## Assembly Bill No. 1183

CHAPTER 758

An act to amend Sections 1266, 1279, 1324.21, 1324.23, 1324.28, 1324.29, 1324.30, 2805, 106925, 123853, 125191, 130501, 130506, and 130542 of, and to add Section 130542.1 to, the Health and Safety Code, to amend Sections 12693.43, 12693.63, and 12693.65 of, and to add Section 12693.271 to, the Insurance Code, and to amend Sections 4061, 4783, 4860, 5777, 14005.11, 14007.9, 14011.16, 14080, 14105.19, 14105.3, 14105.86, 14126.027, 14126.033, 14154, 14154.5, 14166.9, 14166.12, 14166.20, 14166.25, 14301.1, 14526.1, and 16809 of, to amend, repeal, and add Sections 14005.25 and 14166.245 of, to add Sections 4100.2, 4646.4, 7502.5, 14005.42, 14011.17, 14011.18, 14053.3, 14104.93, 14105.191, 14124.11, 14126.034, and 17605.051 to, and to add and repeal Article 2.93 (commencing with Section 14091.3), and Article 6.6 (commencing with Section 14199) of, Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to public health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor September 30, 2008. Filed with Secretary of State September 30, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1183, Committee on Budget. Health.

Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health.

Existing law requires periodic inspection of health facilities by the department as part of licensing and certification of those facilities. Existing law specifies that the department shall inspect for compliance with state law and regulations during a state periodic inspection or at the same time as a federal periodic inspection.

This bill would require the department, with respect to conducting licensing and certification surveys and complaint investigations, to emphasize consistency across the state and its district offices. The bill would authorize the department to issue federal deficiencies, and to recommend federal enforcement actions, as described.

Existing law establishes specified licensing and certification program fees for various health facilities, and contains provisions relating to methodologies for adjustment of those fees. Existing law requires the department to annually prepare a report of all costs of licensing and certification program activities and to include, as part of this report, the recommendations for Licensing and Certification program fees in accordance with specified criteria.

This bill would revise this provision to require the report to also include specified information relating to the department's calculations in creating the report.

Existing law, the Mosquito Abatement and Vector Control District Law, specifies procedures for vector control district formation, provides for the selection of the district board of trustees and officers, and prescribes the duties of the board. Existing law requires the State Department of Public Health to certify government agency employees and pest abatement district employees who handle, apply, or supervise the use of pesticides as vector control technicians.

Existing law authorizes the department to charge and collect a nonreturnable renewal fee of $25, subject to annual adjustment as prescribed in existing law, to be paid by each continuing education certificant. Under existing law, moneys received from the fees are deposited in the Vector Disease Account, and are made available for expenditure upon appropriation by the legislature to implement these certification provisions.

This bill would increase amount of the renewal fee to $120.

Existing law, until June 30, 2008, required the development of a list of drugs to be provided under the HIV/AIDS Pharmacy Pilot Program administered by the State Department of Public Health.

These provisions required the department to establish a pilot program to evaluate the provision of medication therapy management services for people with HIV/AIDS.

This bill would reenact these provisions and extend the program until July 1, 2009.

Existing law also creates the AIDS Drug Assistance Program (ADAP), administered by the State Department of Public Health.

The bill, by no later than January 10 and May 14 of each year, would also require the department to provide the fiscal committees of the Legislature an estimate package for the ADAP, as provided.

Existing law creates the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health, dental, and vision services to eligible children pursuant to a federal program, entitled the State Children's Health Insurance Program. Eligibility requirements include being a child in a family with a household income equal to or less than 200% of the federal poverty level. Existing law requires applicants applying to the purchasing pool to agree to pay family contributions, unless the applicant has a family contribution sponsor. Existing law continuously appropriates funds to the board from the Healthy Families Fund for the program.

This bill, on and after the first day of the 5th month following the enactment of the 2008–09 Budget Act, would increase the family contribution amounts required to be paid under the program. By increasing amounts deposited in a continuously appropriated fund, it would make an appropriation. The bill would also decrease the rates for participating health, dental, and vision plans by 5%, and by adjusting the July 1, 2007, rates downward to account for any reduction in the actuarial value of the benefits

provided to subscribers as of the first day of the 5th month following the enactment of the 2008–09 Budget Act.

Existing law requires the dental benefits provided under the Healthy Families Program to be consistent with those dental benefits provided to state employees, except as provided.

This bill would authorize the board to establish a cap on the amount of dental coverage provided under the Healthy Families Program in a given benefit year, effective the first day of the 5th month following the enactment of the 2008–09 Budget Act. The bill would prohibit the cap from being lower than $1,500 per subscriber per benefit year.

Existing law requires that vision services provided under the Healthy Families Program be equivalent to those provided to state employees.

This bill would exempt from these equivalent vision benefits tinted lenses and photochromatic lenses, unless deemed medically necessary.

Existing law requires the State Department of Mental Health to utilize a joint state-county decision making process to determine the appropriate use of state and local training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system in regard to specified areas, including, but not limited to, providing forums on policy development and direction with respect to mental health program operations and clinical issues.

This bill would additionally require the department to use the joint state-county decisionmaking process to identify and fund a statewide training and technical assistance entity, as described.

This bill, commencing January 10, 2009, and each year thereafter, would require the department to provide the fiscal committees of the Legislature with a fiscal estimate package containing specified information, as provided, by January 10 and at the time of the Governor's May Revision.

Under existing law, the California Early Start Intervention Services Act, various state entities provide coordinated services to infants and toddlers with disabilities and their families. Existing law requires early intervention services to be provided directly to eligible infants and toddlers and their families through the regional center system and the local education system, in accordance with the Lanterman Developmental Disabilities Services Act, its implementing regulations, and with specified family cost participation requirements.

Existing law also contains those family cost participation requirements for specified services obtained by regional centers for children with developmental disabilities who meet specified criteria, including, but not limited to, that the child has a developmental disability

This bill would revise this criteria to apply the family cost participation requirements to a child who has a developmental disability or who is eligible for services under the California Early Intervention Services Act, and would make other technical changes.

Existing law establishes the Habilitation Services Program, under the administration of the State Department of Developmental Services, and establishes the hourly rate for supported employment services provided to

consumers receiving individualized services and group services, and fees required to be paid to the program provider upon intake, and retention of a consumer under the program.

This bill would reduce from $34.24 to $30.82, the hourly rate for those supported employment services, and decrease specified fees paid to providers upon intake, and retention of a consumer under the program.

The bill, commencing September 1, 2008, would require regional centers to ensure at specified phases of a consumer's individual program plan developed pursuant to existing law, or of an individualized family services plan developed pursuant to existing law, the establishment of an internal process that meets certain requirements, as provided. The bill, no later than April 1, 2009, would require the State Department of Developmental Services to provide the fiscal and policy committees of the Legislature with a written update regarding the implementation of these provisions.

Existing law provides for administration of the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) by the State Department of Mental Health.

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

Under existing law, the State Department of Mental Health is required to implement managed mental health care for Medi-Cal recipients through fee-for-service or capitated contracts with counties, counties acting jointly, qualified individuals or organizations, or nongovernmental entities. The State Department of Mental Health, pursuant to an interagency agreement with the State Department of Health Care Services, is responsible for assuming specified program oversight authority over mental health plans, including, but not limited to, the responsibility to monitor the level and quality of services provided, expenditures pursuant to the contract, and conformity with federal and state law.

This bill, commencing July 1, 2008, and until September 1, 2011, would require county mental health plans, in collaboration with the State Department of Mental Health, the federally required external quality review organization, and other specified stakeholders, to establish an advisory statewide performance improvement project to increase the coordination, quality, effectiveness, and efficiency of service delivery to certain children who are either receiving a specified dollar amount in EPSDT services, as provided, or who are identified in the top 5% of the county EPSDT cost, whichever is lowest. The bill would provide that the performance improvement project shall replace one of the two required performance improvement projects that county mental health plans are currently required to perform pursuant to federal regulations.

The bill would also require, each July thereafter until September 1, 2011, the State Department of Mental Health, in consultation with the federally required external quality review organization and county mental health plans, to determine the average monthly cost threshold for counties to use

to identify children to be reviewed who are currently receiving EPSDT services. The bill would also require the State Department of Mental Health to provide an annual update to the Legislature on the results of the statewide performance improvement project by October 1 of each year for the prior fiscal year.

The bill, by no later than January 10 and May 14 of each year, would also require the department to provide the fiscal committees of the Legislature an estimate package for the EPSDT Program, as provided.

Existing law establishes specified state hospitals for the developmentally disabled, including, Porterville Developmental Center.

This bill would prohibit the total number of developmental center residents in the secure treatment facility at Porterville Developmental Center from exceeding 297.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which qualified low-income persons are provided with health care services. Existing law requires the department, to the extent required by federal law, for Medi-Cal recipients who are qualified Medicare beneficiaries, to pay the Medicare premiums, deductibles, and coinsurance for elderly and disabled persons whose income does not exceed the federal poverty level or 200% of a specified Supplemental Security Income program standard.

This bill would require the department, for Medicare beneficiaries to which the above provisions do not apply and who have a share of cost for Medi-Cal benefits, to pay a beneficiary's Medicare Part B premium in the month following each month in which the beneficiary's share of cost has been met. For beneficiaries with a share of cost at or below $500 who do not qualify for assistance because their income exceeds the above-described income requirements, the bill would require the department to pay the beneficiary's Medicare Part B premium on a monthly basis. The bill would also require a county that is informed that an applicant or beneficiary is eligible for Medicare benefits to determine whether the individual is eligible for, and to enroll qualified individuals in, specified programs that assist eligible individuals with Medicare expenses, as provided. By imposing a new duty on counties, this bill would impose a state-mandated local program.

Existing law provides for the Kinship Guardianship Assistance Payment Program (Kin-GAP), which is a part of the CalWORKs program, administered by the State Department of Social Services, and which provides aid on behalf of eligible children who are placed in the home of a relative caretaker. Existing law limits the application of the program to children who have been adjudged a dependent child of the juvenile court and whose dependency has been dismissed on or after January 1, 2000, concurrently or subsequent to the establishment of the kinship guardianship.

This bill would require the department to provide Medi-Cal benefits, without a share of cost, for children on behalf of whom Kin-GAP benefits are received. The bill would require the department and the State Department of Social Services to develop procedures to maximize the availability of federal financial participation for the costs in expanding coverage to these

individuals, and would require that, to the extent federal financial participation is not available, only state funds be used to cover the cost of this expanded coverage.

By increasing the duties of local agencies responsible for making Medi-Cal determinations, this bill would create a state-mandated local program.

Existing law establishes the California Discount Prescription Drug Program, which is administered by the State Department of Health Care Services, and under which qualified individuals are provided with prescription drugs at reduced prices that result from rebate agreements between department and drug manufacturers. Existing law requires all moneys received by the department pursuant to the administration of the program to be deposited into the California Discount Prescription Drug Program Fund, a continuously appropriated fund, for the purpose of providing payment to participating pharmacies and for defraying its costs in administering the program, and prohibits money in the fund from being available for any other purpose.

This bill would state the intent of the Legislature that the program shall be self-financing, and that any General Fund moneys provided to the fund shall be repaid within 5 years after implementation of the program begins. The bill would require the department to provide the Legislature with a 5-year projection of program revenues and expenditures as part of its annual budget request, and to include in the project a projected repayment schedule.

The bill would also authorize the department to use no more than 25% of manufacturer rebate revenues it receives to cover the cost of administering the program, including the funding of a float account to finance payments to participating pharmacies in advance of the receipt of manufacturer rebates, and would make conforming changes. To the extent that this bill establishes a new purpose for use of continuously appropriated funds, this bill would make an appropriation.

Existing law, until September 1, 2008, and subject to the receipt of federal financial participation, requires the department to adopt a federal option under which any employed individual with a disability who meets specified income and resource requirements shall be eligible for benefits under the Medi-Cal program, subject to the payment of premiums. These provisions are repealed on January 1, 2009.

This bill would eliminate the repeal date of these provisions, thereby extending their duration indefinitely.

Because counties are required to make Medi-Cal eligibility determinations and this bill would extend and expand Medi-Cal eligibility under these provisions, the bill would impose a state-mandated local program.

Existing law requires the department, subject to the availability of federal financial participation, to exercise a federal option to expand continuous eligibility to children 19 years of age and younger until the earlier of either the end of a specified 12-month period or the date the individual exceeds the age of 19 years.

Existing law requires certain Medi-Cal beneficiaries to file a semiannual status report to assist the department in ascertaining any change in

circumstances that may affect a beneficiary's eligibility. Existing law exempts certain individuals from these semiannual status reporting requirements, including any beneficiary who has been granted continuous eligibility pursuant to the above-described provisions.

This bill, commencing the first day of the month following 90 days after the effective date of the bill, and until January 1, 2012, would reduce the continuous eligibility period for these individuals to 6 months, and would impose semiannual reporting requirements on these individuals during the period that this provision is in effect. It would require the department to report to the fiscal and health policy committees of the Legislature, by December 15, 2010, on the effects on enrolled children of reducing the continuous eligibility period and the imposition of the semiannual status reporting requirement.

The bill would also exempt from the semiannual status reporting requirements certain individuals, including, but not limited to, pregnant women whose eligibility under Medi-Cal is based on pregnancy, beneficiaries who have a public guardian, and medically indigent children who are not living with a parent or relative and who have a public agency assuming their financial responsibility.

Under existing law, one of the services provided under the Medi-Cal program is dental services, subject to limitations. Existing law limits, until January 1, 2009, and with certain exceptions, reimbursement to providers of dental services provided to individuals 21 years of age and older at the time of the service to not more than $1,800 per beneficiary in any calendar year.

This bill would eliminate the repeal date of these provisions, thereby extending their duration indefinitely.

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

This bill would require, because federal financial participation is not available for the ancillary outpatient services that any state funds and federal reimbursement paid for ancillary services provided to residents in institutions for mental disease shall be recovered from counties by the State Department of Mental Health in accordance with applicable state and federal law and regulation.

Existing law requires the State Department of Health Care Services to implement and administer the Genetically Handicapped Persons Program (GHPP), which provides health services to genetically handicapped persons, and the department and the counties to administer the California Children's Services (CCS) program, which provides services to physically handicapped children under 21 years of age.

Existing law permits the department, in administering these programs and the Medi-Cal program, to enter into contracts on a bid or negotiated basis with manufacturers, distributors, dispensers, or suppliers of pharmaceuticals, appliances, durable medical equipment, medical supplies,

and other product-type health care services for the purpose of obtaining the most favorable prices to the state and to ensure adequate access to each quality and services. This provision is, however, inapplicable to pharmacies or suppliers that provide blood, blood derivatives, or blood factor products, or any product or service provided by those pharmacies or suppliers.

This bill would delete this limitation. The bill would until the earlier of July 1, 2013, or 3 years after implementation, also, with respect to these programs, permit the department, in order to provide specialized care in the distribution of specialty drugs, to enter into contracts with a nonexclusive number of providers licensed to dispense dangerous drugs or devices for programs that qualify for federal funding. It would also permit the department to contract with an intermediary to implement these CCS, genetically-handicapped children, and Medi-Cal contracting provisions.

It would require the department to generate a publicly available report containing specified information relating to the specialty pharmacy program, as provided. Effective July 1, 2008, the bill would also require the department, with respect to these programs, to collect a state rebate in addition to rebates pursuant to state or federal law, for prescribed blood factors.

Existing law contains various provisions governing reimbursement rates, including rates for fee-for-service payments to Medi-Cal providers, and for providers of services received under various health programs, including the above-described programs, the Child Health and Disability Prevention Program, and specified family planning programs.

Existing law requires the Director of Health Care Services to reduce provider payments by 10% for both Medi-Cal fee-for-service benefits and services rendered by providers under these health programs for services rendered on or after July 1, 2008.

This bill would revise these provisions to require the 10% reduction of reimbursement rates to apply to services rendered on or after July 1, 2008, through and including dates of service on February 28, 2009. The bill would, for services rendered on a fee-for-services basis on or after March 1, 2009, require the director to reduce payments for certain benefits, including for services rendered by providers under the above-described health programs, by 1%, and to reduce payments to specified classes of providers and pharmacies by 5%, subject to certain exceptions. The bill would exempt small and rural hospitals, as defined, from the reduction, under specified circumstances.

The bill would specify that the reductions imposed pursuant to the bill would apply only to the General Fund share of the payment, and only to payments for services from funds appropriated to the department.

To the extent federal financial participation is not available with respect to any of the payment reductions required pursuant to these provisions, the bill would authorize the director to not implement those payment reductions.

Existing law permits the department, under certain circumstances, to make changes to various programs through the issuance of provider bulletins.

This bill would authorize the department to distribute provider bulletins regarding the Medi-Cal program by either print or electronic medium, as provided.

This bill, no later than July 1, 2009, would require the department to establish a 2-year pilot program, in accordance with prescribed requirements, to utilize the federal Public Assistance and Reporting Information System (PARIS) to identify veterans and their dependents or survivors who are enrolled in the Medi-Cal program and assist them in obtaining federal veterans' health care benefits. The bill would require the department to select 3 consenting counties, as provided, to participate in the pilot program. It would require the department to evaluate the program and submit a report to the fiscal committees of the Legislature on the findings of that evaluation. It would permit the department, if it determines that the program is cost effective, to implement the program statewide.

Existing law, the Medi-Cal Long-Term Reimbursement Act, requires the department to implement a facility-specific reimbursement ratesetting system for certain freestanding skilled nursing facilities. Reimbursement rates for these facilities are funded by a combination of federal funds and moneys collected pursuant to the above-described uniform quality assurance fee. Existing law provides that this rate methodology shall cease to be implemented on July 1, 2009, with these provisions to be repealed on January 1, 2010.

This bill would require the department to impose the uniform quality assurance fee until July 31, 2011, would extend the implementation date of the freestanding skilled nursing facility rate reimbursement provisions until July 31, 2011, would make various conforming changes in these provisions, and would extend their repeal date for all of these provisions until January 1, 2012. It would also modify, for the 2009–10 and 2010–11 rate years, the facility reimbursement formula to be used under these provisions. It would require the department to convene a workgroup, with prescribed representation, to make recommendations to the department on a variety of issues related to skilled nursing facilities and specifically to these Medi-Cal reimbursement provisions. The department would be required to report to the Legislature on these recommendations by March 1, 2009, and seek necessary legislative changes to implement the recommendations that the department deems feasible to implement as part of the reauthorization of these reimbursement provisions.

Under existing law, one method for the provision of Medi-Cal services is through contracts with managed health care plans.

This bill would, subject to any necessary federal approval, require that the department 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.

The bill, for poststabilization services following an emergency admission at all hospitals, would require payment amounts to be consistent with

specified provisions of federal regulations, as provided, but only to the extent that contract amendment language providing for these payments is approved by the federal Centers for Medicare and Medicaid Services.

Existing law establishes the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, which revises hospital reimbursement methodologies under the Medi-Cal program in order to maximize the use of federal funds consistent with federal Medicaid law and stabilize the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients. This demonstration project provides for funding, in supplementation of Medi-Cal reimbursement, to various hospitals, including designated public hospitals, nondesignated public hospitals, and private hospitals, as defined in accordance with certain provisions relating to disproportionate share hospitals.

This bill would make technical changes to these provisions.

Under these provisions, eligible private hospitals receive funding from the Private Hospital Supplemental Fund, a continuously appropriated fund. Existing law specifies sources of moneys in the fund, which includes an annual transfer of a specified amount from the amount appropriated to the department from the General Fund for the Medi-Cal program.

This bill would reduce the annual amount transferred to the fund for the 2008–09 fiscal year only in accordance with a specified formula.

Existing law provides for the payment of stabilization funding to certain designated public hospitals, project year private disproportionate share hospitals, and nondesignated public hospitals, as those terms are defined, under the demonstration project.

This bill would make various reductions to the calculation of that stabilization funding for purposes of the 2006–07 fiscal year, and would make conforming changes.

Existing law reduces by 10% payments for inpatient hospital services to acute care hospitals not under selective contracts with the department that are provided on and after July 1, 2008.

This bill, until January 1, 2013, would revise this provision by applying this reduction to all hospitals that receive Medi-Cal reimbursement from the department and that are not under selective contracts with the department. The bill, commencing October 1, 2008, and until January 1, 2013, would require the amounts paid for inpatient hospital services to be determined using a prescribed formula, subject to specified exceptions. If specified hospitals choose to enter into selective contracts with the department, the bill would require the California Medical Assistance Commission to negotiate reimbursement rates for those hospitals in accordance with specified criteria. The bill would require the department to report annually, from January 1, 2010, to January 1, 2012, inclusive, to the Legislature on the implementation and impact made by the changes to these rate reduction provisions.

Existing law requires the department to establish and maintain a plan, known as the County Administrative Cost Control Plan, for the purpose of effectively controlling costs related to the county administration of the

determination of eligibility for benefits under the Medi-Cal program within the amounts annually appropriated for that administration. Pursuant to the plan, the department establishes standards and performance criteria to which counties are required to adhere. Existing law authorizes the department to impose a 2% reduction in the allocation of funds to a county that fails to meet certain performance standards, as provided.

This bill would prohibit the department from reducing a county's allocation for failure to meet performance standards during any period of time in which the cost of doing business increase is suspended.

