WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 7. Basic Health Care [14000 - 14199.87] *(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

ARTICLE 3. Administration [14100 - 14124.16] *(Article 3 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

14100. The administration of this chapter shall be carried out by the same agents as are authorized by the several boards of supervisors to administer the public assistance programs.

(Repealed and added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

14100.1. For purposes of administering this chapter and Chapter 8 (commencing with Section 14200) of this part, the director shall have those powers and duties necessary to conform to requirements for securing approval of a state plan under the provisions of the applicable federal law, and the department shall be the single state agency for purposes of Title XIX of the federal Social Security Act.

(Amended by Stats. 1978, Ch. 429.)

14100.2. (a) Except as provided in subdivision (i), all types of information, whether written or oral, concerning a person, made or kept by any public officer or agency in connection with the administration of any provision of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.7 (commencing with Section 14520) and for which a grant-in-aid is received by this state from the United States government pursuant to Title XIX of the Social Security Act shall be confidential, and shall not be open to examination other than for purposes directly connected with the administration of the Medi-Cal program. However, in the context of a petition for the appointment of a conservator for a person with respect to whom this information is made or kept, and in the context of a criminal prosecution for a violation of Section 368 of Penal Code with respect to such a person, all of the following shall apply:

A public officer or employee of any such agency may answer truthfully, at any proceeding related to the petition or prosecution, when asked if he or she is aware of information that he or she believes is related to the legal mental capacity of that aid recipient or the need for a conservatorship for that aid recipient. If the officer or employee states that he or she is aware of this information, the court may order the officer or employee to testify about his or her observations and to disclose any relevant agency records if the court has an other independent reason to believe that the officer or employee has information that would facilitate the resolution of the matter.

(b) Except as provided in this section, and to the extent permitted by federal law or regulation, all information about applicants and recipients as provided for in subdivision (a) to be safeguarded includes, but is not limited to, names and addresses, medical services provided, social and economic conditions or circumstances, agency evaluation of personal information, and medical data, including diagnosis and past history of disease or disability.

(c) Purposes directly connected with the administration of the Medi-Cal program, Chapter 8 (commencing with Section 14200), or Chapter 8.7 (commencing with Section 14520) encompass those administrative activities and responsibilities in which the department and its agents are required to engage to insure effective program operations. These activities include, but are not limited to: establishing eligibility and methods of reimbursement; determining the amount of medical assistance; providing services for recipients; conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Medi-Cal program; and conducting or assisting a legislative investigation or audit related to the administration of the Medi-Cal program.

(d) Any officer, agent, or employee of the department or of any public agency shall provide the Joint Legislative Audit Committee and the State Auditor with any and all the information described in subdivision (b) within a reasonable period of time as determined by the committee in consultation with the department, after receipt of a request from the committee approved by a majority of the members of the committee. The Joint Legislative Audit Committee and the State Auditor may use that information only for the purpose of investigating or auditing the administration of the Medi-Cal program, Chapter 8 (commencing with Section 14200), or

Chapter 8.7 (commencing with Section 14520), and shall not use that information for commercial or political purposes. In any case where disclosure of information is authorized by this section, the Joint Legislative Audit Committee or the State Auditor shall not disclose the identity of any applicant or recipient, except in the case of a criminal or civil proceeding conducted in connection with the administration of the Medi-Cal program.

(e) The access to information provided in subdivision (d) shall be permitted only to the extent and under the conditions provided by federal law and regulations governing the release of such information.

(f) The department may make rules and regulations governing the custody, use, and preservation of all records, papers, files, and communications pertaining to the administration of the laws relating to the Medi-Cal program, Chapter 8 (commencing with Section 14200), or Chapter 8.7 (commencing with Section 14520). The rules and regulations shall be binding on all departments, officials, and employees of the state, or of any political subdivision of the state and may provide for giving information to or exchanging information with agencies, public, or political subdivisions of the state, and may provide for giving information to or exchanging information with agencies, public or private, which are engaged in planning, providing, or securing such services for or in behalf of recipients or applicants; and for making case records available for research purposes, provided that that research will not result in the disclosure of the identity of applicants for or recipients of those services.

(g) Upon request, the department shall release to the negotiator established pursuant to Article 2.6 (commencing with Section 14081) all computer tapes and any modifications thereto, including paid claims, connected with the administration of the Medi-Cal program which are in the possession or under the control of the department, including tapes prepared prior to the effective date of this section.

To ensure compliance with federal law and regulations, the department shall make the minimum necessary modifications to its computer tapes prior to releasing the tapes to the negotiator in order to assure the confidentiality of the identity of all applicants for, or recipients of, those services. The department shall not make any modifications to paid claims tapes that affect information regarding beneficiaries' aid categories or counties of origin.

(h) Any person who knowingly releases or possesses confidential information concerning persons who have applied for or who have been granted any form of Medi-Cal benefits or benefits under Chapter 8 (commencing with Section 14200) or Chapter 8.7 (commencing with Section 14520) for which state or federal funds are made available in violation of this section is guilty of a misdemeanor.

(i) (1) To the extent federal funds are made available from the United States Department of Agriculture, the department may do both of the following:

(A) To the extent permitted by federal law, exercise its option under Section 1396a(a)(7)(B) of Title 42 of the United States Code, in coordination with the State Department of Education, to exchange the information necessary to perform direct verification of the eligibility of children for free or reduced price meals.

(B) To the extent permitted by federal law, in coordination with the State Department of Education, exchange the information necessary to perform direct certification for enrolling children to receive free or reduced price meals.

(2) To the extent permitted by state and federal law, the department and the State Department of Education may review the data only for the purposes of improving the effectiveness of the data matches made pursuant to Sections 49561 and 49562 of the Education Code.

(Amended by Stats. 2008, Ch. 673, Sec. 4. Effective January 1, 2009.)

14100.3. (a) The State Department of Health Care Services shall post on its Internet Web site all submitted state plan amendments and all federal waiver applications and requests for new waivers, waiver amendments, and waiver renewals and extensions, within 10 business days from the date the department submits these documents for approval to the federal Centers for Medicare and Medicaid Services (CMS).

(b) The department shall post on its Internet Web site final approval or denial letters and accompanying documents for all submitted state plan amendments and federal waiver applications and requests within 10 business days from the date the department receives notification of final approval or denial from CMS.

(c) If the department notifies CMS of the withdrawal of a submitted state plan amendment or federal waiver application or request, as described in subdivisions (a) and (b), the department shall post on its Internet Web site the withdrawal notification within 10 business days from the date the department notifies CMS of the withdrawal.

(d) Unless already posted on the Internet Web site pursuant to subdivisions (a) to (c), inclusive, the department shall post on its Internet Web site all pending submitted state plan amendments and federal waiver applications and requests, that the department submitted to CMS in 2009 and every year thereafter.

(Added by Stats. 2013, Ch. 23, Sec. 56. (AB 82) Effective June 27, 2013.)

14100.5. (a) The department shall prepare and submit Medi-Cal program assumptions and estimates to the Department of Finance. The purpose of the assumptions and estimates shall be to clearly identify changes within the Medi-Cal program which have policy or fiscal implications, and to produce reliable forecasts of Medi-Cal expenditures.

(b) (1) Beginning with the estimates for the 2024–25 fiscal year, Medi-Cal program assumptions and estimates shall be organized by and correspond to Budget Act or Budget Bill item numbers, separately identifying expenditures for all of the following:

(A) Purchase of medical care and services.

(B) County and other local assistance administration.

(C) Rate increases.

(2) Estimates and assumptions shall indicate state and federal, as well as total, funds expended.

(c) The department shall submit, by September 10 and March 1 of each year, to the Department of Finance for its approval, all assumptions underlying all Medi-Cal program estimates. The Department of Finance shall approve or modify, in writing, the assumptions underlying all estimates within 15 working days of their receipt. If the Department of Finance does not so approve or modify the assumptions by that date, the assumptions, as presented by the department, shall be deemed to be approved by the Department of Finance as of that date.

(d) The department shall submit an estimate of Medi-Cal program expenditures to the Department of Finance by November 1 and April 20 of each year. All approved estimates and supporting data provided by the department or developed independently by the Department of Finance, shall be made available to the legislative fiscal committees following approval by the Department of Finance. However, departmental estimates with supporting data shall be forwarded to the legislative fiscal committees on or about January 10 and May 15 of each year in the event this information has not been released earlier.

(e) Each Medi-Cal assumption shall contain a clear narrative description of the statutory, regulatory, or policy change, or other change, that has occurred or will occur which affects Medi-Cal program expenditures or which is of policy importance. Each assumption shall include a cost estimate which contains relevant workload, caseload, unit cost and other data or information needed to support the estimate.

(f) The assumptions related to purchase of medical care and services shall include a section with a nontechnical description of the major variables used to produce a base projection. This section shall further contain an estimate of the fiscal impact of the use of these variables. The estimates related to purchase of medical care and services shall include current and budget year base projections of eligibles, users, expenditures and cost per user by quarter with sufficient past actual data to permit evaluation of the projections. The projections shall be prepared by service category and aid category.

(g) Assumptions or estimates related to Medi-Cal county and other local assistance administration costs shall contain a narrative description of how the forecast was prepared. The estimates shall compare past actual and projected workload and expenditures in a format which will permit evaluation of forecasts. Unallocated funds and funds for special projects or special problems shall be separately identified.

(h) The estimates shall compare budgeted to implemented rate increases for the current year. The comparisons shall be by provider category and shall compare budgeted to implemented increases in terms of percentage increases, date of implementation, and revised estimated cost.

(i) This section shall become operative on July 1, 2023.

(Repealed (in Sec. 133) and added by Stats. 2023, Ch. 42, Sec. 134. (AB 118) Effective July 10, 2023. Operative July 1, 2023, by its own provisions.)

14100.51. (a) Each year, by no later than January 10 and concurrently with the release of the May Revision, the State Department of Health Care Services shall provide to the fiscal committees of the Legislature supplemental fiscal information for the Medi-Cal Specialty Mental Health Services Program. This supplemental fiscal information shall include service-type descriptions, children's and adults' caseload and fiscal forecast by service type, a detailed explanation of changes to these forecasts, fiscal charts containing children's and adults' claim costs and unduplicated client counts, and summary fiscal charts with current-year and budget-year proposals.

(b) For purposes of making the information described in subdivision (a) available to the public, the department shall post this information on its Internet Web site.

(Added by Stats. 2013, Ch. 23, Sec. 57. (AB 82) Effective June 27, 2013.)

14100.52. (a) Each year, by no later than January 10 and concurrently with the release of the May Revision, the State Department of Health Care Services shall provide to the fiscal committees of the Legislature supplemental fiscal information for the Drug Medi-

Cal Program. This supplemental fiscal information shall include adult, minor-consent, child, and perinatal unique client counts and summary fiscal charts with current-year and budget-year proposals.

(b) For purposes of making the information described in subdivision (a) available to the public, the department shall post this information on its Internet Web site.

(Added by Stats. 2013, Ch. 23, Sec. 58. (AB 82) Effective June 27, 2013.)

14100.6. The department, in cooperation with the Controller, shall establish a method of providing to the Controller, periodically, updated information regarding changes in the roster of Medi-Cal providers.

(Added by Stats. 1991, Ch. 560, Sec. 1.)

14100.7. (a) Any Medi-Cal provider of incontinence supplies or medical supplies, or both, shall provide, to the department, a bond, or other security satisfactory to the department, of not less than twenty-five thousand dollars ($25,000), pursuant to regulations adopted by the department.

(b) (1) After three years of continuous operation as a provider of incontinence supplies or medical supplies, or both, a Medi-Cal provider may apply to the department for an exemption from the requirements of subdivision (a).

(2) The department shall adopt regulations establishing conditions for the approval or denial of applications for exemption pursuant to paragraph (1).

(c) For purposes of this section, “incontinence supplies” and “medical supplies” mean items prescribed by a licensed practitioner to meet medical needs of the patient, and which are eligible for reimbursement pursuant to this chapter.

(d) Subdivisions (a), (b), and (c) do not apply to individuals who are licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(Amended by Stats. 1998, Ch. 310, Sec. 81. Effective August 19, 1998.)

14100.75. (a) (1) Each provider and each applicant, as defined in Section 14043.1, when applying for enrollment and continued enrollment, shall provide, to the department, a bond, or other security satisfactory to the department, of an amount determined by the department, pursuant to regulations adopted by the department.

(2) The department, in determining the amount of bond or security required by paragraph (1), shall base the determination on the level of estimated billings, and shall not be less than twenty-five thousand dollars ($25,000).

(3) This subdivision shall become operative only if the director executes a declaration, that shall be retained by the director, stating that the surety bonds described in this paragraph are commercially offered throughout the state and by more than one vendor.

(b) (1) After three years of continuous operation as a provider, a Medi-Cal provider may apply to the department for an exemption from the requirements of subdivision (a).

(2) The department shall adopt regulations establishing conditions for the approval or denial of applications for exemption pursuant to paragraph (1).

(c) The department shall establish a mechanism to track rates of participation among providers who are subject to the requirement of subdivision (a) to determine if the requirement is a deterrent to Medi-Cal program participation among provider applicants.

(d) Subdivisions (a) and (b) shall not apply to natural persons licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or to any clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code, or exempt from licensure under subdivision (c) of Section 1206 of the Health and Safety Code, to any health facility licensed under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, or to any provider that is operated by a city, county, school district, county office of education, or state special school, or any professional corporation practicing pursuant to the Moscone-Knox Professional Corporation Act provided for pursuant to Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code.

(e) Nothing in this section shall relieve an applicant or provider of durable medical equipment or home health agency services from complying with subdivisions (a) and (b) of Sections 14100.8 and 14100.9, as applicable.

(Amended by Stats. 2000, Ch. 322, Sec. 26. Effective January 1, 2001.)

14100.8. (a) For purposes of this section, “provider of home health agency services” means a home health agency that is licensed by the department under Section 1726 of the Health and Safety Code that meets the requirements for the medicaid program under Subpart A (commencing with Sec. 441.10) of Part 441 of Title 42 of the Code of Federal Regulations, as amended, that meets the requirements for the Medicare program under Part 484 (commencing with Sec. 481.1) and Part 489 (commencing with Sec. 489.1)

of Title 42 of the Code of Federal Regulations, as amended, and that is enrolled as a provider in the Medi-Cal program. In the event of inconsistent requirements between the medicaid and Medicare programs, medicaid requirements shall take precedence.

(b) Within 90 days after the effective date of a final federal regulation requiring that a provider of home health agency services must acquire a surety bond in order to participate in the medicaid or Medicare program, each provider of home health agency services shall obtain, and thereafter maintain, a surety bond meeting the requirements of the final federal regulation, as amended, as a condition of participation in the Medi-Cal program.

(c) Any entity that has applied to become a provider of home health agency services less than 90 days prior to the date that the final federal regulation described in subdivision (b) becomes effective shall submit a surety bond within 90 days of the effective date of the regulation.

(d) Failure of a provider of home health agency services to obtain and maintain a surety bond as required in this section shall result in denial or recoupment of Medi-Cal reimbursement for services provided during the period for which a surety bond should have been in effect.

(e) Failure of a provider of home health agency services to obtain and maintain a surety bond as required in this section shall result in automatic termination of the provider's participation in the Medi-Cal program.

(Added by Stats. 1998, Ch. 310, Sec. 82. Effective August 19, 1998.)

14100.9. (a) For purposes of this section, "provider of durable medical equipment" means any person or entity that furnishes medical equipment and medical supplies, meets state and local laws applicable to the furnishing of medical equipment and medical supplies, and that is enrolled as a provider in the Medi-Cal program.

(b) Within 90 days after the effective date of a final federal regulation requiring that a provider of durable medical equipment must acquire a surety bond in order to participate in the medicaid or Medicare program, each provider of durable medical equipment shall obtain, and thereafter maintain, a surety bond meeting the requirements of the final federal regulation, as amended, as a condition of participation in the Medi-Cal program.

(c) Any person or entity that has applied to become a provider of durable medical equipment less than 90 days prior to the date that the final federal regulation described in subdivision (b) becomes effective shall submit a surety bond within 90 days of the effective date of the regulation.

(d) Failure of a provider of durable medical equipment to obtain and maintain a surety bond as required in this section shall result in denial or recoupment of Medi-Cal reimbursement for services provided during the period for which a surety bond should have been in effect.

(e) Failure of a provider of durable medical equipment to obtain and maintain a surety bond as required in this section shall result in automatic termination of the provider's participation in the Medi-Cal program.

(f) Subdivisions (a), (b), (c), (d), and (e) do not apply to individuals who are licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(Added by Stats. 1998, Ch. 310, Sec. 83. Effective August 19, 1998.)

14100.95. (a) The department shall enter into demonstration contracts with manufacturers of medical supplies for four items of its own selection of medical supplies existing on the pharmacy claims processing system, for the purpose of establishing rebates or other cost-saving mechanisms and demonstrating cost savings in the purchase of these medical supplies. The department shall maintain a list of the supplies for which contracts have been executed.

(b) Nothing in this section shall prevent a small retail business from continuing to supply medical supplies for use by Medi-Cal beneficiaries.

(c) In establishing these demonstration contracts, the department shall preserve reasonable access to these supplies by beneficiaries. To ensure that the health needs of Medi-Cal beneficiaries are met, the department shall evaluate products and execute contracts pursuant to subdivision (c) of Section 14105.47.

(d) The department shall report the outcomes of these demonstration contracts to the Legislature no later than January 1, 2009.

(Amended by Stats. 2007, Ch. 188, Sec. 61. Effective August 24, 2007.)

14101. The director may contract with other state agencies for services in connection with the administration of this chapter, Chapter 8 (commencing with Section 14200), Chapter 8.5 (commencing with Section 14500), and Chapter 8.7 (commencing with Section 14520) of this part.

(Amended by Stats. 1978, Ch. 429.)

14101.1. The department shall enter into an agreement with the Secretary of Health, Education and Welfare under which such secretary will determine eligibility for Medi-Cal in the case of aged, blind or disabled persons under this state's medical assistance

plan approved under Title XIX of the Social Security Act. The state shall pay the Secretary of Health, Education and Welfare an amount equal to one-half of the cost of carrying out the agreement, but in computing such cost with respect to individuals eligible for benefits under Title XVI of the Social Security Act, such payment shall include only those costs which are additional to the costs incurred in carrying out such title.

(Added by Stats. 1976, Ch. 504.)

14101.5. The department and the State Department of Social Services shall provide to the other any information necessary for the performance of such department's duties under this chapter.

(Amended by Stats. 1977, Ch. 1252.)

14101.7. The Workers' Compensation Appeals Board and the department shall exchange information and cooperate to assure that health services provided by Medi-Cal which are reimbursable by Workers' Compensation are identified, and that Workers' Compensation reimburses the department for those services.

(Added by Stats. 1981, Ch. 102, Sec. 115. Effective June 28, 1981.)

14102. (a) If any program under the Medi-Cal program that provides full-scope Medi-Cal benefits to an applicable individual is not statutorily specified in Section 5000A of the Internal Revenue Code (26 U.S.C. 5000A), nor designated as minimum essential coverage in federal regulations, such as Section 1.5000A-2 of Title 26 of the Code of Federal Regulations, then the department shall apply to the United States Secretary of Health and Human Services for the program to be recognized as minimum essential coverage. Any recognition of minimum essential coverage obtained by the department pursuant to this subdivision shall apply in accordance with the federal approvals received and shall be effective on the first day of the month following the receipt of federal approval unless an earlier effective date is provided in the applicable federal approval.

(b) If the requirement to maintain minimum essential coverage under Section 5000A of the Internal Revenue Code (26 U.S.C. 5000A) is repealed and no similar provision that would cause Medi-Cal beneficiaries to incur a tax penalty for the failure to maintain minimum essential coverage is implemented, this section shall become inoperative, and shall be repealed the following January 1.

(c) For purposes of this section, "applicable individual" shall have the same meaning as that term is defined in Section 5000A(d) of the Internal Revenue Code (26 U.S.C. 5000A(d)).

(Repealed and added by Stats. 2017, Ch. 52, Sec. 25. (SB 97) Effective July 10, 2017. Conditionally inoperative, by its own provisions. Repealed on January 1 following inoperative date, by its own provisions.)

14102.5. (a) The department shall, in collaboration with the Exchange, the counties, consumer advocates, and the Statewide Automated Welfare System consortia, develop and prepare one or more reports that shall be issued on at least a biannual basis and shall be made publicly available within 90 days following the end of each reporting period, for the purpose of informing the California Health and Human Services Agency, the Exchange, the Legislature, and the public about the enrollment process for all insurance affordability programs. The data within the reports shall be aggregated and calculated on at least a quarterly basis. The reports shall comply with federal reporting requirements and shall, at a minimum, include the following information, to be derived from, as appropriate depending on the data element, CalHEERS, MEDS, or the Statewide Automated Welfare System:

(1) For applications received for insurance affordability programs through any venue, all of the following:

(A) The number of applications received through each venue.

(B) The number of applicants included on those applications.

(C) Applicant demographics, including, but not limited to, gender, age, race, ethnicity, and primary language.

(D) The disposition of applications, including all of the following:

(i) The number of eligibility determinations that resulted in an approval for coverage.

(ii) The program or programs for which the individuals in clause (i) were determined eligible.

(iii) The number of applications that were denied for any coverage and the reason or reasons for the denials.

(E) The number of days for eligibility determinations to be completed.

(2) With regard to health plan selection, all of the following:

(A) The health plans that are selected by applicants enrolled in an insurance affordability program, reported by the program.

(B) The number of Medi-Cal enrollees who do not select a health plan but are defaulted into a plan.

(3) For annual redeterminations conducted for beneficiaries, all of the following:

(A) The number of redeterminations processed.

(B) The number of redeterminations that resulted in continued eligibility for the same insurance affordability program.

(C) The number of redeterminations that resulted in a change in eligibility to a different insurance affordability program.

(D) The number of redeterminations that resulted in a finding of ineligibility for any program and the reason or reasons for the findings of ineligibility.

(E) The number of days for redeterminations to be completed.

(4) With regard to disenrollments not related to a redetermination of eligibility, all of the following:

(A) The number of beneficiary disenrollments.

(B) The reasons for the disenrollments.

(C) The number of disenrollments that are caused by an individual disenrolling from one insurance affordability program and enrolling into another.

(5) The number of applications for insurance affordability programs that were filed with the help of an assister or navigator.

(6) The total number of grievances and appeals filed by applicants and enrollees regarding eligibility for insurance affordability programs, the basis for the grievance, and the outcomes of the appeals.

(b) The department shall collect the information necessary for these reports and develop these reports using data obtained from the Statewide Automated Welfare System, CalHEERS, MEDS, and any other appropriate state information management systems.

(c) For purposes of this section, the following definitions shall apply:

(1) “CalHEERS” means the California Healthcare Eligibility, Enrollment, and Retention System developed under Section 15926.

(2) “Exchange” means the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(3) “Statewide Automated Welfare System” means the system developed pursuant to Section 10823.

(4) “MEDS” means the Medi-Cal Eligibility Data System that is maintained by the department.

(Amended by Stats. 2017, Ch. 511, Sec. 24. (AB 1688) Effective January 1, 2018.)

14103. (a) The implementation of the optional expansion of Medi-Cal benefits to adults who meet the eligibility requirements of Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), shall be contingent upon the following:

(1) If the federal medical assistance percentage payable to the state under the ACA for the optional expansion of Medi-Cal benefits to adults is reduced below 90 percent, that reduction shall be addressed in a timely manner through the annual state budget or legislative process. Upon receiving notification of any reduction in federal assistance pursuant to this paragraph, the Director of Finance shall immediately notify the Chairpersons of the Senate and Assembly Health Committees and the Chairperson of the Joint Legislative Budget Committee.

(2) If, prior to January 1, 2018, the federal medical assistance percentage payable to the state under the ACA for the optional expansion of Medi-Cal benefits to adults is reduced to 70 percent or less, the implementation of any provision in this chapter authorizing the optional expansion of Medi-Cal benefits to adults shall cease 12 months after the effective date of the federal law or other action reducing the federal medical assistance percentage.

(b) For purposes of this section, “ACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148) as originally enacted and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(Added by Stats. 2013, 1st Ex. Sess., Ch. 4, Sec. 26. (SB 1 1x) Effective September 30, 2013.)

14103.2. Whenever the director determines that the services or products of a provider cost the program in excess of reasonable value received, the provider shall thereafter be disqualified from participation in the program. The disqualification shall not become effective until an opportunity for a public hearing has been granted.

The department shall conduct a continuing review of reimbursements to all hospitals participating in the program in order to determine if any reimbursements are in excess of reasonable value received.

(Amended by Stats. 2001, Ch. 745, Sec. 249. Effective October 12, 2001.)

14103.4. The director, with the advice of the Medicaid Advisory Committee required by federal law or regulation, shall determine which of the health care and related remedial or preventive services are elective. The director and the committee shall consult with representatives of providers of such services before making a determination.

(Amended by Stats. 1982, Ch. 328, Sec. 22. Effective June 30, 1982.)

14103.5. (a) A noncontract hospital that is in a closed health facility planning area is not eligible to receive reimbursement for services provided to a Medi-Cal beneficiary, unless either of the following apply:

(1) The noncontract hospital provides necessary emergency services to a Medi-Cal beneficiary who is in a life threatening or emergency situation, but cannot be sufficiently stabilized in order to facilitate transport to a contracting hospital.

(2) The noncontract hospital is a facility location of a nonprofit hospital that is an affiliate of a nonprofit health care service plan, the facility location is approved in accordance with the standards of the California Children's Services (CCS) program, and the hospital is providing medically necessary services for treatment of the CCS-eligible condition of a patient when all of the following apply:

(A) The patient is eligible for services under the California Children's Services Act (Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code) as well as the Medi-Cal program.

(B) The patient is a member of the health care services plan for other health care services not related to the CCS condition.

(C) The services for treatment of the CCS-eligible patient are authorized by the CCS program.

(b) A noncontract hospital in a closed health facility planning area that provides necessary emergency services to a Medi-Cal beneficiary who is in a life threatening or emergency situation, but cannot be sufficiently stabilized in order to facilitate transport to a contracting hospital, may only be reimbursed for those necessary emergency services when it obtains an approved treatment authorization request.

(c) Any treatment authorization request submitted for any service classified as a necessary emergency service, which would have been subject to prior authorization had it not been so classified, shall be supported by the attending physician's statement that does all of the following:

(1) Describes in detail the nature of the emergency or life threatening situation, including relevant clinical information about the patient's condition.

(2) States why the patient could not be sufficiently stabilized for transport to a contracting hospital and why the necessary emergency services rendered were considered to be immediately required. A mere statement that an emergency existed is not sufficient. The treatment authorization request shall be comprehensive enough to support a finding that an emergency or a life threatening situation existed.

(3) Contains the signature of the attending physician who had direct knowledge of the emergency described in the statement.

(d) For the purposes of this section, "necessary emergency services" are limited to those health services medically necessary for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions which, if not immediately diagnosed and treated, could lead to significant disability or death.

(e) For the purposes of this section, a "noncontract hospital" means a hospital that has not contracted with the department pursuant to Article 2.6 (commencing with Section 14081) for the provision of inpatient services to Medi-Cal beneficiaries.

(f) Nothing in this section shall be construed as limiting reimbursement for medically necessary care following stabilization, in the event that a contract hospital does not accept transfer of the patient or pending the transfer to a contract hospital.

(Amended by Stats. 2007, Ch. 418, Sec. 1. Effective October 10, 2007.)

14103.6. The director, or a carrier acting under regulations adopted by the director, may require that any individual provider shall receive prior authorization before providing services when the director or carrier determines that the provider has been rendering

unnecessary services.

At any time the director determines that it is necessary to postpone elective services pursuant to Section 14120, he or she shall require prior authorization for those services determined to be generally elective under the provisions of Section 14103.4, except a service which costs less than one hundred dollars ($100) or a lower amount determined by the director. This lower amount may be applied generally or for specific services. The director may terminate the requirement for prior authorization when he or she determines that it is no longer necessary to postpone elective services.

Prior authorization for services provided by persons licensed under the provisions of Chapter 4 (commencing with Section 1600) and Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code shall be determined by consultants licensed under Chapter 4 or Chapter 7 respectively. Prior authorization for all other elective services shall be determined by consultants licensed under the provisions of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, provided, however, that prior authorization for pharmaceutical services may be determined by persons licensed under the provisions of Chapter 9 (commencing with Section 4000) of Division 2 of the Business and Professions Code, and prior authorization for services provided in an inpatient setting may be reviewed and approved, but not denied, by a person licensed under the provisions of Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code, working under the supervision of a consultant licensed under the provisions of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

In no event shall prior authorization be required when there is a bona fide emergency requiring immediate treatment.

In carrying out this section, notwithstanding Section 19130 of the Government Code, the department may contract, either directly or through the fiscal intermediary, for staff to accomplish the treatment authorization request reviews and medical case management, including appeals. 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 those laws.

(Amended (as amended by Stats. 1975, Ch. 1005) by Stats. 2002, Ch. 1161, Sec. 51. Effective September 30, 2002. Superseded on operative date of amendment by Stats. 1985, Ch. 682, as further amended by Stats. 2002, Ch. 1161, Sec. 52.)

14103.6. The director, or a carrier acting under regulations adopted by the director, may require that any individual provider shall receive prior authorization before providing services when the director or carrier determines that the provider has been rendering unnecessary services.

At any time the director determines that it is necessary to postpone elective services pursuant to Section 14120, he or she shall require prior authorization for those services determined to be generally elective under the provisions of Section 14103.4, except a service which costs less than one hundred dollars ($100) or a lower amount determined by the director. This lower amount may be applied generally or for specific services. The director may terminate the requirement for prior authorization when he or she determines that it is no longer necessary to postpone elective services.

Prior authorization for services provided by persons licensed under the provisions of Chapter 4 (commencing with Section 1600) and Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code shall be determined by consultants licensed under Chapter 4 or Chapter 7 respectively. Prior authorization for all other elective services shall be determined by consultants licensed under the provisions of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, provided, however, that prior authorization for pharmaceutical services may be determined by persons licensed under the provisions of Chapter 9 (commencing with Section 4000) of Division 2 of the Business and Professions Code, and prior authorization for services provided in an inpatient setting may be reviewed and approved, but not denied, by a person licensed under the provisions of Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code, working under the supervision of a consultant licensed under the provisions of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

The consultants shall render decisions on prior authorization requests in a timely manner. A timely manner shall be deemed to be an average of five working days after the prior authorization request is received by the department. A decision shall be an approval, denial, modification, or request for additional information. A supplemental authorization request submitted with additional information requested by a consultant shall be processed in a timely manner as if it were an original authorization request. If no decision on a prior authorization request is rendered by the consultant within 30 days of receipt by the department, the request shall be deemed to be approved. Final decisions of the department on all requests for prior authorization shall be reviewable under the department's provider appeal and fair hearing procedures. If the request is denied, the department shall send notice to the provider and beneficiary of the right to appeal the decision.

In no event shall prior authorization be required when there is a bona fide emergency requiring immediate treatment.

In carrying out this section, notwithstanding Section 19130 of the Government Code, the department may contract, either directly or through the fiscal intermediary, for staff to accomplish the treatment authorization request reviews and medical case management, including appeals. 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 those laws.

(Amended (as amended by Stats. 1985, Ch. 682) by Stats. 2002, Ch. 1161, Sec. 52. Effective September 30, 2002. Pursuant to Stats. 1985, Ch. 682, Sec. 2, this version (including the Ch. 682 amendment) is operative upon a determination by U.S. Secretary of Health and Human Services that the changes will not result in denial of federal funding.)

14103.7. The department shall develop procedure codes for durable medical equipment and orthotic and prosthetic equipment and services, to enable the fiscal intermediary to efficiently and expeditiously process claims for the equipment or services.

For the purposes of this section, durable medical equipment, orthotics, and prosthetics shall include such equipment and accessories as the director may provide by regulation, as authorized by this chapter.

(Amended by Stats. 1985, Ch. 1333, Sec. 1.)

14103.75. Prior authorization may be required by the director for services or items prescribed or ordered by a practitioner who has been determined by the director to have been prescribing or ordering medically unnecessary or excessive services or items for Medi-Cal beneficiaries. When this requirement has been imposed upon a practitioner, the department shall give written notice to the practitioner, and shall also give written notice identifying the practitioner to all Medi-Cal providers who may be requested by that practitioner to furnish ordered or prescribed services or items. Payment may not be denied for services or items provided pursuant to an order or prescription issued by these practitioners prior to written notification by the department that these services or items must have prior authorization. After this notice has been received, it shall be the duty of the practitioner to seek prior authorization for all ordered or prescribed services or items within the scope of the director's requirement. Where a practitioner fails to obtain prior authorization for a service or item within the scope of the director's requirement and the service or item is provided or dispensed to a beneficiary by another provider, the prescribing practitioner shall be financially responsible for payment. The department shall not deny payment to the provider for the prescribing practitioner's failure to obtain prior authorization, but shall reimburse the provider as otherwise provided by law and recover the payment from the prescribing practitioner.

(Amended by Stats. 1984, Ch. 1472, Sec. 1.)

14103.8. (a) Medi-Cal services for beneficiaries who are eligible for services under the California Children's Services Act (Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code) as well as the Medi-Cal program shall be subject to prior authorization by the director.

(b) Claims for payment of prior authorized services shall be reviewed by postpayment audit conducted by the department, and shall not be subject to prepayment review under the California Children's Services Act prior to submission to the Medi-Cal fiscal intermediary.

(c) The California Children's Services program may require all applicants who are potentially eligible for cash grant public assistance to apply for Medi-Cal eligibility prior to becoming eligible for funded services.

(Amended by Stats. 1996, Ch. 1023, Sec. 473. Effective September 29, 1996.)

14104. (a) The department may, to the extent feasible, and to the extent permitted or required by applicable provisions of federal law, enter into agreements with organizations of licensed professional persons known as Professional Standards Review Organizations, as the same are defined in, and authorized by, federal law, for the review of inpatient and other health services provided to beneficiaries in accordance with the provisions of this part, to determine whether such services may be approved for payment.

(b) Where such agreements are entered, the department may also enter into agreements for review of services provided to beneficiaries whose health care is funded solely from state or local sources without federal participation under Title XIX of the Social Security Act.

(c) Agreements entered into under this section shall be awarded on a nonbid basis.

(Added by Stats. 1977, Ch. 698.)

14104.3. (a) The department may, to the extent feasible, enter into nonexclusive contracts providing arrangements under which funds available for health care under this chapter shall be administered and disbursed to providers of health care or to their designated agents in consideration for services rendered and supplies furnished by them in accordance with the provisions of the applicable contract and any schedule of charges or formula for determining payments established pursuant to the contract. The contract shall provide that the contractor:

(1) Will take any action as may be necessary to assure that payment for services to hospitals and other facilities and professional services shall be based on standards determined by the director. The formula for the payments shall be determined in accordance

with regulations establishing the methods to be used and the items to be included.

(2) Will take any action which may be necessary to assure that charges by providers will be reasonable and not higher than the charge for a comparable service and under comparable circumstances made to other payors.

(3) Bills for service under this chapter shall be reviewed and rejected or processed for payment within an average of 18 days from receipt of evidence establishing validity of the bill for payment in the office of the contractor. Ninety percent of all bills submitted to the contractor and under the contractor's control, as set forth in the request for proposal, shall be processed and paid in 30 days and 99 percent of all claims submitted to the contractor and under the contractor's control, as set forth in the request for proposal, shall be processed and paid in 90 days. If it is determined by the contractor that additional evidence of validity is required, the evidence shall be requested within 18 days from the date the bill is received by the contractor. In any event, notice shall be given within 30 days from the date the bill is received concerning the status of the bill submitted if the bill is held for peer review by the contractor beyond 18 days. In no event, shall the number of bills not processed for payment within 30 days of receipt exceed 9 percent of the total bills inventory.

(b) Contracts awarded under this section shall be awarded on a bid basis, and before entering into any contract, the director shall publish notice soliciting bids.

(c) Contracts awarded under this section may provide all of the following:

(1) Payments to the contractor may be on a capitation or prepayment basis, or on a combination of both methods of payment.

(2) Providers may assume all or part of the risk of utilization of services, or costs of services, or both, and that providers who agree to assume that risk may be separately classified for purposes of applicable rates of payment or administrative requirements.

(3) Any other provisions which have previously been incorporated into pilot programs established pursuant to Chapter 8 (commencing with Section 14200) and determined by the director to be desirable and feasible.

(Amended by Stats. 2001, Ch. 745, Sec. 250. Effective October 12, 2001.)

14104.35. (a) Any contract amendments, modifications, or change orders to a fiscal intermediary contract entered into by the department for the purposes of implementing Section 14104.3 shall be exempt, except as provided in subdivision (b), from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(b) Subdivision (a) shall not exempt the department from establishing a competitive bid process for awarding new contracts pursuant to Section 14104.3.

(Added by Stats. 2014, Ch. 31, Sec. 49. (SB 857) Effective June 20, 2014.)

14104.36. (a) The following definitions apply for purposes of this section:

(1) "Identified provider" means either a fee-for-service Medi-Cal provider or any other provider participating in a program administered by the department, in good standing, identified by the department for an identified service period.

(2) "Identified service period" means the service dates involving a Medi-Cal Checkwrite contingency as identified by the department.

(3) "Medi-Cal Checkwrite contingency" means any situation involving a delay, nonfunctionality, or system error in the Medi-Cal Checkwrite Schedule provider claims processing system as identified by the department.

(b) (1) Notwithstanding any other law, if there is a Medi-Cal Checkwrite contingency, the department may make a contingency payment to an identified provider during an identified service period to ensure continued access to health care services, subject to approval of the Department of Finance.

(2) The department shall calculate a contingency payment based upon the previous payment claims history of the identified provider as identified in departmental records.

(c) The department shall reconcile the contingency payment for an identified provider against the actual claims for service dates during the identified service period. The department shall subsequently make payment adjustments to the identified provider in accordance with the departmental standards for provider claims processing.

(d) Any provider grievance or complaint arising from either a contingency payment or the reconciliation of a contingency payment shall be governed by Section 14104.5.

(e) This section does not alter the amount of reimbursement due to an identified provider for eligible claims or otherwise change any billing requirement or condition of program participation for a provider subject to this section.

(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 this section by provider manual, provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action.

(g) The department shall seek any necessary approvals from the federal Centers for Medicare and Medicaid Services to implement this section. The department shall implement this section only in a manner that is consistent with federal Medicaid law and regulations, and only to the extent that the necessary approvals are obtained and federal financial participation is not jeopardized.

(Added by Stats. 2019, Ch. 38, Sec. 47. (SB 78) Effective June 27, 2019.)

14104.5. Notwithstanding any other provision of law, the director shall by regulation adopt such procedures as are necessary for the review of a grievance or complaint concerning the processing or payment of money alleged by a provider of services to be payable by reason of any of the provisions of this chapter. After complying with these procedures, if the provider is not satisfied with the director's decision on his or her claim, he or she may not later than one year after receiving notice of the decision, file a petition for writ of mandate pursuant to Section 1085 of the Code of Civil Procedure in the superior court. This section shall be the exclusive remedy available to the provider of services for moneys alleged to be payable by reason of this chapter.

This section shall not apply to those grievances or complaints arising from the findings of an audit or examination made by or on behalf of the director pursuant to Sections 10722 and 14170. Article 5.3 (commencing with Section 14170) shall govern the grievances or complaints.

(Amended by Stats. 2009, Ch. 255, Sec. 2. (AB 839) Effective January 1, 2010.)

14104.6. No Medi-Cal fiscal intermediary contract shall be approved, renewed or continued if a state employee is employed in a management, consultant or technical position by the contractor or a subcontractor to the contractor within one year after the state employee terminated state employment.

For purposes of this section, “state employee” means any appointive or civil service employee of the Governor’s office, the Health and Welfare Agency, the State Department of Health Services, the Controller’s office, the Attorney General, or the Legislature who, within two years prior to leaving state employment, had responsibilities related to development, negotiation, contract management, supervision, technical assistance or audit of a Medi-Cal fiscal intermediary.

The requirements of this section shall not apply to any state employee who terminated state employment prior to the operative date of this section.

(Amended by Stats. 2004, Ch. 193, Sec. 244. Effective January 1, 2005.)

14104.7. The Director of the Department of Health Services shall negotiate a modification of the contract with Computer Sciences Corporation for the provision of fiscal intermediary services for the Medi-Cal program in effect on the effective date of this section to establish providers of durable medical equipment, prosthetic and orthotic devices, and emergency and nonemergency medical transportation as a distinct and separate provider classification for claim processing purposes. The director shall determine which providers qualify as providers for the purposes of this section. The contract shall be further amended to provide that claims of this type shall be processed for payment within an average of 25 days from the date of receipt. If the contractor fails to process such claims within the 25-day standard, the department shall assess maximum liquidated damages against the contractor, per day, until the performance standard is met.

(Added by Stats. 1982, Ch. 91, Sec. 2.)

14104.8. (a) The Secretary of the Health and Welfare Agency shall be responsible for oversight of the contract for fiscal intermediary services awarded by the State Department of Health Services to Computer Sciences Corporation. The director of the department shall confer with the secretary of the agency regarding the progress made in implementing the contract.

(b) Within four months of enactment of this section, the State Director of Health Services shall contract for an 18-month period with a qualified systems engineering firm that has the ability to work at the software level to acquire the system produced by Computer Sciences Corporation for the purposes of monitoring the contract awarded by the department to Computer Sciences Corporation and ascertaining if the system meets contract requirements.

(c) The systems engineering firm shall monitor compliance with all provisions contained within the above-mentioned contract between the department and Computer Sciences Corporation.

(d) The contract shall:

(1) Require the firm to conduct an evaluation of Computer Sciences Corporation contract compliance, including design or operational deficiencies, and, within four months of the award of the monitoring contract, to report on this evaluation to the

Secretary of the Health and Welfare Agency and the State Director of Health Services, who shall forward this report to the Legislature.

(2) Include provisions to permit the firm to develop specific remedies for design and operation deficiencies in the state owned Medi-Cal fiscal intermediary system.

(3) Require the firm to develop, install and operate the type of monitoring and control system required by the contract.

(4) Require production by the firm within one year of a detailed work plan and budget for managing the contract with Computer Sciences Corporation, including job descriptions, staffing levels and organizational controls in order to continue operation of the monitoring and control system at a high level of efficiency and expertise.

(5) Preclude the firm from bidding (or from being a major subcontractor to a prime bidder) on any subsequent contract for fiscal intermediary services for a period of five years from the date of the contract.

(e) If all requested documentation records and deliverables required in the contract between the department and Computer Sciences Corporation are not made available, as specified in that contract, to the designated systems engineering firm, the Secretary of the Health and Welfare Agency, the State Department of Health Services or the Joint Legislative Audit Committee, whichever has so requested, all applicable penalties and fines available under the contract shall be evoked by the State Department of Health Services.

(f) Subject to the approval of the Secretary of Health and Welfare, the State Director of Health Services shall have the authority to enter into a subsequent fiscal intermediary monitoring contract to be in effect upon the expiration of the one-year contract called for in subdivision (b) and to be based upon findings and recommendations produced under subdivision (d).

(Added by Stats. 1981, Ch. 1039, Sec. 2.)

14104.9. Any Medi-Cal contract for fiscal intermediary services entered into on or after January 1, 1992, shall permit the submission of all paper claims for hospital services using billing forms that are as similar as possible to the UB-82, also known as the HCFA-1450. These billing forms shall be designed to be both optically scanned and automatically microfilmed.

(Added by Stats. 1991, Ch. 574, Sec. 1.)

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.

(Added by Stats. 2008, Ch. 758, Sec. 43. Effective September 30, 2008.)

14105. (a) The director shall prescribe the policies to be followed in the administration of this chapter, may limit the rates of payment for health care services, and shall adopt any rules and regulations as are necessary for carrying out, but are not inconsistent with, the provisions thereof.

The policies and regulations shall include rates for payment for services not rendered under a contract pursuant to Chapter 8 (commencing with Section 14200). In order to implement expeditiously the budgeting decisions of the Legislature, the director shall, to the extent permitted by federal law, adopt regulations setting rates that reflect these budgeting decisions within one month after the enactment of the Budget Act and of any other appropriation that changes the level of funding for Medi-Cal services. The proposed regulations shall be submitted to the Department of Finance no later than five days prior to the date of adoption. With the written approval of the Department of Finance, the director shall adopt the regulations as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Part 1, Division 3, Title 2 of the Government Code). For purposes of that act, 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.

(b) (1) Insofar as practical, consistent with the efficient and economical administration of this part, the department shall afford recipients of public assistance a choice of managed care arrangements under which they shall receive health care benefits and a choice of primary care providers under each managed care arrangement.

(2) Notwithstanding any other provision of law, Medi-Cal beneficiaries shall be entitled to affirmatively select, or to be assigned by default to, any primary care provider as defined in paragraph (1) of subdivision (b) of Section 14088.

(3) Notwithstanding any other provision of law, when a Medi-Cal beneficiary is assigned, from any source, to a primary care physician, as defined in Section 14254, and that primary care physician is an employee of a primary care provider, as defined in paragraph (1) of subdivision (b) of Section 14088, the assignment shall constitute an assignment to the primary care provider.

(c) If, in the judgment of the director, the actions taken by the director under subdivision (c) of Section 14120 will not be sufficient to operate the Medi-Cal program within the limits of appropriated funds, he or she may limit the scope and kinds of health care services, except for minimum coverage as defined in Section 14056, available to persons who are not eligible under Section 14005.1. When and if necessary, that action shall be taken by the director in ways consistent with the requirements of the federal Social Security Act.

(d) The director shall adopt regulations implementing regulatory changes required to initially implement, and annually update, the United States Health Care Financing Administration's common procedure coding system as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the purposes of the Administrative Procedure Act, the adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. These regulations shall become effective immediately upon filing with the Secretary of State.

(e) Notwithstanding any other provision of law, prospective reimbursement for any services provided to a Medi-Cal beneficiary in a nursing facility that is a distinct part of an acute care hospital shall not exceed the audited costs of the facility providing the services.

(f) Notwithstanding any other provision of law, reimbursement for anesthesiology, surgical services, and the professional component of radiology procedures except for comprehensive perinatal and obstetrical services shall be reduced by 9.5 percent of the amount of reimbursement provided for any of those services prior to the operative date of this subdivision. The director may exclude emergency surgical services performed in the emergency department of a general acute care hospital. To be excluded, emergency surgical services must be performed by an emergency room physician or a physician on the emergency department's on-call list.

(g) (1) It is the intent of the Legislature in enacting this subdivision to enable the department to obtain Medicare cost reports for the purpose of evaluating its Medi-Cal reimbursement rate methodology for nursing facilities.

