2013.

(7) Existing law, until July 31, 2012, requires that money appropriated for the purposes of the Medi-Cal Long-Term Care Reimbursement Act shall be, in part, used for increasing rates, except as otherwise provided, for freestanding nursing facilities, as specified. Existing law requires that the maximum annual increase in the weighted average Medi-Cal reimbursement rate for the purposes of these provisions shall not exceed a specified amount plus the projected cost of complying with new state and federal mandates. Existing law requires the weighted average Medi-Cal reimbursement rate increase for the 2010–11 and 2011–12 rate years to be adjusted by the department for specified reasons.

This bill would require, except as provided, that for dates of service on and after June 1, 2011, the payments resulting from the application of these rate increases shall be reduced by 10% and would authorize the Director of Health Care Services to adjust the percentage reductions as specified. This bill would require, except as provided, that payments to intermediate care facilities for the developmentally disabled, as specified, for dates of service on and after June 1, 2011, shall not exceed the reimbursement rates that were applicable to those providers in the 2008–09 rate year, reduced by 10%. This bill would also authorize the Director of Health Care Services to adjust the percentage reductions as specified.

(8) Existing law requires, except as otherwise provided, Medi-Cal provider payments to be reduced by 1% or 5%, as specified, for dates of service on and after March 1, 2009. Existing law also requires provider payments for specified non-Medi-Cal programs to be reduced by 1% for dates of service on and after March 1, 2009.

This bill would provide that these provisions shall become inoperative for dates of service on and after June 1, 2011. This bill would require, except as otherwise provided, that Medi-Cal and specified non-Medi-Cal provider payments be reduced by 10%, as prescribed, for dates of service on and after June 1, 2011.

(9) Existing law requires the reimbursement to Medi-Cal pharmacy providers for legend and nonlegend drugs, as defined, to consist of the estimated acquisition cost of the drug, as defined, plus a professional fee for dispensing. Existing law authorizes the State Department of Health Care Services to enter into contracts with manufacturers of single-source and multiple-source drugs, on a bid or nonbid basis, for drugs from each major therapeutic category. Existing law requires, among other things, that contracts executed pursuant to these provisions provide for an equalization

payment amount, as defined, to be remitted to the department by the manufacturer on a quarterly basis.

This bill would, instead, provide that the contracts shall provide for a state rebate, as defined, and would make conforming changes. This bill would also provide that it is the intent of the Legislature to enact legislation by August 1, 2011, that provides for the development of a new reimbursement methodology for pharmacy providers. This bill would, in relation to establishing the new reimbursement methodology, authorize the State Department of Health Care Services to require providers, manufacturers, and wholesalers to submit any data the Director of Health Care Services determines is necessary or useful in preparing for the transition from a methodology based on average wholesale price to a methodology based on actual acquisition price.

(10) Existing law requires Medi-Cal beneficiaries to make set copayments for specified services. Copayments for services, under existing law, do not reduce the reimbursement to the providers. Existing law, with certain exceptions, prohibits a provider from denying services to an individual solely because the person is unable to pay the copayment.

This bill would, commencing as provided, revise the copayment rates, expand the services for which copayments are due, and require the department to reduce the amount of the payment to the provider by the amount of the copayment. The bill would provide that, with certain exceptions, a provider has no obligation to provide services to a beneficiary who does not pay the copayment at the point of service.

(11) Existing law, provides that outpatient services provided by a physician are a covered benefit under the Medi-Cal program, subject to utilization controls.

This bill would, to the extent permitted by federal law, limit physician office and clinic visits that are a covered benefit under the Medi-Cal program, with specified exceptions, to 7 visits per beneficiary per fiscal year. This bill would require these provisions to be implemented on the first day of the first calendar month following 180 days after the effective date of the bill or on the first day of the calendar month following 60 days after federal approval, whichever is later.

(12) Existing law provides for a schedule of benefits under the Medi-Cal program, which includes prescribed drugs subject to the Medi-Cal List of Contract Drugs, enteral formulae subject to the Medi-Cal list of enteral formulae, and hearing aids, all of which are subject to utilization controls. Existing law provides that nonlegend acetaminophen-containing products, with the exception of children's Tylenol, selected by the department are not covered benefits.

This bill would, in relation to these benefits, instead provide that nonlegend acetaminophen-containing products, with the exception of children's acetaminophen-containing products, and nonlegend cough and cold products, selected by the department are not covered benefits. This bill would, in relation to enteral formulae, instead refer to the benefit as enteral nutrition products. This bill would, except as specified, require that the

purchase of enteral nutrition products be limited to those products administered through a feeding tube. This bill would also, with certain exceptions, establish an annual per beneficiary benefit cap amount, as defined, for optional hearing aid benefits.

(13) Existing law provides that it is the intent of the Legislature to provide appropriate funding to the counties for the effective administration of the Medi-Cal program, except for specified fiscal years in regard to any cost-of-doing-business adjustment.

This bill would additionally provide that it is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2011–12 fiscal year.

(14) Existing law, the Adult Day Health Medi-Cal Law, establishes adult day health care services as a Medi-Cal benefit for Medi-Cal beneficiaries who meet certain criteria.

This bill would provide, to the extent permitted by federal law, that notwithstanding existing law, adult day health care be excluded from coverage under the Medi-Cal program. This bill would provide that this provision shall be implemented on the first day of the first calendar month following 90 days after the effective date of the bill or on the first day of the first calendar month after federal approval, whichever is later.

(15) This bill would appropriate $1,000 from the General Fund to the State Department of Health Care Services.

(16) The California Constitution authorizes the Governor to declare a fiscal emergency and to call the Legislature into special session for that purpose. Governor Schwarzenegger issued a proclamation declaring a fiscal emergency, and calling a special session for this purpose, on December 6, 2010. Governor Brown issued a proclamation on January 20, 2011, declaring and reaffirming that a fiscal emergency exists and stating that his proclamation supersedes the earlier proclamation for purposes of that constitutional provision.

This bill would state that it addresses the fiscal emergency declared and reaffirmed by the Governor by proclamation issued on January 20, 2011, pursuant to the California Constitution.

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

(18) 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 12693.43 of the Insurance Code is amended to read:

12693.43. (a) Applicants applying to the purchasing pool shall agree to pay family contributions, unless the applicant has a family contribution

sponsor. Family contribution amounts consist of the following two components:

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

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

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

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

(2) (A) Nine dollars ($9) per child with a maximum required contribution of twenty-seven dollars ($27) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level and for applicants on behalf of children described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

(B) Commencing the first day of the fifth month following the enactment of the 2008–09 Budget Act, the family contribution pursuant to this paragraph shall be twelve dollars ($12) per child with a maximum required contribution of thirty-six dollars ($36) per month per family.

(C) Commencing November 1, 2009, the family contribution pursuant to this paragraph shall be sixteen dollars ($16) per child with a maximum required contribution of forty-eight dollars ($48) per month per family.

(D) Subject to prior federal authorization, the family contribution pursuant to this paragraph shall be thirty dollars ($30) per child with a maximum required contribution of ninety dollars ($90) per month per family, or any lesser increase in family contributions as is authorized by the federal Department of Health and Human Services. The family contribution required by this subparagraph shall commence the first day of the third month following the later of the following:

(i) The effective date of the act adding this subparagraph.

(ii) Receipt of federal authorization for the contribution in the form of an approved amendment to California's state plan under Title XXI of the federal Social Security Act or a waiver of one or more requirements of Title XXI of the federal Social Security Act.

(3) (A) On and after July 1, 2005, fifteen dollars ($15) per child with a maximum required contribution of forty-five dollars ($45) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this subparagraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of

subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this subparagraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

(B) Commencing the first day of the fifth month following the enactment of the 2008–09 Budget Act, the family contribution pursuant to this paragraph shall be seventeen dollars ($17) per child with a maximum required contribution of fifty-one dollars ($51) per month per family.

(C) Commencing November 1, 2009, the family contribution pursuant to this paragraph shall be twenty-four dollars ($24) per child with a maximum required contribution of seventy-two dollars ($72) per month per family.

(D) Subject to prior federal authorization, the family contribution pursuant to this paragraph shall be forty-two dollars ($42) per child with a maximum required contribution of one hundred twenty-six dollars ($126) per month per family, or any lesser increase in family contributions as is authorized by the federal Department of Health and Human Services. The family contribution required by this subparagraph shall commence the first day of the third month following the later of the following:

(i) The effective date of the act adding this subparagraph.

(ii) Receipt of federal authorization for the contribution in the form of an approved amendment to California's state plan under Title XXI of the federal Social Security Act or a waiver of one or more requirements of Title XXI of the federal Social Security Act.

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

(d) The board shall provide a family contribution discount to those applicants who select the health plan in a geographic area that has been designated as the Community Provider Plan. The discount shall reduce the portion of the family contribution described in subdivision (b) to the following:

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

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

described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

(B) Commencing the first day of the fifth month following the enactment of the 2008–09 Budget Act, the family contribution pursuant to this paragraph shall be nine dollars ($9) per child with a maximum required contribution of twenty-seven dollars ($27) per month per family.

(C) Commencing November 1, 2009, the family contribution pursuant to this paragraph shall be thirteen dollars ($13) per child with a maximum required contribution of thirty-nine dollars ($39) per month per family.

(D) Subject to prior federal authorization, the family contribution pursuant to this paragraph shall be twenty-seven dollars ($27) per child with a maximum required contribution of eighty-one dollars ($81) per month per family, or any lesser increase in family contributions as is authorized by the federal Department of Health and Human Services. The family contribution required by this subparagraph shall commence the first day of the third month following the later of the following:

(i) The effective date of the act adding this subparagraph.