Existing law establishes the Medi-Cal Eligibility Data System (MEDS) regarding the status of applications for Medi-Cal coverage. Existing law requires counties to work MEDS error alerts as prescribed, to submit quarterly reconciliation files to the department, and, in some cases, to submit corrective action plans. Existing law authorizes the department to impose a 2% reduction in the allocation of funds to a county that fails to meet interim benchmarks for improvement standards required to be in a corrective action plan.

This bill would prohibit the department from reducing a county's allocation for failure to meet these interim benchmarks for improvement standards during any period of time in which the cost of doing business increase is suspended.

The California Adult Day Health Care Act provides for the licensure and regulation of adult day health centers, with administrative responsibility for this program shared between the State Department of Public Health and the California Department of Aging pursuant to an interagency agreement.

Under existing law, adult day health care services are a covered benefit under the Medi-Cal program. Existing law provides that participation in an adult day health care program under the Medi-Cal program requires prior authorization by the State Department of Health Care Services. Existing law further provides that authorization of an adult day health care treatment authorization request shall be granted only if the participant meets specified criteria.

This bill would exempt participants residing in an intermediate care facility for the developmentally disabled-habilitative from the requirement that these criteria be met. It would provide, however, that an adult day health care treatment authorization request shall be granted for a resident of such a facility only if he or she has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through adult day health care, placement to a more costly institutional level of care would be likely to occur.

Existing law specifies the procedures by which the department determines prospective capitation rates to health plans participating in the Medi-Cal managed care program, and permits the department to utilize a county and health plan specific rate methodology to develop Medi-Cal managed care capitation rates for contracts between the department and case management plans, county health systems, and a geographic managed care pilot project.

Prior to finalizing the Medi-Cal managed care capitation rates, the department is required to provide health plans with information on how the rates were developed and to provide the plans with the opportunity to provide additional supplemental information

This bill, for contracts between the department and county health systems, would require the department, by June 30 of each year, or if the budget has not passed by that date, no later than 5 working days after the budget is signed, to also provide preliminary rates for the upcoming fiscal year.

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

Existing law revises, for the 2007–08 fiscal year, state and county financial responsibilities for certain increases in the CMSP.

This bill would further extend that provision to include all fiscal years thereafter.

Existing law permits a county participating in the CMSP to establish a County Medical Services Program Governing Board, in accordance with prescribed requirements, to govern the program.

Existing law provides for the County Health Services Program Account in the County Health Services Fund. Existing law prohibits moneys in this account from being transferred to any other fund or account in the State Treasury, except as provided. Existing law creates the continuously appropriated Local Revenue Fund, which is divided into various accounts and subaccounts, in order to provide revenue to local jurisdictions for specified local health and social services programs.

Existing law provides for allocations from accounts in the Local Revenue Fund to the County Medical Services Subaccount in the Sales Tax Growth Account.

This bill would, notwithstanding any other provision of law, and upon the request of the County Medical Services Program Governing Board, require the Controller to deposit certain allocations into the County Medical Services Subaccount, in lieu of depositing those amounts into the County Medical Services Program Account of the County Health Services Fund, thus constituting an appropriation. The bill would also, upon the request of the County Medical Services Program Governing Board, require the Controller to transfer amounts deposited into the County Medical Services Subaccount to the County Medical Services Program Governing Board for specified reasons, thus constituting an appropriation.

This bill would reallocate certain amounts appropriated in the Budget Act of 2008 from the Cigarette and Tobacco Products Surtax Fund, with these revenues to be allocated to certain county health services programs.

Beginning in the 2008–09 fiscal year, the bill would require the State Department of Developmental Services to annually provide an update to

the appropriate policy and fiscal committees of the Legislature during the fall legislative interim regarding the impact of the adopted freezes and various cost containment measures on clients and service levels. The bill would authorize the policy committees of the Legislature to hold informational hearings on these issues, as provided, and would require the committees to report their findings for consideration in the annual subcommittee budget process or in legislation.

The bill would require the State Department of Mental Health to confer with the County of San Mateo, relevant constituency groups, and with the State Department of Health Care Services to appropriately craft a transition plan to ensure the continuity of care for mental health clients in the event that the state's contract for the services provided under the San Mateo Pharmacy and Laboratory Project are substantially modified or transitioned to the State Department of Health Care Services. The bill would require the State Department of Mental Health to provide the fiscal and policy committees of the Legislature with a status update regarding the development of a transition plan by no later than December 31, 2008.

Existing law establishes the Mental Health Services Oversight and Accountability Commission, comprised of specified members, to oversee various programs and provisions of law relating to mental health.

This bill would require the State Department of Mental Health to provide the Mental Health Services Oversight and Accountability Commission (OAC) with data, as specified by the OAC, for purposes of the OAC to utilize in its oversight, review, and evaluation capacity regarding specified programs.

Existing law provides for the California Statewide Supportive Housing Initiative Act, which is administered by the State Department of Mental Health. Under the act, the department awards grants to applicants, including public and private agencies, that demonstrate a need for supportive housing for low-income individuals with special needs and a local commitment to providing funding for the purpose of developing and operating supportive housing, as provided.

Existing law separately sets forth various powers and duties of the California Housing Finance Agency in conjunction with the financing of housing.

The bill, commencing July 1, 2008, and each year thereafter, would require the State Department of Mental Health, in collaboration with the California Housing Finance Agency, to provide semiannual updates regarding key results and funding for the capital costs associated with permanent supportive housing for individuals with mental illness, as provided for under the Housing Initiative Program, to the fiscal and policy committees of the Legislature, as provided.

Existing law vests in the State Department of Public Health various responsibilities relating to drinking water quality standards and providers of drinking water.

The bill would require the State Department of Public Health to provide the fiscal and policy committees of the Legislature with a synopsis of key

issues regarding the department's responsibilities and oversight of small water systems, and options for sustainability of the program to meet safe drinking water quality standards.

The bill would also require the department to prepare a fund condition statement for federal Title V Maternal and Child Health Block Grant funds, as approved by the Department of Finance, for inclusion in the annual budget process, and to be published in the Governor's budget documents provided to the Legislature by no later than January 10 of each year.

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

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

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

Appropriation: yes.

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

SECTION 1. Section 1266 of the Health and Safety Code is amended to read:

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

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

| Type of Facility | Fee | |
|---|---|---|
| General Acute Care Hospitals | $ 134.10 | per bed |
| Acute Psychiatric Hospitals | $ 134.10 | per bed |
| Special Hospitals | $ 134.10 | per bed |
| Chemical Dependency Recovery Hospitals | $ 123.52 | per bed |
| Skilled Nursing Facilities | $ 202.96 | per bed |
| Intermediate Care Facilities | $ 202.96 | per bed |
| Intermediate Care Facilities - Developmentally Disabled | $ 592.29 | per bed |
| Intermediate Care Facilities - Developmentally Disabled - Habilitative | $1,000.00 | per facility |

| | | |
|---|---|---|
| Intermediate Care Facilities - Developmentally Disabled - Nursing | $1,000.00 | per facility |
| Home Health Agencies | $2,700.00 | per facility |
| Referral Agencies | $5,537.71 | per facility |
| Adult Day Health Centers | $4,650.02 | per facility |
| Congregate Living Health Facilities | $ 202.96 | per bed |
| Psychology Clinics | $ 600.00 | per facility |
| Primary Clinics - Community and Free | $ 600.00 | per facility |
| Specialty Clinics - Rehab Clinics | | |
| (For profit) | $2,974.43 | per facility |
| (Nonprofit) | $ 500.00 | per facility |
| Specialty Clinics - Surgical and Chronic | $1,500.00 | per facility |
| Dialysis Clinics | $1,500.00 | per facility |
| Pediatric Day Health/Respite Care | $ 142.43 | per bed |
| Alternative Birthing Centers | $2,437.86 | per facility |
| Hospice | $1,000.00 | per facility |
| Correctional Treatment Centers | $ 590.39 | per bed |

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

(d) By February 1 of each year, the department shall prepare the following reports and shall make those reports, and the list of estimated fees required to be published pursuant to subdivision (c), available to the public by submitting them to the Legislature and posting them on the department's Web site:

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

(A) Projected workload and costs shall be grouped for each fee category.

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

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

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

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

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

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

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

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

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

(iv) The number and timeliness of complaint investigations.

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

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

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

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

(f) (1) No fees shall be assessed or collected pursuant to this section from any state department, authority, bureau, commission, or officer, unless federal financial participation would become available by doing so and an appropriation is included in the annual Budget Act for that state department, authority, bureau, commission, or officer for this purpose. No fees shall be

assessed or collected pursuant to this section from any clinic that is certified only by the federal government and is exempt from licensure under Section 1206, unless federal financial participation would become available by doing so.

(2) For the 2006–07 state fiscal year, no fee shall be assessed or collected pursuant to this section from any general acute care hospital owned by a health care district with 100 beds or less.

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

SEC. 2. Section 1279 of the Health and Safety Code is amended to read:

1279. (a) Every health facility for which a license or special permit has been issued shall be periodically inspected by the department, or by another governmental entity under contract with the department. The frequency of inspections shall vary, depending upon the type and complexity of the health facility or special service to be inspected, unless otherwise specified by state or federal law or regulation. The inspection shall include participation by the California Medical Association consistent with the manner in which it participated in inspections, as provided in Section 1282 prior to September 15, 1992.

(b) Except as provided in subdivision (c), inspections shall be conducted no less than once every two years and as often as necessary to ensure the quality of care being provided.

(c) For a health facility specified in subdivision (a), (b), or (f) of Section 1250, inspections shall be conducted no less than once every three years, and as often as necessary to ensure the quality of care being provided.

(d) During the inspection, the representative or representatives shall offer such advice and assistance to the health facility as they deem appropriate.

(e) For acute care hospitals of 100 beds or more, the inspection team shall include at least a physician, registered nurse, and persons experienced in hospital administration and sanitary inspections. During the inspection, the team shall offer advice and assistance to the hospital as it deems appropriate.

(f) The department shall ensure that a periodic inspection conducted pursuant to this section is not announced in advance of the date of inspection. An inspection may be conducted jointly with inspections by entities specified in Section 1282. However, if the department conducts an inspection jointly with an entity specified in Section 1282 that provides notice in advance of the periodic inspection, the department shall conduct an additional periodic inspection that is not announced or noticed to the health facility.

(g) Notwithstanding any other provision of law, the department shall inspect for compliance with provisions of state law and regulations during a state periodic inspection or at the same time as a federal periodic inspection, including, but not limited to, an inspection required under this

section. If the department inspects for compliance with state law and regulations at the same time as a federal periodic inspection, the inspection shall be done consistent with the guidance of the federal Centers for Medicare and Medicaid Services for the federal portion of the inspection.

(h) The department shall emphasize consistency across the state and its district offices when conducting licensing and certification surveys and complaint investigations, including the selection of state or federal enforcement remedies in accordance with Section 1423. The department may issue federal deficiencies and recommend federal enforcement actions in those circumstances where they provide more rigorous enforcement action.

SEC. 3. Section 1324.21 of the Health and Safety Code is amended to read:

1324.21. (a) For facilities licensed under subdivision (c) of Section 1250, there shall be imposed each state fiscal year a uniform quality assurance fee per resident day. The uniform quality assurance fee shall be based upon the entire net revenue of all skilled nursing facilities subject to the fee, except an exempt facility, as defined in Section 1324.20, calculated in accordance with subdivision (b).

(b) The amount of the uniform quality assurance fee to be assessed per resident day shall be determined based on the aggregate net revenue of skilled nursing facilities subject to the fee, in accordance with the methodology outlined in the request for federal approval required by Section 1324.27 and in regulations, provider bulletins, or other similar instructions. The uniform quality assurance fee shall be calculated as follows:

(1) (A) For the rate year 2004–05, the net revenue shall be projected for all skilled nursing facilities subject to the fee. The projection of net revenue shall be based on prior rate year data. Once determined, the aggregate projected net revenue for all facilities shall be multiplied by 2.7 percent, as determined under the approved methodology, and then divided by the projected total resident days of all providers subject to the fee.

(B) Notwithstanding subparagraph (A), the Director of Health Care Services may increase the amount of the fee up to 3 percent of the aggregate projected net revenue if necessary for the implementation of Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(2) For the rate year 2005–06 and subsequent rate years through and including the 2010–11 rate year, the net revenue shall be projected for all skilled nursing facilities subject to the uniform quality assurance fee. The projection of net revenue shall be based on the prior rate year's data. Once determined, the aggregate projected net revenue for all facilities shall be multiplied by 6 percent, as determined under the approved methodology, and then divided by the projected total resident days of all providers subject to the fee. The amounts so determined shall be subject to the provisions of subdivision (d).

(c) The director may assess and collect a nonuniform fee consistent with the methodology approved pursuant to Section 1324.27.

(d) In no case shall the fees collected annually pursuant to this article, taken together with applicable licensing fees, exceed the amounts allowable under federal law.

(e) If there is a delay in the implementation of this article for any reason, including a delay in the approval of the quality assurance fee and methodology by the federal Centers for Medicare and Medicaid Services, in the 2004–05 rate year or in any other rate year, all of the following shall apply:

(1) Any facility subject to the fee may be assessed the amount the facility will be required to pay to the department, but shall not be required to pay the fee until the methodology is approved and Medi-Cal rates are increased in accordance with paragraph (2) of subdivision (a) of Section 1324.28 and the increased rates are paid to facilities.

(2) The department may retroactively increase and make payment of rates to facilities.

(3) Facilities that have been assessed a fee by the department shall pay the fee assessed within 60 days of the date rates are increased in accordance with paragraph (2) of subdivision (a) of Section 1324.28 and paid to facilities.

(4) The department shall accept a facility's payment notwithstanding that the payment is submitted in a subsequent fiscal year than the fiscal year in which the fee is assessed.

SEC. 4. Section 1324.23 of the Health and Safety Code is amended to read:

1324.23. (a) The Director of Health Care Services, or his or her designee, shall administer this article.

(b) The director may adopt regulations as are necessary to implement this article. These regulations may be adopted as emergency regulations 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). For purposes of this article, the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The regulations shall include, but need not be limited to, any regulations necessary for any of the following purposes:

(1) The administration of this article, including the proper imposition and collection of the quality assurance fee not to exceed amounts reasonably necessary for purposes of this article.

(2) The development of any forms necessary to obtain required information from facilities subject to the quality assurance fee.

(3) To provide details, definitions, formulas, and other requirements.

(c) As an alternative to subdivision (b), and 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 director may implement this article, in whole or in part, by means of a provider bulletin, or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July

31, 2010. It is the intent of the Legislature that the regulations adopted pursuant to subdivision (b) shall be adopted on or before July 31, 2010.

SEC. 5. Section 1324.28 of the Health and Safety Code is amended to read:

1324.28. (a) This article shall be implemented as long as both of the following conditions are met:

(1) The state receives federal approval of the quality assurance fee from the federal Centers for Medicare and Medicaid Services.

(2) Legislation is enacted in the 2004 legislative session making an appropriation from the General Fund and from the Federal Trust Fund to fund a rate increase for skilled nursing facilities, as defined under subdivision (c) of Section 1250, for the 2004–05 rate year in an amount consistent with the Medi-Cal rates that specific facilities would have received under the rate methodology in effect as of July 31, 2004, plus the proportional costs as projected by Medi-Cal for new state or federal mandates.

(b) This article shall remain operative only as long as all of the following conditions are met:

(1) The federal Centers for Medicare and Medicaid Services continues to allow the use of the provider assessment provided in this article.

(2) The Medi-Cal Long Term Care Reimbursement Act, Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, as added during the 2003–04 Regular Session by the act adding this section, is enacted and implemented on or before July 31, 2005, or as extended as provided in that article, and remains in effect thereafter.

(3) The state has continued its maintenance of effort for the level of state funding of nursing facility reimbursement for rate year 2005–06, and for every subsequent rate year continuing through the 2010–11 rate year, in an amount not less than the amount that specific facilities would have received under the rate methodology in effect on July 31, 2004, plus Medi-Cal's projected proportional costs for new state or federal mandates, not including the quality assurance fee.

(4) The full amount of the quality assurance fee assessed and collected pursuant to this article remains available for the purposes specified in Section 1324.25 and for related purposes.

(c) If all of the conditions in subdivision (a) are met, this article is implemented, and subsequently, any one of the conditions in subdivision (b) is not met, on and after the date that the department makes that determination, this article shall not be implemented, notwithstanding that the condition or conditions subsequently may be met.

(d) Notwithstanding subdivisions (a), (b), and (c), in the event of a final judicial determination made by any state or federal court that is not appealed, or by a court of appellate jurisdiction that is not further appealed, in any action by any party, or a final determination by the administrator of the federal Centers for Medicare and Medicaid Services, that federal financial participation is not available with respect to any payment made under the methodology implemented pursuant to this article because the methodology

is invalid, unlawful, or contrary to any provision of federal law or regulations, or of state law, this section shall become inoperative.

SEC. 6. Section 1324.29 of the Health and Safety Code is amended to read:

1324.29. The quality assurance fee shall cease to be assessed and collected on or after July 31, 2011.

SEC. 7. Section 1324.30 of the Health and Safety Code is amended to read:

1324.30. This article shall become inoperative on July 31, 2011, and, as of January 1, 2012, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2012, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 8. Section 2805 of the Health and Safety Code is amended to read:

2805. (a) Except as otherwise provided in subdivision (b), every pest abatement district employee who handles, applies, or supervises the use of any pesticide for public health purposes, shall be certified by the state department as a vector control technician in at least one of the following categories commensurate with assigned duties:

(1) Mosquito control.

(2) Terrestrial invertebrate vector control.

(3) Vertebrate vector control.

(b) The state department may establish by regulation exemptions from the requirements of this section that are deemed reasonably necessary to further the purposes of this section.

(c) The state department shall establish by regulation minimum standards for continuing education for any government agency employee certified under Section 116110 and regulations adopted pursuant thereto, who handles, applies, or supervises the use of any pesticide for public health purposes.

(d) An official record of the completed continuing education units shall be maintained by the state department. If a certified technician fails to meet the requirements set forth under subdivision (c), the state department shall suspend the technician's certificate or certificates and immediately notify the technician and the employing district. The state department shall establish by regulation procedures for reinstating a suspended certificate.

(e) The state department shall charge and collect a nonreturnable renewal fee of one hundred twenty dollars ($120) to be paid by each continuing education certificant on or before the first day of July, or on any other date that is determined by the state department. Each person employed on September 29, 1996, in a position that requires certification shall first pay the annual fee the first day of the first July following that date. All new certificants shall first pay the annual fee the first day of the first July following their certification.

(f) The state department shall collect and account for all money received pursuant to this section and shall deposit it in the Vectorborne Disease Account provided for in Section 116112. Notwithstanding Section 116112, fees deposited in the Vectorborne Disease Account pursuant to this section

shall be available for expenditure, upon appropriation by the Legislature, to implement this section.

(g) Fees collected pursuant to this section shall be subject to the annual fee increase provisions of Section 100425.

SEC. 9. Section 106925 of the Health and Safety Code is amended to read:

106925. (a) Except as otherwise provided in subdivision (b) or (i), every government agency employee who handles, applies, or supervises the use of any pesticide for public health purposes, shall be certified by the department as a vector control technician in at least one of the following categories commensurate with assigned duties, as follows:

(1) Mosquito control.

(2) Terrestrial invertebrate vector control.

(3) Vertebrate vector control.

(b) The department may establish by regulation exemptions from the requirements of this section that are deemed reasonably necessary to further the purposes of this section.

(c) The department shall establish by regulation minimum standards for continuing education for any government agency employee certified under Section 116110 and regulations adopted pursuant thereto, who handles, applies, or supervises the use of any pesticide for public health purposes.

(d) An official record of the completed continuing education units shall be maintained by the department. If a certified technician fails to meet the requirements set forth under subdivision (c), the department shall suspend the technician's certificate or certificates and immediately notify the technician and the employing agency. The department shall establish by regulation procedures for reinstating a suspended certificate.

(e) The department shall charge and collect a nonreturnable renewal fee of one hundred twenty dollars ($120) to be paid by each continuing education certificant on or before the first day of July, or on any other date that is determined by the department. Each person employed on September 20, 1988, in a position that requires certification, shall first pay the annual fee the first day of the first July following that date. All new certificants shall first pay the annual fee the first day of the first July following their certification.

(f) The department shall charge and collect nonrefundable examination fees for providing examinations pursuant to this section. When certification is required as a condition of employment, the employing agency shall pay the fees for certified technician applicants. The fees shall not exceed the estimated reasonable cost of providing the examinations, as determined by the director.

(g) The department shall collect and account for all money received pursuant to this section and shall deposit it in the Vectorborne Disease Account provided for in Section 116112. Notwithstanding Section 116112, fees deposited in the Vectorborne Disease Account pursuant to this section shall be available for expenditure, upon appropriation by the Legislature, to implement this section.

(h) Fees collected pursuant to this section shall be subject to the annual fee increase provisions of Section 100425.

(i) Employees of the Department of Food and Agriculture and county agriculture departments holding, or working under the supervision of an employee holding, a valid Qualified Applicator Certificate in Health Related Pest Control, issued by the licensing and certification program of the Department of Pesticide Regulation, shall be exempt from this section.