(2) Skilled nursing facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code shall submit copies of all Medicare cost reports to the department by October 1, 1995, for reporting periods that ended between July 1, 1993, and June 30, 1995.

On or after July 1, 1995, those facilities shall submit the copies to the department on the date that the Medicare cost reports are submitted to the Medicare fiscal intermediary.

(3) Hospitals providing skilled nursing care licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code shall submit a copy of all Medicare cost reports for reporting periods ended:

(A) January 1, 1993, through June 30, 1995, to the department by October 1, 1995.

(B) On or after July 1, 1995, to the department when the Medicare cost reports are submitted to the Medicare fiscal intermediary.

(Amended by Stats. 2002, Ch. 756, Sec. 2. Effective January 1, 2003.)

14105.05. (a) Notwithstanding Section 14105, and any other provision of law, the director may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, take one or both of the following actions:

(1) Establish the reimbursement rates necessitated by the establishment of updated coding systems required for compliance by the federal Health Insurance Portability and Accountability Act (HIPAA).

(2) Adopt and annually update the federal Healthcare Common Procedure Coding System codes (formerly known as the United States Healthcare Common Procedure Coding System HCPCS) or any other coding system required for compliance with this chapter, federal medicaid requirements, or the federal Health Insurance Portability and Accountability Act (HIPAA).

(b) The director may take the actions described in subdivision (a) by means of publication in the California Regulatory Notice Register, the Medi-Cal Provider Manual, or similar publications.

(c) The publication of reimbursement rates or coding systems pursuant to subdivision (a) shall include an effective date for the published rates or coding systems.

(d) Nothing in this section shall be construed to affect the department's compliance with federal medicaid law or regulations relating to the adoption of Medi-Cal reimbursement rates.

(Added by Stats. 2003, Ch. 601, Sec. 13. Effective January 1, 2004.)

14105.06. (a) Notwithstanding Section 14105 and any other provision of law, the Medi-Cal reimbursement rates in effect on August 1, 2003, shall remain in effect through July 31, 2005, for the following providers:

(1) Freestanding nursing facilities licensed as either of the following:

(A) An intermediate care facility pursuant to subdivision (d) of Section 1250 of the Health and Safety Code.

(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.

(2) A skilled nursing facility that is a distinct part of a general acute care hospital. For purposes of this paragraph, “distinct part” shall have the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(3) A subacute care program, as described in Section 14132.25 or subacute care unit, as described in Sections 51215.5 and 51215.8 of Title 22 of the California Code of Regulations.

(4) An adult day health care center.

(b) (1) The director may adopt regulations as are necessary to implement subdivision (a). These regulations shall 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 section, 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.

(2) As an alternative to paragraph (1), and 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 by means of a provider bulletin, or similar instructions, without taking regulatory action.

(c) The director shall implement subdivision (a) in a manner that is consistent with federal medicaid law and regulations. The director shall seek any necessary federal approvals for the implementation of this section. This section shall be implemented only to the extent that federal approval is obtained.

(d) The provisions of subdivision (a) shall apply to a skilled nursing facility, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, only until the first day of the month following federal approval to implement both the skilled nursing quality assurance fee imposed by Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code and the rate methodology developed pursuant to Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9.

(Amended by Stats. 2005, Ch. 508, Sec. 7. Effective October 4, 2005.)

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

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

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

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

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

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

(b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and also consistent with

federal and state law and policies, including any exemptions contained in the act that added this section, provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services, and products.

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

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

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

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

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

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

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

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

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

(Added by Stats. 2011, Ch. 3, Sec. 93. (AB 97) Effective March 24, 2011.)

14105.075. (a) (1) Notwithstanding any other law, for dates of service on or after August 1, 2016, payments to intermediate care facilities for the developmentally disabled that are licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and to facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, as determined by the applicable methodology for setting reimbursement rates for those facilities, shall be the reimbursement rates that were applicable to those facilities in the 2008–09 rate year, increased by 3.7 percent. Payments to the facilities pursuant to this section shall also include the projected cost of complying with new state or federal mandates to the extent applicable to the reimbursement methodology associated with the type of facility.

(2) Notwithstanding paragraph (1) and Sections 14105.191 and 14105.192, and for dates of service on or after August 1, 2021, the reimbursement rates for intermediate care facilities for the developmentally disabled and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to Section 14132.20 shall be determined without applying to that rate any reduction, limitation, or increase, including the 3.7-percent increase, specified in paragraph (1), as described in this section or Sections 14105.191 and 14105.192.

(b) (1) For dates of service on or after August 1, 2021, and for each rate year thereafter, the department shall calculate and publish the reimbursement rates, as specified in paragraph (2) of subdivision (a), plus the projected cost of complying with new state or federal mandates.

(2) For the 2021–22 fiscal year, and for each fiscal year thereafter, the reimbursement rates for intermediate care facilities for the developmentally disabled or facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to Section 14132.20, or both, shall account for, and be inclusive of, supplemental payments, as described under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, or Proposition 56, if the Budget Act of that fiscal year appropriates

funds from the Healthcare Treatment Fund, as established pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, to the department to make those supplemental payments to these facilities.

(3) For dates of service on or after August 1, 2021, and for each rate year thereafter, the reimbursement rate established for an intermediate care facility for the developmentally disabled or a facility providing continuous skilled nursing care to developmentally disabled individuals pursuant to Section 14132.20 shall be the greater of that facility's reimbursement rate established pursuant to paragraphs (1) and (2), or the approved Medi-Cal State Plan reimbursement rate, inclusive of the temporary increased Medicaid payments associated with the COVID-19 Public Health Emergency, plus the Proposition 56 supplemental payment amount, in effect for that facility on the last day of the COVID-19 Public Health Emergency.

(4) For dates of service on or after January 1, 2024, the department shall adopt a rate year based on the calendar year for intermediate care facilities for the developmentally disabled and facilities providing continuous skilled nursing care to developmentally disabled individuals, pursuant to Section 14132.20.

(c) In implementing this section, the department shall seek any federal approvals it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(d) 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 this section, in whole or in part, by means of provider bulletins or other similar instructions, without taking regulatory action.

(e) (1) The department may modify any methodology or provision specified in this section to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized, only if that modification does not violate the spirit, purposes, and intent of this section.

(2) If the department determines that a modification is necessary pursuant to paragraph (1), the department shall consult with affected providers and stakeholders to the extent practicable.

(Amended by Stats. 2023, Ch. 42, Sec. 135. (AB 118) Effective July 10, 2023.)

14105.076. (a) Notwithstanding any other law, for dates of service on or after January 1, 2024, the department shall adopt a rate year based on the calendar year for nursing facilities providing level A services in accordance with Sections 51120 and 51510 of Title 22 of the California Code of Regulations, and intermediate care facilities that are licensed pursuant to subdivision (d) of Section 1250 of the Health and Safety Code.

(b) In implementing this section, the department shall seek any federal approvals it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(c) 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 this section, in whole or in part, by means of provider bulletins or other similar instructions, without taking regulatory action.

(Added by Stats. 2023, Ch. 42, Sec. 136. (AB 118) Effective July 10, 2023.)

14105.08. (a) Notwithstanding any other provision of law, in order to implement changes in the level of funding for radiology services, as defined in Section 51139 of Title 22 of the California Code of Regulations, the director shall reduce reimbursement rates applicable to radiology services, as specified in this section.

(b) Except as otherwise provided in this section, reimbursement rates applicable to radiology services shall not exceed 80 percent of the lowest maximum allowance established under the federal Medicare Program for the same or similar services with dates of service on or after October 1, 2010.

(c) 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 take the actions specified in this section by means of a provider bulletin or notice, policy letter, or other similar instruction, without taking regulatory action.

(d) (1) The reimbursement rates provided for in this section shall be implemented only if the director determines that the rates, as established by this section, will comply with applicable federal Medicaid requirements and that federal financial participation will be available.

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

(3) To the extent that the director determines that the rates do not comply with applicable federal Medicaid requirements, the director shall retain the discretion not to implement that rate and may revise the rate as necessary to comply with the federal Medicaid requirements.

(e) The director shall seek any necessary federal approval for the implementation of this section. To the extent that federal financial participation is not available with respect to any rate of reimbursement described by this section, the director shall retain the discretion not to implement that rate and may revise the rate as necessary to comply with the federal Medicaid requirements.

(Added by Stats. 2010, Ch. 717, Sec. 148. (SB 853) Effective October 19, 2010.)

14105.09. Notwithstanding any other provision of law, if subdivision (b) of Section 3.94 of the Budget Act of 2011 is operative, effective on or after January 1, 2012, the payment reductions in Sections 14105.07, 14105.192, 14126.033, 14131.05, and 14131.07 shall apply to managed care health plans that contract with the department pursuant to Chapter 8.75 (commencing with Section 14591) and to contracts with the Senior Care Action Network and AIDS Healthcare Foundation, to the extent that the services are provided through any of these contracts, payments shall be reduced by the actuarial equivalent amount of the payment reductions pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.

(Amended by Stats. 2012, Ch. 162, Sec. 213. (SB 1171) Effective January 1, 2013.)

14105.1. (a) Notwithstanding any other provision of law, to the extent permitted by federal law, reimbursement to hospitals for inpatient services rendered to Medi-Cal program beneficiaries between July 1, 1981 and June 30, 1982, shall be adjusted to provide that the average payment per discharge upon final settlement shall not exceed a rate of increase of 6 percent over the average payment per discharge at final settlement for services rendered during the period of July 1, 1980 to June 30, 1981.

(b) Interim payment rates to hospitals shall be adjusted on October 1, 1981, or as shortly thereafter as reasonably possible and consistent with federal law, to accomplish a rate of payment increase to hospitals for inpatient services for the period of July 1, 1981 to June 30, 1982, which is consistent with the provisions of this section.

(c) It is the intent of the Legislature that the reimbursement principles employed by the department in final settlement pursuant to this section will be the methods in effect prior to October 1, 1981, for any services rendered prior to that time, and for services rendered between October 1, 1981, and June 30, 1982, that reimbursement principles be in accordance with the alternative methods adopted for use subsequent to October 1, 1981.

(d) Nothing in this section shall be construed to limit adjustments to hospital reimbursement based upon volume or case mix changes.

(Repealed and added by Stats. 1981, Ch. 1163, Sec. 9. Effective October 2, 1981.)

14105.11. (a) The department may negotiate settlements with acute care hospitals with psychiatric units that unintentionally violate Medi-Cal cost reimbursement policies or procedures governing the operation of acute psychiatric hospitals and that had, prior to the violations, been changed by the department.

(b) In any case to which this section applies, the department may waive all or part of the overpayments made under this chapter that would otherwise be reimbursable to the department by an acute care hospital.

(c) This section shall only apply to hospitals in counties of the 20th and 42nd classes.

(Added by Stats. 1997, Ch. 639, Sec. 2. Effective January 1, 1998.)

14105.115. (a) The department may negotiate or renegotiate settlements with any acute care hospital in San Diego County that has a distinct part pediatric convalescent facility and that has violated any Medi-Cal reimbursement policy or procedure governing the operation of acute care hospitals.

(b) In any settlement negotiated or renegotiated pursuant to this section, the department may waive all or part of any overpayment made under this chapter to any acute care hospital described in subdivision (a) that would otherwise be reimbursable to the department by that acute care hospital.

(Added by Stats. 2002, Ch. 486, Sec. 1. Effective September 12, 2002.)

14105.12. (a) The department shall specify circumstances under which requests shall be granted for authorization for services provided by a health facility licensed under subdivisions (c) and (d) of Section 1250 of the Health and Safety Code for periods of up to two years. This subdivision shall be implemented not later than July 1, 1994. The department shall consult with nursing facility providers and appropriate health care professionals in the development of the criteria and process for granting two-year authorizations pursuant to this subdivision.

(b) (1) As of July 1, 1997, the department shall specify circumstances under which requests shall be granted for authorization for services provided by a health facility licensed under subdivisions (e), (g), and (h) of Section 1250 of the Health and Safety Code for

periods up to two years. The department shall consult with facility providers cited in this subdivision and appropriate health care professionals in the development of the criteria and process for granting two-year authorizations pursuant to this subdivision.

(2) The department shall not implement paragraph (1) unless and until federal approval of a change in existing utilization control methods as provided in this section is obtained.

(Amended by Stats. 1996, Ch. 446, Sec. 1. Effective January 1, 1997.)

14105.13. (a) Private duty nursing agencies shall be a provider of skilled nursing services provided on a shift basis covered under the early and periodic screening, diagnosis, and treatment supplemental and home- and community-based waiver programs, subject to federal approval and availability of federal financial participation. In addition to satisfying any other requirements as a condition to participating in the Medi-Cal program under this chapter, a private duty nursing agency licensed under Chapter 8.3 (commencing with Section 1743) of Division 2 of the Health and Safety Code shall satisfy all of the following requirements:

(1) The agency shall be in compliance with the requirements of Chapter 8.3 (commencing with Section 1743) of Division 2 of the Health and Safety Code, and any regulations adopted under that chapter.

(2) The agency shall provide services as specified in Section 1743.2 of the Health and Safety Code.

(3) The agency shall provide skilled nursing services on a shift basis in a patient's home or other community-based site appropriate for patient care.

(b) The department shall request federal approval of an amendment to the existing nursing facility waiver and model nursing facility waiver in order to include private duty nursing agencies as a provider of skilled nursing services on a shift basis.

(c) The department shall review all other federally approved existing waivers that include home health care as a covered service and request federal approval for adding private duty nursing agencies as a provider of skilled nursing services provided on a shift basis, including home- and community-based waivers under Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)).

(Added by Stats. 2001, Ch. 242, Sec. 4. Effective January 1, 2002.)

14105.15. (a) (1) In determining rates of reimbursement for inpatient hospital services the department shall use the reimbursement policy existing on June 29, 1982. The director shall have authority to modify this reimbursement policy. The director shall implement a new reimbursement policy of peer grouping of hospitals through the promulgation of emergency regulations after required federal approvals are obtained. The department may adjust interim payment percentages to hospitals in order to approximate final settlement and may control or freeze charges in order to carry out this section.

(2) This section shall cease to apply to a hospital when the department enters into a contract, pursuant to Article 2.6 (commencing with Section 14081), either with that hospital or with other hospitals to the exclusion of that hospital for services covered under the contracts.

(b) Notwithstanding any other provision of law, the department may make interim rate adjustments and also implement collection procedures to recover overpayments to hospitals, at tentative and final settlement. These recoveries shall be based on audits or examinations made by or on behalf of the department pursuant to Sections 10722 and 14170, including the application of Sections 51536, 51537, and 51539 of Title 22 of the California Administrative Code at tentative and final settlement. Recovery may be made whether or not appeals by the hospitals are pending. Collection of overpayments shall be made in accordance with Section 14172.5.

(c) The amendment of this section made at the 1985 portion of the 1985–86 Regular Session of the Legislature does not constitute a change in, but is declaratory of, the existing law. This declaration shall not apply to any lawsuits filed on or before July 9, 1985.

(d) No new payment system may be implemented without specific authorization from the Legislature.

(e) Notwithstanding any other provision of law, reimbursement for out-of-state acute inpatient hospital services provided to Medi-Cal beneficiaries shall not exceed the current statewide average of contract rates for acute inpatient hospital services negotiated by the California Medical Assistance Commission or the actual billed charges, whichever is less.

(Amended by Stats. 2004, Ch. 193, Sec. 245. Effective January 1, 2005.)

14105.16. (a) The department may establish per diem or bundled reimbursement rates for pharmacies that provide home infusion supplies and services. The per diem or bundled reimbursement rate shall be budget neutral. Only pharmacies that comply with Sections 4127 and 4127.1 of the Business and Professions Code may be determined to be eligible for reimbursement rates established under this subdivision.

(b) In implementing this section the department shall consult with pharmacies providing home infusion supplies and services with respect to all of the following:

(1) Notifying the provider representatives of the proposed change.

(2) Scheduling at least one meeting to discuss the change.

(3) Obtaining actual costs from providers regarding supplies, services, and administrative costs.

(4) Allowing for written input regarding the change.

(5) Providing 30-day advance notice to providers on the implementation and effective date of the change.

(c) Changes made in the Medi-Cal program pursuant to this section are exempt from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500), of Part 1 of Division 3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law.

(Added by Stats. 2006, Ch. 525, Sec. 1. Effective January 1, 2007.)

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

(b) Payments made pursuant to subdivision (a) shall be contingent upon receipt of federal financial participation, and shall be limited by the appropriation in the annual Budget Act for the nonfederal share of these payments. Supplemental payments shall be apportioned among critical access hospitals based upon their number of Medi-Cal outpatient visits.

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

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

(e) The department may adopt emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 1 of Title 2 of the Government Code) to implement this section. One initial adoption of the emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations, and shall remain in effect for no more than 180 days. If the department adopts emergency regulations pursuant to this section, the department shall seek prior input from representatives of the hospital industry, including the California Healthcare Association.

(Added by Stats. 2000, Ch. 93, Sec. 70. Effective July 7, 2000. Conditionally inoperative as provided in subd. (d).)

14105.18. (a) Notwithstanding any other law, provider rates of payment for services rendered in all of the following programs shall be identical to the rates of payment for the same service performed by the same provider type pursuant to the Medi-Cal program:

(1) The California Children's Services Program established pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code.

(2) The Genetically Handicapped Persons Program established pursuant to Article 1 (commencing with Section 125125) of Chapter 2 of Part 5 of Division 106 of the Health and Safety Code.

(3) The Breast and Cervical Cancer Early Detection Program established pursuant to Article 1.3 (commencing with Section 104150) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code and the breast cancer programs specified in Section 30461.6 of the Revenue and Taxation Code.

(4) The State-Only Family Planning Program established pursuant to Division 24 (commencing with Section 24000).

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

(6) The Healthy Families Program established pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code if the health care services are provided by a Medi-Cal provider pursuant to subdivision (b) of Section 12693.26 of the Insurance Code.

(7) The Access for Infants and Mothers Program established pursuant to Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code if the health care services are provided by a Medi-Cal provider.

(b) The director may identify in regulations other programs not listed in subdivision (a) in which providers shall be paid rates of payment that are identical to the rates of payments in the Medi-Cal program pursuant to subdivision (a).

(c) Notwithstanding subdivision (a), services provided under any of the programs described in subdivisions (a) and (b) may be reimbursed at rates greater than the Medi-Cal rate that would otherwise be applicable if those rates are adopted by the director in regulations.

(d) Payment increases made pursuant to Section 14105.196 shall not apply to provider rates of payment described in this section for services provided to individuals not eligible for Medi-Cal or Family PACT.

(e) This section shall become operative on January 1, 2011.

(Amended by Stats. 2015, Ch. 303, Sec. 610. (AB 731) Effective January 1, 2016.)

14105.181. (a) For purposes of this section, the following definitions shall apply:

(1) “The Family Planning, Access, Care, and Treatment (Family PACT) waiver” or “Family PACT waiver” means the program described in subdivision (aa) of Section 14132, as approved by a federal demonstration waiver.

(2) “Comprehensive clinical family planning services” means those services described in paragraph (8) of subdivision (aa) of Section 14132.

(3) “Office visits” means those procedures billed under Common Procedure Terminology codes 99201, 99202, 99203, 99204, 99211, 99212, 99213, and 99214.

(b) Reimbursement rates for office visits billed as comprehensive clinical family planning services by Family PACT waiver providers and for office visits billed as family planning services by Medi-Cal providers shall receive a rate augmentation equal to the weighted average of at least 80 percent of the amount that the federal Medicare program reimburses for these same or similar office visits. The rate augmentation shall be based upon Medicare rates in effect on December 31, 2007.

(c) The augmentation of reimbursement rates described in subdivision (b) shall be made for office visits rendered on or after January 1, 2008.

(d) (1) The director may adopt regulations as necessary to implement this section. 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 section, the adoption of the regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or the general welfare.

(2) As an alternative to paragraph (1), and notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the director may administer this section, in whole or in part, by means of a provider bulletin, or other similar instructions, without taking regulatory action.

(Added by Stats. 2007, Ch. 636, Sec. 1. Effective January 1, 2008.)

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 of this code, 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 14591), 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 licensed 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 licensed 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 State Hospitals 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.

(Amended by Stats. 2012, Ch. 440, Sec. 77. (AB 1488) Effective September 22, 2012.)

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 14591), 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 State Hospitals or the State Department of Developmental Services.

(7) Hospice services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Amended by Stats. 2012, Ch. 440, Sec. 78. (AB 1488) Effective September 22, 2012.)

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

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

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

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

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

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

(b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and consistent with

federal and state law and policies, including exemptions contained in the act that added this section, provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services, and products.

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

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

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

(3) Payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after June 1, 2011. This paragraph shall not apply to inpatient hospital services provided in a hospital that is paid under contract pursuant to Article 2.6 (commencing with Section 14081).

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

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

(e) Notwithstanding this section, payments to hospitals that are not under contract with the department pursuant to Article 2.6 (commencing with Section 14081) for inpatient hospital services provided to Medi-Cal beneficiaries and that are subject to former Section 14166.245 shall be governed by that section.

(f) Notwithstanding this section, both of the following apply:

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

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

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

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

(g) The department may enter into contracts with a vendor for the purposes of implementing this section on a bid or nonbid basis. In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this subdivision is necessary. Therefore, contracts entered into to implement this section and all contract amendments and change orders shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 Division 2 of the Public Contract Code.

(h) To the extent applicable, all of the following services, facilities, and payments shall be exempt from the payment reductions specified in subdivision (d):

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

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

(3) Rural health clinic services.

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

(5) Hospice services.

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

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

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

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

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

(11) (A) Effective for dates of service on or after July 1, 2015, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later, dental services and applicable ancillary services.

(B) For dental managed care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), payments pursuant to contract amendments or change orders effective on or after July 1, 2015, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later.

(12) For dates of service on and after January 1, 2022, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later, providers of complex rehabilitation technology and complex rehabilitation technology services, as described in Section 14132.85.

(13) For dates of service on and after July 1, 2022, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later, all of the following services and providers:

(A) Nurses, including certified nurse-midwives, nurse anesthetists, certified pediatric nurse practitioners, certified family nurse practitioners, and group certified pediatric nurse practitioners.

(B) Alternative birth centers as described in Section 14148.8.

(C) Audiologists and hearing aid dispensers as described in Section 14105.49 of this code and Section 51319 of Title 22 of the California Code of Regulations.

(D) Respiratory care providers as described in Section 51316 of Title 22 of the California Code of Regulations.

(E) Durable medical equipment, as described in Section 51160 of Title 22 of the California Code of Regulations.

(F) Chronic dialysis clinics.

(G) Emergency medical air transportation services as described in Section 76000.10 of the Government Code.

(H) Nonemergency medical transportation services as described in Section 51323 of Title 22 of the California Code of Regulations.

(I) Doula services as described in Section 14132.24.

(J) Community health worker services as described in the approved Medi-Cal State Plan.

(K) Durable medical equipment and related supplies or accessories, as described in Section 14105.48 and Section 51160 of Title 22 of the California Code of Regulations, that is a continuous glucose monitoring system or continuous glucose monitoring system supplies and accessories, as determined by the department.

(L) Health care services delivered via remote patient monitoring, authorized pursuant to subparagraph (B) of paragraph (1) of subdivision (f) of Section 14124.12.

(M) Asthma prevention services as described in the approved Medi-Cal State Plan.

(N) Dyadic services as described in Section 14132.755.

(O) Medication therapy management services as described in Section 14132.969.

(P) Clinical laboratory services, as defined in Section 51137.2 of Title 22 of the California Code of Regulations, that are 2019 Novel Coronavirus (COVID-19) diagnostic testing or specimen collection services, as determined by the department.

(Q) Blood banks, as described in Section 51052 of Title 22 of the California Code of Regulations.

(R) Occupational therapy, as described in Section 51085 of the California Code of Regulations.

(S) Orthotists, as described in Section 51101 of Title 22 of the California Code of Regulations.

(T) Psychologists, as described in Section 51099 of Title 22 of the California Code of Regulations.

(U) Medical social work or medical social services, as described in Section 51147 of Title 22 of the California Code of Regulations.

(V) Speech pathologists, as described in Section 51095 of Title 22 of the California Code of Regulations.

(W) Outpatient heroin detoxification services, as described in Section 51116 of Title 22 of the California Code of Regulations.

(X) Dispensing opticians, as described in Section 51090 of Title 22 of the California Code of Regulations.

(Y) Optometrists, including optometry groups, as described in Section 51091 of Title 22 of the California Code of Regulations.

(Z) Acupuncturists, as described in Section 51074 of Title 22 of the California Code of Regulations.

(AA) Portable imaging services, as described in Section 51193.1 of Title 22 of the California Code of Regulations.

(AB) The following primary care or specialty clinics, as determined by the department:

(i) Community clinics, as defined in Section 1204 of the Health and Safety Code.

(ii) Free clinics, as defined in Section 1204 of the Health and Safety Code.

(iii) Surgical clinics, as defined in Section 1204 of the Health and Safety Code.

(iv) Rehabilitation clinics, as defined in Section 1204 of the Health and Safety Code.

(v) Clinics exempt from licensure under Section 1206 of the Health and Safety Code, including nonhospital county-operated community clinics.

(AC) Services provided under the California Children's Services Program, established pursuant to Article 5 (commencing with Section 123845) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and under the Genetically Handicapped Persons Program, established pursuant to Article 1 (commencing with Section 125125) of Chapter 2 of Part 5 of Division 106 of the Health and Safety Code, as determined by the department.

(AD) Community-Based Adult Services (CBAS), as described in Section 14186.3 and as covered pursuant to subdivision (e) of Section 14184.201.

(14) For dates of service on and after January 1, 2023, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later, both of the following providers:

(A) Podiatrists, as described in Section 51075 of Title 22 of the California Code of Regulations.

(B) Prosthetists, as described in Section 51103 of Title 22 of the California Code of Regulations.

(15) For dates of service on and after January 1, 2024, or the effective date of the payments implemented pursuant to subdivision (a) of Section 14105.201, whichever is later, all of the following services and providers:

(A) Primary care services, including those provided by physicians or nonphysician health professionals, as defined in Section 51170.5 of Title 22 of the California Code of Regulations.

(B) Obstetric care services and doula services as described in Section 14132.24.

(C) Outpatient mental health services that are not the financial responsibility of county mental health plans operating pursuant to Chapter 8.9 (commencing with Section 14700).

(16) (A) For dates of service on and after January 1, 2025, or the effective dates of the payments implemented pursuant to Sections 14124.163 and 14124.165, whichever is later, as applicable, all of the following services and providers:

(i) Physician and professional services subject to reimbursement pursuant to Section 14124.163.

(ii) Abortion services, as defined in subdivision (d) of Section 14124.161, subject to reimbursement pursuant to Section 14124.165.

(B) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to this part at the November 5, 2024, statewide general election, this paragraph shall be inoperative as of January 1, 2025.

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

(j) Notwithstanding any other law, for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates applicable to the following classes of providers shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008–09 rate year, as described in subdivision (f) of Section 14105.191, reduced by 10 percent:

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

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

(3) Rural swing-bed facilities.

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

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

(6) Adult day health care centers.

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

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

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

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

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

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

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

(o) (1) The payment reductions and adjustments set forth in this section shall not be implemented until federal approval is obtained.

(2) To the extent that federal approval is obtained for one or more of the payment reductions and adjustments in this section and Section 14105.07, the payment reductions and adjustments set forth in Section 14105.191 shall cease to be implemented for the same services provided by the same class of providers. If there is a conflict between this section and Section 14105.191, other than the provisions setting forth a payment reduction or adjustment, this section shall govern.

(3) When federal approval is obtained, the payments resulting from the application of this section shall be implemented retroactively to June 1, 2011, or on any other date or dates, as may be applicable.

(4) The director may clarify the application of this subdivision by means of provider bulletins or similar instructions, pursuant to subdivision (k).

(p) Adjustments to pharmacy drug product payment pursuant to this section shall no longer apply when the department determines that the average acquisition cost methodology pursuant to Section 14105.45 has been fully implemented and the department's pharmacy budget reduction targets, consistent with payment reduction levels pursuant to this section, have been met.

(Amended by Stats. 2024, Ch. 40, Sec. 55. (SB 159) Effective June 29, 2024. Note: Condition in paragraph (2) of subdivision (f) was satisfied by addition of Section 14105.07 by Stats. 2011, Ch. 3.)

14105.193. (a) (1) Notwithstanding paragraph (7) of subdivision (j) of Section 14105.192 and any other law, beginning June 1, 2011, reimbursement rates for freestanding pediatric subacute care units, as defined in Section 51215.8 of Title 22 of the California Code of Regulations, shall be the applicable rate for the 2008–09 rate year, reduced by 5.75 percent, plus the projected cost of complying with new state or federal mandates.

(2) The department shall recalculate and publish the rates specified in paragraph (1) for any of the following reasons:

(A) If the federal Centers for Medicare and Medicaid Services (CMS) does not approve exemption changes to the facilities subject to the skilled nursing facility quality assurance fee pursuant to paragraph (4) of subdivision (c) of Section 1324.20 of the Health and Safety Code.

(B) If CMS does not approve any proposed modification to the methodology for calculation of the skilled nursing quality assurance fee pursuant to Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code.

(C) To ensure that the state does not incur any additional General Fund expenses for reimbursement to pediatric subacute care units for dates of service on and after June 1, 2011.

(D) If the difference in the projected skilled nursing quality assurance fee collections for the 2011–12 rate year, pursuant to Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code, would result in any additional General Fund expense to pay for the 2011–12 rate year reimbursement rate.

(b) 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.

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

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

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

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

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

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

(Amended by Stats. 2012, Ch. 162, Sec. 214. (SB 1171) Effective January 1, 2013.)

14105.194. (a) (1) Notwithstanding Sections 14105.191, 14105.192, and 14105.193, and for dates of service on or after August 1, 2021, the reimbursement rates for freestanding pediatric subacute care units, as defined in Section 51215.8 of Title 22 of the California Code of Regulations, shall be determined without applying any reductions or limitations as set forth under Sections 14105.191, 14105.192, and 14105.193.

(2) For dates of service on or after August 1, 2021, and for each rate year thereafter, the department shall calculate and publish the reimbursement rates, as specified in paragraph (1), plus the projected cost of complying with new state or federal mandates.

(3) For the 2021–22 fiscal year, and for each fiscal year thereafter, the reimbursement rates for freestanding pediatric subacute care units shall account for, and be inclusive of, supplemental payments, as described under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, or Proposition 56, if the Budget Act of that fiscal year appropriates funds from the Healthcare Treatment Fund, as established pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, to the department to make those supplemental payments to the freestanding pediatric subacute care units.

(4) Effective for dates of service August 1, 2022, to December 31, 2023, inclusive, the reimbursement rates for freestanding pediatric subacute care units shall continue to be the reimbursement rate in effect on August 1, 2022, inclusive of any federally authorized temporary Medicaid payments.

(5) Effective for dates of service on or after January 1, 2024, the department shall adopt a rate year based on the calendar year for freestanding pediatric subacute care units.

(6) Effective for rate years beginning on or after January 1, 2024, the reimbursement rates for freestanding pediatric subacute care units shall be no less than the reimbursement rate, inclusive of the federally authorized temporary increased Medicaid payments or an equivalent amount described in paragraph (4), in effect for that facility on December 31, 2023.

(b) In implementing this section, the department shall seek any federal approvals it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(c) 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 this section, in whole or in part, by means of provider bulletins or other similar instructions, without taking regulatory action.

(d) (1) The department may modify any methodology or provision specified in this section to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized, only if that modification does not violate the spirit, purposes, and intent of this section.

(2) If the department determines that a modification is necessary pursuant to paragraph (1), the department shall consult with affected providers and stakeholders to the extent practicable.

(Amended by Stats. 2023, Ch. 42, Sec. 138. (AB 118) Effective July 10, 2023.)

14105.195. (a) Notwithstanding Sections 14105.191 and 14105.192, the department shall not seek to retroactively implement the reductions and limitations to the reimbursement for services provided by skilled nursing facilities that are distinct parts of general acute care hospitals set forth in Sections 14105.191 and 14105.192 for dates of service on or after June 1, 2011, and on or before September 30, 2013. 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.

(b) The department shall not seek to recoup any overpayments from skilled nursing facilities that are distinct parts of general acute care hospitals resulting from the reductions and limitations to the reimbursement for these facilities pursuant to Sections 14105.191 and 14105.192 for dates of service on or after June 1, 2011, and on or before September 30, 2013.

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

(Added by Stats. 2016, 2nd Ex. Sess., Ch. 3, Sec. 14. (AB 1 2x) Effective June 9, 2016.)

14105.197. (a) For dates of service on and after July 1, 2022, or the effective date of any necessary federal approvals as required by subdivision (b), whichever is later, the reimbursement rates or payments for all of the following services and providers may be maintained, using General Fund or other state funds appropriated to the department as the state share, at the payment levels in effect on December 31, 2021, including supplemental payments or rate increases, or both, as applicable, under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56, an initiative measure approved at the November 8, 2016, statewide general election) that were implemented with funds from the Healthcare Treatment Fund, as established pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code:

(1) Case management services provided under the Medi-Cal HIV/AIDS Waiver Program.

(2) Targeted payments for qualifying providers of Community-Based Adult Services (CBAS), as described in Section 14186.3 and subdivision (d) of Section 14184.201, based on criteria established and updated by the department, which may include, but need not be limited to, higher operating costs for CBAS providers in certain areas of the state.

(3) Developmental screenings for individuals zero to three years of age, inclusive, as described in Section 14132.195.

(4) Adverse Childhood Experiences (ACEs) trauma screenings.

(5) Nonemergency medical transportation.

(6) Home health providers of medically necessary in-home services for children and adults in the Medi-Cal fee-for-service system or through home and community-based services waivers.

(7) Pediatric day health care facilities in the Medi-Cal fee-for-service system.

(b) In implementing this section, the department shall seek any federal approvals it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(c) 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 this section, in whole or in part, by means of provider bulletins or other similar instructions, without taking any further regulatory action.

(d) The department shall develop the eligibility criteria, methodologies, and parameters for the payments and rate increases maintained pursuant to subdivision (a), and may revise the eligibility criteria, methodologies, and parameters, for purposes including, but not limited to, obtaining or maintaining any necessary federal approvals as required by subdivision (b).

(Added by Stats. 2022, Ch. 47, Sec. 91. (SB 184) Effective June 30, 2022.)

14105.200. (a) The Medi-Cal Provider Payment Reserve Fund is hereby created in the State Treasury.

(b) Notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on moneys in the Medi-Cal Provider Payment Reserve Fund shall be retained in the fund and used solely for the purposes specified in this section.

(c) (1) Subject to an appropriation made by the Legislature, the department shall use the funds transferred to the Medi-Cal Provider Payment Reserve Fund pursuant to paragraph (3) of subdivision (d) of Section 14199.82 for purposes of funding targeted increases to Medi-Cal payments or other investments that advance access, quality, and equity for Medi-Cal beneficiaries and promote provider participation in the Medi-Cal program.

(2) The expenditures of funds appropriated pursuant to paragraph (1) shall include, but not be limited to, all of the following:

(A) Increased costs incurred as a result of the reimbursement requirements established in Section 14105.201.

(B) Transfers authorized in paragraph (2) of subdivision (e) of Section 129385 of the Health and Safety Code.

(C) Transfers, or an appropriation in the annual Budget Act, to the Small and Rural Hospital Relief Fund, as established in Section 130077 of the Health and Safety Code, in the amount of fifty million dollars ($50,000,000) in state fiscal year 2023–24 to support the Small and Rural Hospital Relief Program for seismic assessment and construction.

(d) The department shall provide an annual report to all health plans accounting for the funds deposited in, and expended from, the Medi-Cal Provider Payment Reserve Fund, in a time and manner deemed appropriate by the director.

(e) Notwithstanding any other law, the Controller may use the funds in the Medi-Cal Provider Payment Reserve Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

(f) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to this part at the November 5, 2024, statewide general election, this section shall become operative on January 1, 2025.

(Repealed (in Sec. 56) and added by Stats. 2024, Ch. 40, Sec. 57. (SB 159) Effective June 29, 2024. Operative January 1, 2025, by its own provisions. Inoperative on date prescribed by Section 14199.103. Repealed one year after inoperative date, pursuant to Section 14199.103.)

14105.201. (a) (1) Notwithstanding any other law, for dates of service no sooner than January 1, 2024, or on the effective date of any necessary federal approvals as required by subdivision (e), whichever is later, the reimbursement rates for the following services, as determined in accordance with subdivision (g), shall be the greater of 87.5 percent of the lowest maximum allowance established by the federal Medicare Program for the same or similar services or the level of reimbursement, which shall account for, and be inclusive of, the exemption of these services from payment reductions pursuant to Section 14105.192, and supplemental payments or rate increases, or both, as applicable, under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56, an initiative measure approved at the November 8, 2016, statewide general election) that were implemented with funds from the Healthcare Treatment Fund, as established pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, in effect as of December 31, 2023, as determined by the department:

(A) Primary care services, including those provided by physicians or nonphysician health professionals, as defined in Section 51170.5 of Title 22 of the California Code of Regulations.

(B) Obstetric care services, and doula services as described in Section 14132.24.

(C) Outpatient mental health services that are not the financial responsibility of county mental health plans operating pursuant to Chapter 8.9 (commencing with Section 14700).

(2) The department shall annually review and revise the reimbursement rates in accordance with paragraph (1) based on changes to the lowest maximum allowance established by the federal Medicare Program for the same or similar services. Any revisions to the reimbursement rates determined in accordance with paragraph (1) shall be considered as part of the annual budget development process and take effect beginning on January 1, 2025, and each subsequent January 1 thereafter, of the calendar year following the department's annual review.

(3) The department shall develop and implement a methodology for establishing reimbursement rates or payments for the services described in paragraph (1) where there is no specified maximum allowable rate established by the federal Medicare Program. The department shall review this methodology annually and may, in its sole discretion, modify the methodology on a prospective basis.

(b) (1) (A) For contract periods during which subdivision (a) is implemented, each Medi-Cal managed care plan shall reimburse a network provider furnishing the services subject to subdivision (a) at least the amount the network provider would be paid for those services in the Medi-Cal fee-for-service delivery system, as set forth by the department in the approved Medi-Cal State Plan and guidance issued pursuant to subdivision (f).

(B) Medi-Cal managed care plans that reimburse a network provider furnishing the services identified in subparagraphs (A) to (C), inclusive, of paragraph (1) of subdivision (a) on a capitated basis shall ensure that the network provider receives reimbursement that is equal to, or projected to be equal to, the level of reimbursement required in subparagraph (A) for the applicable services and, as applicable, shall increase reimbursement to the network provider to comply with this subparagraph.

(2) The department may require Medi-Cal managed care plans and network providers of the applicable services to submit information the department deems necessary to implement and monitor compliance with this subdivision, at the times and in the form and manner specified by the department.

(c) (1) The payments implemented pursuant to subdivisions (a) and (b) shall be supported by the managed care organization provider tax revenue, pursuant to Article 7.1 (commencing with Section 14199.80), or other state funds appropriated to the department as the state share for this purpose, including, but not limited to, funds transferred to the Medi-Cal Provider Payment Reserve Fund in accordance with Sections 14105.200 and 14199.82 and to the Healthcare Treatment Fund in accordance with subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(2) Notwithstanding any other law, increases to fee-for-service reimbursement rates and managed care directed payments that are made pursuant to subdivisions (a) and (b) constitute increases in accordance with subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, and all other fee-for-service supplemental payments and managed care directed payments for the services identified in subparagraphs (A) to (C), inclusive, of paragraph (1) of subdivision (a) that are made pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code shall be discontinued on the date the payments implemented pursuant to subdivisions (a) and (b) are effective.

(d) (1) Effective for dates of service on or after January 1, 2025, community health workers shall be an eligible provider type for the rate increases effective pursuant to this section.

(2) In establishing the reimbursement rate for community health workers pursuant to subdivision (a), the department shall set rates equal to 100 percent of the lowest maximum allowance established by the federal Medicare Program for the same or similar services.

(3) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to this part at the November 5, 2024, statewide general election, this subdivision shall be inoperative as of January 1, 2025.

(e) In implementing this section, the department shall seek any federal approvals that it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(f) 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 this section, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or other similar instructions, without taking any further regulatory action.

(g) The department shall develop the methodologies and parameters for the payments implemented pursuant to subdivisions (a), (b), and (d), and may revise the methodologies and parameters, for purposes including, but not limited to, obtaining or maintaining any necessary federal approvals as required by subdivision (e).

(h) For purposes of this section, the following definitions shall apply:

(1) "Community health workers" has the same meaning as set forth in the Medi-Cal State Plan.

(2) “Medi-Cal managed care plan” has the same meaning as that term is defined in subdivision (j) of Section 14184.101.

(3) “Network provider” has the same meaning as that term is defined in Section 438.2 of Title 42 of the Code of Federal Regulations.

(i) The Legislature finds and declares that this section, as it pertains to funding made available for expenditure pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, is consistent and in accordance with the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56, an initiative measure approved at the November 8, 2016, statewide general election).

(Amended by Stats. 2024, Ch. 40, Sec. 58. (SB 159) Effective June 29, 2024.)

14105.2. (a) The allowable markup payable for the dispensing of medical supplies, including diabetic supplies except as indicated in subdivision (b), by assistive device and sickroom supply dealers and pharmacies shall not exceed 23 percent of the estimated acquisition cost of the item dispensed, as defined by the department.

(b) Payment for diabetic test strips, lancets, and insulin syringes shall not exceed the estimated acquisition cost of the item dispensed, as defined by the department, plus a fee equal to the maximum professional fee component used in the payment for legend generic drug types.

(c) In determining the estimated acquisition costs of products pursuant to this section, the department shall consider provider related costs of the product that include, but are not limited to, shipping, handling, storage, and delivery.

(d) This section shall become operative on July 1, 2022.

(Repealed (in Sec. 92) and added by Stats. 2022, Ch. 47, Sec. 93. (SB 184) Effective June 30, 2022. Operative July 1, 2022, by its own provisions.)

14105.21. (a) An assistive device and sickroom supply dealer may not bill the Medi-Cal program for prosthetic and orthotic appliances.

(b) A pharmacy may not bill the Medi-Cal program for prosthetic or orthotic appliances, unless the pharmacy is certified by the National Community Pharmacists Association and only for prosthetic and orthotic appliances that have been identified pursuant to subdivision (c) or otherwise approved by the department.

(c) The department shall establish a list of covered services and maximum allowable reimbursement rates, subject to Section 14107.7, for prosthetic and orthotic appliances, and the list shall be published in provider manuals.

(d) Reimbursement for prosthetic and orthotic appliances, as defined in Section 51160 of Title 22 of the California Code of Regulations, may not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar services.

(e) The department shall repeal Section 51515 of Title 22 of the California Code of Regulations, as it read on the effective date of the act adding this section.

(f) The department may implement this section by provider manual or bulletin. Notwithstanding the provisions of the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code, actions under this section shall not be subject to the rulemaking provisions of the Administrative Procedure Act or to the review and approval of the Office of Administrative Law.

(Added by Stats. 2003, Ch. 230, Sec. 63. Effective August 11, 2003.)

14105.22. (a) (1) It is the intent of the Legislature that the department develop reimbursement rates for clinical laboratory or laboratory services that are comparable to the payment amounts received from other payers for clinical laboratory or laboratory services. Development of these rates will enable the department to reimburse clinical laboratory or laboratory service providers in compliance with state and federal law.

(2) (A) The requirements specified in subdivision (a) of Section 51501 of Title 22 of the California Code of Regulations shall not apply to laboratory providers reimbursed under the new rate methodology developed for clinical laboratories or laboratory services pursuant to this subdivision.

(B) In addition to subparagraph (A), laboratory providers reimbursed under any payment reductions implemented pursuant to this section shall not be subject to the requirements specified in subdivision (a) of Section 51501 of Title 22 of the California Code of Regulations until July 1, 2015.

(3) Reimbursement to providers for clinical laboratory or laboratory services shall not exceed the lowest of the following:

(A) The amount billed.

(B) The charge to the general public.

(C) (i) For dates of service before July 1, 2022, 80 percent of the lowest maximum allowance established by the federal Medicare program for the same or similar services.

(ii) For dates of service on or after July 1, 2022, 100 percent of the lowest maximum allowance established by the federal Medicare program for the same or similar services.

(D) A reimbursement rate based on an average of the lowest amount that other payers and other state Medicaid programs are paying for similar clinical laboratory or laboratory services.

(4) (A) In addition to the payment reductions implemented pursuant to Section 14105.192, payments shall be reduced by up to 10 percent for clinical laboratory or laboratory services, as defined in Section 51137.2 of Title 22 of the California Code of Regulations, for dates of service on and after July 1, 2012. The payment reductions pursuant to this paragraph shall continue until the new rate methodology under this subdivision has been approved by the federal Centers for Medicare and Medicaid Services.

(B) Notwithstanding subparagraph (A), the Family Planning, Access, Care, and Treatment Program pursuant to subdivision (aa) of Section 14132 shall be exempt from the payment reduction specified in this section.

(5) (A) For purposes of establishing reimbursement rates for clinical laboratory or laboratory services pursuant to subparagraph (D) of paragraph (3), laboratory service providers shall submit data reports according to the following schedule:

(i) The data initially provided shall be for the 2018 calendar year. For each subsequent reporting year, the data shall be based on the previous calendar year.

(ii) For purposes of clause (i), “reporting year” means 2019 and every third year thereafter.

(B) A data report submitted pursuant to subparagraph (A) shall specify the provider’s lowest amounts other payers are paying, including other state Medicaid programs and private insurance, minus discounts and rebates. The specific data required for submission under this subparagraph and the format for the data submission shall be determined and specified by the department after receiving stakeholder input pursuant to paragraph (7).

(C) The data submitted pursuant to subparagraph (A) may be used to determine reimbursement rates by procedure code based on an average of the lowest amount other payers are paying providers for similar clinical laboratory or laboratory services, excluding significant deviations of cost or volume factors and with consideration to geographical areas. The department shall have the discretion to determine the specific methodology and factors used in the development of the lowest average amount under this subparagraph to ensure compliance with federal Medicaid law and regulations as specified in paragraph (9).

(D) For purposes of subparagraph (C), the department may contract with a vendor for the purposes of collecting payment data reports from clinical laboratories, analyzing payment information, and calculating a proposed rate.

(E) The proposed rates calculated by the vendor, as described in subparagraph (D), may be used in determining the lowest reimbursement rate for clinical laboratories or laboratory services in accordance with paragraph (3).