(ii) Receipt of federal authorization for the contribution in the form of an approved amendment to California's state plan under Title XXI of the federal Social Security Act or a waiver of one or more requirements of Title XXI of the federal Social Security Act.

(3) (A) On and after July 1, 2005, twelve dollars ($12) per child with a maximum required contribution of thirty-six dollars ($36) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this subparagraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this subparagraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

(B) Commencing the first day of the fifth month following the enactment of the 2008–09 Budget Act, the family contribution pursuant to this paragraph shall be fourteen dollars ($14) per child with a maximum required contribution of forty-two dollars ($42) per month per family.

(C) Commencing November 1, 2009, the family contribution pursuant to this paragraph shall be twenty-one dollars ($21) per child with a maximum required contribution of sixty-three dollars ($63) per month per family.

(D) Subject to prior federal authorization, the family contribution pursuant to this paragraph shall be thirty-nine dollars ($39) per child with a maximum required contribution of one hundred seventeen dollars ($117) per month

per family, or any lesser increase in family contributions as is authorized by the federal Department of Health and Human Services. The family contribution required by this subparagraph shall commence the first day of the third month following the later of the following:

(i) The effective date of the act adding this subparagraph.

(ii) Receipt of federal authorization for the contribution in the form of an approved amendment to California's state plan under Title XXI of the federal Social Security Act or a waiver of one or more requirements of Title XXI of the federal Social Security Act.

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

(f) Applicants, but not family contribution sponsors, who pay the required family contributions by an approved means of electronic fund transfer shall receive a 25-percent discount from the required family contributions.

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

(h) The adoption and one readoption of regulations to implement paragraph (3) of subdivision (b) and paragraph (3) of subdivision (d) shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health, and safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe specific facts showing the need for immediate action and from review by the Office of Administrative Law. For purpose of subdivision (e) of Section 11346.1 of the Government code, the 120-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative Law, is hereby extended to 180 days.

(i) The board may adopt, and may only one time readopt, regulations to implement the changes to this section that are effective the first day of the fifth month following the enactment of the 2008–09 Budget Act. The adoption and one-time readoption of a regulation authorized by this section is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted for this purpose from the requirements of subdivision (b) of Section 11346.1 of the Government Code.

(j) The program shall provide prior notice to any applicant for a subscriber whose premium will increase as a result of amendments made to this section and shall provide the applicant with an opportunity to demonstrate that, based on reduced family income, the subscriber is subject to a lower premium pursuant to this section.

(k) The adoption and readoption, by the board, of regulations to implement the changes made to this section by the act that added this subdivision shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

SEC. 1.5. Section 12693.60 of the Insurance Code is amended to read:

12693.60. (a) Coverage provided to subscribers shall meet the federal coverage requirements in Section 2103 of Title XXI of the Social Security Act. Except as otherwise provided in this part, the covered health benefits provided to subscribers shall be equivalent to those provided to state employees through the Public Employees' Retirement System for the most recent plan year preceding the applicable program plan year, except that the plans may provide a mechanism for inpatient hospital care provided under the mental health benefit through which applicants may agree to a treatment plan in which each inpatient day may be substituted for two residential treatment days or three day treatment program days.

(b) The adoption and readoption, by the Managed Risk Medical Insurance Board, of regulations to implement the changes made to this section by the act that added this subdivision, shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

SEC. 1.7. Section 12693.615 of the Insurance Code is amended to read:

12693.615. (a) The board shall establish the required subscriber copayment levels for specific benefits consistent with the limitations of Section 2103 of Title XXI of the Social Security Act. The copayment levels established by the board shall, to the extent possible, reflect the copayment levels established for state employees, effective January 1, 1998, through the Public Employees' Retirement System. Except as otherwise provided in this section, under no circumstances shall copayments exceed the copayment level established for state employees for the most recent plan year preceding the applicable program plan year through the Public Employees' Retirement System. Total annual copayments charged to subscribers shall not exceed two hundred fifty dollars ($250) per family. The board shall instruct participating health plans to work with their provider networks to provide for extended payment plans for subscribers utilizing a significant number of health services for which copayments are charged. The board shall track the number of subscribers who meet the copayment maximum in each year and make adjustments in the amount if a significant number of subscribers reach the copayment maximum.

(b) No deductibles shall be charged to subscribers for health benefits.

(c) Coverage provided to subscribers shall not contain any preexisting condition exclusion requirements.

(d) No participating health, dental, or vision plan shall exclude any subscriber on the basis of any actual or expected health condition or claims experience of that subscriber or a member of that subscriber's family.

(e) There shall be no variations in rates charged to subscribers including premiums and copayments, on the basis of any actual or expected health condition or claims experience of any subscriber or subscriber's family member. The only variation in rates charged to subscribers, including copayments and premiums, that shall be permitted is that which is expressly authorized by Section 12693.43.

(f) There shall be no copayments for preventive services as defined in Section 1367.35 of the Health and Safety Code.

(g) There shall be no annual or lifetime benefit maximums in any of the coverage provided under the program.

(h) Plans that receive purchasing credits pursuant to Section 12693.39 shall comply with subdivisions (b), (c), (d), (e), (f), and (g).

(i) (1) Effective October 1, 2011, or the first day of the month following 120 days after the federal approval required by subparagraphs (A) and (B) of paragraph (3), whichever occurs later, copayments for emergency room and inpatient hospital services shall be set by the board as follows:

(A) Fifty dollars ($50) for outpatient emergency room services. The copayment shall be waived if the subscriber is hospitalized.

(B) One hundred dollars ($100) for each hospital inpatient day up to a maximum of two hundred dollars ($200) per admission.

(2) The changes made to the copayments in paragraph (1) shall not increase the maximum annual copayment of two hundred fifty dollars ($250) per family described in subdivision (a).

(3) The changes made to the copayments in paragraph (1) shall be implemented only if, and to the extent that, both of the following occur:

(A) The state receives prior federal authorization to implement the copayments in the form of an approved amendment to the state plan under Title XXI of the federal Social Security Act or a waiver of one or more requirements of Title XXI of the federal Social Security Act.

(B) The state receives prior federal authorization for, and implements, copayments in the same amounts for all children enrolled in the Medi-Cal program through an approved amendment to the state plan under Title XIX of the federal Social Security Act or a waiver of one or more requirements of Title XIX of the federal Social Security Act.

(4) Notwithstanding paragraph (1), the state shall not implement the copayments otherwise required by this subdivision at an earlier date than the state implements copayments in the same amounts for all children in the Medi-Cal program.

(5) The adoption and readoption, by the Managed Risk Medical Insurance Board, of regulations to implement the changes made to this section by the act that added this subdivision, shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general

welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

SEC. 2. Section 12693.65 of the Insurance Code is amended to read:

12693.65. (a) Vision benefits shall be provided to subscribers and shall meet the federal coverage requirements in Section 2103 of Title XXI of the Social Security Act.

(b) The covered benefits shall be equivalent to those provided to state employees through the Department of Personnel Administration, except for tinted lenses and also photochromatic lenses, unless otherwise deemed medically necessary.

(c) The board shall establish the required subscriber copayment levels for vision benefits consistent with the limitations of Section 2103 of Title XXI of the Social Security Act. The copayment levels established by the board shall, to the extent possible, reflect the copayment levels provided to state employees through the Department of Personnel Administration.

(d) From March 1, 2011, to June 30, 2012, inclusive, the adoption and readoption, by the board, of regulations to modify vision benefits pursuant to this section, including, but not limited to, restriction of providers through which covered vision benefits may be obtained, restriction of benefits for services from nonparticipating providers, or restriction of products and materials provided as benefits pursuant to this section, shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

SEC. 90. Section 4474.5 of the Welfare and Institutions Code is amended to read:

4474.5. (a) In order to meet the unique medical health needs of consumers transitioning from Agnews Developmental Center into Alameda, San Mateo, and Santa Clara Counties pursuant to the Plan for the Closure of Agnews Developmental Center, and consumers transitioning from Lanterman Developmental Center into various health plans in central and southern California counties pursuant to the Plan for the Closure of Lanterman Developmental Center, whose individual program plans document the need for coordinated medical and specialty care that cannot be met using the traditional Medi-Cal fee-for-service system, services provided under the contract shall be provided by Medi-Cal managed care health plans that are currently operational in these counties. For consumers transitioning from Agnews Developmental Center, the Medi-Cal managed care health plan shall be a county organized health system or a local initiative if consumers, where applicable, choose to enroll. For consumers transitioning from Lanterman Developmental Center, the Medi-Cal managed care health plan shall be any plan operating in the various counties if consumers choose to enroll or, where applicable, are enrolled by mandate pursuant to Section

14182. Reimbursement shall be by the State Department of Health Care Services for all Medi-Cal services provided under the contract that are not reimbursed by the Medicare Program.

(b) (1) Medi-Cal managed care health plans enrolling consumers transitioning from Agnews Developmental Center as referred to in subdivision (a) shall be further reimbursed for the reasonable cost of administrative services.

(2) Notwithstanding subdivision (c), Medi-Cal managed care health plans enrolling consumers transitioning from Lanterman Developmental Center as referred to in subdivision (a) shall be paid a full-risk capitation payment.