SEC. 10. Section 123853 of the Health and Safety Code is amended to read:

123853. (a) The department may enter into contracts with one or more manufacturers on a negotiated or bid basis as the purchaser, but not the dispenser or distributor, of factor replacement therapies under the California Children's Services Program for the purpose of enabling the department to obtain the full range of available therapies and services required for clients with hematological disorders at the most favorable price and to enable the department, notwithstanding any other provision of state law, to obtain discounts, rebates, or refunds from the manufacturers based upon the large quantities purchased under the program. Nothing in this subdivision shall interfere with the usual and customary distribution practices of factor replacement therapies. In order to achieve maximum cost savings, the Legislature hereby determines that an expedited contract process under this section is necessary. Therefore, a contract under this subdivision may be on a negotiated basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code. Contracts entered pursuant to this subdivision 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).

(b) (1) Factor replacement therapy 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. 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.

(2) Following the final resolution of any dispute regarding the amount of a rebate, any underpayment by a manufacturer shall be paid with interest calculated pursuant to paragraph (4), and any overpayment, together with interest at the rate calculated pursuant to paragraph (4), shall be credited by the department against future rebates due.

(3) Interest pursuant to paragraphs (1) and (2) shall begin accruing 38 calendar days from the date of mailing 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.

(4) Interest rates and calculations pursuant to paragraphs (1) and (2) shall be identical to interest rates and calculations set forth in the federal Centers

for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations.

(c) 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, a factor replacement therapy 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. This subdivision does not limit the department's right to otherwise terminate a contract in accordance with the terms of that contract.

(d) The department may enter into contracts on a bid or negotiated basis with manufacturers, distributors, dispensers, or suppliers of pharmaceuticals, appliances, durable medical equipment, medical supplies, and other product-type health care services and laboratories for the purpose of obtaining the most favorable prices to the state and to assure adequate access and quality of the product or service. In order to achieve maximum cost savings, the Legislature hereby determines that an expedited contract process under this subdivision is necessary. Therefore, contracts under this subdivision may be on a negotiated basis and shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code.

(e) The department may contract with one or more manufacturers of each multisource prescribed product or supplier of outpatient clinical laboratory services on a bid or negotiated basis. Contracts for outpatient clinical laboratory services shall require that the contractor be a clinical laboratory licensed or certified by the State of California or certified under Section 263a of Title 42 of the United States Code. Nothing in this subdivision shall be construed as prohibiting the department from contracting with less than all manufacturers or clinical laboratories, including just one manufacturer or clinical laboratory, on a bid or negotiated basis.

SEC. 11. Section 125191 of the Health and Safety Code is amended to read:

125191. (a) The department may enter into contracts with one or more manufacturers on a negotiated or bid basis as the purchaser, but not the dispenser or distributor, of factor replacement therapies under the Genetically Handicapped Person's Program for the purpose of enabling the department to obtain the full range of available therapies and services required for clients with hematological disorders at the most favorable price and to enable the department, notwithstanding any other provision of state law, to obtain discounts, rebates, or refunds from the manufacturers based upon the large quantities purchased under the program. Nothing in this subdivision shall interfere with the usual and customary distribution practices of factor replacement therapies. In order to achieve maximum cost savings, the Legislature hereby determines that an expedited contract process under this section is necessary. Therefore, a contract under this subdivision may be entered into on a negotiated basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public

Contract Code and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code. Contracts entered pursuant to this subdivision 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).

(b) (1) Factor replacement therapy 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. 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.

(2) Following the final resolution of any dispute regarding the amount of a rebate, any underpayment by a manufacturer shall be paid with interest calculated pursuant to paragraph (4), and any overpayment, together with interest at the rate calculated pursuant to paragraph (4), shall be credited by the department against future rebates due.

(3) Interest pursuant to paragraphs (1) and (2) shall begin accruing 38 calendar days from the date of mailing 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.

(4) Interest rates and calculations pursuant to paragraphs (1) and (2) shall be identical to interest rates and calculations set forth in the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations.

(c) 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, a factor replacement therapy 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. This subdivision does not limit the department's right to otherwise terminate a contract in accordance with the terms of that contract.

(d) The department may enter into contracts on a bid or negotiated basis with manufacturers, distributors, dispensers, or suppliers of pharmaceuticals, appliances, durable medical equipment, medical supplies, and other product-type health care services and laboratories for the purpose of obtaining the most favorable prices to the state and to assure adequate access and quality of the product or service. In order to achieve maximum cost savings, the Legislature hereby determines that an expedited contract process under this subdivision is necessary. Therefore, contracts under this subdivision may be entered into on a negotiated basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code.

(e) The department may contract with one or more manufacturers of each multisource prescribed product or supplier of outpatient clinical laboratory services on a bid or negotiated basis. Contracts for outpatient clinical laboratory services shall require that the contractor be a clinical laboratory

licensed or certified by the State of California or certified under Section 263a of Title 42 of the United States Code. Nothing in this subdivision shall be construed as prohibiting the department from contracting with less than all manufacturers or clinical laboratories, including just one manufacturer or clinical laboratory, on a bid or negotiated basis.

SEC. 12. Section 130501 of the Health and Safety Code is amended to read:

130501. For purposes of this division, the following definitions shall apply:

(a) "Average manufacturer's price" has the same meaning as this term is defined in Section 1927(k)(1) of the federal Social Security Act (42 U.S.C. Sec. 1396r-8)(k)(1).

(b) "Department" means the State Department of Health Care Services.

(c) "Eligible Californian" means a resident of the state who meets any one or more of the following:

(1) Has total unreimbursed medical expenses equal to at least 10 percent of his or her family's income where the family's income does not exceed the state median family income.

(2) To the extent allowed by federal law, is enrolled in the Medicare Program, but whose prescription drugs are not covered by the Medicare Program.

(3) Has a family income that does not exceed 300 percent of the federal poverty guidelines and who does not have outpatient prescription drug coverage paid for by any one of the following:

(A) In whole by the Medi-Cal program.

(B) In whole or in part by the Healthy Families Program or other programs funded by the state.

(C) In whole or in part by another third-party payer, provided that the individual has not reached the annual limit on his or her prescription drug coverage.

(4) For purposes of this subdivision, the cost of drugs provided under this division is considered an expense incurred by the family for eligibility determination purposes.

(d) "Fund" means the California Discount Prescription Drug Program Fund.

(e) "Manufacturer" means a drug manufacturer as defined in Section 4033 of the Business and Professions Code.

(f) "Manufacturer's rebate" means the rebate for an individual drug or aggregate rebate for a group of drugs necessary to make the price for the drug ingredients equal to or less than the applicable benchmark price.

(g) "Medicaid best price" has the same meaning as this term is defined in Section 1927(c)(1)(C) of the Social Security Act (42 U.S.C. Sec. 1396r-8)(c)(1)(C).

(h) "Multiple-source drug" has the same meaning as this term is defined in Section 1927(k)(7) of the Social Security Act (42 U.S.C. Sec. 1396r-8)(k)(7).

(i) “National drug code” or “NDC” means the unique 10-digit, three-segment number assigned to each drug product listed under Section 510 of the federal Food, Drug, and Cosmetic Act (21 U.S.C. Sec. 360). This number identifies the labeler or vendor, product, and trade package.

(j) “National sales data” means prescription data obtained from a national-level prescription tracking service.

(k) “Participating manufacturer” means a drug manufacturer that has contracted with the department to provide an individual drug or group of drugs for the program.

(*l*) “Participating pharmacy” means a pharmacy that has executed a pharmacy provider agreement with the department for this program.

(m) “Pharmacy contract rate” means the negotiated per prescription reimbursement rate for drugs dispensed to eligible Californians. The department shall establish a single, basic pharmacy rate, but may contract at different rates with pharmacies in order to provide access throughout the state.

(n) “Prescription drug” means any drug that bears the legend: “Caution: federal law prohibits dispensing without prescription,” “Rx only,” or words of similar import.

(o) “Private discount drug program” means a prescription drug discount card or manufacturer patient assistance program that provides discounted or free drugs to eligible individuals. For the purposes of this division, a private discount drug program is not considered insurance or a third-party payer program.

(p) “Program” means the California Discount Prescription Drug Program.

(q) “Single-source drug” has the same meaning as this term, and the term innovator multiple-source drug, are defined in Section 1927(k)(7) of the Social Security Act (42 U.S.C. Sec. 1396r-8)(k)(7).

(r) “Therapeutic category” means a drug or a grouping of drugs determined by the department to have similar attributes and to be alternatives for the treatment of a specific disease or condition.

(s) “Volume weighted average discount” means the aggregated average discount for the drugs of a manufacturer, weighted by each drug’s percentage of the total prescription volume of that manufacturer’s drugs. For purposes of this calculation, discounts shall include any rebate amounts used to fund program costs pursuant to Section 130542.1. Drugs excluded from contracting by the department, pursuant to subdivision (d) of Section 130506 and in a manner consistent with subdivision (c) of Section 130506, shall be excluded from the calculation of the volume weighted average discount. National sales data shall be used to calculate the volume weighted average discount pursuant to Section 130506. Program utilization data shall be used to calculate the volume weighted average discount pursuant to Section 130507.

SEC. 13. Section 130506 of the Health and Safety Code is amended to read:

130506. (a) The department shall negotiate drug discount agreements with manufacturers to provide discounts for single-source and

multiple-source prescription drugs through the program. The department shall attempt to negotiate the maximum possible discount for an eligible Californian. The department shall attempt to negotiate, with each manufacturer, discounts to offer single-source prescription drugs under the program at a volume weighted average discount that is equal to or below any one of the following benchmark prices:

(1) Eighty-five percent of the average manufacturer price for a drug, as published by the Centers for Medicare and Medicaid Services.

(2) The lowest price provided to any nonpublic entity in the state by a manufacturer to the extent that the Medicaid best price exists under federal law.

(3) The Medicaid best price, to the extent that this price exists under federal law.

(b) The department may require the drug manufacturer to provide information that is reasonably necessary for the department to carry out its duties pursuant to this division.

(c) The department shall pursue manufacturer discount agreements to ensure that the number and type of drugs available through the program is sufficient to give an eligible Californian a formulary comparable to the Medi-Cal list of contract drugs, or if this information is available to the department, a formulary that is comparable to that provided to CalPERS enrollees.

(d) To obtain the most favorable discounts, the department may limit the number of drugs available through the program.

(e) The drug discount agreements negotiated pursuant to this section shall be used to reduce the cost of drugs purchased by program participants and to fund program costs pursuant to Section 130542.1.

(f) All information reported by a manufacturer to, negotiations with, and agreements executed with, the department or its third-party vendor pursuant to this section, shall be considered confidential and corporate proprietary information. This information shall not be subject to disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). The Bureau of State Audits and the Controller shall have access to pricing information in a manner that is consistent with their access to this information under the Medi-Cal program and under law. The Bureau of State Audits and the Controller may use this information only to investigate or audit the administration of the program. Neither the Bureau of State Audits, the Controller, nor the department may disclose this information in a form that identifies a specific manufacturer or wholesaler or prices charged for drugs of this manufacturer or wholesaler. Information provided to the department pursuant to subdivision (e) of Section 130530 shall not be affected by the confidentiality protections established by this subdivision.

(g) (1) Any pharmacy licensed pursuant to Chapter 9 (commencing with Section 4000) of Division 2 of the Business and Professions Code may participate in the program.

(2) Any manufacturer may participate in the program.

SEC. 14. Section 130542 of the Health and Safety Code is amended to read:

130542. (a) The department shall deposit all payments the department receives pursuant to this division into the California Discount Prescription Drug Program Fund, which is hereby established in the State Treasury.

(b) Notwithstanding Section 13340 of the Government Code, the fund is hereby continuously appropriated to the department without regard to fiscal year for the purpose of providing payment to participating pharmacies pursuant to this division and for defraying the costs of administering this division.

(c) Notwithstanding any other provision of law, no money in the fund is available for expenditure for any other purpose or for loaning or transferring to any other fund, including the General Fund, except as provided in Section 130542.1. The fund shall also contain any interest accrued on moneys in the fund.

SEC. 15. Section 130542.1 is added to the Health and Safety Code, to read:

130542.1. (a) It is the intent of the Legislature that the program shall be self-financing and that General Fund moneys provided to the fund shall be repaid within five years after implementation of the program begins. The department shall provide the Legislature with a five-year projection of program revenues and expenditures as part of its annual budget request. The projection shall include a projected General Fund repayment schedule.

(b) The department may use up to 25 percent of manufacturer rebate revenues to administer the program, including the funding of a float account to finance payments to participating pharmacies in advance of the receipt of manufacturer rebates.

SEC. 16. Section 12693.271 is added to the Insurance Code, to read:

12693.271. (a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to reduce General Fund expenditures.

(b) Notwithstanding any other provision of law, beginning the first day of the fifth month following the enactment of the 2008–09 Budget Act, the rates for the participating health, dental, and vision plans shall be set by reducing the rates that were in effect on July 1, 2007, by 5 percent, and by adjusting the July 1, 2007, rates downward to account for any reduction in the actuarial value of the benefits provided to subscribers as of the first day of the fifth month following the enactment of the 2008–09 Budget Act, associated with annual limitations on dental benefits. This requirement does not preclude the board from making other downward adjustments that it deems appropriate as a result of its annual rate negotiation process.

SEC. 17. Section 12693.43 of the Insurance Code is amended to read:

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

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

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

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

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

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

(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) 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) 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. 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.

(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.

(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.

SEC. 18. Section 12693.63 of the Insurance Code is amended to read:

12693.63. (a) The board shall determine the dental benefits to be provided to subscribers by the program. These benefits shall be consistent with those provided to state employees through the Department of Personnel Administration on July 1, 1997, except that orthodontia shall only be a benefit when it is determined to be medically necessary.

(b) The board shall establish the required subscriber copayment levels for dental benefits. 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 on July 1, 1997, except that no copayment shall be charged for medically necessary orthodontia services. There shall be no subscriber copayments for preventive and diagnostic services, including, but not limited to, examinations, teeth cleaning, X-rays, topical fluoride treatments, space maintainers, and sealants.

(c) No deductible shall be charged to subscribers for dental benefits.

(d) (1) The board may establish a cap on the amount of dental coverage provided to a subscriber in a given benefit year effective on and after the first day of the fifth month following enactment of the 2008–09 Budget Act. This dental coverage cap shall not be lower than one thousand five hundred dollars ($1,500) per subscriber per benefit year.

(2) The board may adopt, and may only one-time readopt, regulations to implement paragraph (1). The adoption and one-time readoption of a regulation authorized by this paragraph 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.

SEC. 19. 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 on July 1, 1997, 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 on July 1, 1997.

(d) The board may adopt, and may only one-time readopt, regulations to implement subdivision (b). The adoption and one-time readoption of a regulation authorized by this subdivision 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.

SEC. 20. Section 4061 of the Welfare and Institutions Code is amended to read:

4061. (a) The department shall utilize a joint state-county decisionmaking process to determine the appropriate use of state and local training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system. The department shall use the decisionmaking collaborative process required by this section in all of the following areas:

(1) Providing technical assistance to the State Department of Mental Health and local mental health departments through direction of existing state and local mental health staff and other resources.

(2) Analyzing mental health programs, policies, and procedures.

(3) Providing forums on specific topics as they relate to the following:

(A) Identifying current level of services.

(B) Evaluating existing needs and gaps in current services.

(C) Developing strategies for achieving statewide goals and objectives in the provision of services for the specific area.

(D) Developing plans to accomplish the identified goals and objectives.

(4) Providing forums on policy development and direction with respect to mental health program operations and clinical issues.

(5) Identifying and funding a statewide training and technical assistance entity jointly governed by local mental health directors and mental health constituency representation, which can do all of the following:

(A) Coordinate state and local resources to support training and technical assistance to promote quality mental health programs.

(B) Coordinate training and technical assistance to ensure efficient and effective program development.

(C) Provide essential training and technical assistance, as determined by the state-county decisionmaking process.

(b) Local mental health board members shall be included in discussions pursuant to Section 4060 when the following areas are discussed:

(1) Training and education program recommendations.

(2) Establishment of statewide forums for all organizations and individuals involved in mental health matters to meet and discuss program and policy issues.

(3) Distribution of information between the state, local programs, local mental health boards, and other organizations as appropriate.

(c) The State Department of Mental Health and local mental health departments may provide staff or other resources, including travel reimbursement, for consultant and advisory services; for the training of personnel, board members, or consumers and families in state and local programs and in educational institutions and field training centers approved by the department; and for the establishment and maintenance of field training centers.

SEC. 21. Section 4100.2 is added to the Welfare and Institutions Code, to read:

4100.2. (a) Commencing January 10, 2009, and each year thereafter, the State Department of Mental Health shall provide the fiscal committees of the Legislature with a fiscal estimate package for the current year and budget year for the state hospitals by January 10 and at the time of the Governor's May Revision.

(b) At a minimum, the estimate package shall address patient caseload by commitment category, non-level-of-care and level-of-care staffing requirements, and operating expenses and equipment.

(c) In addition to subdivision (b), each estimate submitted shall include all of the following:

(1) A statement articulating the assumptions and methodologies used for calculating the patient caseload factors, all staffing costs, and operating expenses and equipment.

(2) Where applicable, individual policy changes shall contain a narrative and basis for its proposed and estimated costs.

(3) Fiscal bridge charts shall be included to provide the basis for the year-to-year changes.

(d) The department may provide any additional information as deemed appropriate to provide a comprehensive fiscal perspective to the Legislature for analysis and deliberations for purposes of appropriation.

SEC. 21.5. Section 4646.4 is added to the Welfare and Institutions Code, to read:

4646.4. (a) Effective September 1, 2008, regional centers shall ensure, at the time of development, scheduled review, or modification of a

consumer's individual program plan developed pursuant to Sections 4646 and 4646.5, or of an individualized family service plan pursuant to Section 95020 of the Government Code, the establishment of an internal process. This internal process shall ensure adherence with federal and state law and regulation, and when purchasing services and supports, shall ensure all of the following:

(1) Conformance with the regional center's purchase of service policies, as approved by the department pursuant to subdivision (d) of Section 4434.

(2) Utilization of generic services and supports when appropriate.

(3) Utilization of other services and sources of funding as contained in Section 4659.

(4) Consideration of the family's responsibility for providing similar services and supports for a minor child without disabilities in identifying the consumer's service and support needs as provided in the least restrictive and most appropriate setting. In this determination, regional centers shall take into account the consumer's need for extraordinary care, services, supports and supervision, and the need for timely access to this care.

(b) Final decisions regarding the consumer's individual program plan shall be made pursuant to Section 4646.

(c) Final decisions regarding the individual family support plan shall be made pursuant to Section 95020 of the Government Code.

(d) By no later than April 1, 2009, the department shall provide the fiscal and policy committees of the Legislature with a written update regarding the implementation of this section.

SEC. 22. Section 4783 of the Welfare and Institutions Code is amended to read:

4783. (a) (1) The Family Cost Participation Program is hereby created in the State Department of Developmental Services for the purpose of assessing a cost participation to parents, as defined in Section 50215 of Title 17 of the California Code of Regulations, who have a child to whom all of the following applies:

(A) The child has a developmental disability or is eligible for services under the California Early Intervention Services Act.

(B) The child is zero years of age through 17 years of age.

(C) The child lives in the parents' home.

(D) The child receives services and supports purchased through the regional center.

(E) The child is not eligible for Medi-Cal.

(2) Notwithstanding any other provision of law, a parent described in subdivision (a) shall participate in the Family Cost Participation Program established pursuant to this section.

(3) Application of this section to children zero through two years of age, inclusive, shall be contingent upon approval by the United States Department of Education.

(b) (1) The department shall develop and establish a Family Cost Participation Schedule that shall be used by regional centers to assess the parents' cost participation. The schedule shall consist of a sliding scale for

families with an annual gross income not less than 400 percent of the federal poverty guideline, and be adjusted for the level of annual gross income and the number of persons living in the family home.

(2) The schedule established pursuant to this section shall be exempt from the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) Family cost participation assessments shall only be applied to respite, day care, and camping services that are included in the child's individual program plan or individualized family service plan for children zero through two years of age.

(d) If there is more than one minor child living in the parents' home and receiving services or supports paid for by the regional center, or living in a 24-hour out-of-home facility, including a developmental center, the assessed amount shall be adjusted as follows:

(1) A parent that meets the criteria specified in subdivision (b) with two children shall be assessed at 75 percent of the respite, day care, and camping services in each child's individual program plan or individualized family service plan for each child living at home.

(2) A parent that meets the criteria specified in subdivision (b) with three children shall be assessed at 50 percent of the respite, day care, and camping services included in each child's individual program plan or individualized family service plan for each child living at home.

(3) A parent that meets the criteria specified in subdivision (b) with four children shall be assessed 25 percent of the respite, day care, and camping services included in each child's individual program plan or individualized family service plan for each child living at home.

(4) A parent that meets the criteria specified in subdivision (b) with more than four children shall be exempt from participation in the Family Cost Participation Program.

(e) For each child, the amount of cost participation shall be less than the amount of the parental fee that the parent would pay if the child lived in a 24-hour, out-of-home facility.

(f) Commencing January 1, 2005, each regional center shall be responsible for administering the Family Cost Participation Program.