(F) Data reports submitted to the department shall be certified by the provider’s certified financial officer or an authorized individual.

(G) Clinical laboratory providers that fail to submit data reports within 30 working days from the time requested by the department shall be subject to the suspension standards of subdivisions (a) and (c) of Section 14123.

(6) Data reports provided to the department pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(7) The department shall seek stakeholder input on the ratesetting methodology.

(8) 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, in whole or in part, by means of provider bulletins or notices, policy letters, or other similar instructions, without taking any further regulatory action.

(9) (A) The department shall implement this section in a manner that is consistent with federal Medicaid law and regulations. The director shall seek any necessary federal approvals for the implementation of this section. This section shall be implemented only to the extent that federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

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

(C) To the extent that the director determines that the rates and payments do not comply with applicable federal Medicaid requirements or that federal financial participation is not available with respect to any reimbursement rate, the director retains the discretion not to implement that rate or payment and may revise the rate or payment as necessary to comply with federal Medicaid requirements. The department shall notify the Joint Legislative Budget Committee 10 days prior to revising the rate or payment to comply with federal Medicaid requirements.

(b) Reimbursement rates developed pursuant to subparagraph (D) of paragraph (3) of subdivision (a) and the changes made by the act that added this subdivision shall be effective beginning on July 1, 2020, and on July 1 of every third year thereafter.

(c) Notwithstanding subdivisions (a) and (b), for dates of service from July 1, 2021, to June 30, 2022, inclusive, the department shall establish the reimbursement rates for clinical laboratory or laboratory services at the rates in effect and approved in the Medi-Cal State Plan as of December 31, 2019, pursuant to Section 14105.222.

(Amended by Stats. 2022, Ch. 28, Sec. 162. (SB 1380) Effective January 1, 2023.)

14105.221. Notwithstanding Section 51501(a) of Title 22 of the California Code of Regulations, donation of, or discounts for, clinical laboratory tests or examinations or laboratory services to a federally qualified health center, as defined in Section 1396d(l)(2)(B) of Title 42 of the United States Code, for the purpose of serving its uninsured patients, shall not be considered as a basis for the reduction of Medi-Cal payments below the reimbursement rate established pursuant to Section 14105.22.

(Added by Stats. 2012, Ch. 738, Sec. 1. (AB 969) Effective January 1, 2013.)

14105.222. (a) Notwithstanding Section 14105.22, the department shall not seek to retroactively implement the reductions and limitations to the reimbursement for clinical laboratory or laboratory services set forth in Section 14105.22 for dates of service from January 1, 2020, to June 30, 2021, inclusive. The payment reductions implemented pursuant to Section 14105.192 shall continue to apply for clinical laboratory or laboratory services.

(b) The department shall not seek to recoup any overpayments for clinical laboratory or laboratory services resulting from the reductions and limitations to the reimbursement for clinical laboratory or laboratory services pursuant to Section 14105.22 for dates of service from January 1, 2020, to June 30, 2021, inclusive. Any overpayments for clinical laboratory or laboratory services resulting from the reductions implemented pursuant to Section 14105.192 shall continue to be recouped.

(c) For dates of service from July 1, 2021, to June 30, 2022, inclusive, the department shall establish the reimbursement rates for clinical laboratory or laboratory services at the rates in effect and approved in the Medi-Cal State Plan as of December 31, 2019.

(d) For dates of services on or after July 1, 2022, the department shall establish the reimbursement rates for clinical laboratory or laboratory services pursuant to Section 14105.22.

(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, in whole or in part, by means of provider bulletins or notices, policy letters, or other similar instructions, without taking any further regulatory action.

(f) The department shall implement this section in a manner that is consistent with federal Medicaid law and regulations. The department shall seek any necessary federal approvals for the implementation of this section. This section shall be implemented only to the extent that federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(Added by Stats. 2021, Ch. 143, Sec. 377. (AB 133) Effective July 27, 2021.)

14105.23. (a) Reimbursement for portable X-ray transportation services, as defined in paragraph (2) of subdivision (b) of Section 51531 of Title 22 of the California Code of Regulations, shall not exceed 100 percent of the lowest maximum allowance for California established by the federal Medicare Program for the same or similar services.

(b) Notwithstanding subdivision (a) of Section 14105 and 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 establish the rates of reimbursement for the services described in subdivision (a) by means of a provider bulletin or manual, or similar instructions.

(Added by Stats. 2005, Ch. 80, Sec. 23. Effective July 19, 2005.)

14105.24. (a) Clinics and hospital outpatient departments, except for emergency rooms, owned or operated by Los Angeles County that participated in the California Section 1115 Medicaid Demonstration Project for Los Angeles County (No. 11-W-00076/9) and received 100 percent cost-based reimbursement pursuant to the Special Terms and Conditions of that waiver shall continue to be reimbursed under a cost-based methodology on and after July 1, 2005.

(b) Reimbursement to clinics and hospitals described in subdivision (a) shall be at 100 percent of reasonable and allowable costs for Medi-Cal services rendered to Medi-Cal beneficiaries. Reasonable and allowable costs shall be determined in accordance with applicable cost-based reimbursement provisions of the following regulations and publications:

(1) The Medicare reimbursement methodology as specified at Sections 405.2460 to 405.2470, inclusive, of Title 42 of the Code of Federal Regulations, together with applicable definitions in Subpart X of Part 405 of Title 42 of the Code of Federal Regulations to the extent those definitions are applied by the department in connection with payments to federally qualified health centers in California.

(2) Cost reimbursement principles outlined in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations. In the event of a conflict between the provisions of Part 405 and Part 413, the provisions of Part 405 shall govern.

(3) “Cost Principles for State, Local, and Indian Tribe Governments” (OMB Circular A-87).

(4) “Rural Health and FQHC Manual” (CMS Publication 27).

(5) Subdivision (e) of Section 14087.325 and any implementing regulations.

(c) The methodology for reimbursement adopted by the state to comply with Section 1396a(aa) of Title 42 of the United States Code shall not be applicable to clinics and hospitals that are paid pursuant to this section.

(d) This section shall be implemented on the effective date established by the federal Centers for Medicare and Medicaid Services for an amendment to the California Medicaid State Plan that approves the cost-based reimbursement methodology for the clinics and hospitals described in subdivision (b).

(e) (1) Payments received by clinics and hospital outpatient departments described in subdivision (a), for services rendered to populations described in Section 14182, shall be equivalent to what otherwise would have been received under this section on a fee-for-service basis.

(2) This subdivision shall be implemented only to the extent permitted under federal law and when federal financial participation is available.

(f) Notwithstanding subdivision (a) of Section 14105, and 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 and administer the cost-based rates of reimbursement described in this section by means of provider bulletins or manuals, or similar instructions.

(Amended by Stats. 2010, Ch. 714, Sec. 2. (SB 208) Effective October 19, 2010.)

14105.25. (a) Notwithstanding any other provision of law, to the extent permitted by federal law and regulations, the maximum rate of reimbursement under the Medi-Cal program for any service or item that is a benefit under Part B of the Medicare program, excluding physician and diagnostic clinical laboratory services, shall not exceed the lowest maximum allowance established by the federal Medicare program for that service or item in any area of the state.

(b) The director shall reduce the rate of reimbursement for any service or item, as required, to comply with subdivision (a).

(c) The director shall administer this section and establish standards, procedures, and rates of reimbursement, as the director deems necessary in carrying out this section. Reimbursement rates are not required to be adopted as regulations pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(Added by Stats. 1992, Ch. 722, Sec. 91. Effective September 15, 1992.)

14105.26. (a) Each eligible facility, as described in paragraph (2) of subdivision (b), may, in addition to the rate of payment that the facility would otherwise receive for skilled nursing services, receive supplemental Medi-Cal reimbursement to the extent provided in this section.

(b) (1) Projects eligible for supplemental reimbursement shall include any new capital projects for which final plans have been submitted to the appropriate review agency after January 1, 2000, and before January 1, 2003. For purposes of this section, “capital project” means the construction, expansion, replacement, remodeling, or renovation of an eligible facility, including buildings and fixed equipment. A “capital project” does not include the provision of furnishings or of equipment that is not fixed equipment.

(2) A facility shall be eligible only if the submitting entity had all of the following additional characteristics during the 1998 calendar year:

(A) Provided services to Medi-Cal beneficiaries.

(B) Was a distinct part of an acute care hospital providing skilled nursing care and supportive care to patients whose primary need is for the availability of skilled nursing care on an extended basis. For the purposes of this section, “acute care hospital”

means the facilities defined in subdivision (a) or (b), or both, of Section 1250 of the Health and Safety Code.

(C) Had not less than 300 licensed skilled nursing beds.

(D) Had an average skilled nursing Medi-Cal patient census of not less than 80 percent of the total skilled nursing patient days.

(E) Was owned by a county or city and county.

(c) (1) An eligible facility seeking to qualify for supplemental reimbursement shall submit documentation to the department regarding debt service on revenue bonds or other financing instruments used for financing the capital project.

(2) The department shall confirm in writing project eligibility under this section.

(d) (1) Capital projects receiving funding shall include only the upgrading or construction of buildings and equipment to a level required by currently accepted medical practice standards, including projects designed to correct Joint Commission on Accreditation of Hospitals and Health Systems, fire and life safety, seismic, or other related regulatory standards.

(2) Capital projects receiving funding may expand service capacity as needed to maintain current or reasonably foreseeable necessary bed capacity to meet the needs of Medi-Cal beneficiaries after giving consideration to bed capacity needed for other patients, including unsponsored patients.

(3) Supplemental reimbursement shall only be made for capital projects, or for that portion of capital projects that provide skilled nursing services, and that are available and accessible to patients eligible for services under this chapter.

(e) An eligible facility's supplemental reimbursement for a capital project qualifying pursuant to this section shall be calculated and paid as follows:

(1) For any fiscal year for which the facility is eligible to receive supplemental reimbursement, the facility shall report to the department the amount of debt service on the revenue bonds or other financing instruments issued to finance the capital project.

(2) For each fiscal year in which an eligible facility requests reimbursement, the department shall establish the ratio of skilled nursing Medi-Cal days of care provided by the eligible facility to total skilled nursing patient days of care provided by the eligible facility. The ratio shall be established using data obtained from audits performed by the department, and shall be applied to the corresponding fiscal year of debt service on the revenue bonds or other financing instruments issued to finance the capital project.

(3) The amount of debt service that will be submitted to the federal Health Care Financing Administration for the purpose of claiming reimbursement for each fiscal year shall equal the amount determined annually in paragraph (1) multiplied by the percentage figure determined in paragraph (2).

(4) The supplemental reimbursement to an eligible facility shall be equal to the amount of federal financial participation received as a result of the claims submitted pursuant to paragraph (2) of subdivision (j).

(5) In no instance shall the total amount of supplemental reimbursement received under this section combined with that received from all other sources dedicated exclusively to debt service exceed 100 percent of the debt service for the capital project over the life of the loan, revenue bond, or other financing mechanism.

(6) A facility qualifying for and receiving supplemental reimbursement pursuant to this section shall continue to receive reimbursement until the qualifying loan, revenue bond, or other financing mechanism is paid off, and as long as the facility meets the requirements of paragraph (3) of subdivision (d).

(7) The supplemental Medi-Cal reimbursement provided by this section shall be distributed under a payment methodology based on skilled nursing services provided to Medi-Cal patients at the eligible facility, either on a per diem basis, a per discharge basis, or any other federally permissible basis. The department shall seek approval from the federal Health Care Financing Administration for the payment methodology to be utilized, and shall not make any payment pursuant to this section prior to obtaining that approval.

(8) The supplemental reimbursement provided by this section shall not commence prior to the date upon which the hospital submits to the department a copy of the certificate of occupancy for the capital project.

(f) (1) It is the Legislature's intent in enacting this section to provide a funding source for a portion of the construction costs of eligible facilities without any expenditure from the state General Fund.

(2) The state share of the amount of the debt service submitted to the federal Health Care Financing Administration for purposes of supplemental reimbursement shall be paid with county-only funds and certified to the state as provided in subdivision (g). Any amount of the costs of the capital project that are not reimbursed by federal funds shall be borne solely by the eligible facility.

(3) Prior to receiving any funding through this section, an eligible facility shall demonstrate its ability to cover all of the anticipated costs of construction, including those not reimbursed through federal funding.

(g) The county or city and county, on behalf of any eligible facility, shall do all of the following:

(1) Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for the capital project are eligible for federal financial participation.

(2) Provide evidence supporting the certification as specified by the department.

(3) Submit data, as specified by the department, to determine the appropriate amounts to claim as expenditures qualifying for financial participation.

(4) Keep, maintain, and have readily retrievable, the records as specified by the department in order to fully disclose reimbursement amounts to which the eligible facility is entitled, and any other records required by the federal Health Care Financing Administration.

(h) The department may require that any county or city and county seeking supplemental reimbursement under this section enter into an interagency agreement with the department for the purpose of implementing this section.

(i) All payments received by an eligible facility pursuant to this section shall be placed in a special account, the funds of which shall be used exclusively for the payment of expenses related to the eligible capital project.

(j) (1) The department shall promptly seek any necessary federal approvals for the implementation of this section. If necessary to obtain federal approval, the department may, for federal purposes, limit the program to those costs that are allowable expenditures under Title XIX of the federal Social Security Act (Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code). If federal approval is not obtained for implementation of this section, this section shall become inoperative.

(2) The department shall submit claims for federal financial participation for the expenditures for debt service that are allowable expenditures under federal law.

(3) The department shall, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

(k) Supplemental reimbursement paid under this section shall not duplicate any reimbursement received by an eligible facility pursuant to this chapter for construction costs that would otherwise be eligible for reimbursement under this section. In no event shall the total Medi-Cal reimbursement pursuant to this chapter to a facility eligible under this section be less than what would have been paid had this section not existed.

(l) In the event there is a final judicial determination by any court of appellate jurisdiction or a final determination by the administrator of the federal Health Care Financing Administration that the supplemental reimbursement provided in this section must be made to any facility not described therein, this section shall become immediately inoperative.

(m) Any and all funds expended pursuant to this section shall be subject to review and audit by the department.

(Amended by Stats. 2001, Ch. 159, Sec. 198. Effective January 1, 2002. Conditionally inoperative as provided in subdivision (l).)

14105.27. (a) Each eligible facility, as described in subdivision (b) may, in addition to the rate of payment that the facility would otherwise receive for skilled nursing services, receive supplemental Medi-Cal reimbursement to the extent provided in this section.

(b) A facility shall be eligible for supplemental reimbursement only if the facility has all of the following characteristics continuously during the department's rate year:

(1) Provides services to Medi-Cal beneficiaries.

(2) Is either of the following:

(A) For the department's rate year beginning August 1, 2001, and for subsequent rate years, a distinct part of an acute care hospital providing skilled nursing services. For purposes of this section, "acute care hospital" means a facility described by subdivision (a) or (b), or both, of Section 1250 of the Health and Safety Code.

(B) For the department's rate year beginning August 1, 2006, and for subsequent rate years, a state home, as defined in Section 101 (19) of Title 38 of the United States Code.

(3) Is owned or operated by the state, or by a county, city, city and county, or health care district organized pursuant to Chapter 1 (commencing with Section 32000) of Division 23 of the Health and Safety Code.

(c) An eligible facility's supplemental reimbursement pursuant to this section shall be calculated and paid as follows:

(1) The supplemental reimbursement to an eligible facility, as described in paragraph (4), shall be equal to the amount of federal financial participation received as a result of the claims submitted pursuant to paragraph (2) of subdivision (g).

(2) In no instance shall the amount certified pursuant to paragraph (1) of subdivision (e), when combined with the amount received from all other sources of reimbursement from the Medi-Cal program, exceed 100 percent of allowable costs, as determined pursuant to the Medi-Cal State Plan, for distinct part skilled nursing services at each facility.

(3) Costs associated with the provision of subacute services pursuant to Section 14132.25 shall not be certified for supplemental reimbursement pursuant to this section.

(4) The supplemental Medi-Cal reimbursement provided by this section shall be distributed under a payment methodology based on skilled nursing services provided to Medi-Cal patients at the eligible facility, either on a per diem basis, a per discharge basis, or any other federally permissible basis. The department shall seek approval from the federal Centers for Medicare and Medicaid Services for the payment methodology to be utilized, and shall not make any payment pursuant to this section prior to obtaining that approval.

(d) (1) It is the Legislature's intent in enacting this section to provide the supplemental reimbursement described in this section without any expenditure from the General Fund. An eligible facility, as a condition of receiving supplemental reimbursement pursuant to this section, shall enter into, and maintain, an agreement with the department for the purposes of implementing this section and reimbursing the department for the costs of administering this section.

(2) The state share of the supplemental reimbursement submitted to the federal Centers for Medicare and Medicaid Services for purposes of claiming federal financial participation shall be paid only with funds from the governmental entities described in paragraph (3) of subdivision (b) and certified to the state as provided in subdivision (e).

(e) The particular governmental entity, described in paragraph (3) of subdivision (b), on behalf of any eligible facility shall do all of the following:

(1) Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for distinct part nursing facility services are eligible for federal financial participation.

(2) Provide evidence supporting the certification as specified by the department.

(3) Submit data as specified by the department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.

(4) Keep, maintain, and have readily retrievable, any records specified by the department to fully disclose reimbursement amounts to which the eligible facility is entitled, and any other records required by the federal Centers for Medicare and Medicaid Services.

(f) The department may require that any governmental entity, described in paragraph (3) of subdivision (b), seeking supplemental reimbursement under this section enter into an interagency agreement with the department for the purpose of implementing this section.

(g) (1) The department shall promptly seek any necessary federal approvals, including a federal medicaid waiver, for the implementation of this section. If necessary to obtain federal approval, the department may limit the program to those costs that are allowable expenditures under Title XIX of the federal Social Security Act (Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code). If federal approval is not obtained for implementation of this section, this section shall become inoperative.

(2) The department shall submit claims for federal financial participation for the expenditures for the services described in subdivision (e) that are allowable expenditures under federal law.

(3) The department shall, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

(h) In the event there is a final judicial determination by any court of appellate jurisdiction or a final determination by the administrator of the federal Centers for Medicare and Medicaid Services that the supplemental reimbursement provided in this section must be made to any facility not described in this section, this section shall become immediately inoperative.

(i) All funds expended pursuant to this section are subject to review and audit by the department.

(j) Supplemental reimbursement made pursuant to this section shall be subject to a reconciliation process established in the Medi-Cal State Plan to ensure that it is not made in excess of allowable costs, and to ensure that it is made up to allowable costs.

(Amended by Stats. 2013, Ch. 672, Sec. 1. (AB 498) Effective January 1, 2014. Section conditionally inoperative as provided in subds. (g) and (h).)

14105.28. (a) It is the intent of the Legislature to design a new Medi-Cal inpatient hospital reimbursement methodology based on diagnosis-related groups that more effectively ensures all of the following:

(1) Encouragement of access by setting higher payments for patients with more serious conditions.

(2) Rewards for efficiency by allowing hospitals to retain savings from decreased length of stays and decreased costs per day.

(3) Improvement of transparency and understanding by defining the “product” of a hospital in a way that is understandable to both clinical and financial managers.

(4) Improvement of fairness so that different hospitals receive similar payment for similar care and payments to hospitals are adjusted for significant cost factors that are outside the hospital’s control.

(5) Encouragement of administrative efficiency and minimizing administrative burdens on hospitals and the Medi-Cal program.

(6) That payments depend on data that has high consistency and credibility.

(7) Simplification of the process for determining and making payments to the hospitals.

(8) Facilitation of improvement of quality and outcomes.

(9) Facilitation of implementation of state and federal provisions related to hospital acquired conditions.

(10) Support of provider compliance with all applicable state and federal requirements.

(b) (1) (A) (i) The department shall develop and implement a payment methodology based on diagnosis-related groups, subject to federal approval, that reflects the costs and staffing levels associated with quality of care for patients in all general acute care hospitals in state and out of state, including Medicare critical access hospitals, but excluding public hospitals, psychiatric hospitals, and rehabilitation hospitals, which include alcohol and drug rehabilitation hospitals.

(ii) The payment methodology developed pursuant to this section shall be implemented on July 1, 2012, or on the date upon which the director executes a declaration certifying that all necessary federal approvals have been obtained and the methodology is sufficient for formal implementation, whichever is later.

(B) The diagnosis-related group-based payments shall apply to all claims, except claims for psychiatric inpatient days, rehabilitation inpatient days, managed care inpatient days, and swing bed stays for long-term care services, provided, however, that psychiatric and rehabilitation inpatient days shall be excluded regardless of whether the stay was in a distinct-part unit. The department may exclude or include other claims and services as may be determined during the development of the payment methodology.

(C) Implementation of the new payment methodology shall be coordinated with the development and implementation of the replacement Medicaid Management Information System pursuant to the contract entered into pursuant to Section 14104.3, effective on May 3, 2010.

(2) The department shall evaluate alternative diagnosis-related group algorithms for the new Medi-Cal reimbursement system for the hospitals to which paragraph (1) applies. The evaluation shall include, but not be limited to, consideration of all of the following factors:

(A) The basis for determining diagnosis-related group base price, and whether different base prices should be used taking into account factors such as geographic location, hospital size, teaching status, the local hospital wage area index, and any other variables that may be relevant.

(B) Classification of patients based on appropriate acuity classification systems.

(C) Hospital case mix factors.

(D) Geographic or regional differences in the cost of operating facilities and providing care.

(E) Payment models based on diagnosis-related groups used in other states.

(F) Frequency of grouper updates for the diagnosis-related groups.

(G) The extent to which the particular grouping algorithm for the diagnosis-related groups accommodates ICD-10 diagnosis and procedure codes, and applicable requirements of the federal Health Insurance Portability and Accountability Act of 1996.

(H) The basis for calculating relative weights for the various diagnosis-related groups.

(I) Whether policy adjusters should be used, for which care categories they should be used, and the frequency of updates to the policy adjusters.

(J) The extent to which the payment system is budget neutral and can be expected to result in state budget savings in future years.

(K) Other factors that may be relevant to determining payments, including, but not limited to, add-on payments, outlier payments, capital payments, payments for medical education, payments in the case of early transfers of patients, and payments based on performance and quality of care.

(c) The department shall submit to the Legislature a status report on the implementation of this section on April 1, 2011, April 1, 2012, April 1, 2013, and April 1, 2014.

(d) The alternatives for a new system described in paragraph (2) of subdivision (b) shall be developed in consultation with recognized experts with experience in hospital reimbursement, economists, the federal Centers for Medicare and Medicaid Services, and other interested parties.

(e) In implementing this section, the department may contract, as necessary, on a bid or nonbid basis, for professional consulting services from nationally recognized higher education and research institutions, or other qualified individuals and entities not associated with a particular hospital or hospital group, with demonstrated expertise in hospital reimbursement systems. The rate setting system described in subdivision (b) shall be developed with all possible expediency. This subdivision establishes an accelerated process for issuing contracts pursuant to this section and contracts entered into pursuant to this subdivision shall be exempt from the requirements of Chapter 1 (commencing with Section 10100) and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(f) (1) The department may adopt emergency regulations to implement the provisions of this section in accordance with rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Initial emergency regulations and the one readoption of those regulations shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of those regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations.

(2) As an alternative to paragraph (1), 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, or any other provision of law, the department may implement and administer this section by means of provider bulletins, all-county letters, manuals, or other similar instructions, without taking regulatory action. The department shall notify the fiscal and appropriate policy committees of the Legislature of its intent to issue a provider bulletin, all-county letter, manual, or other similar instruction, at least five days prior to issuance. In addition, the department shall provide a copy of any provider bulletin, all-county letter, manual, or other similar instruction issued under this paragraph to the fiscal and appropriate policy committees of the Legislature.

(Amended by Stats. 2011, Ch. 29, Sec. 11. (AB 102) Effective June 29, 2011.)

14105.281. (a) The Legislature finds and declares all of the following:

(1) That because the implementation of Section 14105.28 is expected to require several years and further rate changes may make the transition to an inpatient hospital reimbursement methodology based on diagnosis-related groups more difficult, and because of the need to take into account the amount of base payments when combined with supplemental payments made to inpatient hospitals, including payments provided as a result of the hospital fee set forth in Article 5.22 (commencing with Section 14167.31) and Article 5.225 (commencing with Section 14167.41), it is necessary to impose the rate freeze enacted in this section.

(2) (A) Upon implementation of Article 5.21 (commencing with Section 14167.1) and Article 5.22 (commencing with Section 14167.31), as added by Assembly Bill 1383 of the 2009–10 Regular Session, supplemental payments shall be made to hospitals that have contracts negotiated pursuant to the Selective Provider Contracting Program, provided that rates under these contracts are not reduced below the contract rates in effect on the effective date of Article 5.21 (commencing with Section 14167.1), as added by Assembly Bill 1383 of the 2009–10 Regular Session.

(B) Assembly Bill 1383 of the 2009–10 Regular Session was signed into law on October 11, 2009, and the effective date of Article 5.21 (commencing with Section 14167.1) was January 1, 2010. Therefore, in consideration of the notice provided by Assembly Bill 1383 of the 2009–10 Regular Session, and in further consideration that the negotiated contract rates in effect on January 1, 2010, or the rates in effect on July 1, 2010, to the extent those rates are lower than the rates in effect on January 1, 2010, as provided in paragraph (1) of subdivision (c), are sufficient to conform with the standards set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code, as well as the existence of supplemental payments to be made under Article 5.21 (commencing with Section 14167.1), the Legislature exercises its discretion, in consultation with the department, to freeze rates at the levels in effect for these hospitals on January 1, 2010, or the rates in effect on July 1, 2010, to the extent that those rates are lower than the rates in effect on January 1, 2010, as provided in paragraph (1) of subdivision (c).

(3) The freeze shall remain in effect during the period of time supplemental payments are made under Article 5.21 (commencing with Section 14167.1), and thereafter, to the extent that the rates, alone or in combination with any available supplemental payments, are consistent with federal law as provided in this section.

(b) Notwithstanding any other provision of law, in order to develop and implement changes in the methodology for payments for hospital inpatient services, the director shall freeze rates applicable to inpatient hospital services, as specified in this section.

(c) (1) Reimbursement rates for inpatient hospital services for all hospitals, except designated public hospitals, as defined in subdivision (d) of Section 14166.1, that receive Medi-Cal reimbursement from the State Department of Health Care Services, both under contract with the Selective Provider Contracting Program as well as noncontract hospitals, shall be frozen to the lesser of the amount paid on January 1, 2010, or the amount paid on July 1, 2010. The rate freeze shall be in effect for reimbursements for inpatient hospital services provided to Medi-Cal beneficiaries beginning on July 1, 2010, through and including the date on which the Medicaid Management Information System converts to claim processing based on the new reimbursement methodology developed pursuant to Section 14105.28 and described in paragraph (1) of subdivision (b) of that section.

(2) In the event a contract hospital terminates its contract and becomes a noncontract hospital, the hospital shall receive the same rate or rates as provided in paragraph (1) as a contract hospital for inpatient hospital services provided to Medi-Cal eligible individuals while the rate freeze specified in paragraph (1) remains in effect.

(3) This section nullifies any agreement between the state and a hospital for rate adjustments that would be inconsistent with this section. Other provisions of any of those agreements shall be unchanged by this section.

(4) In the event a noncontract hospital elects to become a contract hospital after July 1, 2010, at a negotiated rate or negotiated rates less than the freeze amount provided in paragraph (1), the hospital shall receive the contract rate or rates while the freeze remains in effect.

(d) For purposes of this section, the reimbursement for inpatient hospital services includes the amounts paid for all categories of inpatient services allowable by Medi-Cal and shall not include any supplemental payments. The reimbursement includes the amounts paid for routine services together with all related ancillary services.

(e) Within 90 days of the date this section becomes effective, the department shall develop and provide to all hospitals the methodology that will be utilized to implement the rate freeze required by this section for noncontract hospitals.

(f) (1) For dates of service on and after July 1, 2010, the department shall reconcile the payments, as limited by subdivision (c), to the amounts that the hospitals, that are subject to the new methodology set forth in Section 14105.28, would have received if the new methodology had been in effect. The department shall identify the data that will be used in making the reconciliations.

(2) The department shall implement the reconciliation process on the date that the payment methodology based on diagnosis-related groups has been made final, but no later than June 30, 2012. The director shall execute a declaration stating the date on which the new payment methodology has become final.

(3) In the process of reconciliation, no payment, with respect to dates of service prior to the effective date of the act that added this section, shall be reduced below the amount paid pursuant to subdivision (c).

(4) Rates paid to hospitals, or for specified services, that are not subject to the methodology in paragraph (1) of subdivision (b) of Section 14105.28, shall be increased subject to the annual Budget Act.

(g) Notwithstanding subdivision (c) or any other provision of this section, for the 2011–12 fiscal year and each fiscal year thereafter, or portion thereof, in which subdivision (c) remains in effect, the department shall, subject to an appropriation in the annual Budget Act applicable to the particular fiscal year, apply an increase in reimbursement rates for all hospital services that result from the freeze imposed pursuant to subdivision (c).

(h) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in this section by means of provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action.

(i) (1) The rates provided for in this section shall be implemented only if the director determines that the rates, as established by this section, will comply with applicable federal Medicaid requirements and that federal financial participation will be available.

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

(3) To the extent that the director determines that the rates do not comply with the federal Medicaid requirements, the director retains the discretion not to implement that rate and may revise the rate as necessary to comply with federal Medicaid requirements.

(j) The director shall seek any necessary federal approval for the implementation of this section. To the extent that federal financial participation is not available with respect to any rate of reimbursement described by this section, the director retains the discretion not to implement that rate and may revise the rate as necessary to comply with the federal Medicaid requirements.

(k) Subdivisions (a) to (g), inclusive, shall become inoperative, and any rate that was frozen pursuant to this section shall be restored retroactively to the rate that would have been in effect absent this section, on the effective date of the act that added this subdivision. The department shall explore other avenues that do not involve a rate freeze for achieving the stability needed, including determining base payment rates, in order to transition to an inpatient hospital reimbursement methodology based on diagnosis-related groups.

(Amended by Stats. 2011, Ch. 19, Sec. 2. (SB 90) Effective April 13, 2011. Subds. (a) through (g) became inoperative on April 13, 2011, pursuant to subd. (k), which was inserted by Ch. 19.)

14105.29. (a) (1) Subject to subdivision (d), additional Medi-Cal payments shall be made to designated public hospitals and their affiliated government entities, in recognition of the Medi-Cal managed care share of graduate medical education costs. To the extent permissible under federal law, the department shall make these payments directly to the designated public hospitals and their applicable affiliated government entities.

(2) The graduate medical education payments shall consist of the following components:

(A) Direct graduate medical education payments made in recognition and support of the direct costs incurred in the operation of graduate medical education programs, which may include, but are not limited to, salaries, benefits, physician oversight, and allocated overhead costs incurred for interns and residents in medicine, osteopathy, dentistry, podiatry, nursing, and allied health and paramedical programs.

(B) Indirect graduate medical education payments made in recognition and support of the increased operating and patient care costs associated with teaching programs.

(3) Graduate medical education payments shall support, recognize, and enhance the role of designated public hospitals and their affiliated government entities in the training of interns, residents, and fellows who are enrolled in accredited medical or dental programs, in advanced practice nursing or other allied health professional programs, or who are pursuing advanced specialty training.

(4) The graduate medical education payments shall be inflation adjusted.

(5) The department shall determine the maximum amount of graduate medical education payments and distribute to participating designated public hospitals and their affiliated government entities, as applicable, in accordance with a methodology developed in consultation with the designated public hospitals.

(6) Interim graduate medical education payments shall be made on a quarterly basis, and reconciled at the end of the fiscal year to determine the final amounts due based on information reported to the department by the designated public hospitals. To the extent practicable, the department shall seek to minimize the administrative burden on participating designated public hospitals associated with reporting and finalizing graduate medical education payments.

(7) Graduate medical education payments provided pursuant to this section shall not supplant amounts that would otherwise be payable by the department to Medi-Cal managed care plans or to designated public hospitals and their affiliated government entities, or by Medi-Cal managed care plans to designated public hospitals and their affiliated government entities. A Medi-Cal managed care plan shall not withhold or otherwise reduce other payments to a designated public hospital or its affiliated government entities as a result of implementation of payment programs pursuant to this section.

(b) Subject to subdivision (d), the department may, in consultation with designated public hospitals, seek federal approval to provide for other forms of graduate medical education payments to designated public hospitals and their affiliated government entities, including payments that reflect the volume of fee-for-service Medi-Cal services or revenue to the extent the fee-for-service payments do not otherwise recognize graduate medical education costs, or incentive payments.

(c) The nonfederal share of payments under this section shall consist of voluntary intergovernmental transfers of funds provided by designated public hospitals or their affiliated government entities, or other eligible public entities, including those described in Section 14164, in accordance with this section. No state General Fund moneys shall be used to fund the nonfederal share of payments under this section.

(1) The Designated Public Hospital (DPH) Graduate Medical Education (GME) Special Fund is hereby established in the State Treasury. Notwithstanding Section 13340 of the Government Code, moneys deposited into the DPH GME Special Fund shall be

continuously appropriated, without regard to fiscal year, to the department for the purposes specified in this section. All funds derived pursuant to this section shall be deposited in the State Treasury to the credit of the DPH GME Special Fund.

(2) The DPH GME Special Fund shall consist of moneys that a designated public hospital or affiliated government entity, or other public entity, as applicable, elects to transfer to the department for deposit into the fund, to the extent permitted under Section 433.51 of Title 42 of the Code of Federal Regulations and any other applicable federal Medicaid laws. Moneys derived from these intergovernmental transfers in the DPH GME Special Fund shall be used as the source for the nonfederal share of graduate medical education payments authorized under this section, for reimbursing the department's administrative costs in implementing this section, and to otherwise support the Medi-Cal program. The timing and amounts of the intergovernmental transfers shall be determined by the department in consultation with the transferring entities. The department shall determine the intergovernmental transfer amounts for each applicable state fiscal year such that they are sufficient to fund the nonfederal share of the associated graduate medical education payments for that year, plus five percent of the aggregate nonfederal share that would be associated with the graduate medical education payments made pursuant to this section in that applicable state fiscal year as if the federal medical assistance percentage were 50 percent. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify that the transferred funds qualify for federal financial participation pursuant to applicable federal Medicaid laws, and in the form and manner as required by the department.

(3) The department shall claim federal financial participation for graduate medical education payments under this section using moneys derived from intergovernmental transfers made pursuant to this section, and deposited in the DPH GME Special Fund to the full extent permitted by law. In the event federal financial participation is not available with respect to a payment under this section and either is not obtained, or results in a recoupment of payments already made, the department shall return any intergovernmental transfer fund amounts associated with the payment for which federal financial participation is not available to the applicable transferring entities within 14 days from the date of the associated recoupment or other determination, as applicable.

(4) Any intergovernmental transfer of funds made pursuant to this section shall be considered voluntary for purposes of all federal and state laws.

(d) (1) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(2) After consultation with the designated public hospitals, the director may modify the requirements set forth in this section to the extent necessary to meet federal requirements for graduate medical education payments for designated public hospitals and their affiliated government entities or to maximize federal financial participation available under such a program.

(e) (1) The department shall seek any necessary federal approvals from the federal Centers for Medicare and Medicaid Services, through state plan amendments or otherwise, for graduate medical education payments, effective no sooner than January 1, 2017, in accordance with this section.

(2) The department shall consult with the designated public hospitals with regard to the development and implementation, and any subsequent modification, of the payment programs established pursuant to this section.

(3) 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, plan letters, provider bulletins, or other similar instructions, without taking regulatory action. The department shall timely inform, or provide access to, applicable guidance issued pursuant to this authority to affected designated public hospitals and their affiliated government entities. This guidance shall remain publicly available until all payments made pursuant to this section are finalized.

(f) For purposes of this section, the following definitions apply:

(1) "Designated public hospitals" means those hospitals identified in subdivision (f) of Section 14184.10.

(2) "Designated public hospitals and their affiliated government entities" means those hospitals identified in subdivision (f) of Section 14184.10, and the government entities and agencies with which they are affiliated, inclusive of their affiliated government-operated physician practice groups, affiliated government-operated clinics and other settings that provide clinical training, and affiliated government-operated medical and professional training schools and programs.

(Added by Stats. 2017, Ch. 52, Sec. 26. (SB 97) Effective July 10, 2017.)

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 Chapter 9 (commencing with Section 4000) of Division 2 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 meet 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.

(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, 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 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.

(Amended by Stats. 2013, Ch. 23, Sec. 60. (AB 82) Effective June 27, 2013.)

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

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

(b) “Best price” means the negotiated price, or the manufacturer’s lowest price available to any foreign or domestic class of trade organization or entity, including, but not limited to, wholesalers, retailers, hospitals, repackagers, providers, or governmental entities, that contracts with a manufacturer for a specified price for drugs, inclusive of cash discounts, free goods, volume discounts, rebates, and on- or off-invoice discounts or credits, shall be based upon the manufacturer’s commonly used retail package sizes for the drug sold by wholesalers to retail pharmacies.

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

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

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

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

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

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

(i) The amendments made to this section by the act that added this subdivision shall be effective no sooner than January 1, 2021.

(j) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available.

(Amended by Stats. 2020, Ch. 12, Sec. 57. (AB 80) Effective June 29, 2020.)

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

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

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

(3) (A) Utilization data used to determine the state rebate shall exclude data from both of the following:

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

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

(B) This paragraph shall become inoperative on July 1, 2014.

(4) Commencing July 1, 2014, utilization data used to determine the state rebate shall include data from all programs, including, but not limited to, fee-for-service Medi-Cal, and utilization data, as limited in paragraph (5), from health plans contracting with the department to provide services to beneficiaries pursuant to this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591), that qualify for federal drug rebates pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8) or that otherwise qualify for federal funds under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) pursuant to the Medicaid state plan or waivers.

(5) Health plan utilization data shall be limited to those drugs for which a health plan is authorizing a prescription drug described in subparagraph (A), and pursuant to the coverage policies established in subparagraph (B):

(A) A prescription drug for which the department reimburses the health plan through a separate capitated payment or other supplemental payment. Payment shall not be withheld for decisions determined pursuant to Section 1374.34 of the Health and Safety Code.

(B) The department shall develop coverage policies, consistent with the criteria set forth in paragraph (1) of subdivision (c) of Section 14105.39 and in consultation with clinical experts, Medi-Cal managed care plans, and other stakeholders, for prescription drugs described in subparagraph (A). These coverage policies shall apply to the entire Medi-Cal program, including fee-for-service and Medi-Cal managed care, through the Medi-Cal List of Contract Drugs or through provider bulletins, all plan letters, or similar instructions. Coverage policies developed pursuant to this section shall be revised on a semiannual basis or upon approval by the Food and Drug Administration of a new drug subject to subparagraph (A). For the purposes of this section, "coverage policies" include, but are not limited to, clinical guidelines and treatment and utilization policies.

(6) For prescription drugs not subject to the requirements of paragraph (5), utilization data used to determine the state rebate shall include all data from health plans, except for health maintenance organizations, as defined in Section 300e(a) of Title 42 of the United States Code, including those organizations that contract pursuant to Section 1396b(m) of Title 42 of the United States Code.

(7) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific paragraph (5) by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, until the time regulations are adopted. The department shall adopt regulations by October 1, 2017, 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. Notwithstanding Section 10231.5 of the Government Code, beginning six months after the effective date of this section, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

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

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

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

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

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

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

(h) Contracts executed pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

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

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

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

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

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

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

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

(n) If the date of mailing of a state rebate payment is 69 days or more from the date of mailing of the invoice, including supporting utilization data sent to the manufacturer, the interest rate and calculations pursuant to subdivision (k) shall be as specified in

subdivision (m), however the interest rate shall be increased by 10 percentage points. This subdivision shall apply to payments for amounts invoiced for any quarters that begin on or after the effective date of the act that added this subdivision.

(o) If the rebate payment is not received, the department shall send overdue notices to the manufacturer at 38, 68, and 98 days after the date of mailing of the invoice, and supporting utilization data. If the department has not received a rebate payment, including interest, within 180 days of the date of mailing of the invoice, including supporting utilization data, the manufacturer's contract with the department shall be deemed to be in default and the contract may be terminated in accordance with the terms of the contract. For all other manufacturers, if the department has not received a rebate payment, including interest, within 180 days of the date of mailing of the invoice, including supporting utilization data, all of the drug products of those manufacturers shall be made available only through prior authorization effective 270 days after the date of mailing of the invoice, including utilization data sent to manufacturers.

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

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

(r) Beginning January 1, 2026, a beneficiary may obtain covered drugs placed on prior authorization pursuant to subdivision (o) only if their pharmacy provider or prescriber initiates a prior authorization request that is subsequently approved by the department.

(s) Beginning January 1, 2026, a beneficiary may continue to receive drugs previously prescribed but subject to prior authorization if their pharmacy provider or prescriber initiates a prior authorization request that is subsequently approved by the department.

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

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

(Amended by Stats. 2025, Ch. 21, Sec. 93. (AB 116) Effective June 30, 2025.)

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

(Amended by Stats. 2011, Ch. 3, Sec. 96. (AB 97) Effective March 24, 2011.)

14105.334. (a) Notwithstanding any other law, upon approval of the Department of Finance, the department shall seek the necessary federal approvals to establish and administer a drug rebate program to collect rebate payments from drug manufacturers with respect to drugs furnished to selected populations of California residents that are ineligible for full-scope Medi-Cal benefits under this chapter.

(b) The department shall administer the drug rebate program for qualified non-Medi-Cal populations consistent with the applicable requirements and procedures of the federal Medicaid Drug Rebate Program implemented pursuant to Section 14105.33 and Section 1396r-8 of Title 42 of the United States Code.

(c) The department, in consultation with the Department of Finance, shall determine the non-Medi-Cal populations to be included in the drug rebate program administered pursuant to this section based on the level to which the department can demonstrate that their inclusion furthers the goals and objectives of the Medi-Cal program, increases the efficiency and economy of the Medi-Cal program, and sufficiently benefits the Medi-Cal population as a whole.

(d) The department shall seek any federal approvals from the federal Centers for Medicare and Medicaid Services, via submission of State Plan Amendments or other applicable mechanism, it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(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, interpret, or make specific this section, in whole or in part, by means of provider bulletins or other similar instructions, without taking regulatory action.

(f) For purposes of implementing this section, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis with manufacturers of single-source and multiple-source drugs. Contracts entered into or amended pursuant to this section shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services. Contracts entered into or amended pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(g) Any rebate payments collected from manufacturers pursuant to this section shall be deposited in the Medi-Cal Drug Rebate Fund, created pursuant to Section 14105.36.

(Amended by Stats. 2021, Ch. 615, Sec. 451. (AB 474) Effective January 1, 2022. Operative January 1, 2023, pursuant to Sec. 463 of Stats. 2021, Ch. 615.)

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

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

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

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

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

(Amended by Stats. 2011, Ch. 3, Sec. 97. (AB 97) Effective March 24, 2011.)

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

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

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

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

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

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

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

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

(2) Contracts pursuant to Section 14105.3 executed prior to January 1, 1991, shall be considered to be contracts executed pursuant to Section 14105.33, and the department shall exempt the drugs included in these contracts from the initial therapeutic category review in which they would normally be considered.

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

(Amended by Stats. 2002, Ch. 1161, Sec. 60. Effective September 30, 2002.)

14105.36. (a) (1) The Medi-Cal Drug Rebate Fund is hereby created in the State Treasury.

(2) Nonfederal moneys collected by the department pursuant to Sections 14105.33, 14105.332, 14105.436 and 14105.86 and Section 1396r-8 of Title 42 of the United States Code, as part of the state's share of state and federal supplemental Medi-Cal drug rebates, shall be deposited in the Medi-Cal Drug Rebate Fund.

(b) Notwithstanding Section 13340 of the Government Code, the funds deposited in the Medi-Cal Drug Rebate Fund shall be continuously appropriated, without regard to fiscal year, to the department for purposes of funding the nonfederal share of health care services for children, adults, seniors, and persons with disabilities enrolled in the Medi-Cal program.

(c) Notwithstanding Section 16305.7 of the Government Code, the Medi-Cal Drug Rebate Fund shall contain all interest and dividends earned on moneys in the fund and shall be used only for the purpose identified in subdivision (b).

(d) Notwithstanding any other law, the Controller may use the funds in the Medi-Cal Drug Rebate Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

(Added by Stats. 2019, Ch. 38, Sec. 48. (SB 78) Effective June 27, 2019.)

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

(b) If, within 30 days of notification, a manufacturer does not enter into negotiations for a contract pursuant to those sections, the department may suspend or delete from the list of contract drugs, or refuse to consider for addition, drugs of that manufacturer in the selected therapeutic categories.

(c) If, after 120 days from the initial notification, a contract is not executed for a drug currently on the list of contract drugs, the department may suspend or delete the drug from the list of contract drugs.

(d) If, within 120 days from the initial notification, a contract is executed for a drug currently on the list of contract drugs, the department shall retain the drug on the list of contract drugs.

(e) If, within 120 days from the date of the initial notification, a contract is executed for a drug not currently on the list of contract drugs, the department shall add the drug to the list of contract drugs.

(f) The department shall terminate all negotiations 120 days after the initial notification.

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

(h) In the absence of a contract, the department may suspend or delete any drug from the list of contract drugs.

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

(j) Any drug suspended from the list of contract drugs pursuant to this section or Section 14105.35 may be deleted from the list of contract drugs in accordance with Section 14105.38.

(Amended by Stats. 2003, Ch. 230, Sec. 65. Effective August 11, 2003.)

14105.38. When the department determines that a drug should be removed from the list of contract drugs, the department shall provide individual notice to impacted beneficiaries, at least 60 calendar days prior to the drug being removed from the list of contract drugs, that the drug is only obtainable through the prior authorization process. The notice shall include a description of the beneficiary's right to a fair hearing and shall encourage the beneficiary to consult a physician to determine if an appropriate substitute medication is available from Medi-Cal. The department shall also provide provider notice about the removal at least 60 calendar days prior to the drug being removed from the list of contract drugs on the department's internet website.

(Repealed and added by Stats. 2025, Ch. 21, Sec. 95. (AB 116) Effective June 30, 2025.)

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

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

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

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

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

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

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

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

(2) Within 90 days from receipt of the request, the department shall evaluate the request using the criteria identified in subdivision (d), and shall submit the drug to the Medi-Cal Contract Drug Advisory Committee.

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

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

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

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

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

(A) The safety of the drug.

(B) The effectiveness of the drug.

(C) The essential need for the drug.

(D) The potential for misuse of the drug.

(E) The cost of the drug.