(3) "Administrative services" pursuant to this subdivision include, but are not limited to, coordination of care and case management not provided by a regional center, provider credentialing and contracting, quality oversight, assuring member access to covered services, consultation with Agnews Developmental Center staff, regional center staff, State Department of Developmental Services staff, contractors, and family members, and financial management of the program, including claims processing. "Reasonable cost" means the actual cost incurred by the Medi-Cal managed care health plan, including both direct and indirect costs incurred by the Medi-Cal managed care health plan, in the performance of administrative services, but shall not include any incurred costs found by the State Department of Health Care Services to be unnecessary for the efficient delivery of necessary health services. Payment for administrative services shall continue on a reasonable cost basis until sufficient cost experience exists to allow these costs to be part of an all-inclusive capitation rate covering both administrative services and direct patient care services.

(c) Until the State Department of Health Care Services is able to determine by actuarial methods, prospective per capita rates of payment for services for those members who enroll in the Medi-Cal managed care health plans specified in subdivision (a), the State Department of Health Care Services shall reimburse the Medi-Cal managed care health plans for the net reasonable cost of direct patient care services and supplies set forth in the scope of services in the contract between the Medi-Cal managed care health plans and the State Department of Health Care Services and that are not reimbursed by the Medicare Program. "Net reasonable cost" means the actual cost incurred by the Medi-Cal managed care health plans, as measured by the Medi-Cal managed care health plan's payments to providers of services and supplies, less payments made to the plans by third parties other than Medicare, and shall not include any incurred cost found to be unnecessary by the State Department of Health Care Services in the efficient delivery of necessary health services. Reimbursement shall be accomplished by the State Department of Health Care Services making estimated payments at reasonable intervals, with these estimates being reconciled to actual net reasonable cost at least semiannually.

(d) The State Department of Health Care Services shall seek any approval necessary for implementation of this section from the federal government, for purposes of federal financial participation under Title XIX of the Social

Security Act (42 U.S.C. Sec. 1396 et seq.). Notwithstanding any other provision of law, subdivisions (a) to (c), inclusive, shall be implemented only to the extent that federal financial participation is available pursuant to necessary federal approvals.

SEC. 91. Section 14007.9 of the Welfare and Institutions Code, as amended by Section 1 of Chapter 282 of the Statutes of 2009, is amended to read:

14007.9. (a) (1) The department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XIII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII)). In order to be eligible for benefits under this section, an individual shall be required to meet all of the following requirements:

(A) His or her net countable income is less than 250 percent of the federal poverty level for one person or, if the deeming of spousal income applies to the individual, his or her net countable income is less than 250 percent of the federal poverty level for two persons.

(B) He or she is disabled under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 et seq.), Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), or Section 1902(v) of the federal Social Security Act (42 U.S.C. Sec. 1396a(v)). An individual shall be determined to be eligible under this section without regard to his or her ability to engage in, or actual engagement in, substantial gainful activity, as defined in Section 223(d)(4) of the federal Social Security Act (42 U.S.C. Sec. 423(d)(4)).

(C) Except as otherwise provided in this section, his or her net nonexempt resources, which shall be determined in accordance with the methodology used under Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), are not in excess of the limits provided for under those provisions.

(2) To the extent federal financial participation is available, an individual otherwise eligible under this section, but who is temporarily unemployed, may elect to remain on Medi-Cal under this section for up to 26 weeks, provided the individual continues to pay premiums during the temporary period of unemployment.

(b) (1) Countable income shall be determined under Section 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), except that the individual's disability income, including all federal and state disability benefits and private disability insurance, shall be exempted. Resources excluded under Section 1613 of the federal Social Security Act (42 U.S.C. Sec. 1382b) shall be disregarded.

(2) Resources in the form of employer or individual retirement arrangements authorized under the Internal Revenue Code shall be exempted as authorized by Section 1902(r) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)).

(3) (A) For the purposes of calculating countable income under this section, an income exemption shall be applied as necessary to adjust the income standard so that it is the same as the income standard that was in place on May 1, 2009.

(B) This additional income exemption shall cease to be implemented when the SSI/SSP program payment levels increase beyond those in effect on May 1, 2009.

(C) 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 paragraph by means of an all-county letter or similar instruction without taking regulatory action.

(4) Retained earned income of an eligible individual who is receiving health care benefits under this section shall be considered an exempt resource when held in a separately identifiable account and not commingled with other resources, as authorized by Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)).

(5) Social security disability income that converts to social security retirement income upon the retirement of an individual, including any increases in the amount of that income, shall be exempt. The department shall submit a state plan amendment for this specific exemption, and the exemption shall be implemented only if, and to the extent that, the state plan amendment is approved.

(c) All resources exempted pursuant to paragraph (2) of subdivision (b) for an individual who is receiving health care benefits under this section shall continue to be exempt under any other Medi-Cal program that is subject to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)) under which the beneficiary later becomes eligible for medical assistance where that eligibility is based on age, blindness, or disability. The department shall submit a state plan amendment for this specific exemption, and the exemption shall be implemented only if, and to the extent that, the state plan amendment is approved.

(d) After an individual is determined eligible for Medi-Cal benefits under this section, the individual's countable income, as determined under Section 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), shall be used to determine the amount of the individual's required premium payment, as described in subdivision (f). Disability income and converted retirement income made exempt under paragraphs (1) and (5), respectively, of subdivision (b) for eligibility purposes shall be considered countable income for purposes of determining the amount of the required premium payment.

(e) Medi-Cal benefits provided under this chapter pursuant to this section shall be available in the same amount, duration, and scope as those benefits are available for persons who are eligible for Medi-Cal benefits as categorically needy persons and as specified in Section 14007.5.

(f) (1) Individuals eligible for Medi-Cal benefits under this section shall be subject to the payment of premiums determined under this subdivision. Each individual shall pay a monthly premium that is equal to 5 percent of his or her individual countable income, as described in subdivision (d), or if the deeming of spousal income of an ineligible spouse applies, a monthly premium that is equal to 5 percent of the total countable income of both spouses, except that the minimum premium payment per eligible individual

shall be twenty dollars ($20) per month, and the maximum premium payment per eligible individual shall be two hundred fifty dollars ($250) per month.

(2) The amendments made to this subdivision by Chapter 282 of the Statutes of 2009 shall be implemented no later than 90 days after the operative date specified in paragraph (2) of subdivision (k).

(g) In order to implement the collection of premiums under this section, the department may develop and execute a contract with a public or private entity to collect premiums, or may amend any existing or future premium-collection contract that it has executed. Notwithstanding any other provision of law, any contract developed and executed or amended pursuant to this subdivision is exempt from the approval of the Director of General Services and from the Public Contract Code.

(h) Notwithstanding the rulemaking provisions of 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 any regulatory action, 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.

(i) Notwithstanding any other law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation is available pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and only to the extent that the department seeks and obtains approval of all necessary Medicaid state plan amendments.

(j) If any provision of this section, or its application, is held invalid by a final judicial determination, it shall cease to be implemented. A determination of invalidity shall not affect other provisions or applications of this section that can be given effect without the implementation of the invalid provision or application.

(k) (1) Except as provided in paragraph (2), the amendments made to this section by Chapter 282 of the Statutes of 2009 shall not become operative until 30 days after the date that the increase in the state's federal medical assistance percentage (FMAP) pursuant to the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5) is no longer available under that act or any extension of that act.

(2) The amendments made to this section by Chapter 282 of the Statutes of 2009 contained in subdivisions (d) and (f) shall not become operative until 30 days after the date that the director executes a declaration stating that the implementation of subdivisions (d) and (f) will not jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148) or any amendment or extension of that act, any increase in the FMAP available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state.

(3) If at any time the director determines that the statement in the declaration executed pursuant to paragraph (2) may no longer be accurate,

the director shall give notice to the Joint Legislative Budget Committee and to the Department of Finance. After giving notice, the amendments made to this section by Chapter 282 of the Statutes of 2009 contained in subdivisions (d) and (f) shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement subdivisions (d) and (f) in order to receive federal financial participation, any increase in the FMAP available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state, in which case, subdivision (d) of this section, as stated by Section 32 of Chapter 5 of the Fourth Extraordinary Session of the Statutes of 2009, shall be operative.

(4) The director shall post a declaration made pursuant to paragraph (2) or (3) on the department's Internet Web site and the director shall send the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(*l*) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement subdivision (k) by means of all-county letters or similar instruction, without taking regulatory action.

SEC. 92. Section 14091.3 of the Welfare and Institutions Code is amended to read:

14091.3. (a) For purposes of this section, the following definitions shall apply:

(1) "Medi-Cal managed care plan contracts" means those contracts entered into with the department by any individual, organization, or entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.91 (commencing with Section 14089) of this chapter, or Article 1 (commencing with Section 14200) or Article 7 (commencing with Section 14490) of Chapter 8, or Chapter 8.75 (commencing with Section 14590).

(2) "Medi-Cal managed care health plan" means an individual, organization, or entity operating under a Medi-Cal managed care plan contract with the department under this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14590).

(b) The department shall take all appropriate steps to amend the Medicaid State Plan, if necessary, to carry out this section. This section shall be implemented only to the extent that federal financial participation is available. The department shall adopt rules and regulations to carry out this section. Until January 1, 2010, any rules and regulations adopted pursuant to this subdivision may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and

safety or general welfare. The regulations shall become effective immediately upon filing with the Secretary of State.

(c) Any hospital that does not have in effect a contract with a Medi-Cal managed care health plan, as defined in paragraph (2) of subdivision (a), that establishes payment amounts for services furnished to a beneficiary enrolled in that plan shall accept as payment in full, from all these plans, the following amounts:

(1) For outpatient services, the Medi-Cal fee-for-service (FFS) payment amounts.

(2) For emergency inpatient services, the average per diem contract rate specified in paragraph (2) of subdivision (b) of Section 14166.245, except that the payment amount shall not be reduced by 5 percent. For the purposes of this paragraph, this payment amount shall apply to all hospitals, including hospitals that contract with the department under the Medi-Cal Selective Provider Contracting Program described in Article 2.6 (commencing with Section 14081), and small and rural hospitals specified in Section 124840 of the Health and Safety Code.