(g) Family cost participation assessments or reassessments shall be conducted as follows:

(1) (A) A regional center shall assess the cost participation for all parents of current consumers who meet the criteria specified in this section. A regional center shall use the most recent individual program plan or individualized family service plan for this purpose.

(B) A regional center shall assess the cost participation for parents of newly identified consumers at the time of the initial individual program plan or the individualized family service plan.

(C) Reassessments for cost participation shall be conducted as part of the individual program plan or individual family service plan review pursuant to subdivision (b) of Section 4646 or subdivision (f) of Section 95020 of the Government Code.

(D) The parents are responsible for notifying the regional center when a change in family income occurs that would result in a change in the assessed amount of cost participation.

(2) Parents shall self-certify their gross annual income to the regional center by providing copies of W-2 Wage Earners Statements, payroll stubs, a copy of the prior year's state income tax return, or other documents and proof of other income.

(3) A regional center shall notify parents of the parents' assessed cost participation within 10 working days of receipt of the parents' complete income documentation.

(4) Parents who have not provided copies of income documentation pursuant to paragraph (2) shall be assessed the maximum cost participation based on the highest income level adjusted for family size until such time as the appropriate income documentation is provided. Parents who subsequently provide income documentation that results in a reduction in their cost participation shall be reimbursed for the actual cost difference incurred for services identified in the individual program plan or individualized family service plan for respite, day care, and camping services, for 90 calendar days preceding the reassessment. The actual cost difference is the difference between the maximum cost participation originally assessed and the reassessed amount using the parents' complete income documentation, that is substantiated with receipts showing that the services have been purchased by the parents.

(5) The executive director of the regional center may grant a cost participation adjustment for parents who incur an unavoidable and uninsured catastrophic loss with direct economic impact on the family or who substantiate, with receipts, significant unreimbursed medical costs associated with care for a child who is a regional center consumer. A redetermination of the cost participation adjustment shall be made at least annually.

(h) A provider of respite, day care, or camping services shall not charge a rate for the parents' share of cost that is higher than the rate paid by the regional center for its share of cost.

(i) The department shall develop, and regional centers shall use, all forms and documents necessary to administer the program established pursuant to this section. The forms and documents shall be posted on the department's Web site. A regional center shall provide appropriate materials to parents at the initial individual program plan or individualized family service plan meeting and subsequent individual program plan or individualized family service plan review meetings. These materials shall include a description of the Family Cost Participation Program.

(j) The department shall include an audit of the Family Cost Participation Program during its audit of a regional center.

(k) (1) Parents of children ages three through 17 years of age may appeal an error in the amount of the parents' cost participation to the executive director of the regional center within 30 days of notification of the amount of the assessed cost participation. The parents may appeal to the Director of Developmental Services, or his or her designee, any decision by the

executive director made pursuant to this subdivision within 15 days of receipt of the written decision of the executive director.

(2) Parents of children ages three through 17 years of age who dispute the decision of the executive director pursuant to paragraph (5) of subdivision (g) shall have a right to a fair hearing as described in, and the regional center shall provide notice pursuant to, Chapter 7 (commencing with Section 4700). This paragraph shall become inoperative on July 1, 2006.

(3) On and after July 1, 2006, a parent described in paragraph (2) shall have the right to appeal the decision of the executive director to the Director of Developmental Services, or his or her designee, within 15 days of receipt of the written decision of the executive director.

(*l*) For parents of children ages zero through two years of age, inclusive, the complaint, mediation, and due process procedures set forth in Sections 52170 to 52174, inclusive, of Title 17 of the California Code of Regulations shall be used to resolve disputes regarding this section.

(m) The department may adopt emergency regulations to implement this section. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe specific facts showing the need for immediate action. A certificate of compliance for these implementing regulations shall be filed within 24 months following the adoption of the first emergency regulations filed pursuant to this subdivision.

(n) By April 1, 2005, and annually thereafter, the department shall report to the appropriate fiscal and policy committees of the Legislature on the status of the implementation of the Family Cost Participation Program established under this section. On and after April 1, 2006, the report shall contain all of the following:

(1) The annual total purchase of services savings attributable to the program per regional center.

(2) The annual costs to the department and each regional center to administer the program.

(3) The number of families assessed a cost participation per regional center.

(4) The number of cost participation adjustments granted pursuant to paragraph (5) of subdivision (g) per regional center.

(5) The number of appeals filed pursuant to subdivision (k) and the number of those appeals granted, modified, or denied.

SEC. 23. Section 4860 of the Welfare and Institutions Code is amended to read:

4860. (a) (1) The hourly rate for supported employment services provided to consumers receiving individualized services shall be thirty dollars and eighty-two cents ($30.82).

(2) Job coach hours spent in travel to consumer worksites may be reimbursable for individualized services only when the job coach travels

from the vendor's headquarters to the consumer's worksite or from one consumer's worksite to another, and only when the travel is one way.

(b) The hourly rate for group services shall be thirty dollars and eighty-two cents ($30.82), regardless of the number of consumers served in the group. Consumers in a group shall be scheduled to start and end work at the same time, unless an exception that takes into consideration the consumer's compensated work schedule is approved in advance by the regional center. The department, in consultation with stakeholders, shall adopt regulations to define the appropriate grounds for granting these exceptions. When the number of consumers in a supported employment placement group drops to fewer than the minimum required in subdivision (r) of Section 4851 the regional center may terminate funding for the group services in that group, unless, within 90 days, the program provider adds one or more regional center, or Department of Rehabilitation funded supported employment consumers to the group.

(c) Job coaching hours for group services shall be allocated on a prorated basis between a regional center and the Department of Rehabilitation when regional center and Department of Rehabilitation consumers are served in the same group.

(d) When Section 4855 applies, fees shall be authorized for the following:

(1) A three-hundred-sixty-dollar ($360) fee shall be paid to the program provider upon intake of a consumer into a supported employment program. No fee shall be paid if that consumer completed a supported employment intake process with that same supported employment program within the previous 12 months.

(2) A seven-hundred-twenty-dollar ($720) fee shall be paid upon placement of a consumer in an integrated job, except that no fee shall be paid if that consumer is placed with another consumer or consumers assigned to the same job coach during the same hours of employment.

(3) A seven-hundred-twenty-dollar ($720) fee shall be paid after a 90-day retention of a consumer in a job, except that no fee shall be paid if that consumer has been placed with another consumer or consumers, assigned to the same job coach during the same hours of employment.

(e) Notwithstanding paragraph (4) of subdivision (a) of Section 4648 the regional center shall pay the supported employment program rates established by this section.

SEC. 24. Section 5777 of the Welfare and Institutions Code is amended to read:

5777. (a) (1) Except as otherwise specified in this part, a contract entered into pursuant to this part shall include a provision that the mental health plan contractor shall bear the financial risk for the cost of providing medically necessary mental health services to Medi-Cal beneficiaries irrespective of whether the cost of those services exceeds the payment set forth in the contract. If the expenditures for services do not exceed the payment set forth in the contract, the mental health plan contractor shall report the unexpended amount to the department, but shall not be required to return the excess to the department.

(2) If the mental health plan is not the county's, the mental health plan may not transfer the obligation for any mental health services to Medi-Cal beneficiaries to the county. The mental health plan may purchase services from the county. The mental health plan shall establish mutually agreed-upon protocols with the county that clearly establish conditions under which beneficiaries may obtain non-Medi-Cal reimbursable services from the county. Additionally, the plan shall establish mutually agreed-upon protocols with the county for the conditions of transfer of beneficiaries who have lost Medi-Cal eligibility to the county for care under Part 2 (commencing with Section 5600), Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850).

(3) The mental health plan shall be financially responsible for ensuring access and a minimum required scope of benefits, consistent with state and federal requirements, to the services to the Medi-Cal beneficiaries of that county regardless of where the beneficiary resides. The department shall require that the definition of medical necessity used, and the minimum scope of benefits offered, by each mental health contractor be the same, except to the extent that any variations receive prior federal approval and are consistent with state and federal statutes and regulations.

(b) Any contract entered into pursuant to this part may be renewed if the plan continues to meet the requirements of this part, regulations promulgated pursuant thereto, and the terms and conditions of the contract. Failure to meet these requirements shall be cause for nonrenewal of the contract. The department may base the decision to renew on timely completion of a mutually agreed upon plan of correction of any deficiencies, submissions of required information in a timely manner, or other conditions of the contract. At the discretion of the department, each contract may be renewed for a period not to exceed three years.

(c) (1) The obligations of the mental health plan shall be changed only by contract or contract amendment.

(2) A change may be made during a contract term or at the time of contract renewal, where there is a change in obligations required by federal or state law or when required by a change in the interpretation or implementation of any law or regulation. To the extent permitted by federal law and except as provided under subdivision (r) of Section 5778, if any change in obligations occurs that affects the cost to the mental health plan of performing under the terms of its contract, the department may reopen contracts to negotiate the state General Fund allocation to the mental health plan under Section 5778, if the mental health plan is reimbursed through a fee-for-service payment system, or the capitation rate to the mental health plan under Section 5779, if the mental health plan is reimbursed through a capitated rate payment system. During the time period required to redetermine the allocation or rate, payment to the mental health plan of the allocation or rate in effect at the time the change occurred shall be considered interim payments and shall be subject to increase or decrease, as the case may be, effective as of the date on which the change is effective.

(3) To the extent permitted by federal law, either the department or the mental health plan may request that contract negotiations be reopened during the course of a contract due to substantial changes in the cost of covered benefits that result from an unanticipated event.

(d) The department shall immediately terminate a contract when the director finds that there is an immediate threat to the health and safety of Medi-Cal beneficiaries. Termination of the contract for other reasons shall be subject to reasonable notice of the department's intent to take that action and notification of affected beneficiaries. The plan may request a public hearing by the Office of Administrative Hearings.

(e) A plan may terminate its contract in accordance with the provisions in the contract. The plan shall provide written notice to the department at least 180 days prior to the termination or nonrenewal of the contract.

(f) Upon the request of the Director of Mental Health, the Director of the Department of Managed Health Care may exempt a mental health plan contractor or a capitated rate contract from the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code). These exemptions may be subject to conditions the director deems appropriate. Nothing in this part shall be construed to impair or diminish the authority of the Director of the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975, nor shall anything in this part be construed to reduce or otherwise limit the obligation of a mental health plan contractor licensed as a health care service plan to comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Health Care promulgated thereunder. The Director of Mental Health, in consultation with the Director of the Department of Managed Health Care, shall analyze the appropriateness of licensure or application of applicable standards of the Knox-Keene Health Care Service Plan Act of 1975.

(g) (1) The department, pursuant to an agreement with the State Department of Health Care Services, shall provide oversight to the mental health plans to ensure quality, access, and cost efficiency. At a minimum, the department shall, through a method independent of any agency of the mental health plan contractor, monitor the level and quality of services provided, expenditures pursuant to the contract, and conformity with federal and state law.

(2) (A) Commencing July 1, 2008, county mental health plans, in collaboration with the department, the federally required external review organization, providers, and other stakeholders, shall establish an advisory statewide performance improvement project (PIP) to increase the coordination, quality, effectiveness, and efficiency of service delivery to children who are either receiving at least three thousand dollars ($3,000) per month in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program services or children identified in the top 5 percent of the county EPSDT cost, whichever is lowest. The statewide PIP shall replace

one of the two required PIPs that mental health plans must perform under federal regulations outlined in the mental health plan contract.

(B) The federally required external quality review organization shall provide independent oversight and reviews with recommendations and findings or summaries of findings, as appropriate, from a statewide perspective. This information shall be accessible to county mental health plans, the department, county welfare directors, providers, and other interested stakeholders in a manner that both facilitates, and allows for, a comprehensive quality improvement process for the EPSDT Program.

(C) Each July, the department, in consultation with the federally required external quality review organization and the county mental health plans, shall determine the average monthly cost threshold for counties to use to identify children to be reviewed who are currently receiving EPSDT services. The department shall consult with representatives of county mental health directors, county welfare directors, providers, and the federally required external quality review organization in setting the annual average monthly cost threshold and in implementing the statewide PIP. The department shall provide an annual update to the Legislature on the results of this statewide PIP by October 1 of each year for the prior fiscal year.

(D) It is the intent of the Legislature for the EPSDT PIP to increase the coordination, quality, effectiveness, and efficiency of service delivery to children receiving EPSDT services and to facilitate evidence-based practices within the program, and other high-quality practices consistent with the values of the public mental health system within the program to ensure that children are receiving appropriate mental health services for their mental health wellness.

(E) This paragraph shall become inoperative on September 1, 2011.

(h) County employees implementing or administering a mental health plan act in a discretionary capacity when they determine whether or not to admit a person for care or to provide any level of care pursuant to this part.

(i) If a county chooses to discontinue operations as the local mental health plan, the new plan shall give reasonable consideration to affiliation with nonprofit community mental health agencies that were under contract with the county and that meet the mental health plan's quality and cost efficiency standards.

(j) Nothing in this part shall be construed to modify, alter, or increase the obligations of counties as otherwise limited and defined in Chapter 3 (commencing with Section 5700) of Part 2. The county's maximum obligation for services to persons not eligible for Medi-Cal shall be no more than the amount of funds remaining in the mental health subaccount pursuant to Sections 17600, 17601, 17604, 17605, 17606, and 17609 after fulfilling the Medi-Cal contract obligations.

SEC. 25. Section 7502.5 is added to the Welfare and Institutions Code, to read:

7502.5. The total number of developmental center residents in the secure treatment facility at Porterville Developmental Center shall not exceed 297.

SEC. 26. Section 14005.11 of the Welfare and Institutions Code is amended to read:

14005.11. (a) To the extent required by federal law for qualified Medicare beneficiaries, the department shall pay the premiums, deductibles, and coinsurance for elderly and disabled persons entitled to benefits under Title XVIII of the federal Social Security Act, whose income does not exceed the federal poverty level and whose resources do not exceed 200 percent of the Supplemental Security Income program standard.

(b) The department shall, in addition to subdivision (a), pay applicable additional premiums, deductibles, and coinsurance for drug coverage extended to qualified Medicare beneficiaries.

(c) The deductible payments required by subdivision (b) may be covered by providing the same drug coverage as offered to categorically needy recipients, as defined in Section 14050.1.

(d) As specified in this section, it is the intent of the Legislature to assist in the payment of Medicare Part B premiums for qualified low-income Medi-Cal beneficiaries who are ineligible for federal sharing or federal contribution for the payment of those premiums.

(e) Except as provided in subdivision (f), for a Medi-Cal beneficiary who has a share of cost but who is ineligible for the assistance provided pursuant to subdivision (a), or who is ineligible for any other federally funded assistance for the payment of the beneficiary's Medicare Part B premium, the department shall pay for the beneficiary's Medicare Part B premium in the month following each month that the beneficiary's share of cost has been met.

(f) For a Medi-Cal beneficiary who has a share of cost at or below five hundred dollars ($500) but who is ineligible for the assistance provided pursuant to subdivision (a), and is ineligible for any other federally funded assistance for the payment of the beneficiary's Medicare Part B premium, the department shall pay for the beneficiary's Medicare Part B premium on a monthly basis, regardless of whether the beneficiary's share of cost has been met.

(g) When a county is informed that an applicant or beneficiary is eligible for Medicare benefits, the county shall determine whether that individual is eligible under the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLMB) program, or the Qualifying Individual program and enroll the applicant or beneficiary in the appropriate program.

SEC. 27. Section 14005.25 of the Welfare and Institutions Code is amended to read:

14005.25. (a) To the extent federal financial participation is available, the department shall exercise the option under Section 1902(e)(12) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(12)) to extend continuous eligibility to children 19 years of age and younger. A child shall remain eligible pursuant to this subdivision from the date of a determination of eligibility for Medi-Cal benefits until the earlier of either:

(1) The end of a 12-month period following the eligibility determination.

(2) The date the individual exceeds the age of 19 years.

(b) This section shall be implemented only if, and to the extent that, federal financial participation is available.

(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, without taking regulatory action, implement this section by means of all county letters or similar instructions. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) In order to implement changes in the level of funding for health care services, commencing on the first day of the month following 90 days after the operative date of amendments to this section that added this subdivision, the continuous eligibility time period provided in paragraph (1) of subdivision (a) shall be reduced to six months.

(e) This section shall remain in effect only until January 1, 2012, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2012, deletes or extends that date.

SEC. 28. Section 14005.25 is added to the Welfare and Institutions Code, to read:

14005.25. (a) To the extent federal financial participation is available, the department shall exercise the option under Section 1902(e)(12) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(12)) to extend continuous eligibility to children 19 years of age and younger. A child shall remain eligible pursuant to this subdivision from the date of a determination of eligibility for Medi-Cal benefits until the earlier of either:

(1) The end of a 12-month period following the eligibility determination.

(2) The date the individual exceeds the age of 19 years.

(b) This section shall be implemented only if, and to the extent that, federal financial participation is available.

(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, without taking regulatory action, implement this section by means of all county letters or similar instructions. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) This section shall become operative on January 1, 2012.

SEC. 29. Section 14005.42 is added to the Welfare and Institutions Code, to read:

14005.42. (a) The department shall provide full-scope benefits under this chapter, without share of cost, to all individuals on behalf of whom kinship guardians are receiving aid under any of the Kinship Guardian Assistance Payment Programs pursuant to Article 4.5 (commencing with Section 11360) of Chapter 2.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department and

the State Department of Social Services may implement, without taking regulatory action, this section by means of all county letters or similar instruction. Thereafter, as needed, the departments shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) To the extent that federal financial participation is not available, the cost of benefits provided under this section shall be covered only by state funds.

(d) The department and the State Department of Social Services shall work cooperatively to develop procedures that maximize the availability of federal financial participation for the cost of benefits provided under this section. The procedures shall include conforming the application and eligibility determination process for this population to meet the requirements of federal Medicaid law.

SEC. 30. Section 14007.9 of the Welfare and Institutions Code is amended to read:

14007.9. (a) 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:

(1) 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.

(2) He or she is disabled under Title II of the Social Security Act (Subch. 2 (commencing with Sec. 401), Ch. 7, Title 42 U.S.C.), Title XVI of the Social Security Act (Subch. 16 (commencing with Sec. 1381), Ch. 7, Title 42, U.S.C.), or Section 1902(v) of the 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 Social Security Act (42 U.S.C. Sec. 423(d)(4)).

(3) 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.

(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)).

(c) 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.

(d) Individuals eligible for Medi-Cal benefits under this section shall be subject to the payment of premiums determined under this subdivision. The department shall establish sliding-scale premiums that are based on countable income, with a minimum premium of twenty dollars ($20) per month and a maximum premium of two hundred fifty dollars ($250) per month, and shall, by regulations, annually adjust the premiums. Prior to adjustment of any premiums pursuant to this subdivision, the department shall submit a report of proposed premium adjustments to the appropriate committees of the Legislature as part of the annual budget act process.

(e) The department shall adopt regulations specifying the process for discontinuance of eligibility under this section for nonpayment of premiums for more than two months by a beneficiary.

(f) 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.

(g) 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.

(h) Notwithstanding any other provision of 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.).

(i) Subject to subdivision (h), this section shall be implemented commencing April 1, 2000.

SEC. 31. Section 14011.16 of the Welfare and Institutions Code is amended to read:

14011.16. (a) Commencing August 1, 2003, the department shall implement a requirement for beneficiaries to file semiannual status reports as part of the department's procedures to ensure that beneficiaries make timely and accurate reports of any change in circumstance that may affect their eligibility. The department shall develop a simplified form to be used for this purpose. The department shall explore the feasibility of using a form

that allows a beneficiary who has not had any changes to so indicate by checking a box and signing and returning the form.

(b) Beneficiaries who have been granted continuous eligibility under Section 14005.25 shall not be required to submit semiannual status reports. To the extent federal financial participation is available, all children under 19 years of age shall be exempt from the requirement to submit semiannual status reports.

(c) For any period of time that the continuous eligibility period described in paragraph (1) of subdivision (a) of Section 14005.25 is reduced to six months, subdivision (b) shall become inoperative, and all children under 19 years of age shall be required to file semiannual status reports.

(d) Beneficiaries whose eligibility is based on a determination of disability or on their status as aged or blind shall be exempt from the semiannual status report requirement described in subdivision (a). The department may exempt other groups from the semiannual status report requirement as necessary for simplicity of administration.

(e) When a beneficiary has completed, signed, and filed a semiannual status report that indicated a change in circumstance, eligibility shall be redetermined.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all county letters or similar instructions without taking regulatory action. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(g) This section shall be implemented only if and to the extent federal financial participation is available.

SEC. 32. Section 14011.17 is added to the Welfare and Institutions Code, to read:

14011.17. The following persons shall be exempt from the semiannual reporting requirements described in Section 14011.16:

(a) Pregnant women whose eligibility is based on pregnancy.

(b) Beneficiaries receiving Medi-Cal through Aid for Adoption of Children Program.

(c) Beneficiaries who have a public guardian.

(d) Medically indigent children who are not living with a parent or relative and who have a public agency assuming their financial responsibility.

(e) Individuals receiving minor consent services.

(f) Beneficiaries in the Breast and Cervical Cancer Treatment Program.

(g) Beneficiaries who are CalWORKs recipients and custodial parents whose children are CalWORKs recipients.