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

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

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

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

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

(f) A manufacturer of a drug deleted from, or not added to, the list of contract drugs may request inclusion of the drug on the list of preferred prior authorization drugs that is hereby established as a subset of the list of contract drugs. To ensure that the health needs of Medi-Cal beneficiaries are met, the department shall evaluate the request pursuant to subdivision (c). The department shall give preference for prior authorization drugs based on the medical need or continuing care of the beneficiary. The department may contract with manufacturers of drugs on the list of preferred prior authorization drugs. Contracts executed pursuant to this subdivision are subject to Section 14105.33.

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

(Amended by Stats. 2002, Ch. 1161, Sec. 63. Effective September 30, 2002.)

14105.395. (a) The department may implement utilization controls through the establishment of guidelines, protocols, algorithms, or criteria for drugs, medical supplies, durable medical equipment, and enteral formulae. The department shall publish the guidelines, protocols, algorithms, or criteria in the pharmacy and medical provider manuals.

(b) The department shall issue providers written notice of changes pursuant to subdivision (a) at least 30 days prior to implementation.

(c) Changes made pursuant to this section are exempt from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law. The department shall consult with interested parties and appropriate stakeholders in implementing this section with respect to all of the following:

(1) Notifying the provider representatives of the proposed change.

(2) Scheduling at least one meeting to discuss the change.

(3) Allowing for written input regarding the change.

(4) Providing advance notice on the implementation and effective date of the change.

(Added by Stats. 2003, Ch. 230, Sec. 66. Effective August 11, 2003.)

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

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

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

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

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

(1) Physicians.

(2) Pharmacists.

(3) Schools of pharmacy or pharmacologists.

(4) Medi-Cal beneficiaries.

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

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

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

(Amended (as amended by Stats. 2000, Ch. 93, Sec. 77) by Stats. 2002, Ch. 1161, Sec. 65. Effective September 30, 2002.)

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

(b) Any beneficiary filing a fair hearing request regarding the deletion or suspension of a drug from the list of contract drugs shall be granted a treatment authorization request for that drug until a final decision is adopted by the director. Should the beneficiary seek

judicial review of the director's decision, a treatment authorization request shall be granted for that drug until a final decision is issued by the court.

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

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

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

(Amended by Stats. 2002, Ch. 1161, Sec. 66. Effective September 30, 2002.)

14105.406. The director shall, in considering suspension or deletion of drugs from the list of contract drugs, ensure that the department has the ability to process drug treatment authorization requests (TARs) without substantial degradation of the level of service, including response time, to providers which was in effect July 1, 1990.

In considering suspension or deletion of drugs, the director shall seek the advice of the Chief of the Field Services Branch and the Medi-Cal Contract Drug Advisory Committee.

If the treatment authorization request reports provided in subdivision (b) of Section 14105.42 indicate a substantial degradation in the level of service, including response time, for processing TARs, the director shall, within 60 days, hold a public hearing on the functioning of the TAR system.

Subsequent to the hearing, the director shall consult with at least two members of each group represented on the Medi-Cal Contract Drug Advisory Committee as provided in subdivision (b) of Section 14105.4 and take appropriate action to remedy the problem areas discussed in the report and in the public hearing.

Based upon the information gathered as a result of the reports and public hearing referred to above, and in consultation with the Medi-Cal Contract Drug Advisory Committee, the director may add drugs which previously had been suspended or deleted to the list of contract drugs.

(Added by Stats. 1990, Ch. 457, Sec. 13. Effective July 31, 1990.)

14105.41. Moneys accruing to the department from contracts executed pursuant to Section 14105.33 shall be deposited in the Health Care Deposit Fund, and shall be subject to appropriation by the Legislature.

(Amended (as amended by Stats. 2000, Ch. 93, Sec. 80) by Stats. 2002, Ch. 1161, Sec. 68. Effective September 30, 2002.)

14105.42. (a) The department shall report to the Legislature after the first three major therapeutic categories have been reviewed and contracts executed. The report shall include the estimated savings, number of manufacturers entering negotiations, number of contracts executed, number of drugs added and deleted, and impact on Medi-Cal beneficiaries and providers.

(b) The department shall report to the Legislature, through the annual budget process, on the cost-effectiveness of contracts executed pursuant to Section 14105.33.

(Amended by Stats. 2002, Ch. 1161, Sec. 69. Effective September 30, 2002.)

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

This section shall become operative on January 1, 1997.

(Added by renumbering Section 14105.42 (as amended by Stats. 1992, Ch. 723) by Stats. 2000, Ch. 93, Sec. 83. Effective July 7, 2000.)

14105.43. (a) (1) Notwithstanding other provisions of this chapter, any drug which is approved by the federal Food and Drug Administration for use in the treatment of acquired immunodeficiency syndrome (AIDS) or an AIDS-related condition shall be deemed to be approved for addition to the Medi-Cal list of contract drugs only for the purpose of treating AIDS or an AIDS-related condition, for the period prior to the completion of the procedures established pursuant to Section 14105.33.

(2) In addition to any drug that is deemed to be approved pursuant to paragraph (1), any drug that meets any of the following criteria shall be a Medi-Cal benefit, subject to utilization controls:

(A) Any vaccine to protect against human immunodeficiency virus (HIV) infection.

(B) Any antiviral agent, immune modulator, or other agent to be administered to persons who have been infected with human immunodeficiency virus to counteract the effects of that infection.

(C) Any drug or biologic used to treat opportunistic infections associated with acquired immune deficiency syndrome, that have been found to be medically accepted indications and that has either been approved by the federal Food and Drug Administration or recognized for that use in a compendia listed in Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8).

(D) Any drug or biologic used to treat the chemotherapy-induced suppression of the human immune system resulting from the treatment of acquired immune deficiency syndrome.

(3) The department shall add any drug deemed to be approved pursuant to paragraph (1) to the Medi-Cal list of contract drugs or allow the provision of the drug as a Medi-Cal benefit, subject to utilization controls, pursuant to paragraph (2), only if the manufacturer of the drug has executed a contract with the Centers for Medicare and Medicaid Services which provides for rebates in accordance with Section 1396r-8 of Title 42 of the United States Code.

(b) Any drug deemed to be approved pursuant to paragraph (1) of subdivision (a) shall be immediately added to the Medi-Cal list of contract drugs, and shall be exempt from the contract requirements of Section 14105.33.

(c) If it is determined pursuant to subdivision (c) of Section 14105.39 that a drug to which subdivision (a) applies should not be placed on the Medi-Cal list of contract drugs, that drug shall no longer be deemed to be approved for addition to the list of contract drugs pursuant to subdivision (a).

(Amended by Stats. 2009, Ch. 479, Sec. 5. (AB 830) Effective January 1, 2010.)

14105.435. (a) Within 60 days of the approval of a drug in accordance with subdivision (a) of Section 14105.43, the department shall assign to that drug a reimbursement code, and provide notice to providers that the drug is on the Medi-Cal list of contract drugs.

(b) In the event that a manufacturer has not notified the department in writing of the approval of a drug by the United States Food and Drug Administration for the treatment of acquired immune deficiency syndrome (AIDS) or an AIDS-related condition within 15 days of that approval, the department shall be granted an additional 30 days to comply with subdivision (a). Written notification from the drug manufacturer shall include a copy of the United States Food and Drug Administration approval letter and the official labeling for the drug.

(Added by Stats. 1992, Ch. 949, Sec. 2. Effective January 1, 1993.)

14105.436. (a) Effective July 1, 2002, all pharmaceutical manufacturers shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 and reimbursed through the Medi-Cal outpatient fee-for-service drug program. The state rebate shall be negotiated as necessary between the department and the pharmaceutical manufacturer. The negotiations shall take into account offers such as rebates, discounts, disease management programs, and other cost savings offerings and shall be retroactive to July 1, 2002.

(b) The department may use existing administrative mechanisms for any drug for which the department does not obtain a rebate pursuant to subdivision (a). The department may only use those mechanisms in the event that, by February 1, 2003, the manufacturer refuses to provide the additional rebate. This subdivision shall become inoperative on January 1, 2010.

(c) For purposes of this section, “Medi-Cal utilization data” means the data used by the department to reimburse providers under all programs that qualify for federal drug rebates pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8) or that otherwise qualify for federal funds under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) pursuant to the Medicaid state plan or waivers. Medi-Cal utilization data excludes data from covered entities identified in Section 256b(a)(4) of Title 42 of the United States Code in accordance with Sections 256b(a)(5)(A) and 1396r-8(a)(5)(C) of Title 42 of the United States Code, and those capitated plans that include a prescription drug benefit in the capitated rate and that have negotiated contracts for rebates or discounts with manufacturers.

(d) Upon implementation of paragraphs (4) and (5) of subdivision (b) of Section 14105.33 for drugs pursuant to this section, subdivisions (a) and (c) shall become inoperative and “utilization data” shall be described pursuant to subdivision (b) of Section 14105.33. The department shall post on its internet website a notice that it has implemented paragraphs (4) and (5) of subdivision (b) of Section 14105.33 for drugs pursuant to this section.

(e) Effective July 1, 2009, all pharmaceutical manufacturers shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, equal to an amount not less than 10 percent of the average manufacturer price based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2.

(f) Pharmaceutical manufacturers shall, by January 1, 2010, enter into a supplemental rebate agreement for the rebate required in subdivision (e) for drug products added to the Medi-Cal list of contract drugs on or before December 31, 2009.

(g) Effective January 1, 2010, all pharmaceutical manufacturers who have not entered into a supplemental rebate agreement pursuant to subdivisions (e) and (f) shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, equal to an amount not less than 20 percent of the average manufacturer price based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 prior to January 1, 2010. If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement by March 1, 2010, the manufacturer's drug product shall be made available only through an approved treatment authorization request pursuant to subdivision (i).

(h) For a drug product added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 on or after January 1, 2010, a pharmaceutical manufacturer shall provide to the department a state rebate pursuant to subdivision (e). If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement within 60 days after the addition of the drug to the Medi-Cal list of contract drugs, the manufacturer shall provide to the department a state rebate equal to not less than 20 percent of the average manufacturer price based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2. If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement within 120 days after the addition of the drug to the Medi-Cal list of contract drugs, the pharmaceutical manufacturer's drug product shall be made available only through an approved treatment authorization request pursuant to subdivision (i). For supplemental rebate agreements executed more than 120 days after the addition of the drug product to the Medi-Cal list of contract drugs, the state rebate shall equal an amount not less than 20 percent of the average manufacturer price based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2.

(i) Notwithstanding any other law, drug products added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 of manufacturers who do not execute an agreement to pay additional rebates pursuant to this section shall be available only through an approved treatment authorization request.

(j) Changes made to the Medi-Cal list of contract drugs under this 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.

(k) This section shall remain in effect only until January 1, 2026, and as of that date is repealed.

(Amended by Stats. 2025, Ch. 21, Sec. 96. (AB 116) Effective June 30, 2025. Repealed as of January 1, 2026, by its own provisions. See later operative version added by Sec. 97 of Stats. 2025, Ch. 21.)

14105.436. (a) Effective July 1, 2002, all pharmaceutical manufacturers shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 and reimbursed through the Medi-Cal outpatient fee-for-service drug program. The state rebate shall be negotiated as necessary between the department and the pharmaceutical manufacturer. The negotiations shall take into account offers such as rebates, discounts, disease management programs, and other cost savings offerings and shall be retroactive to July 1, 2002.

(b) The department may use existing administrative mechanisms for any drug for which the department does not obtain a rebate pursuant to subdivision (a). The department may only use those mechanisms in the event that, by February 1, 2003, the manufacturer refuses to provide the additional rebate. This subdivision shall become inoperative on January 1, 2010.

(c) For purposes of this section, "Medi-Cal utilization data" means the data used by the department to reimburse providers under all programs that qualify for federal drug rebates pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8) or that otherwise qualify for federal funds under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) pursuant to the Medicaid state plan or waivers. Medi-Cal utilization data excludes data from covered entities identified in Section 256b(a)(4) of Title 42 of the United States Code in accordance with Sections 256b(a)(5)(A) and 1396r-8(a)(5)(C) of Title 42 of the United States Code, and those capitated plans that include a prescription drug benefit in the capitated rate and that have negotiated contracts for rebates or discounts with manufacturers.

(d) Upon implementation of paragraphs (4) and (5) of subdivision (b) of Section 14105.33 for drugs pursuant to this section, subdivisions (a) and (c) shall become inoperative and "utilization data" shall be described pursuant to subdivision (b) of Section 14105.33. The department shall post on its internet website a notice that it has implemented paragraphs (4) and (5) of subdivision (b) of Section 14105.33 for drugs pursuant to this section.

(e) Effective January 1, 2026, all pharmaceutical manufacturers renewing or entering new state rebate agreements shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, in the following amounts based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2:

(1) An amount not less than 20 percent of the average manufacturer price if the federal rebate is less than 50 percent of the average manufacturer price.

(2) An amount not less than 15 percent of the average manufacturer price if the federal rebate is 50 percent or greater of the average manufacturer price.

(f) Pharmaceutical manufacturers shall, by January 1, 2010, enter into a supplemental rebate agreement for the rebate required in subdivision (e) for drug products added to the Medi-Cal list of contract drugs on or before December 31, 2009.

(g) Effective January 1, 2010, all pharmaceutical manufacturers who have not entered into a supplemental rebate agreement pursuant to subdivisions (e) and (f) shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, equal to an amount not less than 20 percent of the average manufacturer price based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 prior to January 1, 2010. If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement by March 1, 2010, the manufacturer's drug product shall be made available only through an approved treatment authorization request pursuant to subdivision (i).

(h) For a drug product added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 on or after January 1, 2026, a pharmaceutical manufacturer shall provide to the department a state rebate pursuant to subdivision (e). If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement within 60 days after the addition of the drug to the Medi-Cal list of contract drugs, the manufacturer shall provide to the department a state rebate equal to not less than 25 percent of the average manufacturer price based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2. If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement within 120 days after the addition of the drug to the Medi-Cal list of contract drugs, the pharmaceutical manufacturer's drug product shall be made available only through an approved treatment authorization request pursuant to subdivision (i). For supplemental rebate agreements executed more than 120 days after the addition of the drug product to the Medi-Cal list of contract drugs, the state rebate shall equal an amount not less than 25 percent of the average manufacturer price based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2.

(i) Notwithstanding any other law, drug products added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 of manufacturers who do not execute an agreement to pay additional rebates pursuant to this section shall be available only through an approved treatment authorization request.

(j) Changes made to the Medi-Cal list of contract drugs under this 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.

(k) This section shall become operative on January 1, 2026.

(Repealed (in Sec. 96) and added by Stats. 2025, Ch. 21, Sec. 97. (AB 116) Effective June 30, 2025. Operative January 1, 2026, by its own provisions.)

14105.44. (a) The department shall establish an expedited review process to examine the effectiveness of investigational drugs and investigational services, and their eligibility for Medi-Cal reimbursement.

(b) The department shall adopt emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 3 of the Government Code to implement subdivision (a). The adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health or safety. Notwithstanding the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted by the department in order to implement subdivision (b) shall not be subject to the review and approval of the Office of Administrative Law. These regulations shall become effective immediately upon filing with the Secretary of State.

(Added by Stats. 1987, Ch. 1470, Sec. 2. Effective September 30, 1987.)

14105.45. (a) For purposes of this section, the following definitions shall apply:

(1) "Actual acquisition cost" has the same meaning as that term is defined in Section 447.502 of Title 42 of the Code of Federal Regulations. The actual acquisition cost shall not be considered confidential and shall be subject to disclosure pursuant to the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

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

(3) "Average wholesale price" means the price for a drug product listed as the average wholesale price in the department's primary price reference source.

(4) "Blood factors" has the same meaning as that term is defined in Section 14105.86.

(5) “Federal upper limit” means the maximum per unit reimbursement when established by the federal Centers for Medicare and Medicaid Services.

(6) “Generically equivalent drugs” means drug products with the same active chemical ingredients of the same strength and dosage form, and of the same generic drug name, as determined by the United States Adopted Names (USAN) Council and accepted by the federal Food and Drug Administration (FDA), as those drug products having the same chemical ingredients.

(7) “Legend drug” means any drug whose labeling states “Caution: Federal law prohibits dispensing without prescription,” “Rx only,” or words of similar import.

(8) “Maximum allowable ingredient cost” (MAIC) means the maximum amount the department will reimburse Medi-Cal pharmacy providers for generically equivalent drugs.

(9) “Innovator multiple source drug,” “noninnovator multiple source drug,” and “single source drug” have the same meaning as those terms are defined in Section 1396r-8(k)(7) of Title 42 of the United States Code.

(10) “Nonlegend drug” means any drug whose labeling does not contain the statement referenced in paragraph (7).

(11) “Pharmacy warehouse” means a physical location licensed as a wholesaler for prescription drugs that acts as a central warehouse and performs intracompany sales or transfers of those drugs to a group of pharmacies under common ownership and control.

(12) “Professional dispensing fee” has the same meaning as that term is defined in Section 447.502 of Title 42 of the Code of Federal Regulations.

(13) “Specialty drugs” means drugs determined by the department pursuant to subdivision (f) of Section 14105.3 to generally require special handling, complex dosing regimens, specialized self-administration at home by a beneficiary or caregiver, or specialized nursing facility services, or may include extended patient education, counseling, monitoring, or clinical support.

(14) “Volume weighted average” means the aggregated average volume for a group of legend or nonlegend drugs, weighted by each drug’s percentage of the group’s total volume in the Medi-Cal fee-for-service program during the previous six months. For purposes of this paragraph, volume is based on the standard billing unit used for the legend or nonlegend drugs.

(15) “Wholesaler” has the same meaning as that term is defined in Section 4043 of the Business and Professions Code.

(16) “Wholesaler acquisition cost” means the price for a drug product listed as the wholesaler acquisition cost in the department’s primary price reference source.

(b) (1) Reimbursement to Medi-Cal pharmacy providers for legend and nonlegend drugs shall not exceed the lowest of either of the following:

(A) The drug ingredient cost plus a professional dispensing fee.

(B) The pharmacy’s usual and customary charge as defined in Section 14105.455.

(2) (A) Effective for dates of service on or before March 31, 2017, the professional dispensing fee shall be seven dollars and twenty-five cents ($7.25) per dispensed prescription, and the professional dispensing fee for legend drugs dispensed to a beneficiary residing in a skilled nursing facility or intermediate care facility shall be eight dollars ($8) per dispensed prescription. For purposes of this paragraph, “skilled nursing facility” and “intermediate care facility” have the same meaning as those terms are defined in Division 5 (commencing with Section 70001) of Title 22 of the California Code of Regulations.

(B) Effective for dates of service on or after April 1, 2017, the professional dispensing fee shall be based upon a pharmacy’s total, both Medicaid and non-Medicaid, annual claim volume of the previous year as follows:

(i) Less than 90,000 claims per year, the professional dispensing fee shall be thirteen dollars and twenty cents ($13.20).

(ii) Ninety thousand or more claims per year, the professional dispensing fee shall be ten dollars and five cents ($10.05).

(C) If the department determines that a change in the amount of the professional dispensing fee is necessary pursuant to this section in order to meet federal Medicaid requirements, the department shall establish a new professional dispensing fee through the state budget process.

(i) When establishing the new professional dispensing fee or fees, the department shall establish the professional dispensing fee or fees consistent with Section 447.518(d) of Title 42 of the Code of Federal Regulations.

(ii) The department shall consult with interested parties and appropriate stakeholders in implementing this subparagraph.

(3) The department shall establish the drug ingredient cost of legend and nonlegend drugs as follows:

(A) Effective for dates of service on or before March 31, 2017, the drug ingredient cost shall be equal to the lowest of the average wholesale price minus 17 percent, the actual acquisition cost, the federal upper limit, or the MAIC.

(B) Effective for dates of service on or after April 1, 2017, the drug ingredient cost shall be equal to the lowest of the actual acquisition cost, the federal upper limit, or the MAIC.

(C) For blood factors, the drug ingredient cost shall be established pursuant to Section 14105.86.

(D) Average wholesale price shall not be used to establish the drug ingredient cost once the department has determined that the actual acquisition cost methodology has been fully implemented.

(4) For purposes of paragraph (3), the department may establish a list of MAICs for generically equivalent drugs. If the department establishes a list of MAICs for generically equivalent drugs, the department shall update the list of MAICs and establish additional MAICs in accordance with all of the following:

(A) The department shall establish a MAIC only when three or more generically equivalent drugs are available for purchase and dispensing by retail pharmacies in California.

(B) The department shall base the MAIC on the mean of the average manufacturer's price of drugs generically equivalent to the particular innovator drug plus a percent markup determined by the department to be necessary for the MAIC to represent the average purchase price paid by retail pharmacies in California.

(C) If average manufacturer prices are unavailable, the department shall establish the MAIC in one of the following ways:

(i) Based on the volume weighted average of wholesaler acquisition costs of drugs generically equivalent to the particular innovator drug plus a percent markup determined by the department to be necessary for the MAIC to represent the average purchase price paid by retail pharmacies in California.

(ii) Pursuant to a contract with a vendor for the purpose of surveying drug price information, collecting data, and calculating a proposed MAIC.

(iii) Based on the volume weighted actual acquisition cost of drugs generically equivalent to the particular innovator drug adjusted by the department to represent the average purchase price paid by Medi-Cal pharmacy providers.

(D) The department shall publish the list of MAICs in pharmacy provider bulletins and manuals, update the MAICs at least annually, and notify Medi-Cal providers at least 30 days prior to the effective date of a MAIC.

(E) The department shall establish a process for providers to seek a change to a specific MAIC when the providers believe the MAIC does not reflect current available market prices. If the department determines a MAIC change is warranted, the department may update a specific MAIC prior to notifying providers.

(F) In determining the average purchase price, the department shall consider the provider-related costs of the products that include, but are not limited to, shipping, handling, and storage. Costs of the provider that are included in the costs of the dispensing shall not be used to determine the average purchase price.

(5) (A) The department may establish the actual acquisition cost in one of the following ways:

(i) Based on the volume weighted actual acquisition cost adjusted by the department to verify that the actual acquisition cost represents the average purchase price paid by retail pharmacies in California.

(ii) Based on the proposed actual acquisition cost as calculated by the vendor pursuant to subparagraph (B).

(iii) Based on a national pricing benchmark obtained from the federal Centers for Medicare and Medicaid Services or on a similar benchmark listed in the department's primary price reference source adjusted by the department to verify that the actual acquisition cost represents the average purchase price paid by retail pharmacies in California.

(B) For the purposes of paragraph (3), the department may contract with a vendor for the purposes of surveying drug price information, collecting data from providers, wholesalers, or drug manufacturers, and calculating a proposed actual acquisition cost.

(C) (i) Medi-Cal pharmacy providers shall submit drug price information to the department or a vendor designated by the department for the purposes of establishing the actual acquisition cost. The information submitted by pharmacy providers shall include, but not be limited to, invoice prices and all discounts, rebates, and refunds known to the provider that would apply to the acquisition cost of the drug products purchased during the calendar quarter. Pharmacy warehouses shall be exempt from

the survey process, but shall provide drug cost information upon audit by the department for the purposes of validating individual pharmacy provider acquisition costs.

(ii) Pharmacy providers that fail to submit drug price information to the department or the vendor as required by this subparagraph shall receive notice that if they do not provide the required information within five working days, they shall be subject to suspension under subdivisions (a) and (c) of Section 14123.

(D) (i) For new drugs or new formulations of existing drugs, if drug price information is unavailable pursuant to clause (i) of subparagraph (C), drug manufacturers and wholesalers shall submit drug price information to the department or a vendor designated by the department for the purposes of establishing the actual acquisition cost. Drug price information shall include, but not be limited to, net unit sales of a drug product sold to retail pharmacies in California divided by the total number of units of the drug sold by the manufacturer or wholesaler in a specified period of time determined by the department.

(ii) Drug products from manufacturers and wholesalers that fail to submit drug price information to the department or the vendor as required by this subparagraph shall not be a reimbursable benefit of the Medi-Cal program for those manufacturers and wholesalers until the department has established the actual acquisition cost for those drug products.

(E) Drug pricing information provided to the department or a vendor designated by the department for the purposes of establishing the actual acquisition cost pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(F) Prior to the implementation of an actual acquisition cost methodology, the department shall collect data through a survey of pharmacy providers for purposes of establishing a professional dispensing fee or fees in compliance with federal Medicaid requirements.

(i) The department shall seek stakeholder input on the retail pharmacy factors and elements used for the pharmacy survey relative to both actual acquisition costs and professional dispensing costs.

(ii) For drug products provided by pharmacy providers pursuant to subdivision (f) of Section 14105.3, a differential professional fee or payment for services to provide specialized care may be considered as part of the contracts established pursuant to that section.

(G) When the department implements the actual acquisition cost methodology, the department shall update the Medi-Cal claims processing system to reflect the actual acquisition cost of drugs not later than 30 days after the department has established actual acquisition cost pursuant to subparagraph (A).

(H) Notwithstanding any other law, if the department implements actual acquisition cost pursuant to clause (i) or (ii) of subparagraph (A), the department shall update actual acquisition costs at least every three months and notify Medi-Cal providers at least 30 days prior to the effective date of any change in an actual acquisition cost.

(I) The department shall make available a process for providers to seek a change to a specific actual acquisition cost when the providers believe the actual acquisition cost does not reflect current available market prices. If the department determines an actual acquisition cost change is warranted, the department may update a specific actual acquisition cost prior to notifying providers.

(c) The director shall implement this section in a manner that is consistent with federal Medicaid law and regulations. The director shall seek any necessary federal approvals for the implementation of this section. This section shall be implemented only to the extent that federal approval is obtained.

(d) 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 a provider bulletin or notice, policy letter, or other similar instructions, without taking regulatory action.

(e) The department may enter into contracts with a vendor for the purposes of implementing this section on a bid or nonbid basis. In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this section is necessary. Therefore, contracts entered into to implement this section, and all contract amendments and change orders, shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(f) (1) The rates provided for in this section shall be implemented only if the director determines that the rates will comply with applicable federal Medicaid requirements and that federal financial participation will be available.

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

(3) To the extent that the director determines that the rates do not comply with applicable federal Medicaid requirements or that federal financial participation is not available with respect to any rate of reimbursement described in this section, the director retains the discretion not to implement that rate and may revise the rate as necessary to comply with federal Medicaid requirements.

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

(h) This section shall not be construed to require the department to collect cost data, to conduct cost studies, or to set or adjust a rate of reimbursement based on cost data that has been collected.

(i) Effective for dates of service on or after April 1, 2017, adjustments to pharmacy drug product payments pursuant to Section 14105.192 shall no longer apply.

(j) Prior to implementation of this section, the department shall provide the appropriate fiscal and policy committees of the Legislature with information on the department's plan for implementation of the actual acquisition cost methodology pursuant to this section.

(Amended by Stats. 2021, Ch. 615, Sec. 450. (AB 474) Effective January 1, 2022. Operative January 1, 2023, pursuant to Sec. 463 of Stats. 2021, Ch. 615.)

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

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

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

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

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

(b) Subject to Section 14105.45, the department may require providers, manufacturers, and wholesalers to submit any data the director determines necessary or useful in preparing for the transition from a methodology based on average wholesale price to a methodology based on actual acquisition cost.

(c) If the AWP ceases to be listed by the department's primary price reference source vendor, the department may direct the fiscal intermediary to establish a process with the primary price reference source vendor to temporarily report the AWP consistent with the definition of AWP in Section 14105.45. If this process is established, it shall be limited in scope and duration, and shall cease when the department has fully implemented the average acquisition cost methodology pursuant to Section 14105.45.

(Amended by Stats. 2011, Ch. 29, Sec. 15. (AB 102) Effective June 29, 2011.)

14105.455. (a) Pharmacy providers shall submit their usual and customary charge when billing the Medi-Cal program for prescribed drugs.

(b) "Usual and customary charge" means the lower of the following:

(1) The lowest price reimbursed to the pharmacy by other third-party payers in California, excluding Medi-Cal managed care plans and Medicare Part D prescription drug plans.

(2) The lowest price routinely offered to any segment of the general public.

(c) Donations or discounts provided to a charitable organization are not considered usual and customary charges.

(d) Pharmacy providers shall keep and maintain records of their usual and customary charges for a period of three years from the date the service was rendered.

(e) Payment to pharmacy providers shall be the lower of the pharmacy's usual and customary charge or the reimbursement rate pursuant to subdivision (b) of Section 14105.45.

(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, interpret, or make specific this section by means of a provider bulletin or notice, policy letter, or other similar instructions, without taking regulatory action.

(Amended by Stats. 2011, Ch. 29, Sec. 16. (AB 102) Effective June 29, 2011.)

14105.456. (a) For purposes of this section, the following definitions shall apply:

(1) “Blood factors” has the same meaning as that term is defined in Section 14105.86.

(2) “Generically equivalent drugs” has the same meaning as that term is defined in Section 14105.45.

(3) “Legend drug” has the same meaning as that term is defined in Section 14105.45.

(4) “Medicare rate” means the rate of reimbursement established by the Centers for Medicare and Medicaid Services for the Medicare Program.

(5) “Nonlegend drug” has the same meaning as that term is defined in Section 14105.45.

(6) “Pharmacy rate of reimbursement” means the reimbursement to a Medi-Cal pharmacy provider pursuant to the provisions of paragraph (3) of subdivision (b) of Section 14105.45.

(7) “Physician-administered drug” means any legend drug, nonlegend drug, or vaccine administered or dispensed to a beneficiary by a Medi-Cal provider other than a pharmacy provider and billed to the department on a fee-for-service basis.

(8) “Volume-weighted average” means the aggregated average volume for generically equivalent drugs, weighted by each drug’s percentage of the total volume in the Medi-Cal fee-for-service program during the previous six months. For purposes of this paragraph, volume is based on the standard billing unit used for the generically equivalent drugs.

(b) The department may reimburse providers for a physician-administered drug using either a Healthcare Common Procedure Coding System code or a National Drug Code.

(c) The Healthcare Common Procedure Coding System code rate of reimbursement for a physician-administered drug shall be equal to the volume-weighted average of the pharmacy rate of reimbursement for generically equivalent drugs. The department shall publish the Healthcare Common Procedure Coding System code rates of reimbursement.

(d) The National Drug Code rate of reimbursement shall equal the pharmacy rate of reimbursement.

(e) Notwithstanding subdivisions (c) and (d), the department may reimburse providers for physician-administered drugs, with the exception of blood factors, at a rate not less than the Medicare rate.

(f) Physician-administered drugs that are blood factors shall be reimbursed pursuant to the provisions of subdivision (b) of Section 14105.86.

(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 this section by means of a provider bulletin or notice, policy letter, or other similar instructions, without taking regulatory action.

(h) (1) The rates provided for in this section shall be implemented commencing January 1, 2011, but only if the director determines that the rates comply with applicable federal Medicaid requirements and that federal financial participation will be available.

(2) In assessing whether federal financial participation is available, the director shall determine whether the rates comply with the federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code. To the extent that the director determines that a rate of reimbursement described in this section does not comply with the federal Medicaid requirements, the director retains the discretion not to implement that rate and may revise the rate as necessary to comply with the federal Medicaid requirements.

(i) The director shall seek any necessary federal approval for the implementation of this section. To the extent that federal financial participation is not available with respect to a rate of reimbursement described in this section, the director retains the discretion not to implement that rate and may revise the rate as necessary to comply with the federal Medicaid requirements.

(Amended by Stats. 2017, Ch. 52, Sec. 28. (SB 97) Effective July 10, 2017.)

14105.46. (a) For purposes of this section:

(1) “Covered entity” means a provider defined as a covered entity in Section 256b of Title 42 of the United States Code.

(2) “340B” means the discount drug purchasing program described in Section 256b of Title 42 of the United States Code.

(b) A covered entity shall dispense only 340B drugs to Medi-Cal beneficiaries.

(c) If a covered entity is unable to purchase a specific 340B drug, the covered entity may dispense a drug purchased at regular drug wholesale rates to a Medi-Cal beneficiary. If a covered entity dispenses a drug purchased at regular drug wholesale rates pursuant to this subdivision, the covered entity is required to maintain documentation of their inability to obtain the 340B drug.

(d) A covered entity shall bill an amount not to exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with Section 256b of Title 42 of the United States Code plus the professional fee pursuant to Section 14105.45 or the dispensing fee pursuant to Section 14132.01.

(e) A covered entity shall identify a 340B drug on the claim submitted to the Medi-Cal program for reimbursement.

(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 take the actions specified in this section by means of a provider bulletin or notice, policy letter, or other similar instructions, without taking regulatory action.

(Added by Stats. 2009, 4th Ex. Sess., Ch. 5, Sec. 40. Effective July 28, 2009.)

14105.467. (a) The department shall establish, implement, and maintain a supplemental payment pool for nonhospital 340B community clinics, subject to an appropriation by the Legislature.

(b) Beginning January 1, 2021, and any subsequent fiscal year to the extent funds are appropriated by the Legislature for the purpose described in this section, the department shall make available fee-for-service-based supplemental payments from a fixed-amount payment pool to qualifying nonhospital 340B community clinics in accordance with this section and any terms of federal approval obtained pursuant to subdivision (f).

(c) (1) On or before July 15, 2020, the department shall establish a stakeholder process, which shall include representatives of qualifying nonhospital 340B community clinics. Representatives shall be geographically diverse and consist of qualifying nonhospital 340B community clinics with differing pharmacy arrangements, including those that operate in-house pharmacies and those with contract pharmacy arrangements. The stakeholder process shall be utilized to develop and implement the methodology for distribution of supplemental pool payments to qualifying nonhospital 340B community clinics. This shall include the eligibility criteria for receipt of supplemental payments, the aggregate amount of pool funding available in a respective fiscal year, the criteria for apportioning the pool funding among qualifying nonhospital 340B community clinics, and the timing, frequency, and amount of the resultant supplemental payments.

(2) The department shall conduct at least three meetings with stakeholders and shall finalize the methodology for distribution no later than October 1, 2020.

(d) (1) For any fiscal year that the department implements this section, the aggregate amount of supplemental payments available shall not exceed the pool amount established by the department for the respective fiscal year pursuant to subdivision (b).

(2) For any fiscal year that the department implements this section, the supplemental payment amounts received by a qualifying nonhospital 340B community clinic shall not exceed the apportioned amounts of the pool funding attributable to that individual clinic under the methodology developed pursuant to subdivision (c).

(e) To the extent permissible under federal law, supplemental payments received by qualifying nonhospital 340B community clinics pursuant to this section shall be considered separate and apart from the prospective payment system (PPS) reimbursement the clinic receives pursuant to Section 1396a(bb) of Title 42 of the United States Code and shall not be considered during annual reconciliation of the PPS rate.

(f) (1) The department may modify any methodology or other requirement specified in this section to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or not otherwise jeopardized.

(2) If the department determines that a modification is necessary pursuant to paragraph (1), the department shall consult with participants of the stakeholder process established pursuant to subdivision (c) to the extent practicable.

(3) If a modification is made, the department shall notify qualifying nonhospital 340B community clinics, the Joint Legislative Budget Committee, and the relevant policy and fiscal committees of the Legislature within 10 business days of that modification.

(g) The department shall implement this section only to the extent that any necessary federal approvals have been obtained, and federal financial participation is available and is not otherwise jeopardized.

(h) Notwithstanding Chapter 3.5 (commencing with section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of provider bulletins or other similar instructions, without taking any further regulatory action.

(i) For purposes of this section:

(1) "340B" means the discount drug purchasing program described in Section 256b of Title 42 of the United States Code.

(2) “Qualifying nonhospital 340B community clinic” means a center or clinic that is licensed under subdivision (a) of Section 1204 of the Health and Safety Code, or a clinic operated by a city, county, city and county, or hospital authority that is exempt from licensure under subdivision (b) of Section 1206 of the Health and Safety Code, and that is a 340B covered entity pursuant to Section 256b of Title 42 of the United States Code for the duration of each applicable fiscal year for which the department implements this section.

(j) Upon implementation of Section 14105.468 and the completion of all closeout activities associated with this section, the director shall execute a declaration, which shall be retained by the director, stating that implementation of Section 14105.468 has commenced and that all closeout activities associated with this section have been completed. This section shall become inoperative one year after the date that the director executes the declaration and shall be repealed on January 1 of the year following the date upon which this section becomes inoperative.

(Amended by Stats. 2024, Ch. 40, Sec. 60. (SB 159) Effective June 29, 2024. Conditionally inoperative as prescribed by its own provisions. Conditionally repealed as prescribed by its own provisions.)

14105.468. (a) (1) Beginning for dates of service on or after January 1, 2025, the department shall establish and implement a directed payment program under which a qualifying nonhospital 340B community clinic may earn payments from contracted Medi-Cal managed care plans, subject to an appropriation by the Legislature.

(2) (A) Beginning for dates of service on or after January 1, 2026, the department shall increase the amount of directed payments pursuant to paragraph (1) with amounts allocated from the Medi-Cal Provider Payment Reserve Fund in accordance with Section 14105.200.

(B) If the voters approve the addition of Chapter 7.5 (commencing with Section 14199.100) to this part at the November 5, 2024, statewide general election, this paragraph shall be inoperative as of January 1, 2025.

(b) The department, in consultation with affected stakeholders, and affected Medi-Cal managed care plans, as applicable, shall establish the methodology or methodologies, parameters, and eligibility criteria for the directed payments pursuant to this section. This shall include, but is not limited to, the milestones and metrics that a qualifying nonhospital 340B community clinic shall meet in order to receive a directed payment from a Medi-Cal managed care plan pursuant to this section. The department may implement the directed payment described in this subdivision using one or more of the models authorized by subsection (c) of Section 438.6 of Title 42 of the Code of Federal Regulations.

(c) To the extent permissible under federal law, directed payments received by qualifying nonhospital 340B community clinics pursuant to this section shall be considered separate and apart from the prospective payment system (PPS) reimbursement the clinic receives pursuant to subsection (bb) of Section 1396a of Title 42 of the United States Code and shall not be considered during annual reconciliation of the PPS rate.

(d) 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 in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or other similar instructions, without taking any further regulatory action.

(e) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(f) For any calendar year in which this section is implemented, in whole or in part, and notwithstanding any other law, neither the department nor a Medi-Cal managed care plan shall be required to make the payments specified in Section 14105.467.

(g) For purposes of this section:

(1) “340B” means the discount drug purchasing program described in Section 256b of Title 42 of the United States Code.

(2) “Qualifying nonhospital 340B community clinic” means a center or clinic that is licensed under subdivision (a) of Section 1204 of the Health and Safety Code, or a clinic operated by a city, county, city and county, or hospital authority that is exempt from licensure under subdivision (b) of Section 1206 of the Health and Safety Code, and that is a 340B covered entity pursuant to Section 256b of Title 42 of the United States Code for the duration of each applicable fiscal year for which the department implements this section.

(Added by Stats. 2024, Ch. 40, Sec. 61. (SB 159) Effective June 29, 2024.)

14105.47. (a) (1) The department shall establish a list of medical supplies. The list shall specify utilization controls to be applied to each medical supply product.

(2) The utilization controls specified shall include, but not be limited to, those provided by regulation of the department.

(3) The department shall notify providers at least 30 days prior to the effective date of a change in utilization controls.

(b) (1) The department shall establish a list of maximum allowable product costs (MAPCS) for medical supplies, which shall be published in provider bulletins.

(2) The department shall update existing MAPCS and establish additional MAPCS in accordance with all of the following:

(A) In establishing the MAPCS, the director shall assure that eligible persons shall receive medical supply products that are available to the public generally, without discrimination or segregation based purely on economic disability.

(B) All related medical supply products within each particular medical supply type available for retail distribution shall be reviewed by the department in consultation with representatives from the California Association of Medical Product Suppliers and the California Pharmacists Association.

(C) The department shall base MAPCS on the mean of the wholesale selling price of related medical supply products that are available in California. For purposes of this section, “wholesale selling price” means the price, including discounts and rebates, paid by a provider to a wholesaler, distributor, or manufacturer for a medical supply product.

(D) In establishing the MAPCS, the department shall consider the provider related costs of the product that include, but are not limited to, shipping, handling, storage, and delivery.

(E) The department shall notify Medi-Cal providers at least 30 days prior to the effective date of MAPCS.

(c) (1) In establishing the list of medical supplies, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis with manufacturers, distributors, dispensers, or suppliers of medical supplies pursuant to Sections 14100.95 and 14105.3.

(2) To ensure that the health needs of Medi-Cal beneficiaries are met, the department shall, when evaluating a decision to execute a contract, and when evaluating medical supplies for retention on, addition to, or deletion from, the list of medical supplies, consider all of the following criteria:

(A) The safety of the product.

(B) The effectiveness of the product.

(C) The essential need for the product.

(D) The potential for misuse of the product.

(E) The immediate or long-term cost effectiveness of the product.

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

(4) In the evaluation of the effectiveness of a product, the department may require the manufacturer, distributor, dispenser, or supplier to submit its products to testing by an independent laboratory. For the purposes of this section, “independent laboratory” means an analytical laboratory that is not a subsidiary of, affiliated with, or on retainer for, the manufacturer, distributor, dispenser, or supplier. The department shall only utilize this paragraph involving products where there is a demonstrated experience of a significant variation in performance among the products subject to this particular contracting process.

(d) Notwithstanding the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code, actions under this section shall not be subject to the Administrative Procedure Act or to the review and approval of the Office of Administrative Law.

(Amended by Stats. 2007, Ch. 188, Sec. 65. Effective August 24, 2007.)

14105.475. (a) In maintaining the lists of medical supplies, incontinence medical supplies, and enteral nutrition products, the department may perform a review of, and contract for, various products in a specific product category.

(b) The department shall notify each manufacturer of products in the categories selected pursuant to Sections 14100.95, 14105.47, 14105.8, and Sections 14125 to 14125.9, inclusive.

(c) If, within 30 days of notification, a manufacturer does not enter into negotiations for a contract pursuant to those sections, the department may delete the products from their respective lists, or refuse to consider for addition, products of that manufacturer in the selected product categories.

(d) If, after 270 days from the initial notification, a contract is not executed for a product currently on the list of medical supplies, incontinence medical supplies, or enteral nutrition products, the department may delete the product from its respective list.

(e) If, within 270 days from the initial notification, a contract is executed for a product currently on the list of medical supplies, incontinence medical supplies, or enteral nutrition products, the department shall retain the product on its respective list.

(f) If, within 270 days from the date of the initial notification, a contract is executed for a product not currently on the list of medical supplies, incontinence medical supplies, or enteral nutrition products, the department shall add the product to its respective list.

(g) The department shall terminate all negotiations 270 days after the initial notification.

(h) The department may delete any product from its respective list at the expiration of the contract term or when the contract between the department and the manufacturer of that product is terminated.

(i) In the absence of a contract, the department may deem any product on the list of medical supplies, incontinence medical supplies, or enteral nutrition products, a nonbenefit of the program and delete that product from its respective list.

(j) Deletions made to the lists of medical supplies, incontinence supplies, and enteral nutrition products, shall become effective no sooner than 30 days after publication of the changes in provider bulletins.

(k) (1) A manufacturer of a medical supply, incontinence supply, or enteral nutrition product denied a contract pursuant to this section, or pursuant to Sections 14100.95, 14105.47, 14105.8, and Sections 14125 to 14125.9, inclusive, may file an appeal of that decision with the director within 30 calendar days of the department's written decision.

(2) The director shall issue a final decision on the appeal within 60 calendar days of the postmark date of the appeal.

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

(Added by Stats. 2007, Ch. 188, Sec. 66. Effective August 24, 2007.)

14105.48. (a) The department shall establish a list of covered services and maximum allowable reimbursement rates for durable medical equipment, as defined in Section 51160 of Title 22 of the California Code of Regulations, and the list shall be published in provider manuals. The list shall specify utilization controls to be applied to each type of durable medical equipment.

(b) Reimbursement for durable medical equipment, except wheelchairs, wheelchair accessories, and speech-generating devices and related accessories, shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, (2) an amount that does not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare Program for the same or similar item or service, or (3) the guaranteed acquisition cost negotiated by means of the contracting process provided for pursuant to Section 14105.3 plus a percentage markup to be established by the department.

(c) Reimbursement for wheelchairs, wheelchair accessories, and speech-generating devices and related accessories shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, (2) an amount that does not exceed 100 percent of the lowest maximum allowance for California established by the federal Medicare Program for the same or similar item or service, or (3) the guaranteed acquisition cost negotiated by means of the contracting process provided for pursuant to Section 14105.3 plus a percentage markup to be established by the department.

(d) Reimbursement for all durable medical equipment billed to the Medi-Cal program utilizing codes with no specified maximum allowable rate shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, (2) the guaranteed acquisition cost negotiated by means of the contracting process provided for pursuant to Section 14105.3 plus a percentage markup to be established by the department, (3) the actual acquisition cost plus a markup to be established by the department, (4) the manufacturer's suggested retail purchase price on or prior to the date of service, and documented by a printed catalog or a hard copy of an electronic catalog page showing that price, reduced by a percentage discount not to exceed 20 percent, or not to exceed 15 percent for wheelchairs and wheelchair accessories if the provider employs or contracts with a qualified rehabilitation technology professional, as defined in Section 14132.85, or (5) a price established through targeted product-specific cost containment provisions developed with providers.

(e) Reimbursement for all durable medical equipment supplies and accessories billed to the Medi-Cal program shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, or (2) the acquisition cost plus a 23 percent markup.

(f) (1) Commencing January 1, 2007, reimbursement for oxygen delivery systems and oxygen contents shall utilize national HCPCS codes, and shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, (2) an amount that does not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare Program for the same or a similar item or service, or (3) the guaranteed acquisition cost negotiated by means of the contracting process provided for pursuant to Section 14105.3, plus a percentage markup to be established by the department.

(2) Effective July 1, 2022, reimbursement for durable medical equipment that is considered to be oxygen and respiratory equipment, as determined by the department, shall not exceed 100 percent of the lowest maximum allowance for California established by the federal Medicare Program for the same or similar item or service.

(g) Within six months of the effective date of the act that added this subdivision, the department shall review utilization of services and equipment resulting from the changes to this section made by that act, and shall assess whether the changes are contributing to inappropriate use of those services or equipment. If the department's review finds an increase in inappropriate use of those services or equipment, the Department of Finance shall notify the Joint Legislative Budget Committee of the State Department of Health Services' findings and recommended changes to ensure program integrity.

(h) Any regulation in Division 3 of Title 22 of the California Code of Regulations that contains provisions for reimbursement rates for durable medical equipment shall be amended or repealed effective for dates of service on or after the date of the act adding this section.