(3) For poststabilization services following an emergency admission, payment amounts shall be consistent with subdivision (e) of Section 438.114 of Title 42 of the Code of Federal Regulations. This paragraph shall only be implemented to the extent that contract amendment language providing for these payments is approved by CMS. For purposes of this paragraph, this payment amount shall apply to all hospitals, including hospitals that contract with the department under the Medi-Cal Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081).

(d) Medi-Cal managed care health plans that, pursuant to the department's encouragement in All Plan Letter 07003, have been paying out-of-network hospitals the most recent California Medical Assistance Commission regional average per diem rate as a temporary rate for purposes of Section 1932(b)(2)(D) of the Social Security Act (SSA), which became effective January 1, 2007, shall make reconciliations and adjustments for all hospital payments made since January 1, 2007, based upon rates published by the department pursuant to Section 1932(b)(2)(D) of the SSA and effective January 1, 2007, to June 30, 2008, inclusive, and, if applicable, provide supplemental payments to hospitals as necessary to make payments that conform with Section 1932(b)(2)(D) of the SSA. In order to provide managed care health plans with 60 working days to make any necessary supplemental payments to hospitals prior to these payments becoming subject to the payment of interest, Section 1300.71 of Title 28 of the California Code of Regulations shall not apply to these supplemental payments until 30 working days following the publication by the department of the rates.

(e) (1) The department shall provide a written report to the policy and fiscal committees of the Legislature on October 1, 2009, and May 1, 2010, on the implementation and impact made by this section, including the impact of these changes on access to hospitals by managed care enrollees and on

contracting between hospitals and managed care health plans, including the increase or decrease in the number of these contracts.

(2) Not later than August 1, 2010, the department shall report to the Legislature on the implementation of this section. The report shall include, but not be limited to, information and analyses addressing managed care enrollee access to hospital services, the impact of this section on managed care health plan capitation rates, the impact of this section on the extent of contracting between managed care health plans and hospitals, and fiscal impact on the state.

(3) For the purposes of preparing the annual status reports and the final evaluation report required pursuant to this subdivision, Medi-Cal managed care health plans shall provide the department with all data and documentation, including contracts with providers, including hospitals, as deemed necessary by the department to evaluate the impact of the implementation of this section. In order to ensure the confidentiality of managed care health plan proprietary information, and thereby enable the department to have access to all of the data necessary to provide the Legislature with accurate and meaningful information regarding the impact of this section, all information and documentation provided to the department pursuant to this section shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act (Division 7 (commencing with Section 6250) of Title 1 of the Government Code).

(f) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.

SEC. 93. Section 14105.07 is added to the Welfare and Institutions Code, to read:

14105.07. (a) The Legislature finds and declares all of the following:

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

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

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

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

(5) As the single state agency for Medicaid in California, the State Department of Health Care Services has unique expertise that can inform

decisions that set or adjust reimbursement methodologies and levels consistent with the requirements of federal law.

(b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and also consistent with federal and state law and policies, including any exemptions contained in the act that added this section, provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services, and products.

(c) (1) Notwithstanding any other provision of law and except as provided in paragraphs (2), (3), and (4), for dates of service on and after June 1, 2011, payments to intermediate care facilities for the developmentally disabled, licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, as determined by the applicable methodology for setting reimbursement rates for these facilities, shall not exceed the reimbursement rates that were applicable to those providers in the 2008–09 rate year, reduced by 10 percent.

(2) Notwithstanding any other provision of law, the director may adjust the percentage reductions specified in paragraph (1), as long as the resulting reductions, in the aggregate, total no more than 10 percent.

(3) The adjustments authorized under this subdivision shall be implemented only if the director determines that the payments resulting from the adjustments comply with subdivision (d).

(4) Payments to facilities owned or operated by the state shall be exempt from the payment reduction as required in paragraph (1).

(d) (1) Notwithstanding any other provision of this section, the payment reductions and adjustments required by subdivision (c) shall be implemented only if the director determines that the payments that result from the application of subdivision (c) will comply with applicable federal Medicaid requirements and that federal financial participation will be available.

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

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

(4) The director shall seek any necessary federal approvals for the implementation of this section. This section shall not be implemented until federal approval is obtained. When federal approval is obtained, the payments resulting from the application of subdivision (c) shall be

implemented retroactively to June 1, 2011, or on any other date or dates as may be applicable.

(e) For managed care health plans that contract with the department pursuant to this chapter and Chapter 8 (commencing with Section 14200), except for contracts with the Senior Care Action Network and AIDS Healthcare Foundation, and to the extent that these services are provided through any of those contracts, payments shall be reduced by the actuarial equivalent amount of the reduced provider reimbursements specified in subdivision (c) pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.

SEC. 93.2. Section 14105.191 of the Welfare and Institutions Code is amended to read:

14105.191. (a) Notwithstanding any other provision of law, in order to implement changes in the level of funding for health care services, the director shall reduce provider payments, as specified in this section.

(b) (1) Except as otherwise provided in this section, payments shall be reduced by 1 percent for Medi-Cal fee-for-service benefits for dates of service on and after March 1, 2009.

(2) Except as provided in subdivision (d), for dates of service on and after March 1, 2009, payments to the following classes of providers shall be reduced by 5 percent for Medi-Cal fee-for-service benefits:

(A) Intermediate care facilities, excluding those facilities identified in paragraph (5) of subdivision (d). For purposes of this section, "intermediate care facility" has the same meaning as defined in Section 51118 of Title 22 of the California Code of Regulations.

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

(C) Rural swing-bed facilities.

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

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

(F) Adult day health care centers.

(3) Except as provided in subdivision (d), for dates of service on and after March 1, 2009, Medi-Cal fee-for-service payments to pharmacies shall be reduced by 5 percent.

(4) Except as provided in subdivision (d), payments shall be reduced by 1 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after March 1, 2009.

(5) For managed health care plans that contract with the department pursuant to this chapter, Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590), payments shall be reduced by the actuarial equivalent amount of the payment reductions specified in this subdivision pursuant to contract amendments or change orders effective on July 1, 2008, or thereafter.

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

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

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

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

(3) Rural health clinic services.

(4) Skilled nursing facilities licensed pursuant to subdivision (c) of Section 1250 of the Health and Safety Code other than those specified in paragraph (2) of subdivision (b).

(5) Intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, or facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14495.10.

(6) Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services.

(7) Hospice services.

(8) Contract services, as designated by the director pursuant to subdivision (g).

(9) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations.

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

(11) Payments to Medi-Cal managed care plans pursuant to Section 4474.5 for services to consumers transitioning from Agnews Developmental Center into the Counties of Alameda, San Mateo, and Santa Clara pursuant to the Plan for the Closure of Agnews Developmental Center.

(12) Breast and cervical cancer treatment provided pursuant to Section 14007.71 and as described in paragraph (3) of subdivision (a) of Section

14105.18 or Article 1.5 (commencing with Section 104160) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code.

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

(14) Small and rural hospitals, as defined in Section 124840 of the Health and Safety Code.

(e) Subject to the exemptions listed in subdivision (d), the payment reductions required by paragraph (1) of subdivision (b) shall apply to the benefits rendered by any provider who may be authorized to bill for provision of the benefit, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse midwives, nurse anesthetists, and organized outpatient clinics.

(f) (1) Notwithstanding any other provision of law, Medi-Cal reimbursement rates applicable to the classes of providers identified in paragraph (2) of subdivision (b), for services rendered during the 2009–10 rate year and each rate year thereafter, shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008–09 rate year.

(2) In addition to the classes of providers described in paragraph (1), Medi-Cal reimbursement rates applicable to the following classes of facilities for services rendered during the 2009–10 rate year, and each rate year thereafter, shall not exceed the reimbursement rates that were applicable to those facilities and services in the 2008–09 rate year:

(A) Facilities identified in paragraph (5) of subdivision (d).

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

(3) Paragraphs (1) and (2) shall not apply to providers that are paid pursuant to Article 3.8 (commencing with Section 14126), or to services, facilities, and payments specified in subdivision (d), with the exception of facilities described in paragraph (5) of subdivision (d).

(4) The limitation set forth in this subdivision shall be applied only after the reductions in paragraph (2) of subdivision (b) have been made.

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

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

(i) The department shall promptly seek any necessary federal approvals for the implementation of this section. To the extent that federal financial participation is not available with respect to any payment that is reduced or limited pursuant to this section, the director may elect not to implement that reduction or limitation.

(j) This section shall become inoperative for dates of service on and after June 1, 2011, and shall, on July 1, 2014, be repealed.

SEC. 93.5. Section 14105.192 is added to the Welfare and Institutions Code, to read:

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

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

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

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

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

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

(b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and consistent with federal and state law and policies, including any exemptions contained in the provisions of the act that added this section, provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services and products.

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

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

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

(3) Payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after June 1, 2011. This paragraph shall not apply

to inpatient hospital services provided in a hospital that is paid under contract pursuant to Article 2.6 (commencing with Section 14081).

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

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

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

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

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

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

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

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

(g) The department may enter into contracts with a vendor for the purposes of implementing this section on a bid or nonbid basis. In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this subdivision is necessary. Therefore, contracts entered into to implement this section and all contract amendments and

change orders shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 Division 2 of the Public Contract Code.

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

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

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

(3) Rural health clinic services.

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

(5) Hospice services.