SEC. 33. Section 14011.18 is added to the Welfare and Institutions Code, to read:

14011.18. (a) On or before December 15, 2010, the State Department of Health Care Services shall report to the fiscal and health policy committees of the Legislature on the effects of reducing the time period of

continuous eligibility for children and imposing a semiannual status reporting requirement to maintain Medi-Cal eligibility for children. The report shall include all of the following information:

(1) The number of children enrolled in Medi-Cal by eligibility category prior to the imposition of semiannual status reporting and on a quarterly basis after the imposition of semiannual reporting. Within each eligibility category, the report also shall identify the number of enrolled children in Medi-Cal managed care and in fee-for-service Medi-Cal.

(2) The annual cost per child enrollee in managed care and by cost category in fee-for-service prior to the imposition of semiannual reporting and for the 2009–10 fiscal year.

(3) An analysis of enrollment interruptions and reinstatements for children prior to the imposition of semiannual reporting and for the 2009–10 fiscal year. The analysis shall include data on the number of children disenrolled as a result of the semiannual reporting requirement, the number of those children who were subsequently reenrolled in Medi-Cal by duration of their enrollment gap, and an analysis, to the extent feasible, of the extent to which enrollment gaps resulted from the failure of families to file a complete semiannual report versus a change in family circumstances that resulted in a child no longer being eligible for no-cost Medi-Cal coverage, and the number of children that transitioned to the Healthy Families Program as a result of semiannual reporting.

(4) An estimate of the additional annual county eligibility administration costs or savings resulting from the processing of semiannual reports for children, disenrollment processing, reinstatement, reenrollment, and caseload reductions.

(b) For purposes of preparing the report, the department shall seek funding, or participation from appropriate nonprofit organizations, including foundations and universities, or both.

SEC. 34. Section 14053.3 is added to the Welfare and Institutions Code, to read:

14053.3. As federal financial participation reimbursement is not allowed for ancillary services provided to persons residing in facilities that have been found to be institutions for mental disease (IMD), and since, consistent with Part 2 (commencing with Section 5600) of Division 5 and Chapter 6 (commencing with Section 17600) of Part 5, counties are financially responsible for mental health services and related ancillary services provided to persons through county mental health programs when Medi-Cal reimbursement is not available, when it is determined that Medi-Cal reimbursement has been paid for ancillary services for residents of IMDs, both the federal financial participation reimbursement and any state funds paid for the ancillary services provided to residents of IMDs shall be recovered from counties by the State Department of Mental Health in accordance with applicable state and federal statutes and regulations.

SEC. 35. Section 14080 of the Welfare and Institutions Code is amended to read:

14080. (a) Notwithstanding any other provision of this chapter, reimbursement to providers for dental services provided to individuals 21 years of age or older at the time of services shall be limited to not more than one thousand eight hundred dollars ($1,800) per beneficiary in any calendar year, commencing January 1, 2006. This limitation shall not apply to any of the following:

(1) Emergency dental services within the scope of covered dental benefits defined as a dental condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(2) Services that are federally mandated under Part 440 (commencing with Section 440.1) of Title 42 of the Code of Federal Regulations, including pregnancy-related services and services for other conditions that might complicate the pregnancy.

(3) Dentures.

(4) Maxillofacial and complex oral surgery.

(5) Maxillofacial services, including dental implants and implant-retained prostheses.

(6) Services provided in long-term care facilities.

(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. No later than January 1, 2008, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) The department shall pursue any state plan amendment or other federal approval necessary in order to effectuate this section. This section shall be implemented only to the extent that federal financial participation is available.

SEC. 42. Article 2.93 (commencing with Section 14091.3) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 2.93. Payments to Hospitals

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), 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 Procedures 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 2.7 (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, through June 30, 2008, 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 the 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.

(f) This section shall remain in effect only until January 1, 2011, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2011, deletes or extends that date.

SEC. 43. Section 14104.93 is added to the Welfare and Institutions Code, to read:

14104.93. (a) The department may distribute provider bulletins and other provider communications for the Medi-Cal program by either print or electronic medium, including posting on the department's Medi-Cal program Web site. The posting may include information relating to the

California Children's Services (CCS) Program, the Genetically Handicapped Persons Program (GHPP), the Family PACT program, and the Every Woman Counts program. Communications on the department's Internet Web site shall be posted in a timely manner and maintained on the Web site for one year from the date of posting.

(b) The department's Web site for the Medi-Cal program shall be appropriately maintained to ensure factual clarity regarding the program, to facilitate ease of use for providers, and to sustain the integrity of the Medi-Cal program.

(c) This section shall be implemented on the first day of the month following 30 days after the operative date of this section.

SEC. 44. Section 14105.19 of the Welfare and Institutions Code is amended to read:

14105.19. (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 provided in subdivision (c), payments shall be reduced by 10 percent for Medi-Cal fee-for-service benefits for dates of service on and after July 1, 2008, through and including dates of service on February 28, 2009.

(2) Except as provided in subdivision (c), 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 July 1, 2008, through and including dates of service on February 28, 2009.

(3) 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 reduction specified in this subdivision pursuant to contract amendments or change orders effective on July 1, 2008.

(4) Notwithstanding paragraphs (1) and (2), payment reductions set forth in this subdivision shall apply to small and rural hospitals, as defined in Section 124840 of the Health and Safety Code, for dates of service on and after July 1, 2008, through and including October 31, 2008.

(c) The services listed in this subdivision shall be exempt from the payment reductions specified in subdivision (b):

(1) Acute hospital inpatient services, except for payments to hospitals not under contract with the State Department of Health Care Services, as provided in Section 14166.245.

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver under subdivision (a) of Section 1315 of Title 42 of the United States Code.

(3) Rural health clinic services.

(4) All of the following facilities:

(A) A skilled nursing facility pursuant to subdivision (c) of Section 1250 of the Health and Safety Code, except a skilled nursing facility that is a

distinct part of a general acute care hospital. For purposes of this paragraph, "distinct part" has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(B) An intermediate care facility for the developmentally disabled pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, or a facility providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14495.10.

(C) A subacute care unit, as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

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

(6) Hospice.

(7) Contract services as designated by the director pursuant to subdivision (e).

(8) 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.

(9) 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.

(10) Payments to Medi-Cal managed care plans pursuant to Section 4474.5 for services to 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.

(11) Breast and cervical cancer treatment provided pursuant to Section 14007.71.

(12) The Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program pursuant to Section 14105.18.

(d) Subject to the exception for services listed in subdivision (c), the payment reductions required by subdivision (b) shall apply to the services 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.

(e) 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 a provider bulletin, or similar instruction, without taking regulatory action.

(f) 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.

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

SEC. 45. Section 14105.191 is added to the Welfare and Institutions Code, 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 (f).

(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 Section 14105.18.

(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) 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.

(g) The reductions 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.

(h) 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 pursuant to this section, the director may elect not to implement such reduction.

SEC. 46. Section 14105.3 of the Welfare and Institutions Code is amended to read:

14105.3. (a) The department is considered to be the purchaser, but not the dispenser or distributor, of prescribed drugs under the Medi-Cal program for the purpose of enabling the department to obtain from manufacturers of prescribed drugs the most favorable price for those drugs furnished by one or more manufacturers, based upon the large quantity of the drugs purchased under the Medi-Cal program, and to enable the department, notwithstanding any other provision of state law, to obtain from the manufacturers discounts, rebates, or refunds based on the quantities purchased under the program, insofar as may be permissible under federal law. Nothing in this section shall interfere with usual and customary distribution practices in the drug industry.

(b) The department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis with manufacturers, distributors, dispensers, or suppliers of appliances, durable medical equipment, medical supplies, and other product-type health care services and with laboratories for clinical laboratory services for the purpose of obtaining the most favorable prices to the state and to assure adequate quality of the product or service. Except as provided in subdivision (f), this subdivision shall not apply to prescribed drugs dispensed by pharmacies licensed pursuant to Article 7 (commencing with Section 4110) of Chapter 9 of Division 2 of the Business and Professions Code.

(c) Notwithstanding subdivision (b), the department may not enter into a contract with a clinical laboratory unless the clinical laboratory operates in conformity with Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code and the regulations adopted thereunder, and Section 263a of Title 42 of the United States Code and the regulations adopted thereunder.

(d) The department shall contract with manufacturers of single-source drugs on a negotiated basis, and with manufacturers of multisource drugs on a bid or negotiated basis.

(e) In order to ensure and improve access by Medi-Cal beneficiaries to both hearing aid appliances and provider services, and to ensure that the state obtains the most favorable prices, the department, by June 30, 2008, shall enter into exclusive or nonexclusive contracts, on a bid or negotiated basis, for purchasing hearing aid appliances.

(f) In order to provide specialized care in the distribution of specialized drugs, as identified by the department and that include, but are not limited to, blood factors and immunizations, the department may enter into contracts with providers licensed to dispense dangerous drugs or devices pursuant to Division 2 (commencing with Section 4000) of the Business and Professions Code, for programs that qualify for federal funding pursuant to the Medicaid state plan, or waivers and the programs authorized by Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of, and Article 1 (commencing with Section 125125) of Chapter 2 of Part 5 of, Division 106 of the Health and Safety Code, in accordance with this subdivision.

(1) The department shall, for purposes of ensuring proper patient care, consult current standards of practice when executing a provider contract.

(2) The department shall, for purposes of ensuring quality of care to people with unique conditions requiring specialty drugs, contract with a nonexclusive number of providers that meets the needs of the affected population, covers all geographic regions in California, and reflects the distribution of the specialty drug in the community. The department may use a single provider in the event the product manufacturer designates a sole source delivery mechanism. The department shall consult with interested parties and appropriate stakeholders in implementing this section with respect to all of the following:

(A) Notifying stakeholder representatives of the potential inclusion or exclusion of drugs in the specialty pharmacy program.

(B) Allowing for written input regarding the potential inclusion or exclusion of drugs into the specialty pharmacy program.

(C) Scheduling at least one public meeting regarding the potential inclusion or exclusion of drugs into the specialty pharmacy program.

(D) Obtaining a recommendation from the Medi-Cal Drug Utilization Review Advisory Committee, established pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8), on the inclusion or exclusion of drugs into the specialty pharmacy program distribution based on clinical best practices related to each drug considered.

(3) For purposes of this subdivision, the definition of “blood factors” has the same meaning as that term is defined in Section 14105.86.

(4) The department shall make every reasonable effort to ensure all medically necessary clotting factor therapies are available for the treatment of people with bleeding disorders.

(5) The department shall generate an annual report, published publicly six months after the end of the first and second years after implementation, which shall include, but not be limited to, all of the following information:

(A) The number and geographic distribution of participating providers.

(B) The number and geographic distribution of beneficiaries receiving specialty drugs, including on a per provider basis.

(C) A summary of problems and complaints received regarding the specialty pharmacy program.

(D) An evaluation of hospital and emergency services before and after implementation for the targeted patient population.

(E) Results of patient satisfaction surveys.

(F) The cost-effectiveness of the program.

(6) This subdivision shall become inoperative three years after the date of implementation, as provided pursuant to a notice to the public issued by the department, or until July 1, 2013, whichever is earlier.

(g) The department may contract with an intermediary to establish provider contracts pursuant to this section for programs that qualify for federal funding pursuant to the Medicaid state plan or waivers and the programs authorized by Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of, and Article 1 (commencing with Section 125125) of Chapter 2 of Part 5 of Division 106 of the Health and Safety Code.

(h) In carrying out contracting activity for this or any section associated with the Medi-Cal list of contract drugs, notwithstanding Section 19130 of the Government Code, the department may contract, either directly or through the fiscal intermediary, for pharmacy consultant staff necessary to accomplish the contracting process or treatment authorization request reviews. The fiscal intermediary contract, including any contract amendment, system change pursuant to a change order, and project or systems development notice shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Chapter 7 (commencing with Section 11700) of Part 1 of Division 3 of Title 2 of the Government Code, and any policies, procedures, or regulations authorized by these provisions.

(i) In order to achieve maximum cost savings the Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Therefore contracts under this section shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(j) For purposes of implementing the contracting provisions specified in this section, the department shall do all of the following:

(1) Ensure adequate access for Medi-Cal patients to quality laboratory testing services in the geographic regions of the state where contracting occurs.

(2) Consult with the statewide association of clinical laboratories and other appropriate stakeholders on the implementation of the contracting provisions specified in this section to ensure maximum access for Medi-Cal patients consistent with the savings targets projected by the 2002–03 Budget Conference Committee for clinical laboratory services provided under the Medi-Cal program.

(3) Consider which types of laboratories are appropriate for implementing the contracting provisions specified in this section, including independent laboratories, outreach laboratory programs of hospital based laboratories, clinic laboratories, physician office laboratories, and group practice laboratories.

SEC. 47. Section 14105.86 of the Welfare and Institutions Code is amended to read:

14105.86. (a) For the purposes of this section, the following definitions apply:

(1) (A) "Average sales price" means the price reported to the Centers for Medicare and Medicaid Services by the manufacturer pursuant to Section 1847A of the federal Social Security Act (42 U.S.C. Sec. 1395w-3a).

(B) "Average manufacturer price" means the price reported to the Centers for Medicare and Medicaid Services pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8).

(2) "Blood factors" means plasma protein therapies and their recombinant analogs. Blood factors include, but are not limited to, all of the following:

(A) Coagulation factors, including:

(i) Factor VIII, nonrecombinant.

(ii) Factor VIII, porcine.

(iii) Factor VIII, recombinant.

(iv) Factor IX, nonrecombinant.

(v) Factor IX, complex.

(vi) Factor IX, recombinant.

(vii) Antithrombin III.

(viii) Anti-inhibitor factor.

(ix) Von Willebrand factor.

(x) Factor VIIa, recombinant.

(B) Immune Globulin Intravenous.

(C) Alpha-1 Proteinase Inhibitor.

(b) The reimbursement for blood factors shall be by national drug code number and shall not exceed 120 percent of the average sales price of the last quarter reported.

(c) The average sales price for blood factors of manufacturers or distributors that do not report an average sales price pursuant to subdivision (a) shall be identical to the average manufacturer price. The average sales price for new products that do not have a calculable average sales price or average manufacturer price shall be equal to a projected sales price, as reported by the manufacturer to the department. Manufacturers reporting a projected sales price for a new product shall report the first monthly average manufacturer price reported to the Centers for Medicare and Medicaid Services. The reporting of an average sales price that does not meet the requirement of this subdivision shall result in that blood factor no longer being considered a covered benefit.

(d) The average sales price shall be reported at the national drug code level to the department on a quarterly basis.

(e) (1) Effective July 1, 2008, the department shall collect a state rebate, in addition to rebates pursuant to other provisions of state or federal law, for blood factors reimbursed pursuant to this section by 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 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 and the programs authorized by Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of, and Article 1 (commencing with Section 125125) of Part 5 of Chapter 2 of Division 106 of the Health and Safety Code. The state rebate shall be negotiated as necessary between the department and the manufacturer. Manufacturers, who do not execute an agreement to pay additional rebates pursuant to this section, shall have their blood factors available only through an approved treatment or service authorization request. All blood factors that meet the definition of a covered outpatient drug pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8) shall remain a benefit subject to the utilization controls provided for in this section.

(2) In reviewing authorization requests, the department shall approve the lowest net cost product that meets the beneficiary's medical need. The review of medical need shall take into account a beneficiary's clinical history or the use of the blood factor pursuant to payment by another third party, or both.

(f) A beneficiary may obtain blood factors that require a treatment or service authorization request pursuant to subdivision (e) if the beneficiary qualifies for continuing care status. To be eligible for continuing care status, a beneficiary must be taking the blood factor and the department has reimbursed a claim for the blood factor with a date of service that is within 100 days prior to the date the blood factor was placed on treatment authorization request status. A beneficiary may remain eligible for continuing care status, provided that a claim is submitted for the blood factor 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 blood factor.

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

SEC. 48. Section 14124.11 is added to the Welfare and Institutions Code, to read:

14124.11. (a) The department shall establish a two-year pilot program to utilize the federal Public Assistance Reporting Information System (PARIS) to identify veterans and their dependents or survivors who are

enrolled in the Medi-Cal program and assist them in obtaining federal veteran health care benefits.

(b) The department shall select three consenting counties that have in operation a United States Department of Veterans Affairs (USDVA) medical center to participate in the pilot program.

(c) Under the pilot program, the department shall exchange information with PARIS and identify veterans and their dependents or survivors who are receiving Medi-Cal benefits in the pilot program counties.

(d) The department shall refer identified Medi-Cal beneficiaries who are receiving high-cost services, including long-term care, to county veteran service officers (CVSOs) to obtain information regarding, and assistance in obtaining, USDVA benefits.

(e) Prior to commencement of the pilot program, the department shall do all of the following:

(1) Enter into an agreement with the California Department of Veterans Affairs (CDVA) to perform CVSO outreach services in connection with the pilot program. The CDVA agreement shall contain performance standards that would allow the department to measure the effectiveness of the pilot program.

(2) Enter into any agreements that are required by the federal government to utilize the PARIS system.

(3) Perform any information technology activities that are necessary to utilize the PARIS system.

(f) The department shall monitor the two-year pilot program, evaluate the outcomes and savings, and provide the fiscal committees of the Legislature with a report on the findings and recommendations. If the department determines that the pilot program is cost effective, it may implement the program statewide at any time and continue operation of PARIS indefinitely.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific, this section by means of written directives without taking further regulatory action.

(h) The department shall implement the pilot program by July 1, 2009.

(i) In order to achieve maximum cost savings the Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Therefore, contracts under this section shall be exempt from the Public Contract Code and from Chapter 3 (commencing with Section 11250) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 49. Section 14126.027 of the Welfare and Institutions Code is amended to read:

14126.027. (a) (1) The Director of Health Care Services, or his or her designee, shall administer this article.

(2) The regulations and other similar instructions adopted pursuant to this article shall be developed in consultation with representatives of the long-term care industry, organized labor, seniors, and consumers.

(b) (1) The director may adopt regulations as are necessary to implement this article. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe specific facts showing the need for immediate action.

(2) The regulations adopted pursuant to this section may include, but need not be limited to, any regulations necessary for any of the following purposes:

(A) The administration of this article, including the specific analytical process for the proper determination of long-term care rates.

(B) The development of any forms necessary to obtain required cost data and other information from facilities subject to the ratesetting methodology.

(C) To provide details, definitions, formulas, and other requirements.

(c) As an alternative to the adoption of regulations pursuant to subdivision (b), and notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this article, in whole or in part, by means of a provider bulletin or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, 2010. It is the intent that regulations adopted pursuant to subdivision (b) shall be in place on or before July 31, 2010.

SEC. 50. Section 14126.033 of the Welfare and Institutions Code is amended to read:

14126.033. (a) 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 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 and 2010–11 rate years, 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.

(E) To the extent that new rates are projected to exceed the adjusted limits calculated pursuant to subparagraph (A) to (D), inclusive, as applicable, the department shall adjust the increase to each skilled nursing facility's projected rate for the applicable rate year by an equal percentage.

(b) The rate methodology shall cease to be implemented on and after July 31, 2011.

(c) (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.

(d) This section shall become inoperative on July 31, 2011, and as of January 1, 2012, is repealed, unless a later enacted statute, that is enacted before January 1, 2012, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 51. Section 14126.034 is added to the Welfare and Institutions Code, to read:

14126.034. (a) (1) The department shall convene a workgroup of interested stakeholders to make recommendations to the department to ensure compliance with the intent of this article, as provided in subdivision (a) of Section 14126.02.

(2) (A) Interested stakeholders shall include consumers or their representatives, or both, including current or former skilled nursing facility residents, and family members of current or former skilled nursing facility residents, or both, seniors or their representatives, or both, skilled nursing facility representatives, labor representatives, and people with disabilities and disability rights advocates.

(B) A stakeholder workgroup of 18 members shall be convened representing interested stakeholders from the groups listed in subparagraph (A), with six members selected from each of the following areas of interest:

(i) Consumers.

(ii) Skilled nursing facility labor.

(iii) Skilled nursing facilities.

(C) Interested stakeholders within each of the areas of interest in subparagraph (B) shall nominate and select six members within their area of interest to serve on the stakeholder workgroup to represent their interests.

(D) The stakeholder workgroup shall also include representatives from the department, the Office of the State Long-Term Care Ombudsman, the State Department of Public Health, the Office of Statewide Health Planning and Development, with members appointed by their respective directors, or their designee, and may also include legislative staff, academics, and other state department representatives, including, but not limited to, representatives from the California Department of Aging and the State Department of Developmental Services.

(b) (1) Each stakeholder workgroup meeting shall be chaired by a facilitator from an organization independent of the department and any of the stakeholder groups, to the extent that foundation funding is made available for this purpose. If no funds are made available for this purpose, the department shall facilitate the stakeholder workgroup meetings.

(2) The consumers, skilled nursing facility labor, and skilled nursing facility stakeholder workgroup members shall each select one representative who will meet with the department and the facilitator to develop meeting agendas after having solicited input from each representative's respective stakeholder group.

(3) To the extent that foundation funding is made available, stakeholder workgroup members shall receive reimbursement for any actual, necessary, and reasonable expenses incurred in connection with their duties as members of the workgroup.

(c) The department shall assign staff as needed to assist the stakeholder workgroup in carrying out its responsibilities.