(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 this section, in whole or in part, by means of provider bulletins or other similar instructions, without taking any further regulatory action.

(j) The department shall consult with interested parties and appropriate stakeholders in implementing this section with respect to all of the following:

(1) Notifying the provider representatives of the proposed change.

(2) Scheduling at least one meeting to discuss the change.

(3) Allowing for written input regarding the change.

(4) Providing advance notice on the implementation and effective date of the change.

(k) The department may require providers of durable medical equipment to appeal Medicare denials for dually eligible beneficiaries as a condition of Medi-Cal payment.

(Amended by Stats. 2022, Ch. 47, Sec. 94. (SB 184) Effective June 30, 2022.)

14105.49. (a) (1) The department shall establish a list of Healthcare Common Procedure Coding System (HCPCS) codes billable to the Medi-Cal program and reimbursement rates, subject to Section 51319 of Title 22 of the California Code of Regulations, hearing aids, and the list shall be published in the Medi-Cal Provider Manual.

(2) The department may implement this section by provider manual or bulletin. Notwithstanding the provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code), actions of the department under this section shall not be subject to the rulemaking provisions of the Administrative Procedure Act or to the review and approval of the Office of Administrative Law.

(b) The maximum reimbursement rate for hearing aids shall not exceed the lesser of the following:

(1) The maximum allowable amount established by the department.

(2) The one-unit wholesale cost, plus a markup determined by the department.

(3) The billed amount.

(4) The rate established by the department's contracting program.

(c) The maximum reimbursement rate for hearing aid supplies and accessories shall not exceed the lesser of the following:

(1) The retail price.

(2) The wholesale cost, plus a markup determined by the department.

(3) The billed amount.

(4) The rate established by the department's contracting program.

(d) The maximum reimbursement rate for molds or inserts shall not exceed the lesser of the following:

(1) The maximum amount allowable established by the department.

(2) The billed amount.

(3) The rate established by the department's contracting program.

(e) The maximum reimbursement for repairs, subsequent to the guarantee period, shall not exceed the lesser of the following:

(1) The invoice cost plus a markup determined by the department.

(2) The billed amount.

(3) The rate established by the department's contracting program.

(Amended by Stats. 2006, Ch. 74, Sec. 67. Effective July 12, 2006.)

14105.5. The director or prepaid health plans shall make no payment for services rendered prior to January 1, 1977, to any health facility that secures a license under the provisions of Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code after July 1, 1970, covering a new facility or additional bed capacity or the conversion of existing bed capacity to a different license category, unless the licensee received a favorable final decision by the voluntary area health planning agency in the area, the consumer members of a voluntary area health planning agency acting as an appeals body or the Advisory Health Council pursuant to Sections 127155 to 127235, inclusive, of the Health and Safety Code; or unless the licensee had filed an application for a license prior to January 1, 1970, and the application met all then-existing requirements and regulations of the appropriate state agency at the time of application including, at least, preliminary submission of plans, and if the licensee commences construction of his or her project prior to July 1, 1971, and if the licensee has on file with the department a notarized affidavit from the building department having jurisdiction indicating that substantial progress on the approved project was attained by January 1, 1973, and the licensee has on file with the county recorder and department a valid notice of construction completion indicating January 1, 1974, as the completion date; except that the department shall extend the foregoing dates by no more than a total of two years in the case of projects where delay has resulted from the death of the original applicant, and shall extend the foregoing dates by no more than a total of one year in the case of projects where other good cause has been shown why the extension should be granted. The exception provided for in the preceding sentence with respect to applications filed prior to January 1, 1970, except for transfers executed before November 30, 1970, or after July 1, 1971, shall not apply to transferees of the applications of the original applicants.

Voluntary area health planning agencies may extend, until July 1, 1972, the date upon which applicants, qualifying under the exception in this section, shall commence construction, if the voluntary area health planning agencies declare that good cause has been shown why the extension should be granted, provided that an applicant applying for the extension had, prior to January 1, 1970, received approval of a health planning association in the county wherein the applicant is located. Applicants receiving extension of the construction commencement date shall have on file with the department a notarized affidavit from the building department having jurisdiction indicating that substantial progress on the approved project was attained by January 1, 1974, and have on file with the county recorder and department a valid notice of construction completion indicating January 1, 1975, as the completion date; except that the department shall extend each of the foregoing dates by no more than a total of one year in the case of projects where good cause has been shown why the extension should be granted.

(a) For the purposes of this section, "substantial progress" is defined and evidenced as follows:

(1) For structures of three or fewer stories, completion of the foundations and footings; the structural frame; the mechanical, electrical, and plumbing rough-in; the rough flooring; the exterior walls and windows; and the finished roof.

(2) For structures of more than three stories, a contractor's schedule of work shall be filed with the department by January 1, 1973. Every three months thereafter, until completion, evidence shall be submitted to the department that construction is progressing on that schedule.

(b) For the purposes of this section, construction of a project is deemed commenced on the date the applicant was so notified by the department, if so notified, or on the date the applicant has completed not less than all of the following:

(1) Submission to the appropriate state agency of a written agreement executed between the applicant and a licensed general contractor to construct and complete the facility within a designated time schedule in accordance with final architectural plans and specifications approved by the agency.

(2) Obtaining the initial permits or approval for commencing work on the project that is customarily issued for projects of the scope of applicant by the governmental agency having jurisdiction over the construction.

(3) Completion of construction work on the project to such a degree as to justify and require a progress payment by the applicant to the general contractor under terms of the construction agreement.

(Amended by Stats. 1996, Ch. 1023, Sec. 473.5. Effective September 29, 1996.)

14105.51. (a) The department shall establish “capped rental” reimbursement for specific items of durable medical equipment. Items in this category shall be reimbursed on a monthly rental basis not to exceed a period of continuous use of 10 months. After 10 months of rental have been paid, the provider shall continue to provide the item without charge, except for maintenance and servicing fees, until the medical necessity ends or Medi-Cal coverage ceases. Monthly reimbursement for the rental of these specific items of durable medical equipment may not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar item or service.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code, actions under subdivision (a) shall not be subject to the rulemaking provisions of the Administrative Procedure Act or to the review and approval of the Office of Administrative Law.

(c) The department shall consult with interested parties and appropriate stakeholders in determining which items will be subject to capped rental, including doing all of the following:

(1) Notifying provider representatives of the items that will be subject to capped rental.

(2) Scheduling at least one meeting to discuss the items.

(3) Allowing for written input regarding the items.

(4) Providing advance notice of the effective date on and after which the items will be subject to capped rental.

(Added by Stats. 2003, Ch. 230, Sec. 67.5. Effective August 11, 2003.)

14105.6. No health facility licensed under the provisions of Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code shall be entitled to receive, or shall receive, any payment whatsoever from the director, or from any prepaid health plan, for any services rendered to any Medi-Cal program beneficiary if the health facility has commenced construction of a project after January 1, 1977, and the health facility has failed to obtain a certificate of need covering such project issued pursuant to Part 1.5 (commencing with Section 437) of Division 1 of the Health and Safety Code. Upon commencement of such a project, or as soon thereafter as possible, the director or the prepaid health plan shall notify the facility in writing of termination of all payments for any services rendered in any portion of the facility after 30 days from the date the notice is mailed.

For the purposes of this section, a “project” shall mean any project for which a certificate of need is required pursuant to Part 1.5 (commencing with Section 437) of Division 1 of the Health and Safety Code.

(Added by Stats. 1976, Ch. 854.)

14105.7. (a) In order to fairly reimburse pharmacies for the furnishing of prescription drugs to Medi-Cal beneficiaries, the director shall update allowable drug product prices within seven days of receiving notice of a drug product price change. Notice to the director shall include, but not be limited to, publication of the price change in the supplier’s catalog or supplement or in nationally distributed drug price reference guides.

(b) No regulation reducing allowable drug product cost reimbursement or removing a drug from the Medi-Cal list of contract drugs shall be operative until at least 30 days after eligible pharmacies have been mailed a notice of the reimbursement limitation by the department or the fiscal intermediary.

(c) The director shall limit the rate of payment for the professional fee portion of prescription services rendered under this chapter pursuant to Section 4064 of the Business and Professions Code or Section 11201 of the Health and Safety Code and the professional fee portion of prescription services rendered as a refill immediately subsequent to such prescription to ensure that the total professional fee paid for the two services does not exceed the professional fee paid for the same prescription refill when provided as a routine service.

(Amended by Stats. 2005, Ch. 80, Sec. 25.5. Effective July 19, 2005.)

14105.75. (a) In order to ensure that drug products in an injectable form that are not administered by the patient are available to Medi-Cal beneficiaries pursuant to federal law, the department shall do all of the following with respect to any such drug product:

(1) (A) Develop and publish a medical benefit drug utilization policy within 180 days of being notified by the manufacturer of approval of the product by the federal Food and Drug Administration. The policy shall be published in the Medi-Cal provider bulletin that immediately follows that 180-day period. The effective date of the drug utilization policy shall be no later than the publication date of the bulletin.

(B) If the department is unable to complete and publish the policy within the period specified in subparagraph (A), the department shall, until completion of the utilization policy, allow providers to use the utilization standards approved by the

federal Food and Drug Administration that are contained in the official package circular or insert for the product when the department reviews a provider's submission for utilization of the product. The department shall allow the product to be billed and reimbursed using a miscellaneous billing code until the permanent code is assigned and published pursuant to paragraph (3).

(2) Evaluate the necessity of utilization controls, and publish all utilization controls in both the final drug utilization policy and the Medi-Cal provider bulletin.

(3) Ensure that the fiscal intermediary enters into the Medi-Cal database the code assigned to the product within 60 days of the date the code was assigned to the product.

(b) Nothing in this section shall be construed to affect the department's authority to require a provider to obtain prior authorization for dispensing or administering an injectable drug.

(Added by Stats. 2006, Ch. 792, Sec. 1. Effective January 1, 2007.)

14105.8. (a) The department may enter into contracts with manufacturers of enteral nutrition products that can be used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food, on a bid or nonbid basis. The department shall maintain a list of those products for which contracts have been executed. For those contracts that generate rebates, those rebates shall be managed through the department's drug rebate accounting system.

(b) (1) To ensure that the health needs of Medi-Cal beneficiaries are met, the department shall, when evaluating a decision to execute a contract, and when evaluating enteral nutrition products for retention on, addition to, or deletion from, the list of enteral nutrition products, consider all of the following criteria:

(A) The safety of the product.

(B) The effectiveness of the product.

(C) The essential need for the product.

(D) The potential for misuse of the product.

(E) The immediate or long-term cost effectiveness of the product.

(2) The deficiency of a product when measured by one of the criteria specified in paragraph (1) may be sufficient to support a decision that the product should be deleted from, should not be added to, or should not be retained on, the list of medical supplies. However, the superiority of a product under one criterion may be sufficient to warrant the addition or retention of the product, notwithstanding a deficiency in another criterion.

(c) In order that Medi-Cal beneficiaries may have access to a comprehensive range of enteral nutrition products pursuant to subdivision (a), the department shall ensure that there is representation on the list of both general use and specialized use enteral nutrition products. The department deems all products designed to meet the normal needs of infants, and all products that are an incomplete source of nutrition, including modular products, and all products intended for use in weight loss, are not benefits of the Medi-Cal program. The department may deem an incomplete product a benefit for patients with diagnoses, including, but not limited to, malabsorption and inborn errors of metabolism, when the product either appropriately lacks only an offending nutrient, or has been shown to not be investigational nor experimental when used as part of a therapeutic regimen to prevent serious disability or death, or when both conditions apply.

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

(e) Deletions made to the list of enteral nutrition products shall become effective no sooner than 30 days after publication of the changes in provider bulletins.

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

(g) The department may provide beneficiaries continuing care for products deleted from the list of enteral nutrition products. The department shall assess the need for continuing care based on the criteria in subdivision (b) and the potential impact on beneficiary access to appropriate therapy. To be eligible for continuing care status under this subdivision, a beneficiary must be taking the

enteral nutrition product when the product is deleted. Additionally, the department shall have received a claim for the enteral nutrition product with a date of service that is within 100 days prior to the date the product was deleted. A beneficiary shall remain eligible for continuing care status provided that a claim is submitted for the enteral nutrition product 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 enteral nutrition product.

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

(i) Enteral nutrition products authorized pursuant to subdivision (a) shall be available only through prior authorization. The department may designate those enteral nutrition products that are without a contract as not being a benefit of the Medi-Cal program, except in the case of continuing care as described in subdivision (h) of this section.

(j) Contracts executed pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(k) (1) Manufacturers shall calculate and pay interest on late or unpaid rebates.

(2) Interest pursuant to paragraph (1) shall begin accruing 38 calendar days from the date of mailing of the quarterly invoice, including supporting utilization data sent to the manufacturer. Interest shall continue to accrue until the date of mailing of the manufacturer's payment.

(3) Interest rates and calculations pursuant to paragraph (1) shall be identical and shall be equal to the drug rebate interest rates as determined by the federal Centers for Medicare and Medicaid Services' Medicaid Drug Rebate Program Releases or regulations.

(4) If the date of mailing of a state rebate payment is 69 days or more from the date of mailing of the invoice, including supporting utilization data sent to the manufacturer, the interest rate shall be as specified in paragraph (3), however the interest rate shall be increased by 10 percentage points.

(l) The department may adopt emergency regulations to implement this section 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).

(Amended by Stats. 2021, Ch. 615, Sec. 447. (AB 474) Effective January 1, 2022. Operative January 1, 2023, pursuant to Sec. 463 of Stats. 2021, Ch. 615.)

14105.85. (a) Effective July 1, 2002, payment for enteral nutrition products dispensed by a pharmacy provider shall be based on the estimated acquisition cost for that product plus a percentage markup to be determined by the department in consultation with provider representatives from the California Association of Medical Product Suppliers and the California Pharmacists Association. Any changes to the percentage markup may be implemented with 30-day notice to the provider community via a provider bulletin or other specific notification to providers.

(b) In determining the estimated acquisition cost of products pursuant to this section, the department shall consider provider related costs of the products that include, but are not limited to, shipping, handling, storage, and delivery.

(Amended by Stats. 2007, Ch. 188, Sec. 68. Effective August 24, 2007.)

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

(1) (A) "Average sales price" means the price reported to the federal 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 federal 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 federal 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, and Article 1 (commencing with Section 125125) of Chapter 2 of Part 5 of, Division 106 of the Health and Safety Code.

(2) Upon implementation of paragraphs (4) and (5) of subdivision (b) of Section 14105.33 for blood factors pursuant to this section, “utilization data” used to determine the state rebate shall be described pursuant to subdivision (b) of Section 14105.33. The department shall post on its Internet Web site a notice that it has implemented paragraphs (4) and (5) of subdivision (b) of Section 14105.33 for blood factors pursuant to this section.

(3) 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.

(4) 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.

(Amended by Stats. 2016, Ch. 30, Sec. 27. (SB 833) Effective June 27, 2016.)

14105.94. (a) An eligible provider, as described in subdivision (b), may, in addition to the rate of payment that the provider would otherwise receive for Medi-Cal ground emergency medical transportation services, receive supplemental Medi-Cal reimbursement to the extent provided in this section.

(b) A provider shall be eligible for supplemental reimbursement if the provider has all of the following characteristics continuously during a state fiscal year:

(1) Provides ground emergency medical transportation services to Medi-Cal beneficiaries.

(2) Is a provider that is enrolled as a Medi-Cal provider for the period being claimed.

(3) Is owned or operated by the state, a city, county, city and county, fire protection district organized pursuant to Part 2.7 (commencing with Section 13800) of Division 12 of the Health and Safety Code, special district organized pursuant to Chapter 1 (commencing with Section 58000) of Division 1 of Title 6 of the Government Code, community services district organized pursuant to Part 1 (commencing with Section 61000) of Division 3 of Title 6 of the Government Code, health care district organized pursuant to Chapter 1 (commencing with Section 32000) of Division 23 of the Health and Safety Code, or a federally recognized Indian tribe.

(c) An eligible provider's supplemental reimbursement pursuant to this section shall be calculated and paid as follows:

(1) The supplemental reimbursement to an eligible provider, as described in subdivision (b), shall be equal to the amount of federal financial participation received as a result of the claims submitted pursuant to paragraph (2) of subdivision (f).

(2) The amount certified pursuant to paragraph (1) of subdivision (e), when combined with the amount received from all other sources of reimbursement from the Medi-Cal program, shall not exceed 100 percent of actual costs, as determined pursuant to the Medi-Cal State Plan, for ground emergency medical transportation services.

(3) The supplemental Medi-Cal reimbursement provided by this section shall be distributed exclusively to eligible providers under a payment methodology based on ground emergency medical transportation services provided to Medi-Cal beneficiaries by eligible providers on a per-transport basis or other federally permissible basis. The department shall obtain approval from the federal Centers for Medicare and Medicaid Services for the payment methodology to be utilized, and may not make any payment pursuant to this section prior to obtaining that approval.

(d) (1) It is the Legislature's intent in enacting this section to provide the supplemental reimbursement described in this section without any expenditure from the General Fund. An eligible provider, as a condition of receiving supplemental reimbursement pursuant to this section, shall enter into, and maintain, an agreement with the department for the purposes of implementing this section and reimbursing the department for the costs of administering this section.

(2) The nonfederal share of the supplemental reimbursement submitted to the federal Centers for Medicare and Medicaid Services for purposes of claiming federal financial participation shall be paid only with funds from the governmental entities described in paragraph (3) of subdivision (b) and certified to the state as provided in subdivision (e).

(e) Participation in the program by an eligible provider described in this section is voluntary. If an applicable governmental entity elects to seek supplemental reimbursement pursuant to this section on behalf of an eligible provider owned or operated by the entity, as described in paragraph (3) of subdivision (b), the governmental entity shall do all of the following:

(1) Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for the ground emergency medical transportation services are eligible for federal financial participation.

(2) Provide evidence supporting the certification as specified by the department.

(3) Submit data as specified by the department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.

(4) Keep, maintain, and have readily retrievable, any records specified by the department to fully disclose reimbursement amounts to which the eligible provider is entitled, and any other records required by the federal Centers for Medicare and Medicaid Services.

(f) (1) The department shall promptly seek any necessary federal approvals for the implementation of this section. The department may limit the program to those costs that are allowable expenditures under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.). If federal approval is not obtained for implementation of this section, this section shall not be implemented.

(2) The department shall submit claims for federal financial participation for the expenditures for the services described in subdivision (e) that are allowable expenditures under federal law.

(3) The department shall annually submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

(g) (1) If a final judicial determination is made by any court of appellate jurisdiction or a final determination is made by the administrator of the federal Centers for Medicare and Medicaid Services that the supplemental reimbursement provided for in this section must be made to any provider not described in this section, the director shall execute a declaration stating that the determination has been made and on that date this section shall become inoperative.

(2) The declaration executed pursuant to this subdivision shall be retained by the director, provided to the fiscal and appropriate policy committees of the Legislature, the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and posted on the department's internet website.

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

(i) Notwithstanding any other law, this section shall become inoperative during the entirety of any Medi-Cal managed care rating period in which Section 14105.945 is implemented, in whole or in part. The department may conduct any necessary and remaining administrative duties related to any time period during which this provision remained operative, even after this section becomes inoperative, and may receive all compensation for those activities until paid in full.

(j) The department, in its sole discretion, may determine it has received all compensation for activities conducted pursuant to this section and completed all administrative duties related to time periods when this section was operative.

(Amended by Stats. 2019, Ch. 544, Sec. 1. (AB 1705) Effective January 1, 2020. Section inoperative as prescribed by its own conditions.)

14105.945. (a) For purposes of this section, the following definitions apply:

(1) "Eligible provider" means a provider who is eligible for reimbursement of Medi-Cal emergency medical transports pursuant to this section, and who continually meets all of the following requirements during the entirety of any Medi-Cal managed care rating period that this section is implemented:

(A) Provides emergency medical transports to Medi-Cal beneficiaries.

(B) Is enrolled as a Medi-Cal provider for the period being claimed.

(C) Is owned or operated by the state, a city, county, city and county, fire protection district organized pursuant to Part 2.7 (commencing with Section 13800) of Division 12 of the Health and Safety Code, special district organized pursuant to Chapter 1 (commencing with Section 58000) of Division 1 of Title 6 of the Government Code, community services district organized pursuant to Part 1 (commencing with Section 61000) of Division 3 of Title 6 of the Government Code, health care district organized pursuant to Chapter 1 (commencing with Section 32000) of Division 23 of the Health and Safety Code, or a federally recognized Indian tribe.

(2) (A) "Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations that are billed with billing codes A0429 BLS Emergency, A0434 Specialty Care Transport, A0225 Neonatal Emergency Transport, A0427 ALS Emergency, and A0433 ALS2, and any equivalent, predecessor, or successor billing codes, as may be determined by the director.

(B) "Emergency medical transport" shall not include transportation of beneficiaries by passenger car, taxicab, litter van, wheelchair van, or other forms of public or private conveyances, nor shall it include transportation by an air ambulance provider. An "emergency medical transport" does not occur if a transport is not provided following evaluation of a patient.

(3) "Medi-Cal managed care rating period" means a period selected by the department for which the actuarially sound capitation rates are developed and documented in the rate certification that the department submits to the federal Centers for Medicare and Medicaid Services as required by Section 438.7(a) of Title 42 of the Code of Federal Regulations.

(b) (1) Commencing no sooner than July 1, 2021, the department shall implement the Public Provider Intergovernmental Transfer Program (program) pursuant to this section for any Medi-Cal managed care rating period that the department has obtained necessary federal approvals.

(2) Notwithstanding any other law, during the entirety of any Medi-Cal managed care rating period for which the requirements of this section are implemented, in whole or in part, supplemental Medi-Cal reimbursements described in Section 14105.94 shall become inoperative.

(c) To the extent authorized under federal and state law, an eligible provider shall receive increased reimbursement by application of an add-on increase, as determined pursuant to subdivision (d), to the associated Medi-Cal fee-for-service payment schedule for emergency medical transports provided to applicable Medi-Cal beneficiaries.

(d) The department shall develop the statewide add-on increase to be provided under the program as follows:

(1) The department shall determine an initial statewide add-on increase that is based on the most recent audited cost reports of eligible providers available at the time the add-on increase is developed, as determined by the department. In determining the initial statewide add-on increase, the department may make adjustments to account for inflation, trend, or other material changes, as appropriate under federal law and actuarial standards.

(2) The initial statewide add-on increase shall represent the difference between both of the following:

(A) The average reimbursement paid pursuant to the applicable base Medi-Cal fee-for-service payment fee schedule for an emergency medical transport during the time period of the applicable cost-report to an eligible provider, and weighted according to those services provided by all eligible providers during the applicable time period.

(B) The average cost directly associated with providing a Medi-Cal emergency medical transport under the Medi-Cal program by an eligible provider during the time period of the applicable cost-report, as determined based on all eligible providers' audited cost reports pursuant to paragraph (1), and weighted according to those services provided by all eligible providers during the applicable time period.

(3) For subsequent Medi-Cal managed care rating periods, the department, in consultation with participating eligible providers, and as determined by the department, may adjust periodically the initial statewide add-on increase to account for inflation, trend adjustments, or other material changes, as appropriate under federal law and actuarial standards.

(4) To the extent that the department deems practicable, the department shall set a schedule for determining the statewide add-on increase before the department submits to the federal Centers for Medicare and Medicaid Services actuarially sound Medi-Cal managed care rates for an applicable Medi-Cal managed care rating period pursuant to subdivision (e).

(5) Once the department determines the add-on increase for a Medi-Cal managed care rating period, the add-on increase shall not be modified for that rating period unless the modification is required for purposes of receiving federal approval or claiming federal financial participation for the requirements of this section.

(e) (1) A Medi-Cal managed care health plan shall satisfy its obligation under Section 438.114(c) of Title 42 of the Code of Federal Regulations for emergency medical transport, and shall provide payment to applicable noncontract emergency medical transport providers consistent with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code.

(2) During the entirety of any Medi-Cal managed care rating period that this section is implemented, the amounts a noncontract eligible provider may collect if a Medi-Cal beneficiary received medical assistance other than through enrollment in a Medi-Cal managed care health plan pursuant to Section 1396u-2(b)(2)(D) of Title 42 of the United States Code shall be the resulting Medi-Cal fee-for-service payment schedule amounts after the application of the add-on increase described in this section. During the Medi-Cal managed care rating period that the requirements of this section are implemented, any reimbursement to a noncontract emergency medical transport provider that is not an eligible provider shall be made in accordance with subdivision (b) of Section 14129.3.

(f) The Medi-Cal reimbursement provided by this section shall be distributed exclusively to eligible providers under a payment methodology based on emergency medical transport provided to Medi-Cal beneficiaries by eligible providers on a per-transport basis or other federally permissible basis.

(g) During the entirety of any Medi-Cal managed care rating period that this section is implemented, in whole or in part, the department shall provide appropriate funding to each applicable Medi-Cal managed care plan to account for the add-on increase obligations of these plans pursuant to this section in federally approved risk based capitation rates developed in accordance with Section 14301.1.

(h) (1) For any Medi-Cal managed care rating period that this section is implemented, the nonfederal share, which is associated with the add-on increase as it applies to the Medi-Cal fee-for-service payment schedule and the portion of the risk-based capitation rate to Medi-Cal managed care health plans, may consist of voluntary intergovernmental transfers of funds provided by eligible providers and their affiliated governmental entities or other public entities pursuant to Section 14164, as applicable. Upon providing any intergovernmental transfer of funds, each transferring entity shall certify, in the form and manner specified by the department, that

the transferred funds qualify for federal financial participation pursuant to applicable laws relating to the federal Medicaid program. Any intergovernmental transfer of funds made pursuant to this section shall be voluntary for purposes of federal law.

(2) The department shall assess a 10-percent fee on each transfer of public funds to the state pursuant to this subdivision to pay for health care coverage and to reimburse the department for its costs associated with administering the program. Excluding this fee, the department shall not assess a percentage fee in connection with any intergovernmental transfer of funds made pursuant to this subdivision.

(3) The department shall develop and maintain, in consultation with participating eligible providers, a protocol and schedule for funding the nonfederal share of expenditures during a Medi-Cal managed care rating period that this section is implemented using voluntary intergovernmental transfers.

(4) This section does not limit or otherwise alter any existing authority of the department to accept intergovernmental transfers for purposes of funding the nonfederal share of expenditures in the Medi-Cal program.

(i) During the entirety of any Medi-Cal managed care rating period for which this section is implemented, in whole or in part, an eligible provider shall be exempt from the quality assurance fee and add-on increase pursuant to Article 3.91 (commencing with Section 14129).

(j) This section shall cease to be operative on the first day of the Medi-Cal managed care rating period beginning on or after the date the department determines, after consultation with participating eligible providers, that implementation of this section is no longer financially and programmatically supportive of the Medi-Cal program. The department shall make this determination if the projected amount of nonfederal share funds available for an applicable Medi-Cal managed care rating period is insufficient to support implementation of this section in the subject Medi-Cal managed care rating period. The department shall post notice of the determination on its internet website.

(k) The director may modify any process or methodology specified in this section to the extent necessary to comply with state or federal law or regulations, or to secure or maintain federal approval or federal financial participation. If the director determines, after consulting with participating eligible providers, that a modification to the process or methodology is necessary, the director shall execute a declaration stating that this determination has been made and describing the modification. The director shall retain the declaration and provide a copy, within five working days of the execution of the declaration, to the fiscal and appropriate policy committees of the Legislature. The director shall post the declaration on the department's internet website.

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

(m) (1) The department shall implement this section only to the extent that federal financial participation is available and any necessary federal approvals are obtained.

(2) The department shall promptly seek any necessary federal approvals for the implementation of this section for an applicable Medi-Cal managed care rating period.

(Added by Stats. 2019, Ch. 544, Sec. 2. (AB 1705) Effective January 1, 2020. Section inoperative as prescribed by its own conditions.)

14105.95. (a) Each eligible facility, as described in subdivision (b), may, in addition to the rate of payment that the facility would otherwise receive for adult day health services, receive supplemental Medi-Cal reimbursement to the extent provided in this section.

(b) A facility shall be eligible for supplemental reimbursement only if the facility has all of the following characteristics continuously during a state fiscal year commencing with the 2002 fiscal year, and thereafter:

(1) Provides services to Medi-Cal beneficiaries.

(2) Is an adult day health center, licensed pursuant to Chapter 3.3 (commencing with Section 1570) of Division 2 of the Health and Safety Code.

(3) Is owned or operated by a county, city, city and county, or health care district organized pursuant to Chapter 1 (commencing with Section 32000) of Division 23 of the Health and Safety Code.

(c) An eligible facility's supplemental reimbursement pursuant to this section shall be calculated and paid as follows:

(1) The supplemental reimbursement to an eligible facility, as described in subdivision (b), shall be equal to the amount of federal financial participation received as a result of the claims submitted pursuant to paragraph (2) of subdivision (g).

(2) In no instance shall the amount certified pursuant to paragraph (1) of subdivision (e), when combined with the amount received from all other sources of reimbursement from the Medi-Cal program, exceed 100 percent of projected costs, as determined pursuant to the Medi-Cal State Plan, for adult day health services at each facility.

(3) The supplemental Medi-Cal reimbursement provided by this section shall be distributed under a payment methodology based on adult day health services provided to Medi-Cal patients at the eligible facility, either on a per-visit basis or any other federally permissible basis. The department shall seek approval from the federal Centers for Medicare and Medicaid Services for the payment methodology to be utilized, and may not make any payment pursuant to this section prior to obtaining that approval.

(d) (1) It is the Legislature's intent in enacting this section to provide the supplemental reimbursement described in this section without any expenditure from the General Fund.

(2) The state share of the supplemental reimbursement submitted to the federal Centers for Medicare and Medicaid Services for purposes of claiming federal financial participation shall be paid only with funds from the governmental entities described in paragraph (3) of subdivision (b) and certified to the state as provided in subdivision (e).

(e) A particular governmental entity described in paragraph (3) of subdivision (b), on behalf of any eligible facility owned or operated by the entity shall do all of the following:

(1) Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for outpatient services are eligible for federal financial participation.

(2) Provide evidence supporting the certification as specified by the department.

(3) Submit data as specified by the department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.

(4) Keep, maintain, and have readily retrievable, any records specified by the department to fully disclose reimbursement amounts to which the eligible facility is entitled, and any other records required by the federal Centers for Medicare and Medicaid Services.

(f) An eligible facility as described in subdivision (b), as a condition of receiving supplemental reimbursement under this section, shall enter into, and maintain, a contract with the department for the purpose of implementing this section, and to reimburse the department for its administrative costs of implementing this section.

(g) (1) The department shall promptly seek any necessary federal approvals for the implementation of this section. If necessary to obtain federal approval, the department may limit the program to those costs that are allowable expenditures under Title XIX of the federal Social Security Act (Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code). If federal approval is not obtained for implementation of this section, this section shall become inoperative.

(2) The department shall submit claims for federal financial participation for the expenditures for the services described in subdivision (e) that are allowable expenditures under federal law.

(3) The department shall, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

(h) All funds expended pursuant to this section are subject to review and audit by the department.

(i) This section shall become inoperative in the event, and on the date, of a final judicial determination by any court of appellate jurisdiction or a final determination by the administrator of the federal Centers for Medicare and Medicaid Services that the supplemental reimbursement provided in this section must be made to any facility not described in this section.

(Amended by Stats. 2003, Ch. 62, Sec. 331. Effective January 1, 2004. Conditionally inoperative as provided in subd. (i).)

14105.96. (a) Each eligible facility, as described in subdivision (b), may, in addition to the rate of payment that the facility would otherwise receive for Medi-Cal outpatient services, receive supplemental Medi-Cal reimbursement to the extent provided in this section.

(b) A facility shall be eligible for supplemental reimbursement only if the facility has all of the following characteristics continuously during a state fiscal year commencing with the 2002 fiscal year, and thereafter:

(1) Provides services to Medi-Cal beneficiaries.

(2) Is an acute care hospital providing outpatient hospital services. For purposes of this paragraph, "acute care hospital" means the facilities described by subdivision (a) or (b), or both, of Section 1250 of the Health and Safety Code.

(3) Is owned or operated by a county, city, city and county, the University of California, or health care district organized pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code.

(c) An eligible facility's supplemental reimbursement pursuant to this section shall be calculated and paid as follows:

(1) The supplemental reimbursement to an eligible facility, as described in subdivision (b), shall be equal to the amount of federal financial participation received as a result of the claims submitted pursuant to paragraph (2) of subdivision (g).

(2) In no instance shall the amount certified pursuant to paragraph (1) of subdivision (e), when combined with the amount received from all other sources of reimbursement from the Medi-Cal program, exceed 100 percent of projected costs, as determined pursuant to the Medi-Cal State Plan, for outpatient services at each facility.

(3) The supplemental Medi-Cal reimbursement provided by this section shall be distributed under a payment methodology based on outpatient services provided to Medi-Cal patients at the eligible facility, either on a per-visit basis, per-procedure basis, or any other federally permissible basis. The department shall seek approval from the federal Centers for Medicare and Medicaid Services for the payment methodology to be utilized, and may not make any payment pursuant to this section prior to obtaining that approval.

(d) (1) It is the Legislature's intent in enacting this section to provide the supplemental reimbursement described in this section without any expenditure from the General Fund.

(2) The state share of the supplemental reimbursement submitted to the federal Centers for Medicare and Medicaid Services for purposes of claiming federal financial participation shall be paid only with funds from the governmental entities described in paragraph (3) of subdivision (b) and certified to the state as provided in subdivision (e).

(e) A particular governmental entity, described in paragraph (3) of subdivision (b), on behalf of any eligible facility owned or operated by the entity, shall do all of the following:

(1) Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for the outpatient services are eligible for federal financial participation.

(2) Provide evidence supporting the certification as specified by the department.

(3) Submit data as specified by the department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.

(4) Keep, maintain, and have readily retrievable, any records specified by the department to fully disclose reimbursement amounts to which the eligible facility is entitled, and any other records required by the federal Centers for Medicare and Medicaid Services.

(f) An eligible facility as described in subdivision (b), as a condition of receiving supplemental reimbursement under this section, shall enter into and maintain a contract with the department for the purpose of implementing this section, and to reimburse the department for its administrative costs of operating this program.

(g) (1) The department shall promptly seek any necessary federal approvals for the implementation of this section. If necessary to obtain federal approval, the department may limit the program to those costs that are allowable expenditures under Title XIX of the federal Social Security Act (Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code). If federal approval is not obtained for implementation of this section, this section shall become inoperative.

(2) The department shall submit claims for federal financial participation for the expenditures for the services described in subdivision (e) that are allowable expenditures under federal law.

(3) The department shall, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

(h) This section shall become inoperative in the event, and on the date, of a final judicial determination by any court of appellate jurisdiction or a final determination by the administrator of the federal Centers for Medicare and Medicaid Services that the supplemental reimbursement provided in this section must be made to any facility not described in this section.

(Amended by Stats. 2003, Ch. 62, Sec. 332. Effective January 1, 2004. Conditionally inoperative as provided in subd. (h).)

14105.97. (a) The department shall annually develop an outpatient disproportionate share factor for each hospital in California that receives Medi-Cal payments for outpatient services. That factor shall be the ratio of the sum of Medi-Cal gross outpatient revenue, county indigent programs gross outpatient revenue, and the outpatient component of other charity deductions from revenue, to total gross outpatient revenue. A hospital with a disproportionate factor that exceeds the mean factor for all hospitals in the state shall receive supplemental Medi-Cal payments in direct proportion to the level of the hospital's disproportionate factor. This subdivision shall only apply to payments for services provided by disproportionate share hospitals on or after July 1, 1993.

(b) Notwithstanding subdivision (a), the outpatient disproportionate share factors for children's hospitals shall be no less than the amounts that would have been established had the disproportionate factors for all hospitals been computed as the ratio of the sum of Medi-Cal gross outpatient revenue, the outpatient component of county indigent programs contractual adjustments, and the outpatient component of other charity deductions from revenue, to total gross outpatient revenue.

(c) The outpatient component of county indigent programs contractual adjustments shall be determined by calculating the ratio of county indigent programs gross outpatient revenue to county indigent programs gross total revenue, by multiplying that ratio by county indigent programs contractual adjustments. The outpatient component of other charity deductions from revenue shall be

determined by calculating the ratio of other payors gross outpatient revenue to other payors gross total revenue, and multiplying that ratio by the sum of other charity deductions from revenue and teaching allowances for University of California teaching hospitals.

(d) For purposes of computing the outpatient disproportionate share factors, the department shall use the data from the Office of Statewide Health Planning and Development quarterly financial and utilization reports, as adjusted by the office for the calendar year preceding the state fiscal year in which the disproportionate factors will be effective. The department shall use the data existing on the office's statewide data base as of April 15 of each year. For the purposes of this section, a hospital shall submit to the office by April 1 of each year any adjustments to its quarterly reports for the preceding calendar year. The office shall make its statewide data base, as adjusted, available to the department by April 20 of each year.

(e) Augmentation rates shall be applied to hospitals with all inclusive rates at the point of final audit settlement and shall be included in subsequent interim reimbursement rates.

(f) (1) If the department deems it necessary to issue general rules in order to implement, interpret, or make specific this section or to establish procedures to implement this section, these rules may be issued without complying with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) and shall remain in effect for a period of 180 days.

(2) Thereafter, any rules that are necessary to implement, interpret, or make specific this section or that govern departmental procedures shall be adopted in compliance with the Administrative Procedure Act.

(3) The adoption, pursuant to paragraph (1), of any emergency regulations that are filed with the Office of Administrative Law within one year of the effective date of this act shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, or safety.

(Amended by Stats. 1993, Ch. 385, Sec. 2. Effective September 8, 1993.)

14105.98. (a) The following definitions shall apply for purposes of this section:

(1) "Disproportionate share list" means an annual list of disproportionate share hospitals that provide acute inpatient services issued by the department for purposes of this section.

(2) "Fund" means the Medi-Cal Inpatient Payment Adjustment Fund, created pursuant to Section 14163.

(3) "Eligible hospital" means a hospital included on a disproportionate share list, which is eligible to receive payment adjustments under this section with respect to a particular state fiscal year.

(4) "Hospital" means a health facility that is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code to provide acute inpatient hospital services, and includes all components of the facility.

(5) "Payment adjustment" or "payment adjustment amount" means an amount paid under this section for acute inpatient hospital services provided by a disproportionate share hospital.

(6) "Payment adjustment year" means the particular state fiscal year with respect to which payments are to be made to eligible hospitals under this section.

(7) "Payment adjustment program" means the system of Medi-Cal payment adjustments for acute inpatient hospital services established by this section.

(8) "Annualized Medi-Cal inpatient paid days" means the total number of Medi-Cal acute inpatient hospital days, regardless of dates of service, for which payment was made by or on behalf of the department to a hospital, under present or previous ownership, during the most recent calendar year ending prior to the beginning of a particular payment adjustment year, including all Medi-Cal acute inpatient covered days of care for hospitals which are paid on a different basis than per diem payments.

(9) "Low-income utilization rate" means a percentage rate determined by the department in accordance with the requirements of Section 1396r-4(b)(3) of Title 42 of the United States Code, and included on a disproportionate share list.

(10) "Low-income number" means a hospital's low-income utilization rate rounded down to the nearest whole number, and included on a disproportionate share list.

(11) "1991 Peer Grouping Report" means the final report issued by the department dated May 1991, entitled "Hospital Peer Grouping."

(12) “Major teaching hospital” means a hospital that meets the definition of a university teaching hospital, major nonuniversity teaching hospital, or large teaching emphasis hospital as set forth on page 51 of the 1991 Peer Grouping Report.

(13) “Children’s hospital” means a hospital that meets the definition of a children’s hospital—state defined, as set forth on page 53 of the 1991 Peer Grouping Report, or which is listed in subdivision (a), or subdivisions (c) to (g), inclusive, of Section 16996.

(14) “Acute psychiatric hospital” means a hospital that meets the definition of an acute psychiatric hospital, a combination psychiatric/alcohol-drug rehabilitation hospital, or a psychiatric health facility, to the extent the facility is licensed to provide acute inpatient hospital service, as set forth on page 52 of the 1991 Peer Grouping Report.

(15) “Alcohol-drug rehabilitation hospital” means a hospital that meets the definition of an alcohol-drug rehabilitation hospital as set forth on page 52 of the 1991 Peer Grouping Report.

(16) “Emergency services hospital” means a hospital that is a licensed provider of basic emergency services as described in Sections 70411 to 70419, inclusive, of Title 22 of the California Code of Regulations, or that is a licensed provider of comprehensive emergency medical services as described in Sections 70451 to 70459, inclusive, of Title 22 of the California Code of Regulations.

(17) “Medi-Cal day of acute inpatient hospital service” means any acute inpatient day of service attributable to patients who, for those days, were eligible for medical assistance under the California state plan, including any day of service that is reimbursed on a basis other than per diem payments.

(18) “Total per diem composite amount” means, for each eligible hospital for a particular payment adjustment year, the total of the various per diem payment adjustment amounts to be paid to the hospital for each eligible day as calculated under the applicable provisions of this section.

(19) “Supplemental lump-sum payment adjustment” means a lump-sum amount paid under this section for acute inpatient hospital services provided by a disproportionate share hospital.

(20) “Projected total payment adjustment amount” means, for each eligible hospital for a particular payment adjustment year, the amount calculated by the department as the projected maximum total amount the hospital is expected to receive under the payment adjustment program for the particular payment adjustment year (including all per diem payment adjustment amounts and any applicable supplemental lump-sum payment adjustments).

(21) “To align the program with the federal allotment” means to modify the size of the payment adjustment program to be as close as reasonably feasible to, but not to exceed, the estimated or actual maximum state disproportionate share hospital allotment for the particular federal fiscal year for California under Section 1396r-4(f) of Title 42 of the United States Code.

(22) “Descending pro rata basis” means an allocation methodology under which a pool of funds is distributed to hospitals on a pro rata basis until one of the recipient hospitals reaches its maximum payment limit, after which all remaining amounts in the pool are distributed on a pro rata basis to the recipient hospitals that have not reached their maximum payment limits, until another hospital reaches its maximum payment limit, and which process is repeated until the entire pool of funds has been distributed among the recipient hospitals.

(23) “Secondary supplemental payment adjustment” means a payment adjustment amount, whether paid or payable, to an eligible hospital as a second type of supplemental distribution earned as of June 30, 1996, with respect to the 1995–96 payment adjustment year.

(24) “OBRA 1993 payment limitation” means the hospital-specific limitation on the total annual amount of payment adjustments to each eligible hospital under the payment adjustment program that can be made with federal financial participation under Section 1396r-4(g) of Title 42 of the United States Code, as implemented pursuant to the Medi-Cal State Plan.

(25) “Public hospital” means a hospital that is licensed to a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state.

(26) “Nonpublic hospital” means a hospital that satisfies all of the following:

(A) The hospital does not meet the definition of a public hospital as described in paragraph (25).

(B) The hospital does not meet the definition of a nonpublic-converted hospital as described in paragraph (27).

(C) The hospital does not meet the definition of a converted hospital as described in paragraph (28).

(27) “Nonpublic-converted hospital” means a hospital that satisfies all of the following, or, if two or more inpatient facilities are licensed by the department under a consolidated license, a hospital as to which any component of the hospital satisfies all of the

following:

(A) The hospital does not meet the definition of a public hospital as described in paragraph (25).

(B) The hospital or such component, at any time during the 1994–95 payment adjustment year, was a public hospital as described in paragraph (25), whether or not the hospital or such component currently is located at the same site as it was located when it was a public hospital.

(C) The hospital does not meet the definition of a converted hospital as described in paragraph (28).

(28) “Converted hospital” means a hospital that satisfies both of the following:

(A) The hospital does not meet the definition of a public hospital as described in paragraph (25).

(B) The hospital, at any time during the 1999–2000 payment adjustment year, was an eligible hospital meeting the definition of a public hospital as described in paragraph (25), whether or not the hospital currently is located at the same site as it was located when it was a public hospital.

(29) “Remained in operation” or “remains in operation” means that, except for closure or other cessation of services caused by natural disasters or other events beyond the hospital’s reasonable control, including labor disputes, the hospital was licensed to provide hospital inpatient services, and continued to provide, or was available to provide, hospital inpatient services to Medi-Cal patients throughout the particular time period in question.

(30) “Maximum state disproportionate share hospital allotment for California” means, with respect to the 1998 federal fiscal year and subsequent federal fiscal years, that amount specified for California under Section 1396r-4(f) of Title 42 of the United State Code for that fiscal year, divided by the federal medical assistance percentage applicable for federal financial participation purposes for Medi-Cal program expenditures with respect to that same federal fiscal year.

(31) “Applicable federal fiscal year” means, with respect to the 2000–01 payment adjustment year and subsequent payment adjustment years, the federal fiscal year that commences on October 1 of the particular payment adjustment year.

(32) “Medical assistance increment” means the federal medical assistance percentage applicable for federal financial participation purposes for Medi-Cal program expenditures, expressed as a percentage, less the number one-half, expressed as a percentage.

(b) For each fiscal year commencing with 1991–92, there shall be Medi-Cal payment adjustment amounts paid to hospitals pursuant to this section. The amount of payments made and the eligible hospitals for each payment adjustment year shall be determined in accordance with the provisions of this section. The payments are intended to support health care services rendered by disproportionate share hospitals.

(c) For each fiscal year commencing with 1991–92, the department shall issue a disproportionate share list. The list shall be developed in accordance with subdivisions (e) and (f), and shall serve as a basis for payments under this section for the particular payment adjustment year.

(d) (1) Except as otherwise provided by this section, the payment adjustment amounts under this section shall be distributed as a supplement to, and concurrent with, payments on all billings for Medi-Cal acute inpatient hospital services that are paid through Medi-Cal claims payment systems on or after July 1, 1991. In connection with those billings, the department shall pay payment adjustment amounts in accordance with subdivision (g), (h), (i), or (j), as applicable, to any hospital qualifying under subdivision (e). In addition, the department shall pay to each of those hospitals any supplemental lump-sum payment adjustment amounts that are payable, and shall adjust payment amounts, in accordance with applicable provisions of this section. The nonfederal share of all payment adjustment amounts shall be funded by amounts from the fund. The department shall obtain federal matching funds for the payment adjustment program through customary Medi-Cal accounting procedures.