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

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

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

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

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

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

(j) Notwithstanding any other provision of law, for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates applicable to the following classes of providers shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008–09 rate year, as described in subdivision (f) of Section 14105.91, reduced by 10 percent:

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

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

(3) Rural swing-bed facilities.

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

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

(6) Adult day health care centers.

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

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

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

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

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

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

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

(o) This section shall not be implemented until federal approval is obtained. When federal approval is obtained, the payments resulting from the application of subdivision (d) shall be implemented retroactively to June 1, 2011, or on such other date or dates as may be applicable.

SEC. 94. 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) "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.

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

(e) "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.

(f) "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).

(g) "State rebate" means the amount negotiated between the manufacturer and the department for reimbursement by the manufacturer, as specified in the contract, in addition to the Medicaid rebate.

(h) "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.

SEC. 95. Section 14105.33 of the Welfare and Institutions Code is amended to read:

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

(b) (1) Contracts executed pursuant to this section shall be for the manufacturer's best price, as defined in Section 14105.31, which shall be specified in the contract, and subject to agreed-upon price escalators, as defined in that section. The contracts shall provide for a state rebate, as defined in Section 14105.31, to be remitted to the department quarterly. The department shall submit an invoice to each manufacturer for the state rebate, including supporting utilization data from the department's prescription drug paid claims tapes within 30 days of receipt of the federal Centers for Medicare and Medicaid Services' file of manufacturer rebate information. In lieu of paying the entire invoiced amount, a manufacturer may contest the invoiced amount pursuant to procedures established by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations by mailing a notice, that shall set forth its grounds for contesting the invoiced amount, to the department within 38 days of the department's mailing of the state invoice and supporting utilization data. For purposes of state accounting practices only, the contested balance shall not be considered an accounts receivable amount until final resolution of the dispute pursuant to procedures established by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations that results in a finding of an underpayment by the manufacturer. Manufacturers may request, and the department shall timely provide, at cost, Medi-Cal provider level drug utilization data, and other Medi-Cal utilization data necessary to resolve a contested department-invoiced rebate amount.

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

(3) Utilization data used to determine the state rebate 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.

(4) Except as provided in paragraph (3), utilization data used to determine the state rebate shall include data from all programs that qualify for federal drug rebates pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8) or that otherwise qualify for federal funds under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) pursuant to the Medicaid state plan or waivers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(o) If the rebate payment is not received, the department shall send overdue notices to the manufacturer at 38, 68, and 98 days after the date of

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

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

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

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

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

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

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

SEC. 96. Section 14105.332 of the Welfare and Institutions Code is amended to read:

14105.332. State and federal rebates that are owed to the state for drugs dispensed to Medi-Cal beneficiaries shall not be reduced to the state if a manufacturer reports, to the federal Centers for Medicare and Medicaid Services or the department, a revised drug product's average manufacturer price or best price as these terms are defined pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8) for any calendar quarter in which the rebate was due.

SEC. 97. Section 14105.34 of the Welfare and Institutions Code is amended to read:

14105.34. (a) The department shall provide for an annual written report of Medi-Cal pharmacy costs or Medi-Cal drug costs, as defined in subdivision (e) of Section 14105.31.

(b) The annual report shall be consistent with the relevant sections of the Quarterly Report of Expenditures for the Medi-Cal Assistance Program, known as the CMS-64 Report, provided to the federal Centers for Medicare and Medicaid Services. The report shall include the following expenditure and receipt information:

(1) The total annual rebate amounts received by the department pursuant to agreements with the federal Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

(2) The total annual rebate amounts received pursuant to state contracts with drug manufacturers.

(3) Total drug cost amounts upon which rebate payments were made.

SEC. 97.5. Section 14105.451 is added to the Welfare and Institutions Code, to read:

14105.451. (a) (1) The Legislature finds and declares all of the following:

(A) The United States Department of Health and Human Services has identified the critical need for state Medicaid agencies to establish pharmacy reimbursement rates based on a pricing benchmark that reflects actual acquisition costs.

(B) The Medi-Cal program currently uses a methodology based on average wholesale price.

(C) Investigations by the federal Office of Inspector General have found that average wholesale price is inflated relative to average acquisition cost.

(2) Therefore, it is the intent of the Legislature to enact legislation by August 1, 2011, that provides for development of a new reimbursement methodology that will enable the department to achieve savings while continuing to reimburse pharmacy providers in compliance with federal law.

(b) The department may require providers, manufacturers, and wholesalers to submit any data the director determines necessary or useful in preparing for the transition from a methodology based on average wholesale price to a methodology based on actual acquisition cost.

SEC. 98. Section 14126.033 of the Welfare and Institutions Code is amended to read:

14126.033. (a) The Legislature finds and declares all of the following:

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

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

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

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

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

(b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and also consistent with federal and state law and policies, including any exemptions contained in the act that added this section, provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services, and products.

(c) This article, including Section 14126.031, shall be funded as follows:

(1) General Fund moneys appropriated for purposes of this article pursuant to Section 6 of the act adding this section shall be used for increasing rates, except as provided in Section 14126.031, for freestanding skilled nursing facilities, and shall be consistent with the approved methodology required to be submitted to the federal Centers for Medicare and Medicaid Services pursuant to Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code.

(2) (A) Notwithstanding Section 14126.023, for the 2005–06 rate year, the maximum annual increase in the weighted average Medi-Cal rate required for purposes of this article shall not exceed 8 percent of the weighted average Medi-Cal reimbursement rate for the 2004–05 rate year as adjusted for the change in the cost to the facility to comply with the nursing facility quality assurance fee for the 2005–06 rate year, as required under subdivision (b) of Section 1324.21 of the Health and Safety Code, plus the total projected Medi-Cal cost to the facility of complying with new state or federal mandates.

(B) Beginning with the 2006–07 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not exceed 5 percent of the weighted average Medi-Cal

reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

(C) Beginning with the 2007–08 rate year and continuing through the 2008–09 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not exceed 5.5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

(D) For the 2009–10 rate year, the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not be increased with respect to the weighted average Medi-Cal reimbursement rate for the 2008–09 rate year, as adjusted for the projected cost of complying with new state or federal mandates.

(3) (A) For the 2010–11 rate year, if the increase in the federal medical assistance percentage (FMAP) pursuant to the federal American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5) is extended for the entire 2010–11 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate for the purposes of this article shall not exceed 3.93 percent, or 3.14 percent, if the increase in the FMAP pursuant to ARRA is not extended for that period of time, plus the projected cost of complying with new state or federal mandates. If the increase in the FMAP pursuant to ARRA is extended at a different rate, or for a different time period, the rate adjustment for facilities shall be adjusted accordingly.

(B) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) shall be adjusted by the department for the following reasons:

(i) If the federal Centers for Medicare and Medicaid Services does not approve exemption changes to the facilities subject to the quality assurance fee.

(ii) If the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the quality assurance fee.

(iii) To ensure that the state does not incur any additional General Fund expenses to pay for the 2010–11 weighted average Medi-Cal reimbursement rate increase.

(C) If the maximum annual increase in the weighted average Medi-Cal rate is reduced pursuant to subparagraph (B), the department shall recalculate and publish the final maximum annual increase in the weighted average Medi-Cal reimbursement rate.

(4) (A) Subject to the following provisions, for the 2011–12 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate for the purpose of this article shall not exceed 2.4 percent, plus the projected cost of complying with new state or federal mandates.

(B) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) shall be adjusted by the department for the following reasons:

(i) For the 2011–12 rate year, the department shall set aside 1 percent of the weighted average Medi-Cal reimbursement rate, from which the department shall transfer the General Fund portion into the Skilled Nursing Facility Quality and Accountability Special Fund, to be used for the supplemental rate pool.

(ii) If the federal Centers for Medicare and Medicaid Services does not approve exemption changes to the facilities subject to the quality assurance fee.

(iii) If the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the quality assurance fee.

(iv) To ensure that the state does not incur any additional General Fund expenses to pay for the 2011–12 weighted average Medi-Cal reimbursement rate increase.

(C) The department may recalculate and publish the weighted average Medi-Cal reimbursement rate increase for the 2011–12 rate year if the difference in the projected quality assurance fee collections from the 2011–12 rate year, compared to the projected quality assurance fee collections for the 2010–11 rate year, would result in any additional General Fund expense to pay for the 2011–12 rate year weighted average reimbursement rate increase.

(5) To the extent that rates are projected to exceed the adjusted limits calculated pursuant to subparagraphs (A) to (D), inclusive, of paragraph (2) and, as applicable, paragraphs (3) and (4), the department shall adjust each skilled nursing facility's projected rate for the applicable rate year by an equal percentage.

(6) (A) (i) Notwithstanding any other provision of law, and except as provided in subparagraphs (B), (C), and (D), payments resulting from the application of paragraphs (3) and (4), the provisions of paragraph (5), and all other applicable adjustments and limits as required by this section, shall be reduced by 10 percent for dates of service on and after June 1, 2011.

(ii) Notwithstanding any other provision of law, the director may adjust the percentage reductions specified in clause (i), as long as the resulting reductions, in the aggregate, total no more than 10 percent.

(iii) The adjustments authorized under this subparagraph shall be implemented only if the director determines that the payments resulting from the adjustments comply with paragraph (7).

(B) Notwithstanding any other provision of law, the 1 percent set aside of the weighted average Medi-Cal reimbursement rate as required by clause (i) of subparagraph (B) of paragraph (4) shall be exempt from the payment reduction required by this paragraph.

(C) Notwithstanding any other provision of law, payments to skilled nursing facilities pursuant to subdivision (m) of Section 14126.022 shall be exempt from the payment reduction required by this paragraph.