(d) In developing recommendations, the stakeholder workgroup shall consider the structure of, and potential changes to, the facility-specific ratesetting system, developed pursuant to Section 14126.023, that may improve the quality of resident care. The stakeholder workgroup members may take into consideration the following factors, or any other factors deemed relevant to ensure the quality of resident care:

(1) Skilled nursing facility staffing levels, including, but not limited to, compliance with existing staffing requirements.

(2) Skilled nursing facility staff wages and benefits, including, but not limited to, geographic disparities in wages and benefits.

(3) Skilled nursing facility staff turnover and retention.

(4) Deficiency reports issued as a result of both surveys and complaint investigations, to the extent that they may be disclosed as public records, and the enforcement actions taken under federal certification and state licensing laws and regulations.

(5) Skilled nursing facility compliance with assessments required to ascertain residents' preference for, and ability to return to, the community as required by Section 1418.81 of the Health and Safety Code, including necessary follow through to assure care necessary for a resident to transition out of skilled nursing facility care and into the community.

(6) The extent to which this article encourages compliance with the United States Supreme Court decision in Olmstead v. L.C. ex rel. Zimring (1999) 527 U.S. 581, including using the ratesetting system to increase Olmstead compliance.

(7) Health care efficiency.

(8) Health care safety.

(9) The extent to which a pay-for-performance program may contribute to improving the quality of resident care and appropriate performance measures for a pay-for-performance program.

(10) Preventable emergency room visits and rehospitalizations.

(11) Resident and family satisfaction with care and resident's quality of life, including improvements on ways to measure satisfaction.

(12) Recommendations for methods to evaluate the effectiveness of the facility-specific ratesetting system, defined in Section 14126.023, in meeting the intent of this article, pursuant to Section 14126.02.

(13) Additional quality measures, included, but not limited to, adequate nutrition and ready availability of durable medical equipment.

(e) The department shall convene the stakeholder workgroup no later than one month following the effective date of this section. The stakeholder workgroup shall meet a minimum of six times through December 31, 2008. Subcommittees may be convened and meet as necessary.

(f) In addition to recommendations provided during stakeholder workgroup meetings, individual members of the stakeholder workgroup and any other interested stakeholders may provide to the department any additional written recommendations on the items considered in the stakeholder workgroup meetings.

(g) The department shall provide technical assistance to the stakeholder workgroup to evaluate the feasibility of its recommendations so that the stakeholder workgroup will have the benefit of the department's analysis when discussing and reviewing proposed recommendations.

(h) The department shall review and analyze all recommendations from the stakeholder workgroup, individual workgroup members, and any other interested stakeholders, and, no later than March 1, 2009, the department shall deliver to the Legislature, both of the following:

(1) The complete recommendations of the stakeholder workgroup, individual workgroup members, and any other interested stakeholders.

(2) The department's analysis of the feasibility to implement the proposed recommendations.

(i) (1) The stakeholder workgroup may continue to meet to carry out its responsibilities pursuant to subdivision (d) for an extension period of up to one year. During this extension period, the stakeholder workgroup shall meet at least quarterly as agreed by the department and those members selected pursuant to paragraph (2) of subdivision (a).

(2) During the extension period the stakeholder workgroup's activities may include assisting the department or Legislature, or both, to enact improvements to the ratesetting system.

(j) The department shall seek partnership with one or more independent, nonprofit groups or foundations, academic institutions, or governmental entities providing grants for health-related activities, to support stakeholder workgroup efforts.

(k) The department shall seek necessary legislative changes to implement the stakeholder workgroup's recommendations that the department determines are feasible to implement as part of the reauthorization of this section.

(*l*) The department may meet the intent of this article, as stated in subdivision (a) of Section 14126.02, by using the stakeholder workgroup's recommendations in order to design an evaluation of the effectiveness of the facility-specific ratesetting system established pursuant to Section 14126.023.

(m) Implementation and administration of this section is not dependent on the availability of foundation funding.

SEC. 52. Section 14154 of the Welfare and Institutions Code is amended to read:

14154. (a) 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. 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), Food Stamp, 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.

(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 fiscal year.

(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 of 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 (c), 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. 53. Section 14154.5 of the Welfare and Institutions Code is amended to read:

14154.5. (a) Each county shall work, on a routine basis, any error alert from the department's Medi-Cal Eligibility Data System (MEDS). Any alert that affects eligibility or the share of cost that is received by the 10th working day of the month shall be processed in time for the change to be effective the beginning of the following month. Any alert that affects eligibility or the share of cost that is received after the 10th working day of the month shall be processed in time for the change to be effective the beginning of the month after the following month. The department shall consult with the County Welfare Directors Association to define those alerts that affect eligibility or the share of cost.

(b) The county shall submit reconciliation files of its Medi-Cal eligible population to the department every three months, based upon a schedule determined by the department and in a format prescribed by the department, to identify any discrepancies between eligibility files in the county records and eligibility as reflected in MEDS. Counties shall be notified of any changes to the standard format for submitting reconciliation files sufficiently in advance to allow for budgeting, scheduling, development, testing, and implementation of any required change in county automated eligibility systems.

(c) For those records that are on the county's files, but not on MEDS, the county shall receive worker alerts from the department that identify these cases, and the county shall fix any data discrepancies. Any worker alert received by the 10th working day of the month shall be processed in time for the change to be effective the beginning of the following month. Any worker alert received after the 10th working day of the month shall be processed in time for the change to be effective the beginning of the month after the following month.

(d) In regard to any record that is on MEDS but not on the county's file, the county shall either correct the county record or MEDS, whichever is appropriate, within the same timeframes specified in subdivision (c).

(e) The department shall terminate a MEDS eligible record if the person is not eligible on the county's file when there has been no eligibility update on the MEDS record for six months.

(f) (1) If the department finds that a county is not performing all of the following activities, the county shall, within 60 days, submit a corrective action plan to the department for approval.

(A) Conducting reconciliations as required in subdivision (b).

(B) Processing 95 percent of worker alerts referred to in subdivisions (c) and (d), within the timeframes specified.

(C) Processing 90 percent of the error alerts referred to in subdivision (a) that affect eligibility or the share of cost, within the timeframes specified.

(2) The corrective action plan shall, at a minimum, include steps that the county shall take to improve its performance on the requirements 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 sanctions.

(g) (1) If the county does not meet the interim benchmarks for improvement standards, the department may, in 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.

(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.

(h) The department, in consultation with the County Welfare Directors Association, shall investigate features that could be installed in MEDS to reduce the number of alerts and streamline the reconciliation process.

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

SEC. 54. Section 14166.9 of the Welfare and Institutions Code is amended to read:

14166.9. (a) The department, in consultation with the designated public hospitals, shall determine the mix of sources of federal funds for payments to the designated public hospitals in a manner that provides baseline funding to hospitals and maximizes federal Medicaid funding to the state during the term of the demonstration project. Federal funds shall be claimed according to the following priorities:

(1) The certified public expenditures of the designated public hospitals for inpatient hospital services and physician and nonphysician practitioner services, as identified in subdivision (e) of Section 14166.4, rendered to Medi-Cal beneficiaries.

(2) Federal disproportionate share hospital allotment, subject to the federal-hospital specific limit, in the following order:

(A) Those hospital expenditures that are eligible for federal financial participation only from the federal disproportionate share hospital allotment.

(B) Payments funded with intergovernmental transfers, consistent with the requirements of the demonstration project, up to the hospital's baseline funding amount or adjusted baseline funding amount, as appropriate, for the project year.

(C) Any other certified public expenditures for hospital services that are eligible for federal financial participation from the federal disproportionate share hospital allotment.

(3) Safety net care pool funds, using the optimal combination of hospital certified public expenditures and certified public expenditures of a hospital, or governmental entity with which the hospital is affiliated, that operates nonhospital clinics or provides physician, nonphysician practitioner, or other health care services that are not identified as hospital services under the Special Terms and Conditions for the demonstration project, except that certified public expenditures reported by the County of Los Angeles or its designated public hospitals shall be the exclusive source of certified public expenditures for claiming those federal funds deposited in the South Los Angeles Medical Services Preservation Fund under Section 14166.25.

(4) Health care expenditures of the state that represent alternate state funding mechanisms approved by the federal Centers for Medicare and Medicaid Services under the demonstration project as set forth in Section 14166.22.

(b) The department shall implement these priorities, to the extent possible, in a manner that minimizes the redistribution of federal funds that are based on the certified public expenditures of the designated public hospitals.

(c) The department may adjust the claiming priorities to the extent that these adjustments result in additional federal Medicaid funding during the term of the demonstration project or facilitate the objectives of subdivision (b).

(d) There is hereby established in the State Treasury the "Demonstration Disproportionate Share Hospital Fund." All federal funds received by the department with respect to the certified public expenditures claimed pursuant to subparagraphs (A) and (C) of paragraph (2) of subdivision (a) shall be transferred to the fund. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department solely for the purposes specified in Section 14166.6.

(e) (1) Except as provided in Section 14166.25, all federal safety net care pool funds claimed and received by the department based on health care expenditures incurred by the designated public hospitals, or other

governmental entities, shall be transferred to the Health Care Support Fund, established pursuant to Section 14166.21.

(2) The department shall separately identify and account for federal safety net care pool funds claimed and received by the department under the health care coverage initiative program authorized under Part 3.5 (commencing with Section 15900) and under paragraphs 43 and 44 of the Special Terms and Conditions for the demonstration project.

(3) With respect to those funds identified under paragraph (2), the department shall separately identify and account for federal safety net care pool funds claimed and received for inpatient hospital services rendered under the health care coverage initiative, including services rendered to enrollees of a managed care organization, by designated public hospitals, nondesignated public hospitals, and project year private DSH hospitals.

SEC. 55. Section 14166.12 of the Welfare and Institutions Code is amended to read:

14166.12. (a) The California Medical Assistance Commission shall negotiate payment amounts, in accordance with the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081), from the Private Hospital Supplemental Fund established pursuant to subdivision (b) for distribution to private hospitals that satisfy the criteria of Section 14085.6, 14085.7, 14085.8, or 14085.9.

(b) The Private Hospital Supplemental Fund is hereby established in the State Treasury. For purposes of this section, "fund" means the Private Hospital Supplemental Fund.

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

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

(1) One hundred eighteen million four hundred thousand dollars ($118,400,000), which shall be transferred annually from General Fund amounts appropriated in the annual Budget Act for the Medi-Cal program, except that for the 2008–09 fiscal year, this amount shall be reduced by thirteen million six hundred thousand dollars ($13,600,000) and by an amount equal to one-half of the difference between eighteen million three hundred thousand dollars ($18,300,000) and the amount of any reduction in the additional payments for distressed hospitals calculated pursuant to subparagraph (B) of paragraph (3) of subdivision (b) of Section 14166.20.

(2) Any additional moneys appropriated to the fund.

(3) All stabilization funding transferred to the fund pursuant to paragraph (2) of subdivision (a) of Section 14166.14.

(4) Any moneys that any county, other political subdivision of the state, or other governmental entity in the state may elect to transfer to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

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

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

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

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

(g) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section.

(h) Any funds remaining in the fund at the end of a fiscal year shall be carried forward for use in the following fiscal year.

(i) Moneys shall be allocated from the fund by the department and shall be applied to obtain federal financial participation in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section. Distributions from the fund shall be supplemental to any other Medi-Cal reimbursement received by the hospitals, including amounts that hospitals receive under the selective provider contracting program (Article 2.6 (commencing with Section 14081)), and shall not affect provider rates paid under the selective provider contracting program.

(j) Each private hospital that was a private hospital during the 2002–03 fiscal year, received payments for the 2002–03 fiscal year from any of the prior supplemental funds, and, during the project year, satisfies the criteria in Section 14085.6, 14085.7, 14085.8, or 14085.9 to be eligible to negotiate for distributions under any of those sections, shall receive no less from the Private Hospital Supplemental Fund for the project year than 100 percent of the amount the hospital received from the prior supplemental funds for the 2002–03 fiscal year. Each private hospital described in this subdivision shall be eligible for additional payments from the fund pursuant to subdivision (k).

(k) All amounts that are in the fund for a project year in excess of the amount necessary to make the payments under subdivision (j) shall be available for negotiation by the California Medical Assistance Commission, along with corresponding federal financial participation, for supplemental

payments to private hospitals, which for the project year satisfy the criteria under Section 14085.6, 14085.7, 14085.8, or 14085.9 to be eligible to negotiate for distributions under any of those sections, and paid for services rendered during the project year pursuant to the selective provider contracting program established under Article 2.6 (commencing with Section 14081).

(*l*) The amount of any stabilization funding transferred to the fund, or the amount of intergovernmental transfers deposited to the fund pursuant to subdivision (o), together with the associated federal reimbursement, with respect to a particular project year, may, in the discretion of the California Medical Assistance Commission, be paid for services furnished in the same project year regardless of when the stabilization funds or intergovernmental transfer funds, and the associated federal reimbursement, become available, provided the payment is consistent with other applicable federal or state law requirements and does not result in a hospital exceeding any applicable reimbursement limitations.

(m) The department shall pay amounts due to a private hospital from the fund for a project year, with the exception of stabilization funding, in up to four installment payments, unless otherwise provided in the hospital's contract negotiated with the California Medical Assistance Commission, except that hospitals that are not described in subdivision (j) shall not receive the first installment payment. The first payment shall be made as soon as practicable after the issuance of the tentative disproportionate share hospital list for the project year, and in no event later than January 1 of the project year. The second and subsequent payments shall be made after the issuance of the final disproportionate hospital list for the project year, and shall be made only to hospitals that are on the final disproportionate share hospital list for the project year. The second payment shall be made by February 1 of the project year or as soon as practicable after the issuance of the final disproportionate share hospital list for the project year. The third payment, if scheduled, shall be made by April 1 of the project year. The fourth payment, if scheduled, shall be made by June 30 of the project year. This subdivision does not apply to hospitals that are scheduled to receive payments from the fund because they meet the criteria under Section 14085.7 and do not meet the criteria under Section 14085.6, 14085.8, or 14085.9, which shall be paid in accordance with the applicable contract or contract amendment negotiated by the California Medical Assistance Commission.

(n) The department shall pay stabilization funding transferred to the fund in amounts negotiated by the California Medical Assistance Commission and shall pay the scheduled payments in accordance with the applicable contract or contract amendment.

(o) Payments to private hospitals that are eligible to receive payments pursuant to Section 14085.6, 14085.7, 14085.8, or 14085.9 may be made using funds transferred from governmental entities to the state, at the option of the governmental entity. Any payments funded by intergovernmental transfers shall remain with the private hospital and shall not be transferred back to any unit of government. An amount equal to 25 percent of the amount of any intergovernmental transfer made in the project year that results in a

supplemental payment made for the same project year to a project year private DSH hospital designated by the governmental entity that made the intergovernmental transfer shall be deposited in the fund for distribution as determined by the California Medical Assistance Commission. An amount equal to 75 percent shall be deposited in the fund and distributed to the private hospitals designated by the governmental entity.

(p) A private hospital that receives payment pursuant to this section for a particular project year shall not submit a notice for the termination of its participation in the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081) until the later of the following dates:

(1) On or after December 31 of the next project year.

(2) The date specified in the hospital's contract, if applicable.

(q) (1) For the 2007–08, 2008–09, and 2009–10 project years, the County of Los Angeles shall make intergovernmental transfers to the state to fund the nonfederal share of increased Medi-Cal payments to those private hospitals that serve the South Los Angeles population formerly served by Los Angeles County Martin Luther King, Jr.-Harbor Hospital. The intergovernmental transfers required under this subdivision shall be funded by county tax revenues and shall total five million dollars ($5,000,000) per project year, except that, in the event that the director determines that any amount is due to the County of Los Angeles under the demonstration project for services rendered during the portion of a project year during which Los Angeles County Martin Luther King, Jr.-Harbor Hospital was operational, the amount of intergovernmental transfers required under this subdivision shall be reduced by a percentage determined by reducing 100 percent by the percentage reduction in Los Angeles County Martin Luther King, Jr.-Harbor Hospital's baseline, as determined under subdivision (c) of Section 14166.5 for that project year.

(2) Notwithstanding subdivision (o), an amount equal to 100 percent of the county's intergovernmental transfers under this subdivision shall be deposited in the fund and, within 30 days after receipt of the intergovernmental transfer, shall be distributed, together with related federal financial participation, to the private hospitals designated by the county in the amounts designated by the county. The director shall disregard amounts received pursuant to this subdivision in calculating the OBRA 1993 payment limitation, as defined in paragraph (24) of subdivision (a) of Section 14105.98, for purposes of determining the amount of disproportionate share hospital replacement payments due a private hospital under Section 14166.11.

SEC. 56. Section 14166.20 of the Welfare and Institutions Code is amended to read:

14166.20. (a) With respect to each project year, the total amount of stabilization funding shall be the sum of the following:

(1) (A) Federal Medicaid funds available in the Health Care Support Fund, established pursuant to Section 14166.21, reduced by the amount necessary to meet the baseline funding amount, or the adjusted baseline

funding amount, as appropriate, for project years after the 2005–06 project year for each designated public hospital, project year private DSH hospitals in the aggregate, and nondesignated public hospitals in the aggregate as determined in Sections 14166.5, 14166.13, and 14166.18, respectively, taking into account all other payments to each hospital under this article. This amount shall be not less than zero.

(B) For purposes of subparagraph (A), federal Medicaid funds available in the Health Care Support Fund shall not include health care coverage initiative amounts identified under paragraph (2) of subdivision (e) of Section 14166.9.

(2) The state general funds that were made available due to the receipt of federal funding for previously state-funded programs through the safety net care pool and any federal Medicaid hospital reimbursements resulting from these expenditures, unless otherwise recognized under paragraph (1), to the extent those funds are in excess of the amount necessary to meet the baseline funding amount, or the adjusted baseline funding amount, as appropriate, for project years after the 2005–06 project year for each designated public hospital, for project year private DSH hospitals in the aggregate, and for nondesignated public hospitals in the aggregate, as determined in Sections 14166.5, 14166.13, and 14166.18, respectively.

(3) To the extent not included in paragraph (1) or (2), the amount of the increase in state General Fund expenditures for Medi-Cal inpatient hospital services for the project year for project year private DSH hospitals and nondesignated public hospitals, including amounts expended in accordance with paragraph (1) of subdivision (c) of Section 14166.23, that exceeds the expenditure amount for the same purpose and the same hospitals necessary to provide the aggregate baseline funding amounts applicable to the project determined pursuant to Sections 14166.13 and 14166.18, and any direct grants to designated public hospitals for services under the demonstration project.

(4) To the extent not included in paragraph (2), federal Medicaid funds received by the state as a result of the General Fund expenditures described in paragraph (3).

(5) The federal Medicaid funds received by the state as a result of federal financial participation with respect to Medi-Cal payments for inpatient hospital services made to project year private DSH hospitals and to nondesignated public hospitals for services rendered during the project year, the state share of which was derived from intergovernmental transfers or certified public expenditures of any public entity that does not own or operate a public hospital.

(6) Federal safety net care pool funds claimed and received for inpatient hospital services rendered under the health care coverage initiative identified under paragraph (3) of subdivision (e) of Section 14166.9.

(b) With respect to the 2005–06, 2006–07, and subsequent project years, the stabilization funding determined under subdivision (a) shall be allocated as follows:

(1) Eight million dollars ($8,000,000) shall be paid to San Mateo Medical Center. All or a portion of this amount may be paid as disproportionate share hospital payments in addition to the hospital's allocation that would otherwise be determined under Section 14166.6. The amount provided for in this paragraph shall be disregarded in the application of the limitations described in paragraph (3) of subdivision (a) of Section 14166.6, and in paragraph (1) of subdivision (a) of Section 14166.7.

(2) (A) Ninety-six million two hundred twenty-eight thousand dollars ($96,228,000) shall be allocated to designated public hospitals to be paid in accordance with Section 14166.75.

(B) Forty-two million two hundred twenty-eight thousand dollars ($42,228,000) shall be allocated to private DSH hospitals to be paid in accordance with Section 14166.14.

(C) Five hundred forty-four thousand dollars ($544,000) shall be allocated to nondesignated public hospitals to be paid in accordance with Section 14166.17.

(D) In the event that stabilization funding is less than one hundred forty-seven million dollars ($147,000,000), the amounts allocated to designated public hospitals, private DSH hospitals, and nondesignated public hospitals under this paragraph shall be reduced proportionately.

(3) (A) An amount equal to the lesser of 10 percent of the total amount determined under subdivision (a) or twenty-three million five hundred thousand dollars ($23,500,000), but at least fifteen million three hundred thousand dollars ($15,300,000), shall be made available for additional payments to distressed hospitals that participate in the selective provider contracting program under Article 2.6 (commencing with Section 14081), including designated public hospitals, in amounts to be determined by the California Medical Assistance Commission. The additional payments to designated public hospitals shall be negotiated by the California Medical Assistance Commission, but shall be paid by the department in the form of a direct grant rather than as Medi-Cal payments.

(B) Notwithstanding subparagraph (A) and solely for the 2006–07 fiscal year, if the amount that otherwise would be made available for additional payments to distressed hospitals under subparagraph (A) is equal to or greater than eighteen million three hundred thousand dollars ($18,300,000), that amount shall be reduced by eighteen million three hundred thousand dollars ($18,300,000) and the state's obligation to make these payments shall be reduced by this amount. In the event the amount that otherwise would be made available under subparagraph (A) is less than eighteen million three hundred thousand dollars ($18,300,000), but greater than or equal to the minimum amount of fifteen million three hundred thousand dollars ($15,300,000), then the amount available under this paragraph shall be zero and the state's obligation to make these payments shall be zero.