(2) As a limitation to paragraph (1), all payment adjustment amounts under this section, which are due with respect to billings paid through Medi-Cal claims payment systems on or after July 1, 1991, shall be suspended until the time federal approval is first obtained for the payment adjustment program as part of the Medi-Cal program. For purposes of this paragraph, federal approval requires both (i) approval by appropriate federal agencies of an amendment to the Medi-Cal State Plan, as referred to in subdivision (o), and (ii) confirmation by appropriate federal agencies regarding the availability of federal financial participation for the payment adjustment program at a level of at least 40 percent of the percentage of federal financial participation that is normally applicable for Medi-Cal expenditures for acute inpatient hospital services. At the time federal approval is first obtained, the department shall proceed pursuant to subparagraphs (A) and (B) in connection with the suspended payment adjustment amounts.

(A) Except as provided by subdivision (l), or by any other subdivision of this section, any payment adjustment amounts which were suspended shall, within 60 days, be paid for all those billings paid through Medi-Cal claims payment systems during periods of time, on or after July 1, 1991, for which federal approval is first effective for the payment adjustment program.

(B) Payment adjustment amounts shall not be paid in connection with any Medi-Cal billings which were paid through Medi-Cal claims payment systems during any period of time for which federal approval is not effective for the payment adjustment program.

(3) As a limitation to paragraph (1), the amendments to this section enacted during calendar year 1993 shall not be implemented until the department has obtained any approvals that are necessary under federal law. Until all necessary federal approvals are obtained, the payment adjustment program shall continue as though no amendments had been enacted during calendar year 1993. When all necessary federal approvals have been obtained, the amendments enacted during calendar year 1993, shall be implemented effective as of the earliest effective date permissible under federal law.

(4) As a limitation to paragraph (1), amendments to this section enacted during calendar year 1994 shall not be implemented until the department has obtained any approvals that are necessary under federal law. Until all necessary federal approvals are obtained, the payment adjustment program shall continue as though no amendments had been enacted during calendar year 1994. When all necessary federal approvals have been obtained, the amendments enacted during calendar year 1994 shall be implemented effective as of the earliest effective date permissible under federal law. Notwithstanding any other provision of law, on or after the date that federal approval is obtained the payments made prior to that date with respect to the 1994–95 payment adjustment year or subsequent payment adjustment years shall be deemed nonfinal payments for purposes of this section and Section 14163. Any of those amounts paid or payable prior to that date shall then be compared to the payments that would have been made pursuant to the program changes as approved by the federal government for all periods of time permissible under federal law, and the difference, if any, shall be paid or recouped by the department, as appropriate.

(5) As a limitation to paragraph (1), amendments to this section enacted during June 1996 shall not be implemented until the department has obtained any approvals that are necessary under federal law. Until all necessary federal approvals are obtained, the payment adjustment program shall continue as though no amendments had been enacted during June 1996. When all necessary federal approvals have been obtained, the amendments enacted during June 1996 shall be implemented effective as of the earliest effective date permissible under federal law. Notwithstanding any other provision of law, on or after the date that federal approval is obtained, the payments made prior to that date with respect to the 1995–96 payment adjustment year shall be deemed nonfinal payments for purposes of this section and Section 14163. Any of those amounts paid or payable prior to that date shall then be compared to the payments that would have been made pursuant to the program changes as approved by the federal government for all periods of time permissible under federal law, and the difference, if any, shall be paid or recouped by the department, as appropriate.

(6) As a limitation to paragraph (1), any amendment of this section enacted during the period August 1, 1996, to September 30, 1996, inclusive, shall not be implemented until the department has obtained any approvals that are necessary under federal law. Until all necessary federal approvals are obtained, the payment adjustment program shall continue as though no amendments had been enacted during the period August 1, 1996, to September 30, 1996, inclusive. When all necessary federal approvals have been obtained, the amendments enacted during the period August 1, 1996, to September 30, 1996, inclusive, shall be implemented effective as of the earliest effective date permissible under federal law. Notwithstanding any other provision of law, on or after the date that federal approval is obtained, the payments made prior to that date with respect to the 1996–97 payment adjustment year shall be deemed nonfinal payments for purposes of this section and Section 14163. Any of those amounts paid or payable prior to that date shall then be compared to the payments that would have been made pursuant to the program changes as approved by the federal government for all periods of time permissible under federal law, and the difference, if any, shall be paid or recouped by the department, as appropriate.

(7) As a limitation to paragraph (1), any amendment of this section enacted during the period September 1, 1997, to September 30, 1997, inclusive, shall not be implemented until the department has obtained any approvals that are appropriate under federal law. Until appropriate federal approvals are obtained, the payment adjustment program shall continue as though amendments had not been enacted during the period September 1, 1997, to September 30, 1997, inclusive. When appropriate federal approvals have been obtained, the amendments enacted during the period September 1, 1997, to September 30, 1997, inclusive, shall be implemented effective as of the earliest effective date permissible under federal law. Notwithstanding any other provision of law, on or after the date that federal approval is obtained, the payments made prior to that date with respect to the 1997–98 payment adjustment year shall be deemed nonfinal payments for purposes of this section and Section 14163. Any of those amounts paid or payable prior to that date shall then be compared to the payments that would have been made pursuant to the program changes as approved by the federal government for all periods of time permissible under federal law, and the difference, if any, shall be paid or recouped by the department, as appropriate.

(8) As a limitation to paragraph (1), any amendment of this section enacted during the 1998 calendar year shall not be implemented until the department has obtained any approvals that are appropriate under federal law. Until appropriate federal approvals are obtained, the payment adjustment program shall continue as though amendments had not been enacted during the 1998 calendar year. When appropriate federal approvals have been obtained, the amendments enacted during the 1998 calendar year shall be implemented effective as of the earliest effective date permissible under federal law. Notwithstanding any other

provision of law, on or after the date that federal approval is obtained, the payments made prior to that date with respect to the particular payment adjustment year shall be deemed nonfinal payments for purposes of this section and Section 14163. Any of those amounts paid or payable prior to that date shall then be compared to the payments that would have been made pursuant to the program changes as approved by the federal government for all periods of time permissible under federal law, and the difference, if any, shall be paid or recouped by the department, as appropriate.

(9) As a limitation to paragraph (1), any amendment of this section enacted during the period of June 1, 1999, to June 30, 1999, inclusive, shall not be implemented until the department has obtained any approvals that are appropriate under federal law. Until appropriate federal approvals are obtained, the payment adjustment program shall continue as though amendments had not been enacted during the period of June 1, 1999, to June 30, 1999, inclusive. When appropriate federal approvals have been obtained, the amendments enacted during the period of June 1, 1999, to June 30, 1999, inclusive, shall be implemented effective as of the earliest effective date permissible under federal law. Notwithstanding any other provision of law, on or after the date that federal approval is obtained, the payments made prior to that date with respect to the particular payment adjustment year shall be deemed nonfinal payments for purposes of this section and Section 14163. Any of those amounts paid or payable prior to that date shall then be compared to the payments that would have been made pursuant to the program changes as approved by the federal government for all periods of time permissible under federal law, and the difference, if any, shall be paid or recouped by the department, as appropriate.

(10) As a limitation to paragraph (1), any amendment of this section enacted during the period of June 1, 2000, to June 30, 2000, inclusive, shall not be implemented until the department has obtained any approvals that are appropriate under federal law. Until appropriate federal approvals are obtained, the payment adjustment program shall continue as though amendments had not been enacted during the period of June 1, 2000, to June 30, 2000, inclusive. When appropriate federal approvals have been obtained, the amendments enacted during the period of June 1, 2000, to June 30, 2000, inclusive, shall be implemented effective as of the earliest effective date permissible under federal law. Notwithstanding any other provision of law, on or after the date that federal approval is obtained, the payments made prior to that date with respect to the particular payment adjustment year shall be deemed nonfinal payments for purposes of this section and Section 14163. Any of those amounts paid or payable prior to that date shall then be compared to the payments that would have been made pursuant to the program changes as approved by the federal government for all periods of time permissible under federal law, and the difference, if any, shall be paid or recouped by the department, as appropriate.

(e) To qualify for payment adjustment amounts under this section, a hospital shall have been included on the disproportionate share list for the particular payment adjustment year. The list shall consist of those hospitals which satisfy both of the following requirements:

(1) The hospital shall meet the federal requirements for disproportionate share status set forth in subsection (d) of Section 1396r-4 of Title 42 of the United States Code.

(2) Either of the following shall apply:

(A) The hospital’s medicaid inpatient utilization rate, as defined in Section 1396r-4(b)(2) of Title 42 of the United States Code, shall be at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the state.

(B) The hospital’s low-income utilization rate shall exceed 25 percent.

(f) (1) For the 1991–92 payment adjustment year, a disproportionate share list shall be issued by the department no later than 65 days after the enactment of this section. For subsequent payment adjustment years, a tentative listing shall be prepared by the department at least 60 days before the beginning of the particular payment adjustment year, and a disproportionate share list shall be issued no later than five days after the beginning of the particular payment adjustment year. All state agencies shall take all necessary steps to supply the most recent data available to the department to meet these deadlines. The Office of Statewide Health Planning and Development shall provide to the department quarterly access to the edited and unedited confidential patient discharge data files for all Medi-Cal eligible patients. The department shall maintain the confidentiality of that data to the same extent as is required of the Office of Statewide Health Planning and Development. In addition, the Office of Statewide Health Planning and Development shall provide to the department no later than March 1 of each year, the data specified by the department, as the data existed on the statewide data base file as of February 1 of each year (except that for the 1991–92 payment adjustment year, the Office of Statewide Health Planning and Development shall provide data as it existed on the statewide data base file as of August 30, 1991), from all of the following:

(A) Hospital annual disclosure reports, filed with the Office of Statewide Health Planning and Development pursuant to Section 443.31 or 128735 of the Health and Safety Code, for hospital fiscal years which ended during the calendar year ending 13 months prior to the applicable February 1.

(B) Annual reports of hospitals, filed with the Office of Statewide Health Planning and Development pursuant to Section 439.2 or 127285 of the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

(C) Hospital patient discharge data reports, filed with the Office of Statewide Health Planning and Development pursuant to subdivision (g) of Section 443.31 or 128735 of the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

(D) Any other materials on file with the Office of Statewide Health Planning and Development.

(2) The disproportionate share list shall show all of the following:

(A) The name and license number of the hospital.

(B) Expressed as a percentage, the hospital's Medi-Cal utilization rate and low-income utilization rate as referred to in paragraph (2) of subdivision (e). The department shall determine these rates in accordance with paragraph (4).

(C) Based on the hospital's low-income utilization rate, the hospital's low-income number.

(3) The department shall determine a hospital's satisfaction of paragraph (1) of subdivision (e) based on the most recent annual data available, as it existed on the Office of Statewide Health Planning and Development statewide data base file as of February 1 of each year, and August 30 for the 1991–92 payment adjustment year, whether the data relates to operations under present or previous ownership.

(4) To determine a hospital's Medi-Cal inpatient utilization rate and low-income utilization rate for purposes of disproportionate share lists, the department shall utilize the same methodology, formulae, and data sources as set forth in connection with interim determinations in Attachment 4.19-A of the Medi-Cal State Plan (effective on or about July 1, 1990), and as subsequently amended by Medi-Cal State Plan amendments relating to the payment adjustment program submitted to and approved by the federal Health Care Financing Administration, except that the following shall apply:

(A) The calculations shall not be interim, but shall be final for purposes of this section.

(B) To the extent permitted by federal law, the payment adjustment amounts provided to hospitals pursuant to this section shall not be included for any purpose in the calculations and determinations made pursuant to this section.

(C) Any other variation otherwise required by this section or by federal law.

(D) The data utilized by the department shall relate to the hospital under present and previous ownership. When there has been a change of ownership, a change in the location of the main hospital facility, or a material change in patient admission patterns during the 24 months immediately prior to the payment adjustment year, and the change has resulted in a diminution of access for Medi-Cal inpatients at the hospital, all as determined by the department, the department shall, to the extent permitted by federal law, utilize current data that are reflective of the diminution of access, even if the data are not annual data.

(E) Unless expressly provided otherwise by this section, the hospital's low-income utilization rate shall be based on the most recent annual data available from annual hospital reports existing on the Office of Statewide Health Planning and Development data base file as of February 1 of each year.

(F) (i) If, for the 1994–95 payment adjustment year, some or all of the annual data elements available to the department from hospital reports filed with the Office of Statewide Health Planning and Development for purposes of computing hospital low-income utilization rates are different than in prior years due to changes in data reporting requirements of the Office of Statewide Health Planning and Development or changes in other state health care programs, the department shall take the necessary steps to obtain from hospitals appropriate data in order to clarify the annual data filed with the Office of Statewide Health Planning and Development. This shall be done by the department in order to ensure that low-income utilization rates are determined in a manner as equivalent as possible to the approach and methodology used for the 1991–92 payment adjustment year.

(ii) The efforts of the department to obtain and apply data for the purposes described in clause (i) shall include a survey to collect, from one or more hospitals, any data necessary to calculate the low-income utilization rates in accordance with clause (i). The purpose for the survey shall be to clarify the data already included by hospitals in their annual reports submitted to the Office of Statewide Health Planning and Development. The data requested by the department in the survey may include, among other things, information regarding the manner in which payments made to hospitals under this section were reported by the hospitals to the Office of Statewide Health Planning and Development. The data requested may also include information regarding the manner in which hospitals reported figures relating to charity care, bad debts, and amounts received in connection with state or local indigent care programs.

(iii) In connection with any survey conducted under clause (ii), the department may require that hospitals submit responses in accordance with a deadline established by the department, and that the responses be supported by a verification of a hospital representative. Should any hospital not respond on a timely basis in accordance with protocols established by the department, the department shall utilize prior year data, adjusted by the department in its discretion, to calculate the hospital's low-income utilization rate.

(G) Notwithstanding any other provision of law, all payment adjustment amounts, including per diem payment adjustment amounts and supplemental lump-sum payment adjustments, paid or payable to a hospital under this section, shall be recorded on an accrual basis of accounting in reports filed by the hospital with the Office of Statewide Health Planning and Development or the department.

(5) For purposes of payment adjustment amounts under this section, each disproportionate share list shall be considered complete when issued by the department pursuant to paragraph (1). Nothing on a disproportionate share list, once issued by the department, shall be modified for any reason, other than mathematical or typographical errors or omissions on the part of the department or the Office of Statewide Health Planning and Development in preparation of the list.

(6) No Medi-Cal State Plan amendment of the type referred to in paragraph (4) shall be valid if inconsistent with this section. For those Medi-Cal State Plan amendments of the type referred to in paragraph (4), to be initially submitted to the federal Health Care Financing Administration on or after the operative date of this paragraph, these amendments shall be provided to representatives of the hospital industry, including, but not limited to, the California Healthcare Association, as soon as possible, but in no event less than 30 days prior to submission of the amendment to the federal Health Care Financing Administration. If, in the public interest, the director determines that exigent circumstances necessitate that the 30-day requirement cannot be met, the director shall immediately in writing advise the Chairperson of the Senate Committee on Health and Human Services and the Assembly Committee on Health of the exigent circumstances and the department's timetable for providing the amendment to the hospital industry.

(g) For each Medi-Cal day of acute inpatient hospital service paid by or on behalf of the department during a payment adjustment year, regardless of dates of service, to a hospital on the applicable disproportionate share list, where that hospital, on the first day of the payment adjustment year, is a major teaching hospital, the hospital shall be paid the sum of all of the following amounts, except as limited by other applicable provisions of this section:

(1) A minimum payment adjustment of three hundred dollars ($300).

(2) The sum of the following amounts, minus three hundred dollars ($300):

(A) A ninety dollar ($90) payment adjustment for each percentage point, from 25 percent to 29 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(B) A seventy dollar ($70) payment adjustment for each percentage point, from 30 percent to 34 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(C) A fifty dollar ($50) payment adjustment for each percentage point, from 35 percent to 44 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(D) A thirty dollar ($30) payment adjustment for each percentage point, from 45 percent to 64 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(E) A ten dollar ($10) payment adjustment for each percentage point, from 65 percent to 80 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(3) If the sum calculated under paragraph (2) is less than zero, it shall be disregarded for payment purposes.

(h) For each Medi-Cal day of acute inpatient hospital service paid by or on behalf of the department during a payment adjustment year, regardless of dates of service, to a hospital on the applicable disproportionate share list, where that hospital, on the first day of the payment adjustment year, is a children's hospital, the hospital shall be paid the sum of four hundred fifty dollars ($450), except as limited by other applicable provisions of this section.

(i) For each Medi-Cal day of acute inpatient hospital service paid by or on behalf of the department during a payment adjustment year, regardless of dates of service, to a hospital on the applicable disproportionate share list, where that hospital, on the first day of the payment adjustment year, is an acute psychiatric hospital or an alcohol-drug rehabilitation hospital, the hospital shall be paid the sum of all of the following amounts, except as limited by other applicable provisions of this section:

(1) A minimum payment adjustment of fifty dollars ($50).

(2) The sum of the following amounts, minus fifty dollars ($50):

(A) A ten dollar ($10) payment adjustment for each percentage point, from 25 to 29 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(B) A seven dollar ($7) payment adjustment for each percentage point, from 30 to 34 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(C) A five dollar ($5) payment adjustment for each percentage point, from 35 to 44 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(D) A two dollar ($2) payment adjustment for each percentage point, from 45 to 64 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(E) A one dollar ($1) payment adjustment for each percentage point, from 65 to 80 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(3) If the sum calculated under paragraph (2) is less than zero, it shall be disregarded for payment purposes.

(j) For each Medi-Cal day of acute inpatient hospital service paid by or on behalf of the department during a payment adjustment year, regardless of dates of service, to a hospital on the applicable disproportionate share list, where that hospital does not meet the criteria for receiving payments under subdivision (g), (h), or (i) above, the hospital shall be paid the sum of all of the following amounts, except as limited by other applicable provisions of this section:

(1) A minimum payment adjustment of one hundred dollars ($100).

(2) If the hospital is an emergency services hospital at the time the payment adjustment is paid, a two hundred dollar ($200) payment adjustment.

(3) The sum of the following amounts minus one hundred dollars ($100), and minus an additional two hundred dollars ($200) if the hospital is an emergency services hospital at the time the payment adjustment is paid:

(A) A forty dollar ($40) payment adjustment for each percentage point, from 25 percent to 29 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(B) A thirty-five dollar ($35) payment adjustment for each percentage point, from 30 percent to 34 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(C) A thirty dollar ($30) payment adjustment for each percentage point, from 35 percent to 44 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(D) A twenty dollar ($20) payment adjustment for each percentage point, from 45 percent to 64 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(E) A fifteen dollar ($15) payment adjustment for each percentage point, from 65 percent to 80 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(4) If the sum calculated under paragraph (3) is less than zero, it shall be disregarded for payment purposes.

(k) (1) For any particular payment adjustment year, no hospital may qualify for payments under more than one subdivision among subdivisions (g), (h), (i), and (j). If any hospital qualifies under more than one subdivision, the department shall determine which subdivision shall apply for payments.

(2) For each payment adjustment year beginning with 1992–93, the total applicable per diem payment adjustment amount calculated for each eligible hospital pursuant to subdivision (g), (h), (i), or (j) shall be adjusted by a percentage identical to the percentage increase in transfer amounts that the department has authorized for use pursuant to paragraph (1) of subdivision (h) of Section 14163 for the particular fiscal year.

(3) If an eligible hospital ordinarily is paid by or on behalf of the department for Medi-Cal acute inpatient hospital services based on a payment methodology other than per diem payments, the eligible hospital shall receive payment adjustment amounts under subdivision (g), (h), (i), or (j) of this section based on its approved Medi-Cal days of acute inpatient hospital care, in the same fashion as all other eligible hospitals under this section.

(l) (1) (A) In determining Medi-Cal days of service for purposes of payment adjustments under this section, the department shall recognize all acute inpatient hospital days of service required to be taken into account under federal law.

(B) For the 1992–93 payment year, the department may consider the Medi-Cal days of service provided by the qualifying hospitals for Medi-Cal patients covered by the prepaid health plans contracting directly with the Medi-Cal program in achieving their maximum payments.

(C) For 1993–94 and subsequent payment years, the department may consider the Medi-Cal days of service provided by hospitals for Medi-Cal patients covered by the prepaid health plans contracting directly with the Medi-Cal program in determining the Medi-Cal utilization rate and the maximum days of payment. Additionally, the department may consider the days of service provided by the qualifying hospitals for Medi-Cal patients covered by the prepaid health plans contracting directly with the Medi-Cal program in achieving their maximum payments in those payment years.

(D) In order to meet the requirements of subparagraph (C), the Office of Statewide Health Planning and Development shall provide to the department quarterly access to all data elements on the edited and unedited confidential patient discharge data files, including Social Security account numbers. The department shall match these data with the department's Medi-Cal Eligibility Data System files to extract any data necessary to meet the requirements of subparagraph (C). The department shall maintain the confidentiality of all patient discharge data to the same extent as is required of the Office of Statewide Health Planning and Development.

(2) Notwithstanding paragraph (1), there shall be, for each eligible hospital, a maximum limit on the number of Medi-Cal acute inpatient hospital days for which payment adjustment amounts may be paid under this section with respect to each payment adjustment year. The maximum limit shall be that number of days that equals 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days, as determined from all Medi-Cal paid claims records available through April 1 preceding the beginning of the payment adjustment year.

(m) No payment rate for any service rendered by any hospital under the Medi-Cal selective provider contracting program shall be reduced as a result of this section.

(n) Notwithstanding any other provision of law, to the extent consistent with federal law, and except as provided by this section, no maximum payment limit shall be placed on the amount of Medi-Cal payment adjustments which may be made to disproportionate share hospitals. The payments made to disproportionate share hospitals pursuant to this section and Section 14105.99 shall not cause any other amounts paid or payable to a hospital to be deemed in excess of any applicable maximum payment limit.

(o) The department shall promptly seek any necessary federal approvals in order to implement this section, including any amendments. Pursuant to Section 1396r-4 of Title 42 of the United States Code, and related federal medicaid statutes and regulations, payment adjustment systems for inpatient hospital services rendered by disproportionate share hospitals shall be included in a state's medicaid plan. Therefore, the department shall, prior to the end of the calendar quarter during which this section is enacted or amended, submit for federal approval an amendment to the Medi-Cal State Plan in connection with the payment adjustment program.

(p) (1) The department shall compute, prior to the beginning of each payment adjustment year, the projected size of the payment adjustment program for the particular payment adjustment year. To do so, the department shall determine the projected total payment adjustment amount for each eligible hospital, and shall add these amounts together to determine the projected total size of the program. To the extent this projected total figure for the program exceeds the portion of the maximum state disproportionate share hospital allotment for California under federal law that the department anticipates will be available for the period in question, the department shall reduce the total per diem composite amounts of the various eligible hospitals in the fashion described below so that the allotment in question will not be exceeded.

(2) As an initial step, all total per diem composite amounts for the entire payment adjustment year shall be reduced proportionately not to exceed 2 percent of each total per diem composite amount.

(3) If the reductions authorized by paragraph (2) are insufficient to align the program with the federal allotment for California, then, to the extent permitted by federal law, the following shall apply:

(A) The adjusted total per diem composite amounts, as calculated under paragraph (2), shall remain in effect for each eligible hospital whose low-income number is 30 percent or more.

(B) The adjusted total per diem composite amounts, as calculated under paragraph (2), for all other eligible hospitals shall be further reduced proportionately to align the program with the federal allotment, but in no event to a level that is less than 65 percent of the total per diem composite amount that would have been payable to the eligible hospital had no reductions taken place.

(4) If the steps set forth in paragraph (3) are not permissible under federal law, or are not adequate to align the program with the federal allotment, the adjusted total per diem composite amounts for all eligible hospitals for the entire payment adjustment year shall be further reduced proportionately to align the program with the federal allotment, but in no event to a level that would result in adjusted total per diem composite amounts that are less than 65 percent of the total per diem composite amounts that would have been payable had no reductions taken place.

(5) When all eligible hospitals have been reduced to the 65-percent level set forth in paragraphs (3) and (4), the adjusted total per diem composite amounts for all eligible hospitals shall be further reduced proportionately as necessary to align the program with

the federal allotment.

(6) This subdivision shall not apply to the 1995–96 payment adjustment year.

(q) (1) If it is necessary to apply the provisions of paragraph (3) of subdivision (p) at any time, the department shall, as soon as practicable, evaluate why the insufficiency arose and identify the projected occurrence and duration of any future insufficiencies.

(2) If the department determines as a result of the evaluations under paragraph (1) that (A) implementation of paragraph (3) of subdivision (p) will likely be necessary to resolve additional insufficiencies for the current payment adjustment year or the next payment adjustment year; and (B) that the level of federal financial participation realized by the payment adjustment program, for the current payment adjustment year as a whole, will be less than 30 percent of the percentage of federal financial participation that normally is applicable for Medi-Cal expenditures for acute inpatient hospital services, and that the level of federal financial participation for the payment adjustment program is expected to continue to remain below that 30-percent level for the next payment adjustment year as a whole, the department shall, as soon as practicable, implement paragraphs (3) and (4).

(3) If the department determines that the circumstances described in paragraph (2) are present, the payment adjustment program shall be terminated, effective as of the earliest date permissible under federal law. In that event, all installment payments to the fund which are already due pursuant to Section 14163 at the time of the department's determination shall remain due, and shall be collected by the Controller. However, installment payments which are not yet due at that time shall not become due.

(4) Within 90 days after the termination of the payment adjustment program, as referred to in paragraph (3), or as soon as practicable, the department shall determine whether any amounts remain in the fund that are not needed to pay prior payment adjustment amounts under this section. If remaining amounts exist in the fund, they shall be refunded to transferor entities on a pro rata basis, within 45 days after the date of the department's determination.

(r) (1) The state shall be held harmless from any federal disallowance resulting from payments made under this section, and from payments made to hospitals based on transfers accepted by the department under Section 14164. Any hospital that has received payments under this section, or based on transfers accepted by the department under Section 14164, shall be liable for any audit exception or federal disallowance only with respect to the payments made to that hospital. The department shall recoup from a hospital the amount of any audit exception or federal disallowance in the manner authorized by applicable laws and regulations.

(2) Notwithstanding any other provisions of law, if any payment adjustment that has been paid, or that otherwise would have been payable to an eligible hospital under this section, exceeds the OBRA 1993 payment limitation for the particular hospital, the department shall withhold or recoup the payment adjustment amount that exceeds the limitation. The nonfederal component of the amount withheld or recouped shall be redeposited in, or shall remain in, the fund, as applicable, until used for the purposes described in paragraph (2) of subdivision (j) of Section 14163.

(s) (1) The department may utilize existing administrative appeal procedures for purposes of any appealable matter that arises under the payment adjustment program. The matters that may be appealed shall be limited to those related to the following:

(A) Paragraph (5) of subdivision (f).

(B) State audit disallowances of amounts paid to hospitals under the payment adjustment program.

(2) Calculations which are final pursuant to paragraph (4) or (5) of subdivision (f) or the procedures or data on which those calculations are based, shall not be appealed.

(t) (1) Except as provided in paragraph (2), the department shall take all appropriate steps permitted by law and the Medi-Cal State Plan to ensure the following for all years of the payment adjustment program:

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

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

(C) That, if pursuant to paragraph (2), any well-baby (nursery) days or acute administrative days are not included in the payment adjustment program for payment purposes for any parts of the 1992–93 or 1993–94 payment adjustment years, all those days are nevertheless included in the total of annualized Medi-Cal inpatient paid days for all purposes under the payment adjustment program, unless otherwise barred by paragraph (2).

(2) In no event shall paragraph (1) be implemented in a fashion that is inconsistent with federal medicaid law or the Medi-Cal State Plan.

(u) (1) For the 1993–94 payment adjustment year, each eligible hospital shall also be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the hospital being included on the disproportionate share list as of September 30, 1993. For purposes of federal medicaid rules, including Section 447.297(d) of Title 42 of the Code of Federal Regulations, the supplemental payment adjustments shall be applicable to the federal fiscal year that ends on September 30, 1993.

(2) The availability of supplemental payment adjustments under this subdivision shall be determined as follows:

(A) The final maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules shall be identified for the 1993 federal fiscal year. This final allotment is two billion one hundred ninety-one million four hundred fifty-one thousand dollars ($2,191,451,000), as specified at page 43186 of Volume 58 of the Federal Register.

(B) The total amount of all per diem payment adjustment amounts under this section, whether paid or payable, that are applicable to the 1993 federal fiscal year shall be determined. The applicability of the per diem payment adjustment amounts to the 1993 federal fiscal year shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(C) The figure determined under subparagraph (B) shall be subtracted from the figure identified under subparagraph (A). If the remainder is a positive figure, supplemental lump-sum payment adjustments shall be made under this subdivision in accordance with paragraph (3).

(3) The amount of the supplemental lump-sum payment adjustment to each eligible hospital shall be computed as follows:

(A) The projected total of all per diem payment adjustment amounts payable to each particular eligible hospital under this section for the 1993–94 payment adjustment year shall be determined. For each hospital, this figure shall be identical to the figure used for the same hospital in the calculations regarding transfer amounts under subdivision (h) of Section 14163 for the 1993–94 state fiscal year.

(B) The projected totals for all eligible hospitals determined under subparagraph (A) shall be added together to determine an aggregate total of all projected per diem payment adjustments for the 1993–94 payment adjustment year. This figure shall be identical to the aggregate figure for all hospitals used in the calculations regarding transfer amounts under subdivision (h) of Section 14163 for the 1993–94 state fiscal year.

(C) The figure determined for each eligible hospital under subparagraph (A) shall be divided by the aggregate figure determined under subparagraph (B), yielding a percentage figure for each hospital.

(D) The percentage figure determined for each hospital under subparagraph (C) shall be multiplied by the positive remainder calculated under subparagraph (C) of paragraph (2).

(E) The product as so determined for each eligible hospital under subparagraph (D) shall be the supplemental lump-sum payment adjustment amount payable to the particular hospital.

(4) The department shall make partial payments of the supplemental lump-sum payment adjustments to eligible hospitals on or before January 1, 1994. The department shall make final calculations regarding the supplemental lump-sum payments based on data available as of March 1, 1994, and shall distribute the final payments promptly thereafter.

(5) The department shall implement this subdivision only to the extent consistent with federal medicaid law and the Medi-Cal State Plan, and only to the extent that the department determines that federal financial participation is available. In doing so, the department shall comply with any procedures instituted by the Health Care Financing Administration in connection with Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(v) (1) For the 1993–94 payment adjustment year, each eligible hospital that remains in operation as of June 30, 1994, shall also be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the hospital being a disproportionate share hospital in operation as of that date.

(2) The availability of supplemental lump-sum payment adjustments under this subdivision shall be determined by the department as follows:

(A) The final maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules shall be identified for the 1994 federal fiscal year. This final allotment is two billion one hundred ninety-one million four hundred fifty-one thousand dollars ($2,191,451,000), as specified on page 22676 of Volume 59 of the Federal Register.

(B) The total amount of all per diem payment adjustment amounts under this section, whether paid or payable, that are applicable to the period October 1, 1993, through June 30, 1994, shall be determined. The applicability of the per diem

payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(C) The figure determined under subparagraph (B) shall be subtracted from the figure identified under subparagraph (A). If the remainder is a positive figure, supplemental lump-sum payment adjustments shall be made under this subdivision in accordance with paragraph (3).

(3) The amount of the supplemental lump-sum payment adjustment to each hospital shall be computed as follows:

(A) The projected total of all other payment adjustment amounts payable to each particular hospital under this section applicable to the 1993–94 payment adjustment year shall be determined. For each hospital, this figure shall be identical to the sum of the figures used for the same hospital in the calculations regarding transfer amounts under subdivision (h) of Section 14163 for the 1993–94 state fiscal year, not including the supplemental lump-sum payments described in this subdivision.

(B) The projected totals for all hospitals determined under subparagraph (A) shall be added together to determine an aggregate total. This aggregate total shall be identical to the aggregate figure for all hospitals used in the calculations regarding transfer amounts under subdivision (h) of Section 14163 for the 1993–94 state fiscal year, not including the supplemental lump-sum payments described in this subdivision.

(C) The figure determined for each hospital under subparagraph (A) shall be divided by the aggregate figure determined under subparagraph (B), yielding a percentage figure for each hospital.

(D) The percentage figure determined for each hospital under subparagraph (C) shall be multiplied by the positive remainder calculated under subparagraph (C) of paragraph (2).

(E) The product determined under subparagraph (D) for each hospital shall be the supplemental lump-sum payment adjustment amount payable to the particular hospital, which shall be payable because the facility is a disproportionate share hospital in operation as of June 30, 1994.

(4) The department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on or before October 31, 1994.

(5) The department shall implement this subdivision only to the extent consistent with federal medicaid law and the Medi-Cal State Plan, and only to the extent that the department determines that federal financial participation is available. In doing so, the department shall comply with any procedures instituted by the Health Care Financing Administration in connection with Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(w) (1) For the 1994–95 payment adjustment year, each eligible hospital that remains in operation as of June 30, 1995, shall also be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the hospital being a disproportionate share hospital in operation as of that date.

(2) The availability of supplemental lump-sum payment adjustments under this subdivision shall be determined by the department as follows:

(A) The final maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules shall be identified for the 1995 federal fiscal year.

(B) The total amount of all per diem payment adjustment amounts under this section, whether paid or payable, that are applicable to the period October 1, 1994, through June 30, 1995, shall be determined. The applicability of the per diem payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(C) The figure determined under subparagraph (B) shall be subtracted from the figure identified under subparagraph (A). If the remainder is a positive figure, supplemental lump-sum payment adjustments shall be made under this subdivision in accordance with paragraph (3).

(3) The amount of the supplemental lump-sum payment adjustment to each hospital shall be computed as follows:

(A) The projected total of all other payment adjustment amounts payable to each particular hospital under this section applicable to the 1994–95 payment adjustment year shall be determined. For each hospital, this figure shall be identical to the sum of the figures used for the same hospital in the calculations regarding transfer amounts under subdivision (h) of Section 14163 for the 1994–95 state fiscal year, not including the supplemental lump-sum payments described in this subdivision.

(B) The projected totals for all hospitals determined under subparagraph (A) shall be added together to determine an aggregate total. This aggregate total shall be identical to the aggregate figure for all hospitals used in the calculations

regarding transfer amounts under subdivision (h) of Section 14163 for the 1994–95 state fiscal year, not including the supplemental lump-sum payments described in this subdivision.

(C) The figure determined for each hospital under subparagraph (A) shall be divided by the aggregate figure determined under subparagraph (B), yielding a percentage figure for each hospital.

(D) The percentage figure determined for each hospital under subparagraph (C) shall be multiplied by the positive remainder calculated under subparagraph (C) of paragraph (2).

(E) The product as so determined under subparagraph (D) for each hospital shall be the supplemental lump-sum payment adjustment amount payable to the particular hospital, which shall be payable because the facility is a disproportionate share hospital in operation as of June 30, 1995.

(4) The department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on or before October 31, 1995.

(5) The department shall implement this subdivision only to the extent consistent with federal medicaid law and the Medi-Cal State Plan, and only to the extent that the department determines that federal financial participation is available. In doing so, the department shall comply with any procedures instituted by the Health Care Financing Administration in connection with Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(x) (1) With respect to per diem payment adjustments otherwise payable in connection with the period of July 1 through September 30 of the 1994–95 payment adjustment year, payment adjustment amounts shall be adjusted as described in paragraph (2).

(2) No per diem payment adjustment amounts shall be payable in connection with the period of July 1 through September 30 of the 1994–95 payment adjustment year. The Medi-Cal days of acute inpatient hospital service paid by or on behalf of the department that otherwise would have given rise to payment adjustment amounts with respect to this period of time shall not count toward the maximum limit set forth in paragraph (2) of subdivision (l).

(y) Notwithstanding any other provision of law, except subdivision (z), the payment adjustment program for the 1995–96 payment adjustment year shall be structured as set forth below.

(1) (A) The department shall, in the manner used for prior years, compute the projected total payment adjustment amounts for all eligible hospitals, by determining for each eligible hospital its total per diem composite amount and multiplying that figure by 80 percent of the hospital's annualized Medi-Cal inpatient paid days.

(B) The products of the calculations under subparagraph (A) for all eligible hospitals shall be added together. The sum of all these figures shall be the unadjusted projected total payment adjustment program for the 1995–96 payment adjustment year.

(2) The remaining amount available as part of the state disproportionate share hospital allotment for California under applicable federal rules for July 1995 through September 1995 (as part of the 1995 federal fiscal year) shall be recognized as being zero.

(3) The department shall estimate what the state disproportionate share hospital allotment for California will be for the 1996 federal fiscal year under applicable federal rules. The estimate shall not exceed the allotment that was applicable for California for the 1995 federal fiscal year.

(4) The estimate identified by the department under paragraph (3) shall be reduced by subtracting the total amount of the supplemental lump-sum payments paid or payable under subdivisions (v) and (w).

(5) The remainder determined under paragraph (4) shall be added to the amount determined under paragraph (2). The total of those two amounts shall be the unadjusted tentative size of the payment adjustment program for the 1995–96 payment adjustment year.

(6) The total per diem composite amount computed for each eligible hospital under subparagraph (A) of paragraph (1) shall be modified as follows:

(A) The department shall reduce the total per diem composite amount for each eligible hospital by multiplying the amount by an identical percentage. The percentage figure to be used for this purpose shall be that percentage that is derived by dividing the amount determined under paragraph (5) by the unadjusted projected total payment adjustment program amount determined under subparagraph (B) of paragraph (1).

(B) The percentage figure derived under subparagraph (A) shall be applied to the total per diem composite amount for each eligible hospital, yielding an adjusted total per diem composite amount for each hospital for the 1995–96 payment adjustment year.

(C) (i) The adjusted total per diem composite amount determined under subparagraph (B) for each eligible hospital shall be multiplied by 80 percent of the hospital's annualized Medi-Cal inpatient paid days.

(ii) The amount computed for each hospital under clause (i) shall be compared to the OBRA 1993 payment limitation that, in accordance with applicable provisions of the Medi-Cal State Plan, the department has computed for the particular hospital.

(iii) Where the amount computed under clause (i) for the particular hospital is less than the OBRA 1993 payment limitation for the hospital, the amount computed under clause (i) shall be used for purposes of clause (v).

(iv) Where the amount computed under clause (i) for the particular hospital exceeds the OBRA 1993 payment limitation for the hospital, the amount computed under clause (i) shall be reduced to an amount equal to the OBRA 1993 payment limitation for the particular hospital. The amount as so reduced shall be used for purposes of clause (v).

(v) The amount for each hospital, as determined under either clause (iii) or clause (iv), as applicable, shall be the adjusted projected total payment adjustment amount for the hospital for the 1995–96 payment adjustment year.

(D) The adjusted figures computed for all eligible hospitals under subparagraph (C) shall be added together, yielding the adjusted tentative size of the payment adjustment program for the 1995–96 payment adjustment year.

(7) The adjusted tentative size of the payment adjustment program for the 1995–96 payment adjustment year as determined under subparagraph (D) of paragraph (6), and the adjusted projected total payment adjustment amount for each eligible hospital, as determined under subparagraph (C) of paragraph (6), shall be distributed as follows:

(A) No per diem payment adjustment amounts shall be payable in connection with the period of July 1 through September 30 of the 1995–96 payment adjustment year. The Medi-Cal days of acute inpatient hospital service paid by or on behalf of the department that otherwise would have given rise to payment adjustment amounts with respect to this period of time shall not count toward the maximum limit set forth in paragraph (2) of subdivision (l).

(B) For all eligible hospitals, the adjusted per diem composite amounts (as determined under subparagraph (B) of paragraph (6)) shall be the amounts payable with respect to the period of October 1 through June 30 of the 1995–96 payment adjustment year, subject to the applicable provisions of subdivision (z).

(8) For the 1995–96 payment adjustment year, each eligible hospital that remains in operation as of June 30, 1996, shall also be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date. The availability of supplemental lump-sum payment adjustments under this paragraph shall be determined by the department as follows:

(A) The adjusted projected total payment adjustment amount for each hospital, as determined under subparagraph (C) of paragraph (6), shall be identified.

(B) The total amount of all per diem payment adjustment amounts under this section, whether paid or payable, that are applicable to the period July 1, 1995, through June 30, 1996, shall be determined for each hospital, taking into account subparagraph (A) of paragraph (7). The applicability of the per diem payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(C) The amount determined under subparagraph (B) for each hospital shall be subtracted from the amount identified under subparagraph (A) for each hospital. If the remainder is a positive figure for the particular hospital, the supplemental lump-sum payment adjustment for the hospital shall be the positive remainder amount, which shall be payable because the facility is a disproportionate share hospital in operation as of June 30, 1996.

(D) The department shall make interim and final payments of the supplemental lump-sum payment adjustments under this paragraph on or before September 30, 1996.

(9) Except as provided in subparagraph (C), for the 1995–96 payment adjustment year each eligible hospital that remains in operation as of June 30, 1996, shall also be eligible to receive a secondary supplemental payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date. The availability of secondary supplemental payment adjustments under this paragraph shall be determined by the department as follows:

(A) The maximum amount of secondary supplemental payment adjustments available pursuant to this paragraph shall be calculated as follows:

(i) The total amount of all per diem payment adjustment amounts, whether paid or payable, for the 1995–96 payment adjustment year, as determined under subparagraph (B) of paragraph (8), shall be identified.

(ii) The total amount of all supplemental lump-sum payment adjustments, whether paid or payable, as determined under subparagraph (C) of paragraph (8), shall be identified.

(iii) The department shall estimate the total amount of payment adjustments under this section that it anticipates will be applicable to the period July 1, 1996, through September 30, 1996. The applicability of the payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(iv) The department shall identify the amount of the final maximum state disproportionate share hospital allotment for California for the 1996 federal fiscal year under applicable federal rules. The amount identified shall not exceed two billion one hundred ninety-one million four hundred fifty-one thousand dollars ($2,191,451,000).

(v) The amounts identified or estimated under clauses (i), (ii), and (iii) shall be added together, and the sum of these amounts shall be subtracted from the amount identified under clause (iv). The remainder determined from this calculation, or the amount of two hundred million dollars ($200,000,000), whichever is less, shall be the maximum amount available for secondary supplemental payment adjustments under this paragraph.

(B) The maximum amount available for secondary supplemental payment adjustments, as identified under clause (v) of subparagraph (A), shall be distributed to eligible hospitals as follows:

(i) The total amount of all per diem payment adjustments and supplemental lump-sum payment adjustments relating to the 1995–96 payment adjustment year, whether paid or payable, shall be identified for each eligible hospital. However, notwithstanding any other provision of law, those hospitals referred to in subparagraph (C) shall not be included in this step, and shall not receive any secondary supplemental payment adjustments, as described in subparagraph (C).

(ii) For purposes of secondary supplemental payment adjustments, the eligible hospitals shall be classified into various groups. No hospital may qualify for more than one of these groups. Notwithstanding subclause (II), the hospitals described in subparagraph (C) shall not be included in any of these groups. The following groups of hospitals shall be recognized:

(I) “State of California hospitals,” which shall include all eligible hospitals that, as of July 1, 1995, were licensed to the State of California or to the University of California.

(II) “County hospitals,” which shall include all eligible hospitals that, as of July 1, 1995, were licensed to a county or a city and county, but shall exclude those hospitals referred to in subparagraph (C).

(III) “Other public hospitals,” which shall include all eligible hospitals that, as of July 1, 1995, were licensed to a local hospital district, a local health authority, a city, or any other noncounty political subdivision of the state.

(IV) “Children’s hospitals,” which shall include all eligible hospitals that, as of July 1, 1995, were included in the children’s hospital group under subdivision (h).

(V) “Other nonpublic hospitals,” which shall include all eligible hospitals that are not included in any group described in subclauses (I) through (IV).

(iii) The amount determined to be the maximum amount of secondary supplemental payment adjustments under clause (v) of subparagraph (A) shall first be allocated among the groups of hospitals referred to in clause (ii), as follows:

(I) “State of California hospitals”: 64.35 percent of the maximum amount.

(II) “County hospitals”: 18.095 percent of the maximum amount.

(III) “Other public hospitals”: 0.65 percent of the maximum amount.

(IV) “Children’s hospitals”: 6.755 percent of the maximum amount.

(V) “Other nonpublic hospitals”: 10.15 percent of the maximum amount.

(iv) (I) The amount of funds allocated pursuant to clause (iii) to each of the particular groups of hospitals referred to in clauses (ii) and (iii) shall then be distributed as secondary supplemental payment adjustments among the eligible hospitals within each particular group. The secondary supplemental distributions shall be made on a descending pro rata basis within each group. Each cycle of the descending pro rata distribution shall be considered to be a phase of the process. As described in subclauses (II) to (V), inclusive, in each phase of the descending pro rata distribution, the pro rata share of the distribution to each hospital that remains eligible to receive additional distributions shall be computed based on the ratio of the total payment adjustments that the particular hospital has already earned under the payment adjustment program for

the 1995–96 payment adjustment year, as compared to the total payment adjustments already earned by the other hospitals in the particular group that remain eligible to receive the additional distributions.

(II) For the first phase, the total amount of payment adjustments under this section for the 1995–96 payment adjustment year, including all per diem payment adjustments and all supplemental lump-sum payment adjustments, that are determined by the department as already being paid or payable to each hospital eligible for the distribution shall be determined.

(III) The figures determined under subclause (II) for each hospital in the particular group shall be added together to determine an aggregate total.

(IV) The figures determined for each hospital under subclause (II) shall be divided by the aggregate total determined under subclause (III), yielding a percentage figure for each hospital.

(V) The percentage figure determined for each hospital under subclause (IV) shall be applied to the maximum portion of the funds allocated to the particular group under clause (iii) that can be distributed in the particular phase until a hospital in the particular group reaches the limitation set forth in clause (v).

(v) For each hospital, no secondary supplemental payment adjustment shall be paid to the extent that either of the following conditions exist:

(I) The secondary supplemental payment adjustment would cause the total of all payment adjustments to the hospital under this section relating to the 1995–96 payment adjustment year to exceed the amount that is the product of multiplying 0.95 times the particular hospital's OBRA 1993 payment limitation for the 1995–96 payment adjustment year, as computed by the department in accordance with applicable provisions of the Medi-Cal State Plan.

(II) Without regard to any secondary supplemental payment adjustment, the hospital has already received or has earned payment adjustments relating to the 1995–96 payment adjustment year that equal or exceed the product referred to in subclause (I).

(vi) Any secondary supplemental payment adjustment amount, or portion thereof, that otherwise would have been payable to a particular hospital under this paragraph, but that is barred by the limitation described in clause (v), shall be distributed by the department through additional phases of the descending pro rata distribution process to those hospitals within the same group, as set forth in clauses (ii) and (iii), as the particular hospital. For each additional phase, the mathematical steps referred to in subclauses (II) to (V), inclusive, of clause (iv) shall be repeated for those hospitals that have not reached the limitation set forth in clause (v). The phases shall continue until the funds allocated to the particular group under clause (iii) have been fully exhausted. No such distribution, however, shall be in an amount that would cause any hospital to exceed the limitation set forth in clause (v).