(D) Payments to facilities owned or operated by the state shall be exempt from the payment reduction required by this paragraph.

(7) (A) Notwithstanding any other provision of this section, the payment reductions and adjustments required by paragraph (6) shall be implemented only if the director determines that the payments that result from the application of paragraph (6) will comply with applicable federal Medicaid requirements and that federal financial participation will be available.

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

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

(8) For managed care health plans that contract with the department pursuant to this chapter and Chapter 8 (commencing with Section 14200), except for contracts with the Senior Care Action Network and AIDS Healthcare Foundation, and to the extent that these services are provided through any of those contracts, payments shall be reduced by the actuarial equivalent amount of the reduced provider reimbursements specified in paragraph (6) pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.

(9) The director shall seek any necessary federal approvals for the implementation of this section. This section shall not be implemented until federal approval is obtained. When federal approval is obtained, the payments resulting from the application of paragraph (6) shall be implemented retroactively to June 1, 2011, or on any other date or dates as may be applicable.

(d) The rate methodology shall cease to be implemented after July 31, 2012.

(e) (1) It is the intent of the Legislature that the implementation of this article result in individual access to appropriate long-term care services, quality resident care, decent wages and benefits for nursing home workers, a stable workforce, provider compliance with all applicable state and federal requirements, and administrative efficiency.

(2) Not later than December 1, 2006, the Bureau of State Audits shall conduct an accountability evaluation of the department’s progress toward implementing a facility-specific reimbursement system, including a review of data to ensure that the new system is appropriately reimbursing facilities within specified cost categories and a review of the fiscal impact of the new system on the General Fund.

(3) Not later than January 1, 2007, to the extent information is available for the three years immediately preceding the implementation of this article, the department shall provide baseline information in a report to the Legislature on all of the following:

(A) The number and percent of freestanding skilled nursing facilities that complied with minimum staffing requirements.

(B) The staffing levels prior to the implementation of this article.

(C) The staffing retention rates prior to the implementation of this article.

(D) The numbers and percentage of freestanding skilled nursing facilities with findings of immediate jeopardy, substandard quality of care, or actual harm, as determined by the certification survey of each freestanding skilled nursing facility conducted prior to the implementation of this article.

(E) The number of freestanding skilled nursing facilities that received state citations and the number and class of citations issued during calendar year 2004.

(F) The average wage and benefits for employees prior to the implementation of this article.

(4) Not later than January 1, 2009, the department shall provide a report to the Legislature that does both of the following:

(A) Compares the information required in paragraph (2) to that same information two years after the implementation of this article.

(B) Reports on the extent to which residents who had expressed a preference to return to the community, as provided in Section 1418.81 of the Health and Safety Code, were able to return to the community.

(5) The department may contract for the reports required under this subdivision.

SEC. 99. Section 14126.036 is added to the Welfare and Institutions Code, to read:

14126.036. This article shall become inoperative on August 1, 2012, and as of January 1, 2013, is repealed, unless a later enacted statute that is enacted before January 1, 2013, deletes or extends that date.

SEC. 100. Section 14131.05 is added to the Welfare and Institutions Code, to read:

14131.05. (a) Notwithstanding any other provision of this chapter or Chapter 8 (commencing with Section 14200), optional hearing aid benefits are subject to per beneficiary benefit cap amounts under the Medi-Cal program.

(b) For the purposes of this section, "benefit cap amount" means the maximum amount of Medi-Cal coverage for optional hearing aid benefits as specified in subdivision (c), for each beneficiary, for each fiscal year.

(c) Hearing aid benefits are subject to a benefit cap amount of one thousand five hundred ten dollars ($1,510).

(d) Pregnancy-related benefits and benefits for the treatment of other conditions that might complicate the pregnancy are not subject to the benefit cap amount in subdivision (c).

(e) The benefit cap amount in subdivision (c) does not apply to the following:

(1) Beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment Program.

(2) Beneficiaries receiving long-term care in a nursing facility that is both of the following:

(A) A skilled nursing facility or intermediate care facility as defined in subdivisions (c), (d), (e), (g), and (h), respectively, of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the program established by Section 14132.20.

(B) A licensed nursing facility pursuant to subdivision (k) of Section 1250 of the Health and Safety Code.

(f) For managed care health plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except for contracts with the Senior Care Action Network and AIDS Healthcare Foundation, payments for optional hearing aid benefits shall be reduced by the actuarial equivalent amount of the benefit reductions resulting from the implementation of the benefit cap amount specified in this section pursuant to contract amendments or change orders effective on July 1, 2011, or any date thereafter.

(g) This section shall be implemented only to the extent permitted by federal law.

(h) Notwithstanding 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), the department may implement the provisions of this section by means of all-county letters, provider bulletins, or similar instructions, without taking further regulatory action.

(i) This section shall be implemented on the first day of the first calendar month following 210 days after the effective date of this section, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later. If the implementation date occurs after July 1, 2011, then the benefit cap described in subdivision (c) for the first year of implementation shall be applied from the implementation date through June 30 of the state fiscal year in which implementation commences. Thereafter, the benefit cap shall apply on a state fiscal year basis.

SECTION 100.5. Section 14131.07 is added to the Welfare and Institutions Code, to read:

14131.07. (a) Notwithstanding any other provision of this chapter or Chapter 8 (commencing with Section 14200), the total number of physician office and clinic visits for physician services provided by a physician, or under the direction of a physician, that are a covered benefit under the Medi-Cal program shall be limited to seven visits per beneficiary per fiscal year, excepting visits that meet the conditions set forth in subdivision (b). For purposes of this limit, a visit shall include physician services provided at any federally qualified health center, rural health clinic, community clinic, outpatient clinic, and hospital outpatient department. The department may seek input from consumer organizations and the provider community, as applicable, prior to implementation.

(b) (1) Visits exceeding seven per beneficiary per fiscal year shall be required to be certified by the physician, or other medical professional under

the supervision of a physician, attesting that one or more of the following circumstances is applicable:

(A) The services will prevent deterioration in a beneficiary's condition that would otherwise foreseeably result in admission to the emergency department.

(B) The services will prevent deterioration in the beneficiary's condition that would otherwise result in inpatient admission.

(C) The services will prevent disruption in ongoing medical therapy or surgical therapy, or both, including, but not limited to, medications, radiation, or wound management.

(D) The services constitute diagnostic workup in progress that would otherwise foreseeably result in inpatient or emergency department admission.

(E) The services are for the purpose of assessment and form completion for Medi-Cal recipients seeking or receiving in-home supportive services.

(2) The certification shall consist of a written declaration by the physician, or other medical professional under the supervision of the physician, that the visit meets the requirements of any one or more of the circumstances set forth in paragraph (1), and shall include a description of the services provided.

(3) The certification shall be maintained onsite at the physician's office or clinic location at which the medical records for the beneficiary are maintained and shall be subject to audit and inspection by the department.

(4) This subdivision does not authorize or direct a beneficiary to obtain services at a physician office or clinic visit for an emergency medical condition or that should properly be provided in the emergency department or as hospital inpatient services.

(c) Specialty mental health services furnished or arranged for the provision of mental health services to Medi-Cal beneficiaries pursuant to Part 2.5 (commencing with Section 5775) of Division 5, shall not be subject to the limit provided in subdivision (a).

(d) Any pregnancy-related visit, or any visit for the treatment of any other condition that might complicate a pregnancy, shall not be subject to the limit provided in subdivision (a).

(e) The limit on physician office and clinic visits provided in subdivision (a) shall not apply to any of the following:

(1) A beneficiary under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

(2) A beneficiary receiving long-term care in a nursing facility that is both of the following:

(A) A skilled nursing facility or intermediate care facility as defined in subdivisions (c), (d), (e), (g), and (h), respectively, of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to persons with developmental disabilities under the pilot project established pursuant to Section 14132.20.

(B) Licensed pursuant to subdivision (k) of Section 1250 of the Health and Safety Code.

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

(g) This section shall be implemented only to the extent permitted by federal law.

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

(i) This section shall be implemented on the first day of the first calendar month following 180 days after the effective date of the act that added this section, or on the first day of the calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later. If the implementation date occurs after July 1, 2011, then the benefit caps described in subdivision (a) for the first year of implementation shall be applied from the implementation date to June 30 of the state fiscal year in which implementation begins. Thereafter, the benefit caps shall apply on a state fiscal year basis.

SEC. 101. Section 14132 of the Welfare and Institutions Code is amended to read:

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

(a) Outpatient services are covered as follows:

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

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

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

(d) (1) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(2) Purchase of drugs used to treat erectile dysfunction or any off-label uses of those drugs are covered only to the extent that federal financial participation is available.

(3) (A) To the extent required by federal law, the purchase of outpatient prescribed drugs, for which the prescription is executed by a prescriber in written, nonelectronic form on or after April 1, 2008, is covered only when executed on a tamper resistant prescription form. The implementation of this paragraph shall conform to the guidance issued by the federal Centers of Medicare and Medicaid Services but shall not conflict with state statutes on the characteristics of tamper resistant prescriptions for controlled substances, including Section 11162.1 of the Health and Safety Code. The department shall provide providers and beneficiaries with as much flexibility in implementing these rules as allowed by the federal government. The department shall notify and consult with appropriate stakeholders in implementing, interpreting, or making specific this paragraph.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instructions without taking regulatory action.

(4) (A) (i) For the purposes of this paragraph, nonlegend has the same meaning as defined in subdivision (a) of Section 14105.45.

(ii) Nonlegend acetaminophen-containing products, with the exception of children's acetaminophen-containing products, selected by the department are not covered benefits.