(4) An amount equal to 0.64 percent of the total amount determined under subdivision (a), to nondesignated public hospitals to be paid in accordance with Section 14166.19.

(5) The amount remaining after subtracting the amount determined in paragraphs (1) and (2), subparagraph (A) of paragraph (3), and paragraph (4), without taking into account subparagraph (B) of paragraph (3), shall be allocated as follows:

(A) Sixty percent to designated public hospitals to be paid in accordance with Section 14166.75.

(B) Forty percent to project year private DSH hospitals to be paid in accordance with Section 14166.14.

(c) By April 1 of the year following the project year for which the payment is made, and after taking into account final amounts otherwise paid or payable to hospitals under this article, the director shall calculate in accordance with subdivision (a), allocate in accordance with subdivision (b), and pay to hospitals in accordance with Sections 14166.75, 14166.14, and 14166.19, as applicable, the stabilization funding.

(d) For purposes of determining amounts paid or payable to hospitals under subdivision (c), the department shall apply the following:

(1) In determining amounts paid or payable to designated public hospitals that are based on allowable costs incurred by the hospital, or the governmental entity with which it is affiliated, the following shall apply:

(A) If the final payment amount is based on the hospital's Medicare cost report, the department shall rely on the cost report filed with the Medicare fiscal intermediary for the project year for which the calculation is made, reduced by a percentage that represents the average percentage change from total reported costs to final costs for the three most recent cost reporting periods for which final determinations have been made, taking into account all administrative and judicial appeals. Protested amounts shall not be considered in determining the average percentage change unless the same or similar costs are included in the project year cost report.

(B) If the final payment amount is based on costs not included in subparagraph (A), the reported costs as of the date the determination is made under subdivision (c), shall be reduced by 10 percent.

(C) In addition to adjustments required in subparagraphs (A) and (B), the department shall adjust amounts paid or payable to designated public hospitals by any applicable deferrals or disallowances identified by the federal Centers for Medicare and Medicaid Services as of the date the determination is made under subdivision (c) not otherwise reflected in subparagraphs (A) and (B).

(2) Amounts paid or payable to project year private DSH hospitals and nondesignated public hospitals shall be determined by the most recently available Medi-Cal paid claims data increased by a percentage to reflect an estimate of amounts remaining unpaid.

(e) The department shall consult with hospital representatives regarding the appropriate calculation of stabilization funding before stabilization funds are paid to hospitals. The calculation may be comprised of multiple steps involving interim computations and assumptions as may be necessary to determine the total amount of stabilization funding under subdivision (a) and the allocations under subdivision (b). No later than 30 days after this

consultation, the department shall establish a final determination of stabilization funding that shall not be modified for any reason other than mathematical errors or mathematical omissions on the part of the department.

(f) The department shall distribute 75 percent of the estimated stabilization funding on an interim basis throughout the project year.

(g) The allocation and payment of stabilization funding shall not reduce the amount otherwise paid or payable to a hospital under this article or any other provision of law, unless the reduction is required by the demonstration project's Special Terms and Conditions or by federal law.

(h) It is the intent of the Legislature that the amendments made to Sections 14166.12 and to this section by the act that added this subdivision in the 2007–08 Regular Session shall not be construed to amend or otherwise alter the ongoing structure of the department's Medicaid Demonstration Project and Waiver approved by the federal Centers for Medicare and Medicaid Services to begin on September 1, 2005.

SEC. 57. Section 14166.245 of the Welfare and Institutions Code is amended to read:

14166.245. (a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California.

(b) (1) Notwithstanding any other provision of law, except as provided in Article 2.93 (commencing with Section 14091.3), for hospitals that receive Medi-Cal reimbursement from the State Department of Health Care Services and that are not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9, the amounts paid as interim payments for inpatient hospital services provided on and after July 1, 2008, shall be reduced by 10 percent.

(2) (A) Beginning on October 1, 2008, amounts paid that are calculated pursuant to paragraph (1) shall not exceed the applicable regional average per diem contract rate for tertiary hospitals and for all other hospitals established as specified in subparagraph (C), reduced by 5 percent, multiplied by the number of Medi-Cal covered inpatient days for which the interim payment is being made.

(B) This paragraph shall not apply to small and rural hospitals specified in Section 124840 of the Health and Safety Code, or to hospitals in open health facility planning areas that were open health facility planning areas on October 1, 2008, unless either of the following apply:

(i) The open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area as determined by the California Medical Assistance Commission.

(ii) The open health facility planning area has three or more hospitals with licensed general acute care beds.

(C) (i) For purposes of this subdivision and subdivision (c), the average regional per diem contract rates shall be derived from unweighted average

contract per diem rates that are publicly available on June 1 of each year, trended forward based on the trends in the California Medical Assistance Commission's Annual Report to the Legislature. For tertiary hospitals, and for all other hospitals, the regional average per diem contract rates shall be based on the geographic regions in the California Medical Assistance Commission's Annual Report to the Legislature. The applicable average regional per diem contract rates for tertiary hospitals and for all other hospitals shall be published by the department on or before October 1, 2008, and these rates shall be updated annually for each state fiscal year and shall become effective each July 1, thereafter. Supplemental payments shall not be included in this calculation.

(ii) For purposes of clause (i), both the federal and nonfederal share of the designated public hospital cost-based rates shall be included in the determination of the average contract rates by multiplying the hospital's interim rate, established pursuant to Section 14166.4 and that is in effect on June 1 of each year, by two.

(iii) For the purposes of this section, a tertiary hospital is a children's hospital specified in Section 10727, or a hospital that has been designated as a Level I or Level II trauma center by the Emergency Medical Services Authority established pursuant to Section 1797.1 of the Health and Safety Code.

(D) For purposes of this section, the terms "open health facility planning area" and "closed health facility planning area" shall have the same meaning and be applied in the same manner as used by the California Medical Assistance Commission in the implementation of the hospital contracting program authorized in Article 2.6 (commencing with Section 14081).

(c) (1) Notwithstanding any other provision of law, for hospitals that receive Medi-Cal reimbursement from the State Department of Health Care Services and that are not under contract with the State Department of Health Care Services, pursuant to Article 2.6 (commencing with Section 14081), the reimbursement amount paid by the department for inpatient services provided to Medi-Cal recipients for dates of service on and after July 1, 2008, shall not exceed the amount determined pursuant to paragraph (3).

(2) For purposes of this subdivision, the reimbursement for inpatient services includes the amounts paid for all categories of inpatient services allowable by Medi-Cal. The reimbursement includes the amounts paid for routine services, together with all related ancillary services.

(3) When calculating a hospital's cost report settlement for a hospital's fiscal period that includes any dates of service on and after July 1, 2008, the settlement for dates of service on and after July 1, 2008, shall be limited to the lesser of the following:

(A) Ninety percent of the hospital's audited allowable cost per day for those services multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year on or after July 1, 2008.

(B) Beginning for dates of service on and after October 1, 2008, the applicable average regional per diem contract rate established as specified in subparagraph (A) of paragraph (2) of subdivision (b), reduced by 5

percent, multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year, or portion thereof. This subparagraph shall not apply to small and rural hospitals specified in Section 124840 of the Health and Safety Code, or to hospitals in open health facility planning areas that were open health facility planning areas on July 1, 2008, unless either of the following apply:

(i) The open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area as determined by the California Medical Assistance Commission.

(ii) The open health facility planning area has more than three hospitals with licensed general acute care beds.

(d) Except as provided in Article 2.93 (commencing with Section 14091.3), hospitals that participate in the Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081) and designated public hospitals under Section 14166.1, except Los Angeles County Martin Luther King, Jr./Charles R. Drew Medical Center and Tuolumne General Hospital, shall be exempt from the limitations required by this section.

(e) 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 director may implement and administer this section by means of provider bulletins, or other similar instructions, without taking regulatory action.

(f) The director shall promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan.

(g) Notwithstanding any other provision of this section, small and rural hospitals, as defined in Section 124840 of the Health and Safety Code, shall be exempt from the payment reductions set forth in this section for dates of service on and after November 1, 2008.

(h) For hospitals that are subject to clauses (i) and (ii) of subparagraph (B) of paragraph (2) of subdivision (b) and that choose to contract pursuant to Article 2.6 (commencing with Section 14081), the California Medical Assistance Commission shall negotiate rates taking into account factors specified in Section 14083.

(i) (1) In January 2010 and in January 2011, the department and the California Medical Assistance Commission shall submit a written report to the policy and fiscal committees of the Legislature on the implementation and impact of the changes made by this section, including, but not limited to, the impact of those changes on the number of hospitals that are contract and noncontract, patient access, and cost savings to the state.

(2) On or before January 1, 2012, the department, in consultation with the California Medical Assistance Commission, shall report on the implementation of this section. The report shall include, but not be limited to, information and analyses addressing patient access, capacity and needs within the health facility planning area, reimbursement of hospital costs, changes in the number of open and closed health facility planning areas,

the impact of this section on the extent of hospital contracting, and fiscal impact on the state.

(j) 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. 58. Section 14166.245 is added to the Welfare and Institutions Code, to read:

14166.245. (a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California.

(b) Notwithstanding any other provision of law, for acute care hospitals not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9, the amounts paid as interim payments for inpatient hospital services provided on and after July 1, 2008, shall be reduced by 10 percent.

(c) (1) Notwithstanding any other provision of law, for acute care hospitals not under contract with the State Department of Health Care Services, the reimbursement amount for inpatient services provided to Medi-Cal recipients for dates of service on and after July 1, 2008, shall not exceed the amount determined pursuant to paragraph (3).

(2) For purposes of this subdivision, the reimbursement for inpatient services includes the amounts paid for all categories of inpatient services allowable by Medi-Cal. The reimbursement includes the amounts paid for routine services, together with all related ancillary services.

(3) When calculating a hospital's cost report settlement for a hospital's fiscal period that includes any dates of service on and after July 1, 2008, the settlement for dates of service on and after July 1, 2008, shall be limited to 90 percent of the hospital's audited allowable cost per day for those services multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year on or after July 1, 2008.

(d) Hospitals that participate in the Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081) and designated public hospitals under Section 14166.1, except Los Angeles County Martin Luther King, Jr./Charles R. Drew Medical Center and Tuolumne General Hospital, shall be exempt from the 10 percent reduction required by this section.

(e) 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 director may implement subdivision (b) by means of a provider bulletin, or other similar instruction, without taking regulatory action.

(f) The director shall promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan.

(g) This section shall become operative on January 1, 2013.

SEC. 59. Section 14166.25 of the Welfare and Institutions Code is amended to read:

14166.25. (a) The Legislature finds and declares all of the following:

(1) In light of the closure of Los Angeles County Martin Luther King, Jr.-Harbor Hospital, there is a need to ensure adequate funding for continued health care services to the uninsured population of South Los Angeles, including, but not limited to, the Cities of Compton, Lynwood, South Gate, Huntington Park, the southern and central portions of the Cities of Los Angeles, Inglewood, Gardena, and surrounding unincorporated communities.

(2) The state, the County of Los Angeles, and all health care providers in the South Los Angeles community must work together to meet the health care needs of the community until the critical hospital services previously provided by Los Angeles County Martin Luther King, Jr.-Harbor Hospital can be restored at this location.

(3) The Medi-Cal Hospital/Uninsured Care Demonstration Project provides a critical source of funding for services to low-income communities throughout the state that are provided by California's safety net hospital systems.

(4) The special funding provided in this section is predicated on the express intent of the County of Los Angeles to restore hospital services on the hospital campus, to be operated by either a private or public entity. The county has undertaken a specific plan to do so as quickly as possible.

(5) The Legislature anticipates that demonstration project funds will be available to help fund the reopened hospital. The nature and amount of that funding cannot be determined until the new structure and operation of the hospital is known.

(6) As an interim response to the specific circumstances caused by the closure of this hospital, and until hospital services can be restored at this location, a special fund will be created to receive demonstration project funding to be available to the County of Los Angeles for expenditures to preserve health care services for the uninsured population of South Los Angeles, as defined above.

(b) The South Los Angeles Medical Services Preservation Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department for the purposes specified in this section.

(c) Subject to the conditions in this section, a maximum amount of one hundred million dollars ($100,000,000) of the safety net care pool funds claimed and received by the state that are based on the certified public expenditures of the County of Los Angeles or its designated public hospitals shall be transferred to the South Los Angeles Medical Services Preservation Fund for each of the three project years, 2007–08, 2008–09, and 2009–10.

(1) In the event that the director determines that any amount is due to the County of Los Angeles under the demonstration project for services rendered during the portion of a project year during which Los Angeles County Martin Luther King, Jr.-Harbor Hospital was operational, the amount

deposited in the fund under this subdivision shall be reduced by a percentage determined by reducing 100 percent by the percentage reduction in the hospital's baseline as determined under subdivision (c) of Section 14166.5 for that project year.

(2) If in the aggregate, the federal medical assistance percentage of the certified public expenditures reported by the County of Los Angeles and its designated public hospitals under Section 14166.8, excluding those certified public expenditures reported under paragraph (1) of subdivision (b) of Section 14166.8, in any project year do not exceed the amounts paid or payable to the county and its designated public hospitals in the aggregate under Section 14166.6, excluding disproportionate share payments funded with intergovernmental transfers, Section 14166.7, and subdivision (d) for the same project year, then the amount deposited in the fund under subdivision (c) shall be reduced by the amount of excess payments over the federal medical assistance percentage of certified public expenditures.

(d) Moneys in the South Los Angeles Medical Services Preservation Fund shall be distributed to the County of Los Angeles in amounts equal to the costs incurred by the county, including indirect costs associated with adequately maintaining the hospital building so that it can be reopened, in providing, or compensating other providers for, health services rendered to the uninsured population of South Los Angeles, including all of the following:

(1) Services provided in the multiservice ambulatory care center operating on the former Los Angeles County Martin Luther King, Jr.-Harbor Hospital campus.

(2) Services rendered to patients in beds at other designated public hospitals operated by the County of Los Angeles that have been opened specifically for the purpose of serving patients that would have been served by the former Los Angeles County Martin Luther King, Jr.-Harbor Hospital.

(3) Services rendered in the county operated health center and the comprehensive health center formerly operated under Los Angeles County Martin Luther King, Jr.-Harbor Hospital.

(4) Services rendered to the uninsured by other public or private health care providers for which the County of Los Angeles has agreed to pay under a contract with the provider as a result of the downsizing or closure of Los Angeles County Martin Luther King, Jr.-Harbor Hospital.

(e) As a condition for receiving distributions from the South Los Angeles Medical Services Preservation Fund in any project year, the County of Los Angeles shall assure the director that it will not reduce the county's ongoing, systemwide financial contribution to the county department of health services during that project year for health care services to the uninsured.

(f) No funds shall be available from the South Los Angeles Medical Services Preservation Fund for services rendered when a hospital on the former Los Angeles County Martin Luther King, Jr.-Harbor Hospital campus is certified for Medi-Cal participation.

(g) If the full amount of the South Los Angeles Medical Services Preservation Fund for any project year is not distributed to the County of

Los Angeles, based on the cost of services identified in subdivision (d) that were rendered during that project year, any remaining amounts shall revert to the Health Care Support Fund established pursuant to Section 14166.21.

(h) To the extent that the County of Los Angeles receives distributions from the South Los Angeles Medical Services Preservation Fund based on the cost of services rendered by county operated providers, or based on payments made to private providers for services rendered to the uninsured population of South Los Angeles, the costs of the services rendered shall not be considered for purposes of any of the following determinations with respect to either the county or the private provider:

(1) Medi-Cal payments under the selective provider contracting program under Article 2.6 (commencing with Section 14081), including payments to distressed hospitals under Section 14166.23.

(2) Baseline amounts, or adjustments thereto, under Section 14166.5, 14166.13, or 14166.18.

(3) Any other payment under Medi-Cal or other health care program.

(i) This section shall be implemented only to the extent that the director determines that it will not result in the loss of federal funds under the demonstration project.

SEC. 60. Article 6.6 (commencing with Section 14199) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 6.6. HIV/AIDS Pharmacy Pilot Program

14199. The department shall continue the pilot program established on September 1, 2004, for the purpose of evaluating the provision of medication therapy management services for people with HIV/AIDS. The continuation of this program shall be effective July 1, 2008, for services rendered on or after that date.

14199.1. For purposes of this article, "medication therapy management" means a distinct service or group of services that optimize therapeutic outcomes for individual patients. Medication therapy management services are independent of, but can occur in conjunction with, the provision of a medication product.

14199.2. (a) The pilot program provided for under this article shall provide the necessary information to assess the effectiveness of pharmacist care in improving health outcomes for HIV/AIDS patients. If the department determines that the pilot program has shown that HIV/AIDS-related medication therapy management service is effective at improving the health outcomes of HIV/AIDS patients and is cost effective, then the department may seek federal authorization, through a state plan amendment or Medicaid waiver application, to receive federal financial participation for this service.

(b) The department shall implement an HIV/AIDS-related medication therapy management service pilot project in no more than 10 pharmacies.

(c) The selection of the pharmacy providers shall be based on all of the following:

(1) Percentage of HIV/AIDS patients serviced by the pharmacy. More than 90 percent of the total patients serviced by the pharmacy in the months of May, June, and July 2004, must have been HIV/AIDS patients.

(2) Ability of the pharmacy to immediately provide specialized services. The provider shall be required to establish specialized services with capability to implement all statutorily mandated services on the implementation date of the project. The pharmacy shall provide all the services listed in subdivision (e).

(3) All specialized services shall be rendered by a qualified pharmacist or other health care provider operating within his or her scope of practice. The department shall develop, in consultation with pharmacy providers, the appropriate professional qualifications needed by the pharmacists rendering services, including any continuing education requirements.

(d) The department shall select the first pharmacies that apply and meet the criteria specified in subdivision (c) for the pilot program.

(e) Pharmacies that participate in this pilot program shall provide the following services:

(1) Patient-specific and individualized services provided directly by a pharmacist to the patient, or in limited circumstances, the patient's caregiver. These services are distinct from generalized patient education and information activities already required by law and provided for in the professional fee for dispensing.

(2) Face-to-face interaction between the patient or caregiver and the pharmacist during delivery of medication therapy management services. When barriers to face-to-face communication exist, patients shall have equitable access to appropriate alternative delivery methods.

(3) Pharmacists and other qualified health care providers to identify patients who should receive medication therapy management services.

(f) The department shall consult with the pilot program pharmacies to establish appropriate outcome measures and the required timeframes for reporting those measures, which in no case shall be less than annually. The department shall retain the ability to require additional outcome measures during the course of the project.

(g) The medication therapy management services shall be based on the individual patient's needs and may include, but are not limited to, the following:

(1) Performing or obtaining necessary assessments of the patient's health status.

(2) Formulating a medication treatment plan.

(3) Selecting, initiating, modifying, or administering medication therapy.

(4) Monitoring and evaluating the patient's response to therapy, including safety and effectiveness.

(5) Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events.

(6) Documenting the care delivered and communicating essential information to the patient's other primary care providers.

(7) Providing verbal education and training, beyond what is already required by law, that is designed to enhance patient understanding and appropriate use of the patient's medications.

(8) Providing information, support services, and resources, such as compliance packaging, designed to enhance patient adherence to his or her therapeutic regimens.

(9) Coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

(10) Home delivery of medications.

(h) Participants in this pilot program shall be paid an additional dispensing fee of nine dollars and fifty cents ($9.50) per prescription for drug products added to or maintained on the Medi-Cal List of Contract Drugs pursuant to Section 14105.43 for services rendered on or after July 1, 2008.

(i) Notwithstanding any other provision of law, the department shall not make any payments for services listed in subdivision (g) that were rendered during any time period in which subdivision (b) of Section 14105.45 has been enjoined by a court order or is otherwise not in effect.

(j) Pilot project contracts under this section may be executed on a noncompetitive bid basis and shall be exempt from the requirements of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(k) Pharmacies shall maintain a sufficient quantity of HIV/AIDS medication in their inventories.

(*l*) Pharmacies shall purchase HIV medications from state licensed wholesalers.

14199.3. This article shall become inoperative on July 1, 2009, and, as of January 1, 2010, is repealed, unless a later enacted statute that is enacted before January 1, 2010, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 61. Section 14301.1 of the Welfare and Institutions Code is amended to read:

14301.1. (a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health plan and county specific rates. The department shall utilize a county and model specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

(1) Health plan specific encounter and claims data.

(2) Supplemental utilization and cost data submitted by the health plans.

(3) Fee-for-service data for the underlying county of operation or other appropriate counties as deemed necessary by the department.

(4) Department of Managed Health Care financial statement data specific to Medi-Cal operations.

(5) Other demographic factors, such as age, gender, or diagnostic-based risk adjustments, as the department deems appropriate.

(b) To the extent that the department is unable to obtain sufficient actual plan data, it may substitute plan model, similar plan, or county specific fee-for-service data.

(c) The department shall develop rates that include administrative costs, and may apply different administrative costs with respect to separate aid code groups.