(C) Notwithstanding any other provision of law, prior to the allocation or distribution of any secondary supplemental payment adjustments, hospitals that, as of July 1, 1995, were part of a county-operated health system of three or more eligible hospitals licensed to the county, shall be deemed to have reached the limitations on total payments described in subclause (II) of clause (v) of subparagraph (B). Data regarding payment adjustments earned by these hospitals with respect to the 1995–96 payment adjustment year, whether paid or payable, shall be included in the computations under subparagraph (A), but excluded from the computations under subparagraph (B).

(D) The department shall make payments of the secondary supplemental payment adjustments to hospitals on or before November 30, 1996.

(10) The final total amount of per diem payment adjustments paid by the department for the 1995–96 payment adjustment year, plus the final total amount of supplemental lump-sum payment adjustments and secondary supplemental payment adjustments paid by the department for the 1995–96 payment adjustment year, shall be the maximum size of the payment adjustment program for the 1995–96 payment adjustment year.

(11) The department shall implement this subdivision only to the extent consistent with federal medicaid law and the Medi-Cal State Plan, and only to the extent that the department determines that federal financial participation is available. In doing so, the department shall comply with any procedures instituted by the Health Care Financing Administration in connection with Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(z) (1) (A) Notwithstanding any other provision of law (except for subparagraph (B)), all Medi-Cal days of acute inpatient hospital service paid by or on behalf of the department that give rise to payment adjustment amounts with respect to the period October 1, 1994, through June 30, 1995, shall be treated as involving 1.4 days for purposes of payment adjustments with respect to this period of time. As a result, each per diem payment adjustment amount otherwise payable to the hospital in connection with these days shall be increased by 40 percent. The Medi-Cal days in question shall be treated as involving 1.4 days toward the maximum limit set forth

in paragraph (2) of subdivision (l). The Medi-Cal days in question shall be treated as involving 1.0 days for purposes of determining the hospital's annualized Medi-Cal inpatient paid days for the next applicable payment adjustment year.

(B) For the 1994–95 payment adjustment year, no eligible hospital shall receive total payment adjustments, including per diem payment adjustment amounts and any supplemental lump-sum payment adjustment amounts, in excess of the projected total payment adjustment amounts that were computed or recomputed, as applicable, for the hospital by the department with respect to the 1994–95 payment adjustment year. For each hospital, this maximum figure shall not exceed the sum of the following two components:

(i) The final figure computed by the department as the hospital's total per diem composite amount (including any applicable adjustments under subdivision (p)), multiplied by 80 percent of the hospital's annualized Medi-Cal inpatient paid days.

(ii) The amount calculated by the department as the hospital's pro rata share (based on the figures for all hospitals computed under clause (i)) of the remainder determined by subtracting (I) the sum of the figures computed for all hospitals under clause (i) from (II) the final maximum state disproportionate share hospital allotment for California under applicable federal rules for the 1995 federal fiscal year.

(C) Any payment adjustment amount that otherwise would be payable to a hospital, but that is barred by subparagraph (B), shall be withheld or recouped by the department and distributed on a descending pro rata basis as part of the supplemental lump-sum distribution described in subdivision (w) to those hospitals that have not reached their maximum figures as described in subparagraph (B).

(2) (A) Notwithstanding any other provision of law, except for subparagraph (B), all Medi-Cal days of acute inpatient hospital service paid by or on behalf of the department that give rise to payment adjustment amounts with respect to the period October 1, 1995, through June 30, 1996, shall be treated as involving 1.4 days for purposes of payment adjustments with respect to this period of time. As a result, each per diem payment adjustment amount otherwise payable to the hospital in connection with these days shall be increased by 40 percent. The Medi-Cal days in question shall be treated as involving 1.4 days toward the maximum limit set forth in paragraph (2) of subdivision (l). The Medi-Cal days in question shall be treated as involving 1.0 days for purposes of determining the hospital's annualized Medi-Cal inpatient paid days for the next applicable payment adjustment year.

(B) For the 1995–96 payment adjustment year, no eligible hospital shall receive total payment adjustments, including per diem payment adjustment amounts, supplemental lump-sum payment adjustment amounts, and secondary supplemental payment adjustments in excess of the hospital's OBRA 1993 payment limitation as computed by the department pursuant to the Medi-Cal State Plan. No hospital shall receive secondary supplemental payment adjustments to the extent the payment adjustments would be inconsistent with paragraph (9) of subdivision (y).

(C) Any payment adjustment amount that otherwise would be payable to a hospital, but that is barred by subparagraph (B), shall be withheld or recouped by the department and thereafter distributed to other eligible hospitals, refunded to transferors, or otherwise processed in accordance with this section and Section 14163.

(3) Notwithstanding any other provision of law, to the extent necessary or appropriate to implement and administer the amendments to this section enacted during the 1994 calendar year, the department may utilize an approach involving interim payments, with reconciliation to final payments within a reasonable time.

(aa) (1) For the 1996–97 payment adjustment year, each eligible hospital that remains in operation as of June 30, 1997, shall also be eligible to receive a supplemental lump-sum payment adjustment, that shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date. The availability of supplemental lump-sum payment adjustments under this paragraph shall be determined by the department as follows:

(A) The projected total payment adjustment amount for each hospital, as determined by the department at the outset of the payment adjustment year, including any reductions arising from payment limitations under this section, shall be identified. For each hospital, this amount shall be identical to the amount that was used for the same hospital in the calculations made at the outset of the 1996–97 state fiscal year regarding transfer amounts under subdivision (h) of Section 14163 for that fiscal year.

(B) The total amount of all per diem payment adjustment amounts under this section, whether paid or payable, that are applicable to the period July 1, 1996, through June 30, 1997, shall be determined for each hospital. The applicability of the per diem payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(C) The amount determined under subparagraph (B) for each hospital shall be subtracted from the amount identified under subparagraph (A) for each hospital. If the remainder is a positive figure for the particular hospital, the supplemental lump-sum payment adjustment for the hospital shall be the positive remainder amount, which shall be payable because the facility is a disproportionate share hospital in operation as of June 30, 1997.

(D) The department shall make interim and final payments of the supplemental lump-sum payment adjustments under this paragraph on or before September 30, 1997.

(2) The department shall implement this subdivision only to the extent consistent with federal medicaid law and the Medi-Cal State Plan, and only to the extent that the department determines that federal financial participation is available. In doing so, the department shall comply with any procedures instituted by the Health Care Financing Administration in connection with Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(ab) (1) For the 1997–98 payment adjustment year, eligible hospitals that meet the requirements of this subdivision and that remain in operation as of September 30, 1997, shall be eligible to receive a special supplemental payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date. For purposes of federal medicaid rules, including Section 447.297(d) of Title 42 of the Code of Federal Regulations, the special supplemental payment adjustments shall be applicable to the federal fiscal year that ends on September 30, 1997.

(2) The availability of special supplemental payment adjustments under this subdivision shall be determined as follows:

(A) The final maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules shall be identified for the 1997 federal fiscal year.

(B) The total amount of all per diem payment adjustment amounts and supplemental payment adjustments under this section (exclusive of any payments under this subdivision) applicable to the 1997 federal fiscal year, whether paid or payable, shall be determined. The applicability of per diem payment adjustment amounts and supplemental payment adjustments of all types to the 1997 federal fiscal year shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(C) The figure determined under subparagraph (B) shall be subtracted from the figure identified under subparagraph (A). If the remainder is a positive figure, special supplemental payment adjustments shall be made under this subdivision in accordance with paragraph (3). The positive remainder shall be the maximum amount of special supplemental payment adjustments under this subdivision.

(3) (A) For purposes of these special supplemental payment adjustments, only hospitals that can be categorized into either of the two groups specified in clauses (i) and (ii) shall be eligible to receive the supplemental payment adjustments, and no hospital may qualify for more than one of the two groups. The following groups of hospitals shall be recognized:

(i) “Public hospitals,” which shall include all eligible hospitals that, as of July 1, 1997, met the definition of a public hospital.

(ii) “Nonpublic hospitals,” which shall include all eligible hospitals that, as of July 1, 1997, met the definition of a nonpublic hospital.

(B) The amount determined to be the maximum amount of special supplemental payment adjustments under subparagraph (C) of paragraph (2) shall first be allocated between the two groups of hospitals referred to in subparagraph (A) as follows:

(i) “Public hospitals”: 74.885 percent of the maximum amount.

(ii) “Nonpublic hospitals”: 25.115 percent of the maximum amount.

(C) The amount of funds allocated pursuant to subparagraph (B) to each of the particular groups of hospitals referred to in subparagraphs (A) and (B) shall then be distributed as special supplemental payment adjustments among the eligible hospitals within each particular group as follows:

(i) The department shall compute the projected total payment adjustment amounts for all eligible hospitals for the 1997–98 payment adjustment year, exclusive of any payments under this subdivision, subdivision (ad), or subdivision (af), by determining for each eligible hospital its total per diem composite amount and multiplying that figure by the maximum number of the hospital’s Medi-Cal inpatient paid days determined under paragraph (2) of subdivision (l). For purposes of this clause, the determinations shall be without regard to the OBRA 1993 payment limitations.

(ii) The amount computed under clause (i) for each hospital described in subparagraph (A) shall be compared to the amount that is the product of multiplying 0.95 times the OBRA 1993 payment limitation that, in accordance with applicable provisions of the Medi-Cal State Plan, the department has computed for the particular hospital for the 1997–98 payment adjustment year.

(iii) Where the amount computed under clause (i) for the particular hospital is equal to or exceeds the product computed for the hospital under clause (ii), the hospital shall not receive a special supplemental payment adjustment. Data regarding hospitals that have reached this limitation shall not be used for purposes of clauses (v) through (viii).

(iv) Where the amount computed under clause (i) for the particular hospital is less than the product computed for the hospital under clause (ii), the amount computed under clause (i) for the hospital shall be used for purposes of clauses (v) through (viii).

(v) The figures determined under clause (iv) for each hospital in the particular group shall be added together to determine an aggregate total for each group.

(vi) The figures determined for each hospital under clause (iv) shall be divided by the aggregate total determined under clause (v) for the particular group, yielding a percentage figure for each hospital.

(vii) The percentage figure determined for each hospital under clause (vi) shall be applied to the maximum portion of the funds allocated to the particular group under subparagraph (B), to determine the hospital's pro rata share of the special supplemental lump-sum payment adjustments. Except, however, in the case of a nonpublic hospital that, as of July 1, 1997, meets the definition of a children's hospital, such pro rata share otherwise determined shall be multiplied by a factor of 1.09, yielding a modified pro rata share. The pro rata share for the other nonpublic hospitals shall be reduced accordingly, yielding a modified pro rata share, so that the maximum portion of the funds allocated to the nonpublic hospitals group will not be exceeded. The pro rata share or modified pro rata share, as applicable, for each hospital, as computed under this clause, shall also be used for all purposes relating to descending pro rata distributions under clause (viii).

(viii) In no event shall a hospital receive special supplemental payment adjustment amounts in excess of the difference between the product computed for the hospital under clause (ii) and the amount computed for the hospital under clause (i). Any special supplemental payment adjustment amount, or portion thereof, that otherwise would have been payable under this paragraph to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals within the same group.

(D) The department shall make interim and final payments of the special supplemental payment adjustments to hospitals on or before February 28, 1998.

(4) The department shall implement this subdivision only if consistent with federal medicaid law and the Medi-Cal State Plan, and only if the department determines that federal financial participation is available.

(ac) Notwithstanding any other provision of law, the payment adjustment program with respect to the period October 1, 1997 through June 30, 1998, shall be structured as set forth below and in subdivisions (ad) and (af). However, if the effective date of the Medi-Cal State Plan amendment relating to this subdivision is later than October 1, 1997, as approved by the federal Health Care Financing Administration, all references in this subdivision to the period October 1, 1997, through June 30, 1998, shall be references to the period that commences on that effective date and continues through June 30, 1998.

(1) (A) The department shall utilize the computations made pursuant to clause (i) of subparagraph (C) of paragraph (3) of subdivision (ab) of the projected total payment adjustment amounts for all eligible hospitals for the entire 1997–98 payment adjustment year, exclusive of any supplemental payments under subdivision (ab), (ad), or (af).

(B) The computed amount referred to in subparagraph (A) for each hospital shall be compared to the OBRA 1993 payment limitation that, in accordance with applicable provisions of the Medi-Cal State Plan, the department has computed for the particular hospital.

(C) Where the computed amount referred to in subparagraph (A) for the particular hospital exceeds the OBRA 1993 payment limitation for the hospital, the amount computed under subparagraph (A) shall be reduced to an amount equal to the OBRA 1993 payment limitation for the particular hospital. The amount so reduced shall be used for purposes of subparagraph (E).

(D) Where the computed amount referred to in subparagraph (A) for the particular hospital is equal to or less than the OBRA 1993 payment limitation for the hospital, the computed amount referred to in subparagraph (A) shall be used for purposes of subparagraph (E).

(E) The amounts determined under subparagraphs (C) and (D) for all eligible hospitals shall be added together, yielding an aggregate sum. The aggregate sum shall be the unadjusted projected total payment adjustment program for the entire 1997–98 payment adjustment year, exclusive of any supplemental payments under subdivision (ab) or (ad).

(2) The initial maximum size of the payment adjustment program for the entire 1997–98 payment adjustment year shall be set at one billion seven hundred fifty million dollars ($1,750,000,000), exclusive of any supplemental payments under subdivision (ab) or (ad).

(3) The department shall increase or decrease the amount determined for each eligible hospital under subparagraph (C) or (D) of paragraph (1), as applicable, by multiplying the amount by an identical percentage, yielding the hospital's tentative adjusted projected total payment adjustment amount for the 1997–98 payment adjustment year. The identical percentage figure to be used

for this purpose shall be that percentage that is derived by dividing the amount set forth in paragraph (2) by the aggregate sum determined under subparagraph (E) of paragraph (1). Except, however, the amount determined for a hospital under subparagraph (C) or (D) of paragraph (1) shall not be increased if it would exceed the OBRA 1993 payment limitation for the hospital.

(4) The tentative adjusted projected total payment adjustment amount computed for each eligible hospital under paragraph (3) shall be further adjusted as follows:

(A) (i) For each eligible hospital that met the definition of a nonpublic-converted hospital as of July 1, 1997, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic-converted hospital adjustment factor." The applicable adjustment factor shall be that which is necessary to result in an amount, for each hospital, equal to the amount used for the particular hospital under subparagraph (E) of paragraph (1). The amount so adjusted shall be used for purposes of clause (iii).

(ii) The total amount of all per diem payment adjustment amounts under this section, whether paid or payable, applicable to the period July 1, 1997, through September 30, 1997, shall be determined for each hospital referred to in clause (i). The applicability of the per diem payment adjustment amounts to the period July 1, 1997, through September 30, 1997, shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations. However, if the effective date of the Medi-Cal State Plan amendment relating to this subdivision is later than October 1, 1997, as approved by the federal Health Care Financing Administration, all determinations under this clause shall include per diem payment adjustment amounts applicable to the period July 1, 1997, through the date that is one day prior to that effective date.

(iii) The amount determined for each hospital under clause (i) shall be reduced by the amount determined under clause (ii) for the hospital. The resulting figure shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 1997, through June 30, 1998, which shall be paid to the hospital in accordance with paragraph (5).

(B) (i) For each eligible hospital that met the definition of a nonpublic hospital as of July 1, 1997, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(I) The tentative adjusted projected total payment adjustment amounts determined under paragraph (3) for each nonpublic hospital described above shall be added together.

(II) The amount identified in paragraph (2) shall be divided by 2.38. The resulting figure shall then be reduced by the sum of the amounts determined for all nonpublic-converted hospitals under clauses (ii) and (iii) of subparagraph (A).

(III) The amount computed under subclause (II) shall be divided by 2, and the result thereof further reduced by the amount of thirty-seven million five hundred thousand dollars ($37,500,000).

(IV) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (III) by the amount derived in subclause (I).

(ii) The total amount of all per diem payment adjustment amounts under this section, whether paid or payable, applicable to the period July 1, 1997, through September 30, 1997, shall be determined for each hospital referred to in clause (i). The applicability of the per diem payment adjustment amounts to the period July 1, 1997, through September 30, 1997, shall be determined in accordance with federal medicaid rules including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations. However, if the effective date of the Medi-Cal State Plan amendment relating to this subdivision is later than October 1, 1997, as approved by the federal Health Care Financing Administration, all determinations under this clause shall include per diem payment adjustment amounts applicable to the period July 1, 1997, through the date that is one day prior to that effective date.

(iii) The amount determined for each hospital under clause (i) shall be reduced by the amount determined under clause (ii) for the hospital. The resulting figure shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 1997, through June 30, 1998, which shall be paid to the hospital in accordance with paragraph (5).

(C) (i) For each eligible hospital that met the definition of a public hospital as of July 1, 1997, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "public hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(I) The tentative adjusted projected total payment adjustment amounts determined under paragraph (3) for each public hospital described above shall be added together.

(II) The amount identified in paragraph (2) shall be reduced by the sum of the amounts determined for all nonpublic-converted hospitals under clauses (ii) and (iii) of subparagraph (A) and the sum of the amounts determined for all

nonpublic hospitals under clauses (ii) and (iii) of subparagraph (B).

(III) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (II) by the amount derived in subclause (I).

(ii) The total amount of all per diem payment adjustment amounts under this section, whether paid or payable, applicable to the period July 1, 1997, through September 30, 1997, shall be determined for each hospital referred to in clause (i). The applicability of the per diem payment adjustment amounts to the period July 1, 1997, through September 30, 1997, shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations. However, if the effective date of the Medi-Cal State Plan amendment relating to this subdivision is later than October 1, 1997, as approved by the federal Health Care Financing Administration, all determinations under this clause shall include per diem payment adjustment amounts applicable to the period July 1, 1997, through the date that is one day prior to that effective date.

(iii) The amount determined for each hospital under clause (i) shall be reduced by the amount determined under clause (ii) for the hospital. The resulting figure shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 1997, through June 30, 1998, which shall be paid to the hospital in accordance with paragraph (5).

(5) The final adjusted projected total payment adjustment amount determined for each eligible hospital for the period October 1, 1997, through June 30, 1998, shall be distributed in 16 or fewer equal installments to be paid no later than the 10th and 25th day of each month during the period that commences on the effective date of the Medi-Cal State Plan amendment relating to this subdivision, as approved by the federal Health Care Financing Administration, and continues through May 25, 1998.

(6) Notwithstanding any other provision of law, for the entire 1997–98 payment adjustment year, no eligible hospital shall receive total payment adjustments, including per diem payment adjustments, payments under this subdivision, and any supplemental payments under subdivision (ab) or (ad), in excess of the hospital's OBRA 1993 payment limitation as computed by the department pursuant to the Medi-Cal State Plan. No hospital shall receive any special supplemental payment adjustments or supplemental lump-sum payment adjustments to the extent the payments would be inconsistent with subdivision (ab) or (ad), respectively.

(7) The aggregate sum of the final adjusted projected total payment adjustment amounts computed under paragraph (4) for each eligible hospital for the period October 1, 1997, through June 30, 1998, plus the aggregate sum of the amounts determined for each eligible hospital under clause (ii) of subparagraph (A) of paragraph (4), clause (ii) of subparagraph (B) of paragraph (4) and clause (ii) of subparagraph (C) of paragraph (4), shall be the maximum size of the payment adjustment program for the entire 1997–98 payment adjustment year, exclusive of the special supplemental payment adjustments provided for under subdivision (ab) and the supplemental lump-sum payment adjustments provided for under subdivision (ad).

(8) The department shall implement this subdivision only if consistent with federal medicaid law and the Medi-Cal State Plan, and only if the department determines that federal financial participation is available.

(ad) (1) For the 1997–98 payment adjustment year, eligible hospitals that meet the requirements of this subdivision and that remain in operation as of June 30, 1998, shall be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date, but only if the hospital has remained in operation for the period October 1, 1997, to June 30, 1998, inclusive.

(2) The amount of supplemental lump-sum payment adjustments available to hospitals under this subdivision shall be four hundred five million dollars ($405,000,000).

(3) (A) For purposes of these supplemental lump-sum payment adjustments, only hospitals that can be categorized into either of the two groups specified in clauses (i) and (ii) shall be eligible to receive the supplemental payment adjustments, and no hospital may qualify for more than one of the two groups. The following groups of hospitals shall be recognized:

(i) "Public hospitals," which shall include all eligible hospitals that, as of July 1, 1997, met the definition of a public hospital.

(ii) "Nonpublic hospitals," which shall include all eligible hospitals that, as of July 1, 1997, met the definition of a nonpublic hospital.

(B) The amount of supplemental lump-sum payment adjustments as referred to in paragraph (2) shall first be allocated between the two groups of hospitals referred to in subparagraph (A) as follows:

(i) "Public hospitals": 72.17 percent of the amount.

(ii) "Nonpublic hospitals": 27.83 percent of the amount.

(C) The amount of funds allocated pursuant to subparagraph (B) to each of the particular groups of hospitals referred to in subparagraphs (A) and (B) shall then be distributed as supplemental lump-sum payment adjustments among the eligible hospitals within each particular group as follows:

(i) The department shall identify for each eligible hospital the total amount of payment adjustments under this section (exclusive of any payments under this subdivision and subdivision (af)) applicable to the 1997–98 payment adjustment year, whether paid or payable. The applicability of the payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(ii) The amount identified for each hospital under clause (i) shall be compared to the OBRA 1993 payment limitation that, in accordance with applicable provisions of the Medi-Cal State Plan, the department has computed for the particular hospital for the 1997–98 payment adjustment year.

(iii) Where the amount computed under clause (i) for the particular hospital is equal to or exceeds the OBRA 1993 payment limitation for the hospital, the hospital shall not receive a supplemental lump-sum payment adjustment. Data regarding hospitals that have reached this limitation shall not be used for purposes of clauses (v) through (viii).

(iv) Where the amount computed under clause (i) for the particular hospital is less than the OBRA 1993 payment limitation for the hospital, the amount computed under clause (i) minus that amount paid or payable to the hospital under subdivision (ab) shall be used for purposes of clauses (v) through (viii).

(v) The figures determined under clause (iv) for each hospital in the particular group shall be added together to determine an aggregate total for each group.

(vi) The figures determined for each hospital under clause (iv) shall be divided by the aggregate total determined under clause (v) for the particular group, yielding a percentage figure for each hospital.

(vii) The percentage figure determined for each hospital under clause (vi) shall be applied to the maximum portion of the funds allocated to the particular group under subparagraph (B), to determine the hospital's pro rata share of the supplemental lump-sum payment adjustments. Except, however, in the case of a nonpublic hospital that, as of July 1, 1997, meets the definition of a children's hospital, the pro rata share otherwise determined shall be multiplied by a factor of 1.09, yielding a modified pro rata share. The pro rata share for the other nonpublic hospitals shall be reduced accordingly, yielding a modified pro rata share, so that the maximum portion of the funds allocated to the nonpublic hospitals group will not be exceeded. The pro rata share or modified pro rata share, as applicable, for each hospital, as computed under this clause, shall also be used for all purposes relating to descending pro rata distributions under clause (viii).

(viii) In no event shall a hospital receive supplemental lump-sum payment adjustment amounts in excess of the difference between the OBRA 1993 payment limitation for the hospital and the amount computed for the hospital under clause (i). Any supplemental lump-sum payment adjustment amount, or portion thereof, that otherwise would have been payable under this paragraph to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals within the same group.

(D) The department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on or before August 15, 1998.

(4) The department shall implement this subdivision only if consistent with federal medicaid law and the Medi-Cal State Plan, and only if the department determines that federal financial participation is available.

(5) Notwithstanding any other provision of law, the payment adjustments, data, and related aspects of subdivision (af) shall not be taken into account for any purpose under this subdivision, subdivision (ab), or subdivision (ac).

(ae) (1) In the event that any provision of subdivision (ab), (ac), or (ad), as reflected in a proposed Medi-Cal State Plan amendment, is not approved by the federal Health Care Financing Administration, the director shall modify the proposed Medi-Cal State Plan amendment in a manner intended to be consistent with all applicable federal requirements. Subject to the requirements of federal law, in developing the modified proposed Medi-Cal State Plan amendment, the director shall, to the extent practicable, incorporate, implement, and modify, as necessary, the payment methodologies applicable to the 1997–98 payment adjustment year in a manner that is as consistent as possible with the approach and intent of subdivisions (ab), (ac), and (ad), respectively.

(2) In the event that any provision of subdivision (af), (ag), (ah), (ai), or (aj), as reflected in a proposed Medi-Cal State Plan amendment, is not approved by the federal Health Care Financing Administration, the director shall modify that proposed Medi-Cal State Plan amendment in a manner intended to be consistent with all applicable federal requirements. Subject to the requirements of federal law, in developing the modified proposed Medi-Cal State Plan amendment, the director shall, to the extent practicable, incorporate, implement, and modify, as necessary, the payment methodologies applicable to the 1997–98, 1998–99, and 1999–

2000 payment adjustment years in a manner that is as consistent as possible with the approach and intent of subdivisions (af), (ag), (ah), (ai), and (aj), respectively.

(3) In the event that any provision of subdivision (ak), (al), (am), or (an), as reflected in a proposed Medi-Cal State Plan amendment, is not approved by the federal Health Care Financing Administration, the director shall modify that proposed Medi-Cal State Plan amendment in a manner intended to be consistent with all applicable federal requirements. Subject to the requirements of federal law, in developing the modified proposed Medi-Cal State Plan amendment, the director shall, to the extent practicable, and after consulting with representatives of the hospital industry, including, but not limited to, the California Healthcare Association, incorporate, implement, and modify, as necessary, the payment methodologies applicable to the 2000–01 payment adjustment year and subsequent payment adjustment years in a manner that is as consistent as possible with the approach and intent of subdivisions (ak), (al), (am), and (an), respectively.

(af) (1) The provisions of this subdivision shall apply for the 1997–98 payment adjustment year, and, for all purposes under the program, shall be implemented subsequent to the provisions of subdivisions (ab), (ac), and (ad). Under this subdivision, eligible hospitals that, as of October 1, 1997, were part of a county-operated health system of three or more eligible hospitals licensed to the county, and that are in operation as of June 30, 1998, shall be eligible to receive an additional supplemental lump-sum payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date, but only if the hospital has remained in operation for the period October 1, 1997, through June 30, 1998.

(2) The maximum amount of additional supplemental lump-sum payment adjustments under this subdivision shall be one hundred sixty-six million dollars ($166,000,000).

(3) The maximum amount of funds specified under paragraph (2) shall be distributed as additional supplemental lump-sum payment adjustments among the hospitals eligible under this subdivision as follows:

(A) The department shall identify for each eligible hospital the total amount of payment adjustments under this section (exclusive of any payments under this subdivision) applicable to the 1997–98 payment adjustment year, whether paid or payable. The applicability of the payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(B) The amount identified for each hospital under subparagraph (A) shall be compared to the OBRA 1993 payment limitation that, in accordance with applicable provisions of the Medi-Cal State Plan, the department has computed for the particular hospital for the 1997–98 payment adjustment year.

(C) Where the amount computed under subparagraph (A) for the particular hospital is equal to or exceeds the OBRA 1993 payment limitation for the hospital, the hospital shall not receive an additional supplemental lump-sum payment adjustment. Data regarding hospitals that have reached this limitation shall not be used for purposes of subparagraphs (E) through (H).

(D) Where the amount computed under subparagraph (A) for the particular hospital is less than the OBRA 1993 payment limitation for the hospital, the amount computed under subparagraph (A) shall be used for purposes of subparagraphs (E) through (H).

(E) The figures determined under subparagraph (D) for each hospital eligible to receive additional supplemental lump-sum payment adjustments under this subdivision shall be added together to determine an aggregate total.

(F) The figures determined for each hospital under subparagraph (D) shall be divided by the aggregate total determined under subparagraph (E), yielding a percentage figure for each hospital.

(G) The percentage figure determined for each hospital under subparagraph (F) shall be applied to the maximum amount specified in paragraph (2), to determine the hospital's pro rata share of the additional supplemental lump-sum payment adjustments.

(H) In no event shall a hospital receive additional supplemental lump-sum payment adjustment amounts in excess of the difference between the OBRA 1993 payment limitation for the hospital and the amount computed for the hospital under subparagraph (A). Any additional supplemental lump-sum payment adjustment amount, or portion thereof, that otherwise would have been payable under this paragraph to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals eligible for distributions under this subdivision that have not reached their OBRA 1993 payment limitation.

(4) The department shall make interim and final payments of the additional supplemental lump-sum payment adjustments to hospitals on or before August 15, 1998.

(5) The department shall implement this subdivision only to the extent consistent with federal medicaid law and the Medi-Cal State Plan, and only to the extent that the department determines that federal financial participation is available.

(ag) Notwithstanding any other provision of law, the payment adjustment program for the 1998–99 payment adjustment year shall be structured as set forth below and in subdivision (ah).

(1) (A) The department shall compute the projected total payment adjustment amounts for all eligible hospitals for the 1998–99 payment adjustment year by determining for each eligible hospital its total per diem composite amount and multiplying that figure by the maximum number of the hospital's Medi-Cal inpatient paid days determined under paragraph (2) of subdivision (l). For purposes of this subparagraph, these determinations shall be without regard to the OBRA 1993 payment limitations. With respect to a public hospital that, as of July 1, 1998, is part of a county-operated health system of three or more eligible hospitals licensed to the county, the projected total payment adjustment amount shall be reduced by an amount equal to the amount paid or payable to the hospital under subdivision (af).

(B) The computed amount referred to in subparagraph (A) for each hospital shall be compared to the OBRA 1993 payment limitation that, in accordance with applicable provisions of the Medi-Cal State Plan, the department has computed for the particular hospital.

(C) Where the computed amount referred to in subparagraph (A) for the particular hospital exceeds the OBRA 1993 payment limitation for the hospital, the amount computed under subparagraph (A) shall be reduced to an amount equal to the OBRA 1993 payment limitation for the particular hospital. The amount so reduced shall be used for purposes of subparagraph (E). Except, however, with respect to a public hospital that, as of July 1, 1998, is part of a county-operated health system of three or more eligible hospitals licensed to the county, the amount as so reduced shall be increased by an amount equal to the amount paid or payable to the hospital under subdivision (af), and used for purposes of subparagraph (E).

(D) Where the computed amount referred to in subparagraph (A) for the particular hospital is equal to or less than the OBRA 1993 payment limitation for the hospital, the computed amount referred to in subparagraph (A) shall be used for purposes of subparagraph (E). Except, however, with respect to a public hospital that, as of July 1, 1998, is part of a county-operated health system of three or more eligible hospitals licensed to the county, the computed amount shall be increased by an amount equal to the amount paid or payable to the hospital under subdivision (af), and used for purposes of subparagraph (E).

(E) The amounts determined under subparagraphs (C) and (D) for all eligible hospitals shall be added together, yielding an aggregate sum. The aggregate sum shall be the unadjusted projected total payment adjustment program for the 1998–99 payment adjustment year, exclusive of any supplemental payment adjustments under subdivision (ah).

(2) The initial maximum size of the payment adjustment program for the 1998–99 payment adjustment program shall be set at one billion seven hundred fifty million dollars ($1,750,000,000), exclusive of any supplemental payment adjustments under subdivision (ah).

(3) (A) The department shall increase or decrease the amount determined for each eligible hospital under subparagraph (C) or (D) of paragraph (1), as applicable, by multiplying the amount by an identical percentage, yielding the hospital's tentative adjusted projected total payment adjustment amount for the 1998–99 payment adjustment year. The identical percentage figure to be used for this purpose shall be that percentage that is derived by dividing the amount set forth in paragraph (2) by the aggregate sum determined under subparagraph (E) of paragraph (1). Except, however, the amount determined for a hospital under subparagraph (C) or (D) of paragraph (1), as applicable, shall not be increased so that it would exceed the OBRA 1993 payment limitation for the hospital, and, where that would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis so that the aggregate sum of the tentative adjusted projected total payment adjustment amounts for all hospitals equals the amount set forth in paragraph (2).

(B) (i) With respect to a public hospital that, as of July 1, 1998, is part of a county-operated health system of three or more eligible hospitals licensed to the county, the amount determined under subparagraph (C) or (D) of paragraph (1), as applicable, shall be reduced by an amount equal to the amount paid or payable to the hospital under subdivision (af), prior to applying the OBRA 1993 payment limitation under subparagraph (A).

(ii) Notwithstanding clause (i), all other computations under subparagraph (A), including the determination of the hospital's pro rata share of any reallocations, shall be made as though the reduction described in clause (i) had not occurred.

(4) The tentative adjusted projected total payment adjustment amount computed for each eligible hospital under paragraph (3) shall be further adjusted as follows:

(A) (i) For each eligible hospital that meets the definition of a nonpublic-converted hospital as of July 1, 1998, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic-converted hospital adjustment factor." The applicable adjustment factor shall be that which is necessary to result for each such hospital in an amount equal to the amount used for the particular hospital under subparagraph (E) of paragraph (1).

(ii) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the 1998–99 payment adjustment year, which shall be paid to the hospital in accordance with paragraph (5).

(B) (i) For each eligible hospital that meets the definition of a converted hospital as of July 1, 1998, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "converted hospital adjustment factor." The applicable adjustment factor shall be that which is necessary to result for each such hospital in an amount equal to: (I) the maximum number of the hospital's annualized Medi-Cal inpatient paid days determined under paragraph (2) of subdivision (l); multiplied by (II) the total per diem composite amount determined for the hospital, the calculation of the per diem composite amount being restricted by a maximum low-income number of 40 percent for the hospital, regardless if the hospital's low-income number would otherwise be higher. In no case shall the product of this calculation exceed the amount used for the particular hospital under subparagraph (E) of paragraph (1).

(ii) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the 1998–99 payment adjustment year, which shall be paid to the hospital in accordance with paragraph (5).

(C) (i) For each eligible hospital that meets the definition of a nonpublic hospital as of July 1, 1998, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(I) The tentative adjusted projected total payment adjustment amounts determined under paragraph (3) for each nonpublic hospital described above shall be added together.

(II) The amount identified in paragraph (2) shall be divided by 2.347. The resulting figure shall then be reduced by the sum of the amounts determined for all nonpublic-converted hospitals under clause (ii) of subparagraph (A) and the amounts determined for all converted hospitals under clause (ii) of subparagraph (B).

(III) The amount computed under subclause (II) shall be divided by 2, and the result thereof further reduced by the amount of thirty-seven million five hundred thousand dollars ($37,500,000).

(IV) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (III) by the amount derived in subclause (I).

(ii) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the 1998–99 payment adjustment year, which shall be paid to the hospital in accordance with paragraph (5). Except, however, in no case shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where that would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other nonpublic hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all nonpublic hospitals equals the amount derived in subclause (III) of clause (i).

(D) (i) For each eligible hospital that meets the definition of a public hospital as of July 1, 1998, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "public hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(I) The tentative adjusted projected total payment adjustment amounts determined under paragraph (3) for each public hospital described above shall be added together.

(II) The amount identified in paragraph (2) shall be reduced by the sum of the amounts determined for all nonpublic-converted hospitals under clause (ii) of subparagraph (A), the amounts determined for all converted hospitals under clause (ii) of subparagraph (B) and the amounts determined for all nonpublic hospitals under clause (ii) of subparagraph (C).

(III) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (II) by the amount derived in subclause (I).

(ii) The product determined for each hospital under clause (i) shall be further adjusted as follows:

(I) The product shall be reduced as necessary so as not to exceed the hospital's OBRA 1993 payment limitation.

(II) With respect to a public hospital that, as of July 1, 1998, is part of a county-operated health system of three or more eligible hospitals licensed to the county, the product shall, prior to the application of subclause (I), be reduced by an amount equal to the amount paid or payable to the hospital under subdivision (af).

(III) Any amounts that would otherwise have been allocated to a hospital but for the hospital's OBRA 1993 payment limitation as applied under subclause (I) shall be reallocated to all other public hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis. With respect to a public hospital described in subclause (II), the hospital's pro rata share of any reallocated amounts shall be based on the product derived for the hospital under clause (i).

(IV) The amount determined for each hospital pursuant to subclause (I) and subclause (II), as applicable (including the reduction under subclause (II)), plus any reallocations to the hospital under subclause (III), shall be the final adjusted projected total payment adjustment amount for the hospital for the 1998–99 payment adjustment year, which shall be paid to the hospital in accordance with paragraph (5).

(5) The final adjusted projected total payment adjustment amount determined for each eligible hospital for the 1998–99 payment adjustment year shall be distributed as set forth below.

(A) With respect to the period July 1, 1998, through September 30, 1998, payment adjustment amounts shall be payable only to those eligible hospitals that, as of July 1, 1998, were not part of a county-operated health system of three or more eligible hospitals licensed to the county.

(i) The maximum amount of payment adjustments payable to eligible hospitals under this paragraph for the period of July 1, 1998, through September 30, 1998, shall be determined as follows:

(I) The maximum state disproportionate share hospitals allotment for California under the provisions of applicable federal medicaid rules shall be identified for the 1998 federal fiscal year. This maximum allotment is two billion one hundred seventeen million eight hundred ninety-nine thousand six hundred sixty-eight dollars ($2,117,899,668).

(II) The total amount of all payment adjustments under this section (exclusive of any payments under this subparagraph) applicable to the 1998 federal fiscal year, whether paid or payable, shall be determined. The applicability of payment adjustment amounts to the 1998 federal fiscal year shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(III) The figure determined under subclause (II) shall be subtracted from the figure identified under subclause (I). The positive remainder shall be the maximum amount of payment adjustments payable with respect to the period July 1, 1998, through September 30, 1998, under this subparagraph.

(ii) With respect to an eligible hospital that, as of July 1, 1998, meets the definition of a nonpublic-converted hospital, the maximum amount payable for the period July 1, 1998, through September 30, 1998, shall be equal to the product of the final adjusted projected total payment adjustment amount determined for the hospital pursuant to paragraph (4), multiplied by a fraction that is computed as follows:

(I) The maximum amount derived in subclause (III) of clause (i) shall be increased by an amount equal to the total amount of payment adjustments paid or payable under subdivision (af).

(II) The figure derived in subclause (I) shall be divided by the amount specified in paragraph (2).

(iii) With respect to an eligible hospital that, as of July 1, 1998, meets the definition of a converted hospital, the maximum amount payable for the period July 1, 1998, through September 30, 1998, shall be equal to the product of the final adjusted projected total payment adjustment amount determined for the hospital pursuant to paragraph (4), multiplied by a fraction that is computed as follows:

(I) The maximum amount derived in subclause (III) of clause (i) shall be increased by an amount equal to the total amount of payment adjustments paid or payable under subdivision (af).

(II) The figure derived in subclause (I) shall be divided by the amount specified in paragraph (2).

(iv) With respect to an eligible hospital that, as of July 1, 1998, meets the definition of a nonpublic hospital, the maximum amount payable for the period July 1, 1998, through September 30, 1998, shall be equal to the product of the final adjusted projected total payment adjustment amount determined for the hospital pursuant to paragraph (4), multiplied by a fraction that is computed as follows:

(I) The maximum amount derived in subclause (III) of clause (i) shall be increased by an amount equal to the total amount of payment adjustments paid or payable under subdivision (af).

(II) The figure derived in subclause (I) shall be divided by the amount specified in paragraph (2).

(v) With respect to an eligible hospital that, as of July 1, 1998, meets the definition of a public hospital, the maximum amount payable for the period July 1, 1998, through September 30, 1998, shall be equal to the product of the final adjusted projected total payment adjustment amount determined for the hospital pursuant to paragraph (4), multiplied by a fraction that is computed as follows:

(I) The maximum amount derived in subclause (III) of clause (i) shall be reduced by the sum of the amounts determined for all nonpublic-converted hospitals under clause (ii), the amounts determined for all converted hospitals under clause (iii) and the amounts determined for all nonpublic hospitals under clause (iv).

(II) The amounts computed under paragraph (4) with respect to all public hospitals that are subject to this subparagraph (A) shall be added together, yielding an aggregate sum.

(III) The figure derived in subclause (I) shall be divided by the aggregate sum derived in subclause (II).

(vi) The resulting product determined for each hospital pursuant to clauses (ii) through (v), as applicable, shall be distributed to the hospital in three equal installments, each payable as of the last day of each month from July 1998 through September 1998. However, no hospital shall receive an installment for any month in which the hospital does not remain in operation for the entire month. To the extent that any hospital is not entitled to receive an installment that otherwise would be payable but for the hospital's failure to remain in operation through the last day of a particular month, the amount that would have been paid to the hospital shall be redistributed among those hospitals within the same hospital group (as those groups are described in clauses (ii) through (v)) that remain in operation from July 1, 1998, through September 30, 1998, to be distributed on a pro rata basis. The redistributed amounts shall be payable as of September 30, 1998.

(B) (i) With respect to the period October 1, 1998, through June 30, 1999, payment adjustment amounts shall be payable to each eligible hospital in the amount equal to the final adjusted projected total payment adjustment amount determined for the hospital pursuant to paragraph (4), less any payment adjustments paid or payable to the hospital, or payment adjustments that would have been payable but for the hospital's failure to remain in operation for a particular month, under subparagraph (A). The payment adjustments shall be distributed in eight equal amounts, each payable as of the last day of each month from October 1998 through May 1999. However, no hospital shall receive an installment for any month in which the hospital does not remain in operation for the entire month.

(ii) To the extent that any hospital of either of the hospital types described in clause (iv) or (v) of subparagraph (A) is not entitled to receive an installment that otherwise would be payable but for the hospital's failure to remain in operation through the last day of a particular month, the amount that would have been paid to the hospital shall be redistributed among those hospitals of the same hospital type that remain in operation from October 1, 1998, through June 30, 1999, to be distributed on a pro rata basis. The redistributed amounts shall be payable as of June 30, 1999.

(iii) With respect to a public hospital that, as of July 1, 1998, is part of a county-operated health system of three or more eligible hospitals licensed to the county, the hospital's pro rata share of any reallocations under clause (ii) shall be based on the final adjusted projected total payment adjustment amount determined for the hospital pursuant to paragraph (4), as increased by an amount equal to the amount paid or payable to the hospital under subdivision (af).

(6) Notwithstanding any other provision of law, for the 1998–99 payment adjustment year, no eligible hospital shall receive total payment adjustments in excess of the hospital's OBRA 1993 payment limitation as computed by the department pursuant to the Medi-Cal State Plan.

(7) The aggregate sum of the final adjusted projected total payment adjustment amounts computed under paragraph (4) for each eligible hospital shall be the maximum size of the payment adjustment program for the 1998–99 payment adjustment year, exclusive of the supplemental payment adjustments provided for under subdivision (ah).

(8) The department shall implement this subdivision only to the extent consistent with federal medicaid law and the Medi-Cal State Plan, and only to the extent that the department determines that federal financial participation is available.

(ah) (1) For the 1998–99 payment adjustment year, eligible hospitals that meet the requirements of this subdivision and that are in operation as of June 30, 1999, shall be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date, but only if the hospital has remained in operation for the period October 1, 1998, through June 30, 1999.

(2) The availability of supplemental lump-sum payment adjustments under this subdivision shall be determined as follows:

(A) The maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules shall be identified for the 1999 federal fiscal year. It is estimated that this amount will be two billion seventy-one million seven hundred seventy-four thousand nine hundred seventy-six dollars ($2,071,774,976).

(B) The total amount of all payment adjustment amounts under this section (exclusive of any payments under this subdivision) applicable to the 1999 federal fiscal year, whether paid or payable, shall be determined. The applicability of payment adjustment amounts to the 1999 federal fiscal year shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(C) The figure determined under subparagraph (B) shall be subtracted from the figure identified under subparagraph (A). If the remainder is a positive figure, supplemental lump-sum payment adjustments shall be made under this subdivision in accordance with paragraph (3). The positive remainder shall be the maximum amount of supplemental lump-sum payment adjustments under this subdivision.

(3) (A) For purposes of supplemental lump-sum payment adjustments under this subdivision, only hospitals that can be categorized into either of the two groups specified in clauses (i) and (ii) below shall be eligible to receive the supplemental payment adjustments, and no hospital may qualify for more than one of the two groups. The following groups of hospitals shall be recognized:

(i) “Public hospitals,” which shall include all eligible hospitals that, as of July 1, 1998, met the definition of a public hospital.

(ii) “Nonpublic hospitals,” which shall include all eligible hospitals that, as of July 1, 1998, met the definition of a nonpublic hospital.

(B) The amount determined to be the maximum amount of supplemental lump-sum payment adjustments under subparagraph (C) of paragraph (2) shall first be allocated between the two groups of hospitals referred to in subparagraph (A) as follows:

(i) “Public hospitals”: 72.78 percent of the maximum amount.

(ii) “Nonpublic hospitals”: 27.22 percent of the maximum amount.

(C) The amount of funds allocated pursuant to subparagraph (B) to each of the particular groups of hospitals referred to in subparagraphs (A) and (B) shall then be distributed as supplemental lump-sum payment adjustments among the eligible hospitals within each particular group as follows:

(i) The department shall identify for each eligible hospital the total amount of payment adjustments under this section (exclusive of any payments under this subdivision) applicable to the 1998–99 payment adjustment year, whether paid or payable. The applicability of the payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(ii) The amount identified for each hospital under clause (i) shall be compared to the OBRA 1993 payment limitation that, in accordance with applicable provisions of the Medi-Cal State Plan, the department has computed for the particular hospital for the 1998–99 payment adjustment year.

(iii) Where the amount computed under clause (i) for the particular hospital is equal to or exceeds the OBRA 1993 payment limitation for the hospital, the hospital shall not receive a supplemental lump-sum payment adjustment. Data regarding hospitals that have reached this limitation shall not be used for purposes of clauses (v) through (viii).

(iv) Where the amount computed under clause (i) for the particular hospital is less than the OBRA 1993 payment limitation for the hospital, the amount computed under clause (i) shall be used for purposes of clauses (v) through (viii). Except, however, with respect to a public hospital that, as of July 1, 1998, was part of a county-operated health system of three or more eligible hospitals licensed to the county, the amount computed under clause (i) plus the amounts paid or payable to the hospital pursuant to subdivision (af) shall be used for purposes of clauses (v) through (vii), while the amount computed under clause (i) only shall be used for purposes of applying the limitation described in clause (viii).

(v) The figures determined under clause (iv) for each hospital in the particular group shall be added together to determine an aggregate total for each group.