(iii) Nonlegend cough and cold products selected by the department are not covered benefits. This clause shall be implemented on the first day of the first calendar month following 90 days after the effective date of the act that added this clause, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.

(iv) Beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment Program shall be exempt from clauses (ii) and (iii).

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instruction without taking regulatory action.

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

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

medical procedure or for portable X-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

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

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

(A) Periodontal treatment is not a benefit.

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

(C) Laboratory processed crowns are not a benefit.

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

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

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

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

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

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

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

Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated, is covered subject to utilization controls. When there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

Therapeutic shoes and inserts are covered when provided to beneficiaries with a diagnosis of diabetes, subject to utilization controls, to the extent that federal financial participation is available.

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

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with 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).

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

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

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

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) (1) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(2) Commencing 30 days after the effective date of the act that added this paragraph, and notwithstanding the number of days previously approved through a treatment authorization request, adult day health care is covered for a maximum of three days per week.

(3) As provided in accordance with paragraph (4), adult day health care is covered for a maximum of five days per week.

(4) As of the date that the director makes the declaration described in subdivision (g) of Section 14525.1, paragraph (2) shall become inoperative and paragraph (3) shall become operative.

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, other prophylaxis treatment for children 17 years of age and under, are covered.

(2) All dental hygiene services provided by a registered dental hygienist in alternative practice pursuant to Sections 1768 and 1770 of the Business

and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article.

(2) All providers enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, "in-home medical care service" includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

As used in this subdivision, in-home medical care services, include, but are not limited to:

(1) Level of care and cost of care evaluations.

(2) Expenses, directly attributable to home care activities, for materials.

(3) Physician fees for home visits.

(4) Expenses directly attributable to home care activities for shelter and modification to shelter.

(5) Expenses directly attributable to additional costs of special diets, including tube feeding.

(6) Medically related personal services.

(7) Home nursing education.

(8) Emergency maintenance repair.

(9) Home health agency personnel benefits which permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(11) Emergency and nonemergency medical transportation.

(12) Medical supplies.

(13) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(14) Utility use directly attributable to the requirements of home care activities which are in addition to normal utility use.

(15) Special drugs and medications.

(16) Home health agency supervision of visiting staff which is medically necessary, but not included in the home health agency rate.

(17) Therapy services.

(18) Household appliances and household utensil costs directly attributable to home care activities.

(19) Modification of medical equipment for home use.

(20) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(21) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

Beneficiaries receiving in-home medical care services are entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services may be covered to the extent that federal financial participation is available for those services under waivers granted in accordance with Section 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service which is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services which are authorized and reimbursable under this chapter, and services which are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for beneficiaries with a diagnosis of AIDS or ARC, who require intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to individual beneficiaries in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible beneficiaries. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department, a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Program.

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United States Code, which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes

imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United States Code. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and Medicaid Services and only to the extent that federal financial participation is available for the services. Nothing in this section shall prohibit the department from seeking the Family PACT successor state plan amendment during the operation of the waiver.

(3) Solely for the purposes of the waiver or Family PACT successor state plan amendment and notwithstanding any other provision of law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other provision of law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, without taking regulatory action, the provisions of the waiver after its approval by the federal Health Care Financing Administration and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) In the event that the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) or the Family PACT successor state plan amendment is no longer cost effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive

family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, "comprehensive clinical family planning services" means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at the next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(F) Services, drugs, devices, and supplies deemed by the federal Centers for Medicare and Medicaid Services to be appropriate for inclusion in the program.

(9) In order to maximize the availability of federal financial participation under this subdivision, the director shall have the discretion to implement the Family PACT successor state plan amendment retroactively to July 1, 2010.

(ab) (1) Purchase of prescribed enteral nutrition products is covered, subject to the Medi-Cal list of enteral nutrition products and utilization controls.

(2) Purchase of enteral nutrition products is limited to those products to be administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube. Beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment Program shall be exempt from this paragraph.

(3) Notwithstanding paragraph (2), the department may deem an enteral nutrition product, not administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube, a benefit for patients with diagnoses, including, but not limited to, malabsorption and inborn errors of metabolism, if the product has been shown to be neither investigational nor experimental when used as part of a therapeutic regimen to prevent serious disability or death.

(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the amendments to this subdivision made by the act that added this paragraph by means of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.

(5) The amendments made to this subdivision by the act that added this paragraph shall be implemented June 1, 2011, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

SEC. 101.2. Section 14134 of the Welfare and Institutions Code is amended to read:

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

(1) Copayment of five dollars ($5) shall be made for nonemergency services received in an emergency room. For the purposes of this section, "nonemergency services" means any services not required for the alleviation of severe pain or the immediate diagnosis and treatment of severe medical conditions which, if not immediately diagnosed and treated, would lead to disability or death.

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

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

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

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

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

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

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

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

(D) Any woman receiving perinatal care.

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

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

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

(10) The director shall adopt any regulations necessary to implement this section as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The director shall transmit these emergency regulations directly to the Secretary of State for filing and the

regulations shall become effective immediately upon filing. Upon completion of the formal regulation adoption process and prior to the expiration of the 120 day duration period of emergency regulations, the director shall transmit directly to the Secretary of State for filing the adopted regulations, the rulemaking file, and the certification of compliance as required by subdivision (e) of Section 11346.1 of the Government Code.

(b) This section shall become inoperative on the implementation date for copayments stated in the declaration executed by the director pursuant to Section 14134 as added by Section 101.5 of the act that added this subdivision, and is repealed on January 1 of the following year.

SEC. 101.5. Section 14134 is added to the Welfare and Institutions Code, to read:

14134. (a) The Legislature finds and declares all of the following:

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

(2) In order to minimize the need for drastically cutting enrollment standards or benefits or imposing further reductions on Medi-Cal providers during times of economic crisis, it is crucial to find areas within the program where beneficiaries can share responsibility for utilization of health care, whether they are participating in the fee-for-service or the managed care model of service delivery.

(3) The establishment of cost-sharing obligations within the Medi-Cal program is complex and is subject to close supervision by the United States Department of Health and Human Services.

(4) As the single state agency for Medicaid in California, the State Department of Health Care Services has unique expertise that can inform decisions that set or adjust cost-sharing responsibilities for Medi-Cal beneficiaries receiving health care services.

(b) Therefore, it is the intent of the Legislature for the department to obtain federal approval to implement cost-sharing for Medi-Cal beneficiaries and permit providers to require that individuals meet their cost-sharing obligation prior to receiving care or services.

(c) A Medi-Cal beneficiary shall be required to make copayments as described in this section. These copayments represent a contribution toward the rate of payment made to providers of Medi-Cal services and shall be as follows:

(1) Copayment of up to fifty dollars ($50) shall be made for nonemergency services received in an emergency room. For the purposes of this section, “nonemergency services” means services not required for the alleviation of severe pain or the immediate diagnosis and treatment of unforeseen medical conditions that, if not immediately diagnosed and treated, would lead to disability or death.

(2) Copayment of up to fifty dollars ($50) shall be made for emergency services received in an emergency room. For purposes of this section, “emergency services” means services required for the alleviation of severe pain or the immediate diagnosis and treatment of unforeseen medical

conditions that, if not immediately diagnosed and treated, would lead to disability or death.

(3) Copayment of up to one hundred dollars ($100) shall be made for each hospital inpatient day, up to a maximum of two hundred dollars ($200) per admission.

(4) Copayment of up to three dollars ($3) shall be made for each preferred drug prescription or refill. A copayment of up to five dollars ($5) shall be made for each nonpreferred drug prescription or refill. Except as provided in subdivision (g), "preferred drug" shall have the same meaning as in Section 1916A of the Social Security Act (42 U.S.C. Sec. 1396o-1).

(5) Copayment of up to five dollars ($5) shall be made for each visit for services under subdivision (a) of Section 14132 and for dental services received on an outpatient basis provided as a Medi-Cal benefit pursuant to this chapter or Chapter 8 (commencing with Section 14200), as applicable.

(6) This section does not apply to services provided pursuant to subdivision (aa) of Section 14132.

(d) The copayments established pursuant to subdivision (c) shall be set by the department, at the maximum amount provided for in the applicable paragraph, except that each copayment amount shall not exceed the maximum amount allowable pursuant to the state plan amendments or other federal approvals.

(e) The copayment amounts set forth in subdivision (c) may be collected and retained or waived by the provider. The department shall deduct the amount of the copayment from the payment the department makes to the provider whether retained, waived, or not collected by the provider.

(f) Notwithstanding any other provision of law, and only to the extent allowed pursuant to federal law, a provider of service has no obligation to provide services to a Medi-Cal beneficiary who does not, at the point of service, pay the copayment assessed pursuant to this section. If the provider provides services without collecting the copayment, and has not waived the copayment, the provider may hold the beneficiary liable for the copayment amount owed.

(g) (1) Notwithstanding any other provision of law, except as described in paragraph (2), this section shall apply to Medi-Cal beneficiaries enrolled in a health plan contracting with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except for Senior Care Action Network or AIDS Healthcare Foundation. To the extent permitted by federal law and pursuant to any federal waivers or state plan adjustments obtained, a managed care health plan may establish a lower copayment or no copayment.

(2) For the purpose of paragraph (4) of subdivision (c), copayments assessed against a beneficiary who receives Medi-Cal services through a health plan described in paragraph (1) shall be based on the plan's designation of a drug as preferred or nonpreferred.

(3) To the extent provided by federal law, capitation payments shall be calculated on an actuarial basis as if copayments described in this section were collected.