(d) The department shall develop rates that shall include, but are not limited to, assumptions for underwriting, return on investment, risk, contingencies, changes in policy, and a detailed review of health plan financial statements to validate and reconcile costs for use in developing rates.

(e) The department may develop rates that pay plans based on performance incentives, including quality indicators, access to care, and data submission.

(f) The department may develop and adopt condition-specific payment rates for health conditions, including, but not limited to, childbirth delivery.

(g) (1) Prior to finalizing Medi-Cal managed care capitation rates, the department shall provide health plans with information on how the rates were developed, including rate sheets for that specific health plan, and provide the plans with the opportunity to provide additional supplemental information.

(2) For contracts entered into between the department and any entity pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7, the department, by June 30 of each year, or if the budget has not passed by that date, no later than five working days after the budget is signed, shall provide preliminary rates for the upcoming fiscal year.

(h) For the purposes of developing capitation rates through implementation of this ratesetting methodology, Medi-Cal managed care health plans shall provide the department with financial and utilization data in a form and substance as deemed necessary by the department to establish rates. This data 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.

(i) The department shall report, upon request, to the fiscal and policy committees of the respective houses of the Legislature regarding implementation of this section.

SEC. 62. Section 14526.1 of the Welfare and Institutions Code is amended to read:

14526.1. (a) Initial and subsequent treatment authorization requests may be granted for up to six calendar months.

(b) Treatment authorization requests shall be initiated by the adult day health care center, and shall include all of the following:

(1) The signature page of the history and physical form that shall serve to document the request for adult day health care services. A complete history and physical form, including a request for adult day health care services signed by the participant's personal health care provider, shall be maintained in the participant's health record. This history and physical form shall be developed by the department and published in the inpatient/outpatient provider manual. The department shall develop this form jointly with the statewide association representing adult day health care providers.

(2) The participant's individual plan of care, pursuant to Section 54211 of Title 22 of the California Code of Regulations.

(c) Every six months, the adult day health care center shall initiate a request for an updated history and physical form from the participant's personal health care provider using a standard update form that shall be maintained in the participant's health record. This update form shall be developed by the department for that use and shall be published in the inpatient/outpatient provider manual. The department shall develop this form jointly with the statewide association representing adult day health care providers.

(d) Except for participants residing in an intermediate care facility/developmentally disabled-habilitative, authorization or reauthorization of an adult day health care treatment authorization request shall be granted only if the participant meets all of the following medical necessity criteria:

(1) The participant has one or more chronic or post acute medical, cognitive, or mental health conditions that are identified by the participant's personal health care provider as requiring one or more of the following, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization, or other institutionalization:

(A) Monitoring.

(B) Treatment.

(C) Intervention.

(2) The participant has a condition or conditions resulting in both of the following:

(A) Limitations in the performance of two or more activities of daily living or instrumental activities of daily living, as those terms are defined in Section 14522.3, or one or more from each category.

(B) A need for assistance or supervision in performing the activities identified in subparagraph (A) as related to the condition or conditions specified in paragraph (1) of subdivision (d). That assistance or supervision shall be in addition to any other nonadult day health care support the participant is currently receiving in his or her place of residence.

(3) The participant's network of non-adult day health care center supports is insufficient to maintain the individual in the community, demonstrated by at least one of the following:

(A) The participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.

(B) The participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant.

(C) The participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant.

(4) A high potential exists for the deterioration of the participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if adult day health care services are not provided.

(5) The participant's condition or conditions require adult day health care services specified in subdivisions (a) to (d), inclusive, of Section 14550.5, on each day of attendance, that are individualized and designed to maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization.

(e) Reauthorization of an adult day health care treatment authorization request shall be granted when the criteria specified in subdivision (d) or (f), as appropriate, have been met and the participant's condition would likely deteriorate if the adult day health care services were denied.

(f) For individuals residing in an intermediate care facility/developmentally disabled-habilitative, authorization or reauthorization of an adult day health care treatment authorization request shall be granted only if the resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through adult day health care, placement to a more costly institutional level of care would be likely to occur.

SEC. 63. Section 16809 of the Welfare and Institutions Code is amended to read:

16809. (a) (1) The board of supervisors of a county that contracted with the department pursuant to Section 16709 during the 1990–91 fiscal year and any county with a population under 300,000, as determined in accordance with the 1990 decennial census, by adopting a resolution to that effect, may elect to participate in the County Medical Services Program. The governing board shall have responsibilities for specified health services to county residents certified eligible for those services by the county.

(2) The board of supervisors of a county that has contracted with the governing board pursuant to paragraph (1) may also contract with the governing board for the delivery of health care and health-related services to county residents other than under the County Medical Services Program by adopting a resolution to that effect. The governing board shall have responsibilities for the delivery of specified health services to county residents as agreed upon by the governing board and the county. Participation by a county pursuant to this paragraph shall be voluntary, and funds shall be provided solely by the county.

(b) The governing board may contract with the department or any other person or entity to administer the County Medical Services Program.

(1) If the governing board contracts with the department to administer the County Medical Services Program, that contract shall include, but need not be limited to, all of the following:

(A) Provisions for the payment to participating counties for making eligibility determinations as determined by the governing board.

(B) Provisions for payment of expenses of the governing board.

(C) Provisions relating to the flow of funds from counties' vehicle license fees, sales taxes, and participation fees and the procedures to be followed if a county does not pay those funds to the program.

(D) Those provisions, as applicable, contained in the 1993–94 fiscal year contract with counties under the County Medical Services Program.

(E) Provisions for the department to administer the County Medical Services Program pursuant to regulations adopted by the governing board or as otherwise determined by the governing board.

(F) Provisions requiring that the governing board reimburse the state costs of providing administrative support to the County Medical Services Program in accordance with amounts determined between the governing board and the department.

(2) If the governing board does not contract with the department for administration of the County Medical Services Program, the governing board may contract with the department for specified services to assist in the administration of that program. Any contract with the department under this paragraph shall require that the governing board reimburse the state costs of providing administrative support.

(3) The department shall not be liable for any costs related to decisions of the governing board that are in excess of those set forth in the contract between the department and the governing board.

(c) Each county intending to participate in the County Medical Services Program pursuant to this section shall submit to the governing board a notice of intent to contract adopted by the board of supervisors no later than April 1 of the fiscal year preceding the fiscal year in which the county will participate in the County Medical Services Program.

(d) A county participating in the County Medical Services Program pursuant to this section, or a county contracting with the governing board pursuant to paragraph (2) or (3) of subdivision (a), or participating in a pilot project or contracting with the governing board for an alternative product pursuant to Section 16809.4, shall not be relieved of its indigent health care obligation under Section 17000.

(e) (1) The County Medical Services Program Account is established in the County Health Services Fund. The County Medical Services Program Account is continuously appropriated, notwithstanding Section 13340 of the Government Code, without regard to fiscal years. The following amounts may be deposited in the account:

(A) Any interest earned upon money deposited in the account.

(B) Moneys provided by participating counties or appropriated by the Legislature to the account.

(C) Moneys loaned pursuant to subdivision (n).

(2) The methods and procedures used to deposit funds into the account shall be consistent with the methods used by the program during the 1993–94 fiscal year, unless otherwise determined by the governing board.

(f) Moneys in the program account shall be used by the governing board, or by the department if the department contracts with the governing board for this purpose, to pay for health care services provided to the persons meeting the eligibility criteria established pursuant to subdivision (j) and to pay the governing board expenses and program administrative costs. In addition, moneys in this account may be used to reimburse the department for state costs pursuant to subparagraph (F) of paragraph (1) of subdivision (b).

(g) (1) Moneys in this account shall be administered on an accrual basis and notwithstanding any other provision of law, except as provided in this section and Section 17605.051, shall not be transferred to any other fund or account in the State Treasury except for purposes of investment as provided in Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code.

(2) (A) All interest or other increment resulting from the investment shall be deposited in the program account, notwithstanding Section 16305.7 of the Government Code.

(B) All interest deposited pursuant to subparagraph (A) shall be available to reimburse program-covered services, governing board expenses, and program administrative costs.

(h) The governing board shall establish a reserve account for the purpose of depositing funds for the payment of claims and unexpected contingencies. Funds in the reserve account in excess of the amounts the governing board determines necessary for these purposes shall be available for expenditures in years when program expenditures exceed program funds, and to augment the rates, benefits, or eligibility criteria under the program.

(i) (1) Counties shall pay participation fees as established by the governing board and their jurisdictional risk amount in a method that is consistent with that established in the 1993–94 fiscal year.

(2) A county may request, due to financial hardship, the payments under paragraph (1) be delayed. The request shall be subject to approval by the governing board.

(3) Payments made pursuant to this subdivision shall be deposited in the program account, unless otherwise directed by the governing board.

(4) Payments may be made as part of the deposits authorized by the county pursuant to Sections 17603.05 and 17604.05.

(j) (1) (A) Beginning in the 1992–93 fiscal year and for each fiscal year thereafter, counties and the state shall share the risk for cost increases of the County Medical Services Program not funded through other sources. The state shall be at risk for any cost that exceeds the cumulative annual growth in dedicated sales tax and vehicle license fee revenue, up to the

amount of twenty million two hundred thirty-seven thousand four hundred sixty dollars ($20,237,460) per fiscal year, except for the 1999–2000, 2000–01, 2001–02, 2002–03, 2003–04, 2004–05, 2005–06, 2006–07, 2007–08 fiscal years, and all fiscal years thereafter. Counties shall be at risk up to the cumulative annual growth in the Local Revenue Fund created by Section 17600, according to the table specified in paragraph (2), to the County Medical Services Program, plus the additional cost increases in excess of twenty million two hundred thirty-seven thousand four hundred sixty dollars ($20,237,460) per fiscal year, except for the 1999–2000, 2000–01, 2001–02, 2002–03, 2003–04, 2004–05, 2005–06, 2006–07, 2007–08 fiscal years, and all fiscal years thereafter.

(B) For the 1999–2000, 2000–01, 2001–02, 2002–03, 2003–04, 2004–05, 2005–06, 2006–07, 2007–08 fiscal years, and all fiscal years thereafter, the state shall not be at risk for any cost that exceeds the cumulative annual growth in dedicated sales tax and vehicle license fee revenue. Counties shall be at risk up to the cumulative annual growth in the Local Revenue Fund created by Section 17600, according to the table specified in paragraph (2), to the County Medical Services Program, plus any additional cost increases for the 1999–2000, 2000–01, 2001–02, 2002–03, 2003–04, 2004–05, 2005–06, 2006–07, 2007–08 fiscal years, and all fiscal years thereafter.

(C) (i) The governing board shall establish uniform eligibility criteria and benefits among all counties participating in the County Medical Services Program listed in paragraph (2). For counties that are not listed in paragraph (2) and that elect to participate pursuant to paragraph (1) of subdivision (a), the eligibility criteria and benefit structure may vary from those of counties participating pursuant to paragraph (2) of subdivision (a).

(ii) Notwithstanding clause (i), the governing board may establish and maintain pilot projects to identify or test alternative approaches for determining eligibility or for providing or paying for benefits under the County Medical Services Program, and may develop and implement alternative products with varying levels of eligibility criteria and benefits outside of the County Medical Services Program.

(2) For the 1991–92 fiscal year, and each year thereafter, jurisdictional risk limitations shall be as follows:

| Jurisdiction | Amount |
|---|---|
| Alpine | $ 13,150 |
| Amador | 620,264 |
| Butte | 5,950,593 |
| Calaveras | 913,959 |
| Colusa | 799,988 |
| Del Norte | 781,358 |
| El Dorado | 3,535,288 |
| Glenn | 787,933 |
| Humboldt | 6,883,182 |
| Imperial | 6,394,422 |
| Inyo | 1,100,257 |

| | |
|---|---|
| Kings | 2,832,833 |
| Lake | 1,022,963 |
| Lassen | 687,113 |
| Madera | 2,882,147 |
| Marin | 7,725,909 |
| Mariposa | 435,062 |
| Mendocino | 1,654,999 |
| Modoc | 469,034 |
| Mono | 369,309 |
| Napa | 3,062,967 |
| Nevada | 1,860,793 |
| Plumas | 905,192 |
| San Benito | 1,086,011 |
| Shasta | 5,361,013 |
| Sierra | 135,888 |
| Siskiyou | 1,372,034 |
| Solano | 6,871,127 |
| Sonoma | 13,183,359 |
| Sutter | 2,996,118 |
| Tehama | 1,912,299 |
| Trinity | 611,497 |
| Tuolumne | 1,455,320 |
| Yuba | 2,395,580 |

(3) Beginning in the 1991–92 fiscal year and in subsequent fiscal years, the jurisdictional risk limitation for the counties that did not contract with the department pursuant to Section 16709 during the 1990–91 fiscal year shall be the amount specified in subparagraph (A) plus the amount determined pursuant to subparagraph (B), minus the amount specified by the governing board as participation fees.

(A)

| Jurisdiction | Amount |
|---|---|
| Merced | 2,033,729 |
| Placer | 1,338,330 |
| San Luis Obispo | 2,000,491 |
| Santa Cruz | 3,037,783 |
| Yolo | 1,475,620 |

(B) The amount of funds necessary to fully fund the anticipated costs for the county shall be determined by the governing board before a county is permitted to participate in the County Medical Services Program.

(4) The specific amounts and method of apportioning risk to each participating county may be adjusted by the governing board.

(k) The Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Contracts under this section shall be exempt from Part 2 (commencing with Section 10100) of Division

2 of the Public Contract Code. Contracts of the department pursuant to this section shall have no force or effect unless they are approved by the Department of Finance.

(*l*) The state shall not incur any liability except as specified in this section.

(m) Third-party recoveries for services provided under this section may be pursued.

(n) The Department of Finance may authorize a loan of up to thirty million dollars ($30,000,000) for deposit into the program account to ensure that there are sufficient funds available to reimburse providers and counties pursuant to this section.

(o) Moneys appropriated from the General Fund to meet the state risk, as set forth in subparagraph (A) of paragraph (1) of subdivision (j), shall not be available for those counties electing to disenroll from the County Medical Services Program.

SEC. 64. Section 17605.051 is added to the Welfare and Institutions Code, to read:

17605.051. (a) Notwithstanding any other provision of law, upon request of the County Medical Services Program Governing Board, the Controller shall deposit amounts received pursuant to Sections 16809.3, 17603.05, 17604.05, 17605.07, and 17606.20 into the County Medical Services Subaccount in lieu of depositing these amounts into the County Medical Services Program Account of the County Health Services Fund.

(b) Deposits made pursuant to this section shall be treated in the same manner as deposits that are made into the County Medical Services Program Account of the County Health Services Fund.

(c) Upon request of the County Medical Services Program Governing Board, the Controller shall transfer amounts deposited into the County Medical Services Subaccount to the County Medical Services Program Governing Board for the purposes described in subdivision (f) of Section 16809.

SEC. 65. (a) Of the funds appropriated in Item 4265-111-0001 of Section 2.00 of the Budget Act of 2008 from the Cigarette and Tobacco Products Surtax Fund, twenty-four million eight hundred three thousand dollars ($24,803,000) shall be allocated in accordance with subdivision (b) for the 2008–09 fiscal year from the following accounts:

(1) Twenty-two million six hundred fifty-one thousand dollars ($22,651,000) from the Hospital Services Account.

(2) Two million one hundred fifty-two thousand dollars ($2,152,000) from the Physician Services Account.

(b) The funds specified in subdivision (a) shall be allocated proportionately as follows:

(1) Twenty-two million three hundred twenty-four thousand dollars ($22,324,000) shall be administered and allocated for distribution through the California Healthcare for Indigents Program (CHIP) provided for pursuant to Chapter 5 (commencing with Section 16940) of Part 4.7 of Division 9 of the Welfare and Institutions Code.

(2) Two million four hundred seventy-nine thousand dollars ($2,479,000) shall be administered and allocated through the Rural Health Services Program provided for pursuant to Chapter 4 (commencing with Section 16930) of Part 4.7 of Division 9 of the Welfare and Institutions Code.

(c) (1) Funds allocated pursuant to this section from the Physician Services Account and the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund shall be used only for the reimbursement of physicians for losses incurred in providing uncompensated emergency services in general acute care hospitals providing basic, comprehensive, or standby emergency services, as defined in Section 16953 of the Welfare and Institutions Code. Funds shall be transferred to the Physician Services Account in the county Emergency Medical Services Fund established pursuant to Sections 16951 and 16952 of the Welfare and Institutions Code, and shall be paid only to physicians who directly provide emergency medical services to patients, based on claims submitted or a subsequent reconciliation of claims. Payments shall be made as provided in Sections 16951 to 16959, inclusive, of the Welfare and Institutions Code, and payments shall be made on an equitable basis, without preference to any particular physician or group of physicians.

(2) If a county has an Emergency Medical Services Fund Advisory Committee that includes both emergency physicians and emergency department on-call backup panel physicians, and if the committee unanimously approves, the administrator of the Emergency Medical Services Fund may create a special fee schedule and claims submission criteria for reimbursement for services rendered to uninsured trauma patients, provided that no more than 15 percent of the tobacco tax revenues allocated to the county's Emergency Medical Services Fund is distributed through this special fee schedule, that all physicians who render trauma services are entitled to submit claims for reimbursement under this special fee schedule, and that no physician's claim may be reimbursed at greater than 50 percent of losses under the special fee schedule.

SEC. 66. The State Department of Mental Health shall provide the Mental Health Services Oversight and Accountability Commission (OAC) with data, as specified and requested by the OAC, for the purpose of the OAC to utilize in its oversight, review, and evaluation capacity regarding projects and programs funded with the mental health services funds.

SEC. 67. The State Department of Mental Health, in collaboration with the California Housing Finance Agency, shall provide the fiscal and policy committees of the Legislature with semiannual updates regarding key results and funding for the capital costs associated with development, acquisition, construction, and rehabilitation of permanent supportive housing for individuals with mental illness, as provided for under the Housing Initiatives Program as administered by the state. The semiannual updates shall commence as of July 1, 2008, and shall be provided to the Legislature as described in this section within 30 days after the end of the first and third quarters of each fiscal year thereafter.

SEC. 68. The State Department of Mental Health shall confer with the County of San Mateo, relevant constituency groups, and with the State Department of Health Care Services to appropriately craft a transition plan to ensure the continuity of care for mental health clients in the event that the state's contract for the services provided under the San Mateo Pharmacy and Laboratory Project are substantially modified or transitioned to the State Department of Health Care Services. The State Department of Mental Health shall provide the fiscal and policy committees of the Legislature with a status update regarding the development of a transition plan by no later than December 31, 2008.

SEC. 69. By no later than January 10 and May 14 of each year, the State Department of Mental Health shall provide the fiscal committees of the Legislature with an estimate package for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. This estimate package shall include all assumptions underlying the estimate for the EPSDT's current-year and budget-year proposals and shall contain concise information identifying applicable estimate components, such as caseload, client utilization, policy changes, all funding information, and other assumptions necessary to support the estimate. The submittal shall include a projection of the fiscal impact of any assumptions related to regulatory, statutory, or policy change, a detailed explanation of any changes to the base estimate projections from the previous estimate, and a projection of the fiscal impact of that change to the base estimate. Other supporting data, such as fiscal charts, client utilization, or other data may also be provided.

SEC. 70. The State Department of Developmental Services shall provide an update to the appropriate policy and fiscal committees of the Legislature during the fall legislative interim on an annual basis, beginning in the 2008–09 fiscal year, regarding the impact of the adopted freezes and various cost containment measures on clients and service levels. The policy committees of the Legislature may choose to hold informational hearings on these issues to further review and explore the prioritization and levels at which a cost containment measure or measures may be proposed for modification or elimination and shall report these findings for consideration in the annual subcommittee budget process or in legislation, where appropriate.

SEC. 72. In an effort to more comprehensively clarify issues regarding the state's responsibilities and oversight of small water systems, including the payment structure, the State Department of Public Health shall provide the fiscal and policy committees of the Legislature with a synopsis of key issues regarding the program and options for addressing the sustainability of the program to meet safe drinking water quality standards.

SEC. 73. The State Department of Public Health shall prepare a Fund Condition statement for federal Maternal and Child Health Title V funds, and approved by the Department of Finance, for inclusion in the annual budget process and to be published in the Governor's budget documents provided to the Legislature by no later than January 10 of each year.

SEC. 74. By no later than January 10 and May 14 of each year, the State Department of Public Health shall provide the fiscal committees of the Legislature with an estimate package for the AIDS Drug Assistance Program (ADAP) authorized by Chapter 6 (commencing with Section 120950) of Part 4 of Division 105 of the Health and Safety Code. This estimate package shall include all significant assumptions underlying the estimate for the ADAP's current-year and budget-year proposals, and shall contain concise information identifying applicable estimate components, such as caseload, client utilization, drug rebate information, policy changes, federal fund information, and other assumptions necessary to support the estimate. The submittal shall include a projection of the fiscal impact of any assumptions related to regulatory, statutory, or policy changes, a detailed explanation of any changes to the base estimate projections from the previous estimate, and a projection of the fiscal impact of those changes to the base estimate. Other supporting data, such as fiscal charts, client utilization, or data provided by the pharmacy benefit manager who administers the program at the local level may also be provided.

SEC. 75. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 76. 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 2008 at the earliest possible time, it is necessary that this act take effect immediately.

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