(h) This section shall be implemented only to the extent that federal financial participation is available. The department shall seek and obtain any federal waivers or state plan amendments necessary to implement this section. The provisions for which appropriate federal waivers or state plan amendments cannot be obtained shall not be implemented, but provisions for which waivers or state plan amendments are either obtained or found to be unnecessary shall be unaffected by the inability to obtain federal waivers or state plan amendments for the other provisions.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, all-plan letters, provider bulletins, or similar instructions, without taking further regulatory actions.

(j) (1) This section shall become operative on the date that the act adding this section is effective, but shall not be implemented until the date in the declaration executed by the director pursuant to paragraph (2). In no event shall the director set an implementation date prior to the date federal approval is received.

(2) The director shall execute a declaration that states the date that implementation of the copayments described in this section will commence and shall post the declaration on the department's Internet Web site and provide a copy of the declaration to the Chair of the Joint Legislative Budget Committee, the Chief Clerk of the Assembly, the Secretary of the Senate, the Office of the Legislative Counsel, and the Secretary of State.

SEC. 101.7. Section 14134.1 of the Welfare and Institutions Code is amended to read:

14134.1. (a) Except as provided in paragraph (2) of subdivision (a) of Section 14134, no provider under this chapter may deny care or services to an individual eligible for care or services under this chapter because of the individual's inability to pay a copayment, as defined in Section 14134. The requirements of this section shall not extinguish the liability of the individual to whom the care or services were furnished for payment of the copayment.

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

(c) This section shall become inoperative on the implementation date for copayments stated in the declaration executed by the director pursuant to Section 14134 as added by Section 101.5 of the act that added this subdivision, and is repealed on January 1 of the following year.

SEC. 102. Section 14154 of the Welfare and Institutions Code is amended to read:

14154. (a) (1) The department shall establish and maintain a plan whereby costs for county administration of the determination of eligibility for benefits under this chapter will be effectively controlled within the amounts annually appropriated for that administration. The plan, to be known

as the County Administrative Cost Control Plan, shall establish standards and performance criteria, including workload, productivity, and support services standards, to which counties shall adhere. The plan shall include standards for controlling eligibility determination costs that are incurred by performing eligibility determinations at county hospitals, or that are incurred due to the outstationing of any other eligibility function. Except as provided in Section 14154.15, reimbursement to a county for outstationed eligibility functions shall be based solely on productivity standards applied to that county's welfare department office.

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

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

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

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

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

(4) The department and county welfare departments shall develop procedures to ensure the data clarity, consistency, and reliability of information contained in the county budget survey document submitted by counties to the department. These procedures shall include the format of the county budget survey document and process, data submittal and its documentation, and the use of the county budget survey documents for the development of determining county administration costs. Communication between the department and the county welfare departments shall be ongoing as needed regarding the content of the county budget surveys and any potential issues to ensure the information is complete and well understood by involved parties. Any changes developed pursuant to this section shall be incorporated within the state's annual budget process by no later than the 2011–12 fiscal year.

(5) The department shall provide a clear narrative description along with fiscal detail in the Medi-Cal estimate package, submitted to the Legislature in January and May of each year, of each component of the county administrative funding for the Medi-Cal program. This shall describe how

the information obtained from the county budget survey documents was utilized and, where applicable, modified and the rationale for the changes.

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

(c) (1) The Legislature finds and declares that in order for counties to do the work that is expected of them, it is necessary that they receive adequate funding, including adjustments for reasonable annual cost-of-doing-business increases. The Legislature further finds and declares that linking appropriate funding for county Medi-Cal administrative operations, including annual cost-of-doing-business adjustments, with performance standards will give counties the incentive to meet the performance standards and enable them to continue to do the work they do on behalf of the state. It is therefore the Legislature's intent to provide appropriate funding to the counties for the effective administration of the Medi-Cal program at the local level to ensure that counties can reasonably meet the purposes of the performance measures as contained in this section.

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

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

(1) Complete eligibility determinations as follows:

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

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

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

(B) Upon the development and implementation of the best-practice guidelines and expedited processes, the department and the counties may develop an expedited enrollment timeframe for newborns that is separate

from the standards for all other applications, to the extent that the timeframe is consistent with these guidelines and processes.

(C) Notwithstanding the rulemaking procedures of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-county letters or similar instructions, without further regulatory action.

(3) Perform timely annual redeterminations, as follows:

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

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

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

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

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

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

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

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

(e) The department shall develop procedures in collaboration with the counties and stakeholder groups for determining county review cycles, sampling methodology and procedures, and data reporting.

(f) On January 1 of each year, each applicable county, as determined by the department, shall report to the department on the county's results in meeting the performance standards specified in this section. The report shall

be subject to verification by the department. County reports shall be provided to the public upon written request.

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

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

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

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

(j) No later than September 1, 2005, the department shall issue a revised annual redetermination form to allow a parent to indicate parental consent to forward the annual redetermination form to the Healthy Families Program if the child is determined to have a share of cost.

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

SEC. 104. Article 6 (commencing with Section 14589) is added to Chapter 8.7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 6. Cessation of Adult Day Health Care and Assistance with Transition from Adult Day Health Care Services to Other Services

14589. (a) The Legislature finds and declares the following:

(1) During times of economic crisis, it is crucial to find areas within the program where efficiencies can be achieved while continuing to provide community-based services that support independence.

(2) Adult Day Health Care (ADHC) has been vulnerable to fraud and, despite attempts to curtail and prevent fraud, including, but not limited to, a moratorium on new facilities and onsite treatment authorization request review, fraud continues in this area.

(3) The state has added services and programs to enable vulnerable populations to remain in the community, including, but not limited to, the Money follows the Person project, California's 1115 Comprehensive Medi-Cal Demonstration Project Waiver: a Bridge to Reform, and services and supports, including day programs, provided under the Lanterman Act. It also continues to explore opportunities to add additional services and programs to help individuals remain in the community, including, but not limited to, pilot projects to better meet the health care needs of individuals dually eligible for both Medicare and Medicaid, and exploring the Community First Choice Option as a Medi-Cal benefit.

(4) There are alternative services to meet the needs of Medi-Cal beneficiaries utilizing ADHC, including in-home supportive services, physical, occupational, and speech therapies, nonemergency medical transportation, and home health services.

(b) Therefore, it is the intent of the Legislature for the department to obtain federal approval to eliminate ADHC as an optional Medi-Cal benefit.

14589.5. (a) Notwithstanding any other provision of law related to the Medi-Cal program or to adult day health care, adult day health care is excluded from coverage under the Medi-Cal program.

(b) This section shall only be implemented to the extent permitted by federal law.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the provisions of this section by means of all-county letters, provider bulletins, or similar instructions, without taking further regulatory action.

(d) This section shall be implemented on the first day of the first calendar month following 90 days after the effective date of the act that adds this section or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.

14590. (a) As a result of the enactment of this article to eliminate adult day health care as an optional benefit under the Medi-Cal program, the department shall implement a short-term program to fund organizations to assist individuals receiving ADHC services to transition to other Medi-Cal services, social services, and respite programs, or to provide social activities and respite assistance for individuals who were receiving ADHC services at the time the services were eliminated. The goal of this funding is to minimize the risk of institutionalization by identifying needed services

available in the community and providing beneficiaries assistance in accessing those services.

(b) To ensure a smooth transition, adult day health care centers shall provide relevant participant information, including the most recent copy of a participant's individual plan of care, to the department. Final Medi-Cal payment to adult day health care centers is contingent upon the provision of participants' individual plan of care and all documentation supporting that individual plan of care, including medical records, to the grantee. Failure to provide documents under this section is grounds for a temporary withhold of payment to the adult day health care center under the process established pursuant to Section 14107.11.

(c) To implement this section, the department may contract with public or private entities and utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary. Contracts entered into for the purposes of implementing this article, including any contract amendments, system changes pursuant to a change order, and any project or system development notices, may be developed using a competitive process established by the department and shall be exempt from Chapter 5.6 (commencing with Section 11545) of Part 1 of Division 3 of Title 2 of the Government Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, and the Public Contract Code, and any associated policies, procedures, or regulations under those provisions, and shall be exempt from review or approval by any division of the Department of General Services and the California Technology Agency. A contract may provide for periodic advance payments for services to be performed.

(d) Notwithstanding 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), the department may implement this article through provider bulletins or similar instructions without taking regulatory action.

(e) Implementation of the short-term program to assist individuals receiving ADHC services to transition to other Medi-Cal services, social services, and respite programs, or to provide social activities and respite assistance for individuals who were receiving ADHC services at the time the services were eliminated, is subject to an appropriation in the annual Budget Act.

SEC. 105. During the 2011–12 Regular Session of the Legislature, legislation will be adopted to create a new program called the Keeping Adults Free from Institutions (KAFI) program. This program will provide a well-defined scope of services to eligible beneficiaries who meet a high medical acuity standard and are at significant risk of institutionalization in the absence of such community-based services. It is the intent of the Legislature that the program allow current recipients of Adult Day Health Care (ADHC) services that meet certain high acuity measures to immediately transition to KAFI services. As prescribed by subsequent statute, the Department of Health Care Services shall develop a federal waiver to

maximize federal reimbursement for the KAFI program to the extent permitted by federal law. The Budget Act of 2011 includes funding for the KAFI program.

SEC. 105.5. The sum of one thousand dollars ($1,000) is hereby appropriated from the General Fund to the State Department of Health Care Services for administration.

SEC. 106. This act addresses the fiscal emergency declared and reaffirmed by the Governor by proclamation on January 20, 2011, pursuant to subdivision (f) of Section 10 of Article IV of the California Constitution.

SEC. 107. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

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 make the necessary statutory changes to implement the Budget Act of 2011 at the earliest possible time, it is necessary that this act take effect immediately.

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