(vi) The figures determined for each hospital under clause (iv) shall be divided by the aggregate total determined under clause (v) for the particular group, yielding a percentage figure for each hospital.

(vii) The percentage figure determined for each hospital under clause (vi) shall be applied to the maximum portion of the funds allocated to the particular group under subparagraph (B), to determine the hospital’s pro rata share of the supplemental lump-sum payment adjustments. Except, however, in the case of a nonpublic hospital that, as of July 1, 1998, met the definition of a children’s hospital, the pro rata share otherwise determined shall be multiplied by a factor of 1.09, yielding a modified pro rata share. The pro rata share for the other nonpublic hospitals shall be reduced accordingly, yielding a modified pro rata share, so that the maximum portion of the funds allocated to the nonpublic hospitals group will

not be exceeded. The pro rata share or modified pro rata share, as applicable, for each hospital, as computed under this clause, shall also be used for all purposes relating to descending pro rata distributions under clause (viii).

(viii) In no event shall a hospital receive supplemental lump-sum payment adjustment amounts in excess of the difference between the OBRA 1993 payment limitation for the hospital and the amount computed for the hospital under clause (i). Any supplemental lump-sum payment adjustment amount, or portion thereof, that otherwise would have been payable under this paragraph to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals within the same group.

(D) The department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on or before August 15, 1999.

(4) The department shall implement this subdivision only to the extent consistent with federal medicaid law and the Medi-Cal State Plan, and only to the extent that the department determines that federal financial participation is available.

(ai) Notwithstanding any other provision of law, no payment adjustment amounts shall be payable in connection with the period of July 1 through September 30 of the 1999–2000 payment adjustment year. The payment adjustment program with respect to the period October 1, 1999, through June 30, 2000, shall be structured as set forth below and in subdivision (aj).

(1) (A) The department shall compute the projected total payment adjustment amounts for all eligible hospitals for the 1999–2000 payment adjustment year, by determining for each eligible hospital its total per diem composite amount and multiplying that figure by the maximum number of the hospital's Medi-Cal inpatient paid days determined under paragraph (2) of subdivision (l). For purposes of this subparagraph, these determinations shall be without regard to the OBRA 1993 payment limitations.

(B) The computed amount referred to in subparagraph (A) for each hospital shall be compared to the OBRA 1993 payment limitation that, in accordance with applicable provisions of the Medi-Cal State Plan, the department has computed for the particular hospital.

(C) Where the computed amount referred to in subparagraph (A) for the particular hospital exceeds the OBRA 1993 payment limitation for the hospital, the amount computed under subparagraph (A) shall be reduced to an amount equal to the OBRA 1993 payment limitation for the particular hospital. The amount so reduced shall be used for purposes of subparagraph (E).

(D) Where the computed amount referred to in subparagraph (A) for the particular hospital is equal to or less than the OBRA 1993 payment limitation for the hospital, the computed amount referred to in subparagraph (A) shall be used for purposes of subparagraph (E).

(E) The amounts determined under subparagraphs (C) and (D) for all eligible hospitals shall be added together, yielding an aggregate sum. The aggregate sum shall be the unadjusted projected total payment adjustment program for the period of October 1, 1999, through June 30, 2000, exclusive of any supplemental payment adjustments under subdivision (aj).

(2) The initial maximum size of the payment adjustment program for the period October 1, 1999, through June 30, 2000, shall be set at one billion seven hundred fifty million dollars ($1,750,000,000), exclusive of any supplemental payment adjustments under subdivision (aj).

(3) The department shall increase or decrease the amount determined for each eligible hospital under subparagraph (C) or (D) of paragraph (1), as applicable, by multiplying the amount by an identical percentage, yielding the hospital's tentative adjusted projected total payment adjustment amount for the period October 1, 1999, through June 30, 2000. The identical percentage figure to be used for this purpose shall be that percentage that is derived by dividing the amount set forth in paragraph (2) by the aggregate sum determined under subparagraph (E) of paragraph (1). Except, however, the amount determined for a hospital under subparagraphs (C) or (D) of paragraph (1) shall not be increased so that it would exceed the OBRA 1993 payment limitation for the hospital, and, where that would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis so that the aggregate sum of the tentative adjusted projected total payment adjustment amount for all hospitals equals the amount set forth in paragraph (2).

(4) The tentative adjusted projected total payment adjustment amount computed for each eligible hospital under paragraph (3) shall be further adjusted as follows:

(A) (i) For each eligible hospital that meets the definition of a nonpublic-converted hospital as of July 1, 1999, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic-converted hospital adjustment factor." The applicable adjustment factor shall be that which is necessary to result in an amount for each such hospital equal to the amount used for the particular hospital under subparagraph (E) of paragraph (1).

(ii) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 1999, through June 30, 2000, which shall be paid to the hospital in accordance with paragraph (5).

(B) (i) For each eligible hospital that meets the definition of a converted hospital as of July 1, 1999, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "converted hospital adjustment factor." The applicable adjustment factor shall be that which is necessary to result for each such hospital in an amount equal to: (I) the maximum number of the hospital's annualized Medi-Cal inpatient paid days determined under paragraph (2) of subdivision (l); multiplied by (II) the total per diem composite amount determined for the hospital, the calculation of the per diem composite amount being restricted by a maximum low-income number of 40 percent for the hospital, regardless if the hospital's low-income number would otherwise be higher. In no case shall the product of this calculation exceed the amount used for the particular hospital under subparagraph (E) of paragraph (1).

(ii) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 1999, through June 30, 2000, which shall be paid to the hospital in accordance with paragraph (5).

(C) (i) For each eligible hospital that meets the definition of a nonpublic hospital as of July 1, 1999, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(I) The tentative adjusted projected total payment adjustment amounts determined under paragraph (3) for each nonpublic hospital shall be added together.

(II) The amount identified in paragraph (2) shall be divided by 2.130. The resulting figure shall then be reduced by the sums of the amounts determined for all nonpublic-converted hospitals under clause (ii) of subparagraph (A) and all converted hospitals under clause (ii) of subparagraph (B).

(III) The amount computed under subclause (II) shall be divided by 2, and the result thereof further reduced by the amount of thirty-seven million five hundred thousand dollars ($37,500,000).

(IV) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (III) by the amount derived in subclause (I).

(ii) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 1999, through June 30, 2000, which shall be paid to the hospital in accordance with paragraph (5). Except, however, in no case shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where that would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other nonpublic hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all nonpublic hospitals equals the amount derived in subclause (III) of clause (i).

(D) (i) For each eligible hospital that meets the definition of a public hospital as of July 1, 1999, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "public hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(I) The tentative adjusted projected total payment adjustment amounts determined under paragraph (3) for each public hospital described above shall be added together.

(II) The amount identified in paragraph (2) shall be reduced by the sums of the amounts determined for all nonpublic-converted hospitals under clause (ii) of subparagraph (A) and all converted hospitals under clause (ii) of subparagraph (B), and the sum of the amounts determined for all nonpublic hospitals under clause (ii) of subparagraph (C).

(III) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (II) by the amount derived in subclause (I).

(ii) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 1999, through June 30, 2000, which shall be paid to the hospital in accordance with paragraph (5). Except, however, in no case shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where that would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other public hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all public hospitals equals the amount derived in subclause (II) of clause (i).

(5) (A) The final adjusted projected total payment adjustment amount determined for each eligible hospital for the period October 1, 1999, through June 30, 2000, shall be distributed to the hospital in 8 equal installments, each payable as of the last day of each

month from October 1999 through May 2000. However, no hospital shall receive an installment for any month in which the hospital does not remain in operation for the entire month.

(B) To the extent that any hospital of either of the hospital types described in subparagraph (C) or (D) of paragraph (4) is not entitled to receive an installment that otherwise would be payable but for the hospital's failure to remain in operation through the last day of a particular month, the amount that would have been paid to the hospital shall be redistributed among those hospitals of the same hospital type that remain in operation from October 1, 1999, through June 30, 2000, to be distributed on a pro rata basis. The redistributed amounts shall be payable as of June 30, 2000.

(6) Notwithstanding any other provision of law, with respect to a hospital that meets the definition of a public hospital as of July 1, 1999, the provisions of paragraphs (1) through (5) shall initially be implemented for the period October 1, 1999, through December 31, 1999, without application of the OBRA 1993 payment limitations. As of January 1, 2000, the department shall recalculate all determinations under paragraphs (1) through (5) for the payment adjustment year, taking into account the hospital's OBRA 1993 payment limitation as determined pursuant to federal medicaid law in existence as of January 1, 2000, and adjust, as necessary, the monthly payment installments from January 2000 through May 2000 to take into account any modifications to the recalculated amounts payable for the period October 1999 through December 1999 as may arise from the application of this paragraph.

(7) Notwithstanding any other provision of law, for the entire 1999–2000 payment adjustment year, no eligible hospital shall receive total payment adjustments in excess of the hospital's OBRA 1993 payment limitation as computed by the department pursuant to the Medi-Cal State Plan.

(8) The aggregate sum of the final adjusted projected total payment adjustment amounts computed under paragraph (4) for each eligible hospital for the period October 1, 1999, through June 30, 2000, shall be the maximum size of the payment adjustment program for the entire 1999–2000 payment adjustment year, exclusive of the supplemental payment adjustments provided for under subdivision (aj).

(9) The department shall implement this subdivision only to the extent consistent with federal medicaid law and the Medi-Cal State Plan, and only to the extent that the department determines that federal financial participation is available.

(aj) (1) For the 1999–2000 payment adjustment year, eligible hospitals that meet the requirements of this subdivision and that are in operation as of June 30, 2000, shall be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date, but only if the hospital has remained in operation for the period October 1, 1999, through June 30, 2000.

(2) The availability of supplemental lump-sum payment adjustments under this subdivision shall be determined as follows:

(A) The maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules shall be identified for the 2000 federal fiscal year.

(B) The total amount of all payment adjustment amounts under this section (exclusive of any payments under this subdivision) applicable to the 2000 federal fiscal year, whether paid or payable, shall be determined. The applicability of payment adjustment amounts to the 2000 federal fiscal year shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(C) (i) The figure determined under subparagraph (B) shall be subtracted from the figure identified under subparagraph (A). If the remainder is a positive figure, supplemental lump-sum payment adjustments shall be made under this subdivision in accordance with this subparagraph and paragraph (3).

(ii) The positive remainder derived under clause (i) shall be the maximum amount of supplemental lump-sum payment adjustments under this subdivision where: (I) effective for at least the 1999–2000 payment adjustment year, federal legislation is enacted regarding the application of the OBRA 1993 payment limitation with provisions substantially similar in effect to Section 4721(e) of the federal Balanced Budget Act of 1997 (P.L. 105-33) as that related to the 1997–98 and 1998–99 payment adjustment years; and (II) all necessary amendments to the Medi-Cal State Plan implementing that federal legislation as it relates to the 1999–2000 payment adjustment year have been approved by the federal Health Care Financing Administration.

(iii) If any element set forth in clause (ii) is not satisfied, the maximum amount of supplemental lump-sum payment adjustments under this subdivision shall be the lesser of: (I) the positive remainder derived in clause (i); or (II) one hundred six million dollars ($106,000,000).

(3) (A) For purposes of supplemental lump-sum payment adjustments under this subdivision, only hospitals that can be categorized into either of the two groups specified in clauses (i) and (ii) below shall be eligible to receive the supplemental payment adjustments, and no hospital may qualify for more than one of the two groups. The following groups of hospitals shall be recognized:

(i) “Public hospitals,” which shall include all eligible hospitals that, as of July 1, 1999, met the definition of a public hospital.

(ii) “Nonpublic hospitals,” which shall include all eligible hospitals that, as of July 1, 1999, met the definition of a nonpublic hospital.

(B) The amount determined to be the maximum amount of supplemental lump-sum payment adjustments under subparagraph (C) of paragraph (2) shall first be allocated between the two groups of hospitals referred to in subparagraph (A) as follows:

(i) “Public hospitals”: 71.64 percent of the maximum amount.

(ii) “Nonpublic hospitals”: 28.36 percent of the maximum amount.

(C) The amount of funds allocated pursuant to subparagraph (B) to each of the particular groups of hospitals referred to in subparagraphs (A) and (B) shall then be distributed as supplemental lump-sum payment adjustments among the eligible hospitals within each particular group as follows:

(i) The department shall identify for each eligible hospital the total amount of payment adjustments under this section (exclusive of any payments under this subdivision) applicable to the 1999–2000 payment adjustment year, whether paid or payable. The applicability of the payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(ii) The amount identified for each hospital under clause (i) shall be compared to the OBRA 1993 payment limitation that, in accordance with applicable provisions of the Medi-Cal State Plan, the department has computed for the particular hospital for the 1999–2000 payment adjustment year. For all purposes under this subdivision, calculations of the OBRA 1993 payment limitations for public hospitals shall not be performed prior to January 1, 2000, as referred to in paragraph (6) of subdivision (ai).

(iii) Where the amount computed under clause (i) for the particular hospital is equal to or exceeds the OBRA 1993 payment limitation for the hospital, the hospital shall not receive a supplemental lump-sum payment adjustment. Data regarding hospitals that have reached this limitation shall not be used for purposes of clauses (v) through (viii).

(iv) Where the amount computed under clause (i) for the particular hospital is less than the OBRA 1993 payment limitation for the hospital, the amount computed under clause (i) shall be used for purposes of clauses (v) through (viii).

(v) The figures determined under clause (iv) for each hospital in the particular group shall be added together to determine an aggregate total for each group.

(vi) The figures determined for each hospital under clause (iv) shall be divided by the aggregate total determined under clause (v) for the particular group, yielding a percentage figure for each hospital.

(vii) The percentage figure determined for each hospital under clause (vi) shall be applied to the maximum portion of the funds allocated to the particular group under subparagraph (B), to determine the hospital’s pro rata share of the supplemental lump-sum payment adjustments. Except, however, in the case of a nonpublic hospital that, as of July 1, 1999, met the definition of a children’s hospital, that pro rata share otherwise determined shall be multiplied by a factor of 1.09, yielding a modified pro rata share. The pro rata share for the other nonpublic hospitals shall be reduced accordingly, yielding a modified pro rata share, so that the maximum portion of the funds allocated to the nonpublic hospitals group will not be exceeded. The pro rata share or modified pro rata share, as applicable, for each hospital, as computed under this clause, shall also be used for all purposes relating to descending pro rata distributions under clause (viii).

(viii) In no event shall a hospital receive supplemental lump-sum payment adjustment amounts in excess of the difference between the OBRA 1993 payment limitation for the hospital and the amount computed for the hospital under clause (i). Any supplemental lump-sum payment adjustment amount, or portion thereof, that otherwise would have been payable under this paragraph to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals within the same group.

(D) The department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on or before August 15, 2000.

(4) The department shall implement this subdivision only to the extent consistent with federal medicaid law and the Medi-Cal State Plan, and only to the extent that the department determines that federal financial participation is available.

(ak) Notwithstanding any other provision of law, no payment adjustment amounts shall be payable in connection with the period of July 1 through September 30 of the 2000–01 payment adjustment year. The payment adjustment program with respect to the period October 1, 2000, through June 30, 2001, shall be structured as set forth below and in subdivision (al).

(1) (A) The department shall compute the projected total payment adjustment amounts for all eligible hospitals for the 2000–01 payment adjustment year, by determining for each eligible hospital its total per diem composite amount and multiplying that figure by the maximum number of the hospital's Medi-Cal inpatient paid days determined under paragraph (2) of subdivision (l). For purposes of this subparagraph, these determinations shall be without regard to the OBRA 1993 payment limitations. Notwithstanding the foregoing, with respect to a hospital that, as of July 1, 2000, meets the definition of converted hospital, the amount otherwise determined under this subparagraph shall be reduced as necessary so as not to exceed the total amount of all payment adjustment amounts payable to the hospital under this section for that payment adjustment year in which the hospital was last an eligible hospital meeting the definition of a public hospital.

(B) The computed amount referred to in subparagraph (A) for each hospital shall be compared to the OBRA 1993 payment limitation that, in accordance with applicable provisions of the Medi-Cal State Plan, the department has computed for the particular hospital.

(C) Where the computed amount referred to in subparagraph (A) for the particular hospital exceeds the OBRA 1993 payment limitation for the hospital, the amount computed under subparagraph (A) shall be reduced to an amount equal to the OBRA 1993 payment limitation for the particular hospital. The amount so reduced shall be used for purposes of subparagraph (E).

(D) Where the computed amount referred to in subparagraph (A) for the particular hospital is equal to or less than the OBRA 1993 payment limitation for the hospital, the computed amount referred to in subparagraph (A) shall be used for purposes of subparagraph (E).

(E) The amounts determined under subparagraphs (C) and (D) for all eligible hospitals shall be added together, yielding an aggregate sum. The aggregate sum shall be the unadjusted projected total payment adjustment program for the period of October 1, 2000, through June 30, 2001, exclusive of any supplemental payment adjustments under subdivision (al).

(2) The initial maximum size of the payment adjustment program for the period October 1, 2000, through June 30, 2001, shall be set at one billion seven hundred fifty million dollars ($1,750,000,000), exclusive of any supplemental payment adjustments under subdivision (al).

(3) The department shall increase or decrease the amount determined for each eligible hospital under subparagraph (C) or (D) of paragraph (1), as applicable, by multiplying the amount by an identical percentage, yielding the hospital's tentative adjusted projected total payment adjustment amount for the period October 1, 2000, through June 30, 2001. The identical percentage figure to be used for this purpose shall be that percentage that is derived by dividing the amount set forth in paragraph (2) by the aggregate sum determined under subparagraph (E) of paragraph (1). Notwithstanding the foregoing, however, the amount determined for a hospital under subparagraphs (C) or (D) of paragraph (1) shall not be increased so that it would exceed the OBRA 1993 payment limitation for the hospital, and, where that would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis so that the aggregate sum of the tentative adjusted projected total payment adjustment amount for all hospitals equals the amount set forth in paragraph (2).

(4) The tentative adjusted projected total payment adjustment amount computed for each eligible hospital under paragraph (3) shall be further adjusted as follows:

(A) (i) For each eligible hospital that meets the definition of a nonpublic-converted hospital as of July 1, 2000, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic-converted hospital adjustment factor." The applicable adjustment factor for the particular hospital shall be 0.81; except however, where the hospital also meets the definition of a major teaching hospital as of July 1, 2000, the applicable adjustment factor shall be that which is necessary to result in an amount for the particular hospital equal to forty million dollars ($40,000,000).

(ii) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 2000, through June 30, 2001, which shall be paid to the hospital in accordance with paragraph (5). Notwithstanding the foregoing, however, in no case shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation.

(B) (i) For each eligible hospital that meets the definition of a converted hospital as of July 1, 2000, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "converted hospital adjustment factor," derived as follows:

(I) The maximum OBRA 1993 payment limitation specified by federal law, expressed as a maximum percentage of uncompensated care costs, that is applicable to the hospital for the 2000–01 payment adjustment year shall be subtracted from that maximum percentage of uncompensated care costs that the hospital was subject to as a public hospital during the 1999–2000 payment adjustment year.

(II) The converted hospital adjustment factor shall be that figure derived in subclause (I), expressed as a fraction, subtracted from 1.00.

(ii) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 2000, through June 30, 2001, which shall be paid to the hospital in accordance with paragraph (5). Notwithstanding the foregoing, however, in no case shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation.

(C) (i) For each eligible hospital that meets the definition of a nonpublic hospital as of July 1, 2000, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(I) The tentative adjusted projected total payment adjustment amounts determined under paragraph (3) for each nonpublic hospital shall be added together.

(II) The amount identified in paragraph (2) shall be divided by 2.1527.

(III) The amount derived under subclause (II) shall be reduced by the sum of the amounts determined for all nonpublic-converted hospitals under clause (ii) of subparagraph (A), and the sum of the amounts determined for all converted hospitals under clause (ii) of subparagraph (B) that exceed that amount equal to 31 percent of all payment adjustment amounts payable to each converted hospital under this section for that payment adjustment year in which the hospital was last an eligible hospital meeting the definition of a public hospital.

(IV) The amount computed under subclause (III) shall be divided by 2, and the result thereof further reduced by the amount of thirty-three million five hundred thousand dollars ($33,500,000).

(V) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (IV) by the amount derived in subclause (I).

(ii) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 2000, through June 30, 2001, which shall be paid to the hospital in accordance with paragraph (5). Notwithstanding the foregoing, however, in no case shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where that would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other nonpublic hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all nonpublic hospitals equals the amount derived in subclause (IV) of clause (i).

(D) (i) For each eligible hospital that meets the definition of a public hospital as of July 1, 2000, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "public hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(I) The tentative adjusted projected total payment adjustment amounts determined under paragraph (3) for each public hospital described above shall be added together.

(II) The amount identified in paragraph (2) shall be reduced by the sums of the amounts determined for all nonpublic-converted hospitals under clause (ii) of subparagraph (A) and all converted hospitals under clause (ii) of subparagraph (B), and the sum of the amounts determined for all nonpublic hospitals under clause (ii) of subparagraph (C).

(III) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (II) by the amount derived in subclause (I).

(ii) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 2000, through June 30, 2001, which shall be paid to the hospital in accordance with paragraph (5). Notwithstanding the foregoing, however, in no case shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where that would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other public hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all public hospitals equals the amount derived in subclause (II) of clause (i).

(5) (A) The final adjusted projected total payment adjustment amount determined for each eligible hospital for the period October 1, 2000, through June 30, 2001, shall be distributed to the hospital in 8 equal installments, each payable as of the last day of each month from October 2000 through May 2001. However, no hospital shall receive an installment for any month in which the hospital does not remain in operation for the entire month.

(B) To the extent that any hospital of either of the hospital types described in subparagraph (C) or (D) of paragraph (4) is not entitled to receive an installment that otherwise would be payable but for the hospital's failure to remain in operation through the last day of a particular month, the amount that would have been paid to the hospital shall be redistributed among those hospitals of the same hospital type that remain in operation from October 1, 2000, through June 30, 2001, to be distributed on a pro rata basis. The redistributed amounts shall be payable as of June 30, 2001.

(6) If, effective for the 2001 federal fiscal year, federal legislation is enacted that amends Section 1396r-4(f) of Title 42 of the United States Code to increase the amount for California for that fiscal year above the amount that would have otherwise been identified pursuant to that section as in existence on January 1, 2000, the department shall implement the provisions of paragraphs (1) through (5) as modified below.

(A) The department shall determine the maximum state disproportionate share hospital allotment for California for the 2001 federal fiscal year under the provisions of applicable federal medicaid rules.

(B) The department shall determine the maximum state disproportionate share hospital allotment for California for the 2001 federal fiscal year that would have resulted had Section 1396r-4(f) of Title 42 of the United States Code not been amended from the version of that section as in existence on January 1, 2000.

(C) The amount determined under subparagraph (B) shall be subtracted from the amount determined under subparagraph (A).

(D) For purposes of the calculations set forth in paragraph (3) regarding each hospital's tentative adjusted projected total payment adjustment amount, the initial amount as set forth in paragraph (2) shall, in each instance prior to its application in those calculations, be increased by the amount derived in subparagraph (C).

(E) The difference derived in subparagraph (C) shall be divided by the amount determined in subparagraph (B). The resulting fraction shall be multiplied by 1.145, and the result thereof added to 1.00, yielding a factor for purposes of modifying the determination of the applicable nonpublic hospital adjustment factor pursuant to subparagraph (F).

(F) The amount determined under subclause (II) of clause (i) of subparagraph (C) of paragraph (4) shall be multiplied by the factor derived in subparagraph (E). The resulting amount shall be used for purposes of the calculations set forth in subclause (III) of clause (i) of subparagraph (C) of paragraph (4).

(G) For purposes of the calculations set forth in clause (i) of subparagraph (D) of paragraph (4) regarding the determination of the applicable public hospital adjustment factor, the initial amount as set forth in paragraph (2) shall, in each instance prior to its application in those calculations, be increased by the amount derived in subparagraph (C).

(7) Notwithstanding any other provision of law, for the entire 2000–01 payment adjustment year, no eligible hospital shall receive total payment adjustments in excess of the hospital's OBRA 1993 payment limitation as computed by the department pursuant to the Medi-Cal State Plan.

(8) The aggregate sum of the final adjusted projected total payment adjustment amounts computed under paragraph (4) for each eligible hospital for the period October 1, 2000, through June 30, 2001, shall be the maximum size of the payment adjustment program for the entire 2000–01 payment adjustment year, exclusive of the supplemental payment adjustments provided for under subdivision (al).

(9) The department shall implement this subdivision only to the extent consistent with federal medicaid law and the Medi-Cal State Plan, and only to the extent that the department determines that federal financial participation is available.

(al) (1) For the 2000–01 payment adjustment year, eligible hospitals that meet the requirements of this subdivision and that are in operation as of June 30, 2001, shall be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date, but only if the hospital has remained in operation for the period October 1, 2000, through June 30, 2001.

(2) The availability of supplemental lump-sum payment adjustments under this subdivision shall be determined as follows:

(A) The maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules shall be identified for the 2001 federal fiscal year.

(B) The total amount of all payment adjustment amounts under this section (exclusive of any payments under this subdivision) applicable to the 2001 federal fiscal year, whether paid or payable, shall be determined. The applicability of payment adjustment amounts to the 2001 federal fiscal year shall be determined in accordance with federal medicaid rules.

(C) The figure determined under subparagraph (B) shall be subtracted from the figure identified under subparagraph (A). If the remainder is a positive figure, supplemental lump-sum payment adjustments shall be made under this subdivision in

accordance with this subparagraph and paragraph (3). The positive remainder so derived shall be the maximum amount of supplemental lump-sum payment adjustments under this subdivision.

(3) (A) For purposes of supplemental lump-sum payment adjustments under this subdivision, only hospitals that can be categorized into either of the two groups specified in clauses (i) and (ii) below shall be eligible to receive the supplemental payment adjustments, and no hospital may qualify for more than one of the two groups. The following groups of hospitals shall be recognized:

(i) “Public hospitals,” which shall include all eligible hospitals that, as of July 1, 2000, met the definition of a public hospital.

(ii) “Nonpublic hospitals,” which shall include all eligible hospitals that, as of July 1, 2000, met the definition of a nonpublic hospital.

(B) The amount determined to be the maximum amount of supplemental lump-sum payment adjustments under subparagraph (C) of paragraph (2) shall first be allocated between the two groups of hospitals referred to in subparagraph (A) as follows:

(i) “Public hospitals”: 75 percent of the maximum amount.

(ii) “Nonpublic hospitals”: 25 percent of the maximum amount.

(C) The amount of funds allocated pursuant to subparagraph (B) to each of the particular groups of hospitals referred to in subparagraphs (A) and (B) shall then be distributed as supplemental lump-sum payment adjustments among the eligible hospitals within each particular group as follows:

(i) The department shall identify for each eligible hospital the total amount of payment adjustments under this section, exclusive of any payments under this subdivision, applicable to the 2000–01 payment adjustment year, whether paid or payable. The applicability of the payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules.

(ii) The amount identified for each hospital under clause (i) shall be compared to the OBRA 1993 payment limitation that, in accordance with applicable provisions of the Medi-Cal State Plan, the department has computed for the particular hospital for the 2000–01 payment adjustment year.

(iii) Where the amount computed under clause (i) for the particular hospital is equal to or exceeds the OBRA 1993 payment limitation for the hospital, the hospital shall not receive a supplemental lump-sum payment adjustment. Data regarding hospitals that have reached this limitation shall not be used for purposes of clauses (v) through (viii).

(iv) Where the amount computed under clause (i) for the particular hospital is less than the OBRA 1993 payment limitation for the hospital, the amount computed under clause (i) shall be used for purposes of clauses (v) through (viii).

(v) The figures determined under clause (iv) for each hospital in the particular group shall be added together to determine an aggregate total for each group.

(vi) The figures determined for each hospital under clause (iv) shall be divided by the aggregate total determined under clause (v) for the particular group, yielding a percentage figure for each hospital.

(vii) The percentage figure determined for each hospital under clause (vi) shall be applied to the maximum portion of the funds allocated to the particular group under subparagraph (B), to determine the hospital’s pro rata share of the supplemental lump-sum payment adjustments. Notwithstanding the foregoing, however, in the case of a nonpublic hospital that, as of July 1, 2000, met the definition of a children’s hospital, that pro rata share otherwise determined shall be multiplied by a factor of 1.69, yielding a modified pro rata share to be applied only with respect to the first one million dollars ($1,000,000) of the funds allocated pursuant to clause (ii) of subparagraph (B), and, with respect to the remainder of the funds so allocated, the pro rata share otherwise determined shall be multiplied by a factor of 1.09, yielding a modified pro rata share to be applied. The pro rata share for the other nonpublic hospitals shall be reduced accordingly, yielding a modified pro rata share, so that the maximum portion of the funds allocated to the nonpublic hospitals group will not be exceeded. The pro rata share or modified pro rata share, as applicable, for each hospital, as computed under this clause, shall also be used for all purposes relating to descending pro rata distributions under clause (viii).

(viii) In no event shall a hospital receive supplemental lump-sum payment adjustment amounts in excess of the difference between the OBRA 1993 payment limitation for the hospital and the amount computed for the hospital under clause (i). Any supplemental lump-sum payment adjustment amount, or portion thereof, that otherwise would have been payable under this paragraph to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals within the same group.

(D) The department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on June 30, 2001.

(4) The department shall implement this subdivision only to the extent consistent with federal medicaid law and the Medi-Cal State Plan, and only to the extent that the department determines that federal financial participation is available.

(am) Notwithstanding any other provision of law, no payment adjustment amounts shall be payable in connection with the period of July 1 through September 30 of the 2001–02 payment adjustment year and subsequent payment adjustment years. The payment adjustment program with respect to the period October 1 through June 30 of the 2001–02 payment adjustment year and subsequent payment adjustment years shall be structured as set forth below and in subdivision (an).

(1) (A) The department shall compute the projected total payment adjustment amounts for all eligible hospitals for the applicable payment adjustment year, by determining for each eligible hospital its total per diem composite amount and multiplying that figure by the maximum number of the hospital's Medi-Cal inpatient paid days determined under paragraph (2) of subdivision (l). For purposes of this subparagraph, these determinations shall be without regard to the OBRA 1993 payment limitations. Notwithstanding the foregoing, with respect to a hospital that, as of July 1 of the applicable payment adjustment year, meets the definition of a converted hospital, the amount otherwise determined under this subparagraph shall be reduced as necessary so as not to exceed the total amount of all payment adjustment amounts payable to the hospital under this section for that payment adjustment year in which the hospital was last an eligible hospital meeting the definition of a public hospital.

(B) The computed amount referred to in subparagraph (A) for each hospital shall be compared to the OBRA 1993 payment limitation that, in accordance with applicable provisions of the Medi-Cal State Plan, the department has computed for the particular hospital.

(C) Where the computed amount referred to in subparagraph (A) for the particular hospital exceeds the OBRA 1993 payment limitation for the hospital, the amount computed under subparagraph (A) shall be reduced to an amount equal to the OBRA 1993 payment limitation for the particular hospital. The amount so reduced shall be used for purposes of subparagraph (E).

(D) Where the computed amount referred to in subparagraph (A) for the particular hospital is equal to or less than the OBRA 1993 payment limitation for the hospital, the computed amount referred to in subparagraph (A) shall be used for purposes of subparagraph (E).

(E) The amounts determined under subparagraphs (C) and (D) for all eligible hospitals shall be added together, yielding an aggregate sum. The aggregate sum shall be the unadjusted projected total payment adjustment program for the period of October 1 through June 30 of the applicable payment adjustment year, exclusive of any supplemental payment adjustments under subdivision (an).

(2) (A) The department shall determine the maximum state disproportionate share hospital allotment for California for the applicable federal fiscal year under the provisions of applicable federal medicaid rules.

(B) The initial maximum size of the payment adjustment program for the period October 1 through June 30 of each applicable payment adjustment year, shall be set at one billion six hundred million dollars ($1,600,000,000), exclusive of any supplemental payment adjustments under subdivision (an).

(3) The department shall increase or decrease the amount determined for each eligible hospital under subparagraph (C) or (D) of paragraph (1), as applicable, by multiplying the amount by an identical percentage, yielding the hospital's tentative adjusted projected total payment adjustment amount for the period October 1 through June 30 of the applicable payment adjustment year. The identical percentage figure to be used for this purpose shall be that percentage that is derived by dividing the amount set forth in subparagraph (B) of paragraph (2) by the aggregate sum determined under subparagraph (E) of paragraph (1). Notwithstanding the foregoing, however, the amount determined for a hospital under subparagraph (C) or (D) of paragraph (1) shall not be increased so that it would exceed the OBRA 1993 payment limitation for the hospital, and, where that would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis so that the aggregate sum of the tentative adjusted projected total payment adjustment amount for all hospitals equals the amount set forth in subparagraph (B) of paragraph (2).

(4) The tentative adjusted projected total payment adjustment amount computed for each eligible hospital under paragraph (3) shall be further adjusted as follows:

(A) (i) For each eligible hospital that meets the definition of a nonpublic-converted hospital as of July 1 of the applicable payment adjustment year, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic-converted hospital adjustment factor." The applicable adjustment factor for the particular hospital shall be 0.835; except, however, where the hospital also meets the definition of a major teaching hospital as of July 1 of the applicable

payment adjustment year, the applicable adjustment factor shall be the lesser of 1.00, or that which is necessary to result in an amount for the particular hospital equal to thirty-five million eight hundred thousand dollars ($35,800,000).

(ii) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1 through June 30 of the applicable payment adjustment year, which shall be paid to the hospital in accordance with paragraph (5). Notwithstanding the foregoing, however, in no case shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation.

(B) (i) For each eligible hospital that meets the definition of a converted hospital as of July 1 of the applicable payment adjustment year, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "converted hospital adjustment factor," derived as follows:

(I) The maximum OBRA 1993 payment limitation specified by federal law, expressed as a maximum percentage of uncompensated care costs, that is applicable to the hospital for the particular payment adjustment year shall be subtracted from that maximum percentage of uncompensated care costs that the hospital was subject to as a public hospital during the 1999–2000 payment adjustment year.

(II) The converted hospital adjustment factor shall be that figure derived in subclause (I), expressed as a fraction, subtracted from 1.00.

(ii) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1 through June 30 of the applicable payment adjustment year, which shall be paid to the hospital in accordance with paragraph (5). Notwithstanding the foregoing, however, in no case shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation.

(C) (i) For each eligible hospital that meets the definition of a nonpublic hospital as of July 1 of the applicable payment adjustment year, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(I) The tentative adjusted projected total payment adjustment amounts determined under paragraph (3) for each nonpublic hospital shall be added together.

(II) The amount identified in subparagraph (B) of paragraph (2) shall be divided by 2.237.

(III) The resulting figure in subclause (II) shall be increased by an amount equal to the product of the medical assistance increment multiplied by the maximum amount identified in subparagraph (A) of paragraph (2).

(IV) The amount derived under subclause (III) shall be reduced by the sum of the amounts determined for all nonpublic-converted hospitals under clause (ii) of subparagraph (A), and the sum of the amounts determined for all converted hospitals under clause (ii) of subparagraph (B) that exceed that amount equal to 31 percent of all payment adjustment amounts payable to each converted hospital under this section for that payment adjustment year in which the hospital was last an eligible hospital meeting the definition of a public hospital.

(V) The amount computed under subclause (IV) shall be divided by 2, and the result thereof further reduced by the amount of thirty-three million five hundred thousand dollars ($33,500,000).

(VI) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (V) by the amount derived in subclause (I).

(ii) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1 through June 30 of the applicable payment adjustment year, which shall be paid to the hospital in accordance with paragraph (5). Notwithstanding the foregoing, however, in no case shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and where that would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other nonpublic hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all nonpublic hospitals equals the amount derived in subclause (V) of clause (i).

(D) (i) For each eligible hospital that meets the definition of a public hospital as of July 1 of the applicable payment adjustment year, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "public hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(I) The tentative adjusted projected total payment adjustment amounts determined under paragraph (3) for each public hospital described above shall be added together.

(II) The amount identified in subparagraph (B) of paragraph (2) shall be reduced by the sums of the amounts determined for all nonpublic-converted hospitals under clause (ii) of subparagraph (A) and all converted hospitals under clause (ii) of subparagraph (B) and the sum of the amounts determined for all nonpublic hospitals under clause (ii) of subparagraph (C).

(III) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (II) by the amount derived in subclause (I).

(ii) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1 through June 30 of the applicable payment adjustment year, which shall be paid to the hospital in accordance with paragraph (5). Notwithstanding the foregoing, however, in no case shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where that would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other public hospitals that have not reached their OBRA 1993 payment limitation on a pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all public hospitals equals the amount derived in subclause (II) of clause (i).

(5) (A) The final adjusted projected total payment adjustment amount determined for each eligible hospital for the period October 1 through June 30 of the applicable payment adjustment year shall be distributed to the hospital in 8 equal installments, each payable as of the last day of each month from October through May of the applicable payment adjustment year. However, no hospital shall receive an installment for any month in which the hospital does not remain in operation for the entire month.

(B) To the extent that any hospital of either of the hospital types described in subparagraph (C) or (D) of paragraph (4) is not entitled to receive an installment that otherwise would be payable but for the hospital's failure to remain in operation through the last day of a particular month, the amount that would have been paid to the hospital shall be redistributed among those hospitals of the same hospital type that remain in operation from October 1 through June 30 of the applicable payment adjustment year, to be distributed on a pro rata basis. The redistributed amounts shall be payable as of June 30 of the applicable payment adjustment year.

(6) If, with respect to the 2001–02 payment adjustment year or any subsequent payment adjustment year, the amount identified for California for the applicable federal fiscal year pursuant to Section 1396r-4(f) of Title 42 of the United States Code exceeds the amount of eight hundred seventy-seven million dollars ($877,000,000), the department shall implement the provisions of paragraphs (1) through (5) with respect to the applicable payment adjustment year as modified below.

(A) The department shall determine the maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules.

(B) The department shall calculate the maximum state disproportionate share hospital allotment for California, by substituting in the calculation the amount of eight hundred seventy-seven million dollars ($877,000,000), as though that amount was identified for California for the applicable federal fiscal year pursuant to Section 1396r-4(f) of Title 42 of the United States Code.

(C) The amount determined under subparagraph (B) shall be subtracted from the amount determined under subparagraph (A).

(D) For purposes of the calculations set forth in paragraph (3) regarding each hospital's tentative adjusted projected total payment adjustment amount, the initial amount as set forth in subparagraph (B) of paragraph (2) shall, in each instance prior to its application in those calculations, be increased by the amount derived in subparagraph (C).

(E) The difference derived in subparagraph (C) shall be divided by the amount determined in subparagraph (B).

(F) For purposes of the determination made under clause (i) of subparagraph (A) of paragraph (4) regarding nonpublic-converted hospitals that also meet the definition of a major teaching hospital, the amount of thirty-five million eight hundred thousand dollars ($35,800,000) as specified therein shall be multiplied by a number equal to the sum of the fraction derived in subparagraph (E) plus the number 1.00.

(G) The fraction derived in subparagraph (E) shall be multiplied by 1.226, and the result thereof added to 1.00, yielding a factor for purposes of modifying the determination of the applicable nonpublic hospital adjustment factor pursuant to subparagraphs (H) and (I).

(H) The amount determined under subclause (II) of clause (i) of subparagraph (C) of paragraph (4) shall be multiplied by the factor derived in subparagraph (G), and the resulting amount shall be used for purposes of the calculations set forth in subclause (III) of clause (i) of subparagraph (C) of paragraph (4), as modified by subparagraph (I) below.

(I) For purposes of the calculations in subclause (III) of clause (i) of subparagraph (C) of paragraph (4), the recalculated maximum amount derived in subparagraph (B) shall be used in lieu of the maximum amount determined in subparagraph (A)

of paragraph (2).

(J) For purposes of the calculations set forth in subclause (II) of clause (i) of subparagraph (D) of paragraph (4) regarding the determination of the applicable public hospital adjustment factor, the initial amount as set forth in subparagraph (B) of paragraph (2) shall, in each instance prior to its application in those calculations, be increased by the amount derived in subparagraph (C).

(7) Notwithstanding any other provision of law, for the entire payment adjustment year, no eligible hospital shall receive total payment adjustments in excess of the hospital's OBRA 1993 payment limitation as computed by the department pursuant to the Medi-Cal State Plan.

(8) The aggregate sum of the final adjusted projected total payment adjustment amounts computed under paragraph (4) for each eligible hospital for the period October 1 through June 30 of the applicable payment adjustment year, shall be the maximum size of the payment adjustment program for the entire payment adjustment year, exclusive of the supplemental payment adjustments provided for under subdivision (an).

(9) The department shall implement this subdivision only to the extent consistent with federal medicaid law and the Medi-Cal State Plan, and only to the extent that the department determines that federal financial participation is available.

(an) (1) For the 2001–02 payment adjustment year and subsequent payment adjustment years, eligible hospitals that meet the requirements of this subdivision and that are in operation as of June 30 of the applicable payment adjustment year, shall be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date, but only if the hospital has remained in operation for the period October 1 through June 30 of the applicable payment adjustment year.

(2) The availability of supplemental lump-sum payment adjustments under this subdivision shall be determined as follows:

(A) The maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules shall be identified for the applicable federal fiscal year.

(B) The total amount of all payment adjustment amounts under this section, exclusive of any payments under this subdivision, applicable to the applicable federal fiscal year, whether paid or payable, shall be determined. The applicability of payment adjustment amounts to the 2000 federal fiscal year shall be determined in accordance with federal medicaid rules.

(C) The figure determined under subparagraph (B) shall be subtracted from the figure identified under subparagraph (A). If the remainder is a positive figure, supplemental lump-sum payment adjustments shall be made under this subdivision in accordance with this subparagraph and paragraph (3). The positive remainder so derived shall be the maximum amount of supplemental lump-sum payment adjustments under this subdivision for the applicable payment adjustment year.

(3) (A) For purposes of supplemental lump-sum payment adjustments under this subdivision, only hospitals that can be categorized into either of the two groups specified in clauses (i) and (ii) below shall be eligible to receive the supplemental payment adjustments, and no hospital may qualify for more than one of the two groups. The following groups of hospitals shall be recognized:

(i) "Public hospitals," which shall include all eligible hospitals that, as of July 1 of the applicable payment adjustment year, met the definition of a public hospital.

(ii) "Nonpublic hospitals," which shall include all eligible hospitals that, as of July 1 of the applicable payment adjustment year, met the definition of a nonpublic hospital.

(B) The amount determined to be the maximum amount of supplemental lump-sum payment adjustments under subparagraph (C) of paragraph (2) shall first be allocated between the two groups of hospitals referred to in subparagraph (A) as follows:

(i) "Public hospitals": 75 percent of the maximum amount.

(ii) "Nonpublic hospitals": 25 percent of the maximum amount.

(C) The amount of funds allocated pursuant to subparagraph (B) to each of the particular groups of hospitals referred to in subparagraphs (A) and (B) shall then be distributed as supplemental lump-sum payment adjustments among the eligible hospitals within each particular group as follows:

(i) The department shall identify for each eligible hospital the total amount of payment adjustments under this section, exclusive of any payments under this subdivision, applicable to the payment adjustment year, whether paid or payable. The applicability of the payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules.

(ii) The amount identified for each hospital under clause (i) shall be compared to the OBRA 1993 payment limitation that, in accordance with applicable provisions of the Medi-Cal State Plan, the department has computed for the particular hospital for the applicable payment adjustment year.

(iii) Where the amount computed under clause (i) for the particular hospital is equal to or exceeds the OBRA 1993 payment limitation for the hospital, the hospital shall not receive a supplemental lump-sum payment adjustment. Data regarding hospitals that have reached this limitation shall not be used for purposes of clauses (v) through (viii).

(iv) Where the amount computed under clause (i) for the particular hospital is less than the OBRA 1993 payment limitation for the hospital, the amount computed under clause (i) shall be used for purposes of clauses (v) through (viii).

(v) The figures determined under clause (iv) for each hospital in the particular group shall be added together to determine an aggregate total for each group.

(vi) The figures determined for each hospital under clause (iv) shall be divided by the aggregate total determined under clause (v) for the particular group, yielding a percentage figure for each hospital.

(vii) The percentage figure determined for each hospital under clause (vi) shall be applied to the maximum portion of the funds allocated to the particular group under subparagraph (B), to determine the hospital's pro rata share of the supplemental lump-sum payment adjustments. Notwithstanding the foregoing, however, in the case of a nonpublic hospital that, as of July 1 of the applicable payment adjustment year, met the definition of a children's hospital, that pro rata share otherwise determined shall be multiplied by a factor of 1.69, yielding a modified pro rata share to be applied only with respect to the first one million dollars ($1,000,000) of the funds allocated pursuant to clause (ii) of subparagraph (B), and, with respect to the remainder of the funds so allocated, the pro rata share otherwise determined shall be multiplied by a factor of 1.09, yielding a modified pro rata share to be applied. The pro rata share for the other nonpublic hospitals shall be reduced accordingly, yielding a modified pro rata share, so that the maximum portion of the funds allocated to the nonpublic hospitals group will not be exceeded. The pro rata share or modified pro rata share, as applicable, for each hospital, as computed under this clause, shall also be used for all purposes relating to descending pro rata distributions under clause (viii).

(viii) In no event shall a hospital receive supplemental lump-sum payment adjustment amounts in excess of the difference between the OBRA 1993 payment limitation for the hospital and the amount computed for the hospital under clause (i). Any supplemental lump-sum payment adjustment amount, or portion thereof, that otherwise would have been payable under this paragraph to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals within the same group.

(D) The department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on June 30 of the applicable payment adjustment year.

(4) The department shall implement this subdivision only to the extent consistent with federal medicaid law and the Medi-Cal State Plan, and only to the extent that the department determines that federal financial participation is available.

(Amended by Stats. 2000, Ch. 48, Sec. 1. Effective June 29, 2000.)

14105.982. (a) (1) The department may adopt emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 1 of Title 2 of the Government Code to specify a process for the preparation and issuance of any or all of the following:

(A) The tentative listing, as that term is used in paragraph (1) of subdivision (f) of Section 14105.98.

(B) The disproportionate share list, as that term is used in paragraphs (1) and (2) of subdivision (f) of Section 14105.98.

(C) Hospital-specific payment determinations pursuant to Section 14105.98.

(2) The process may include, but shall not be limited to, all of the following:

(A) Identification of the particular information to be prepared and issued.

(B) The opportunity for an affected hospital to review its individual hospital data elements.

(C) The timeframes for issuance and review of the items described in paragraph (1).

(D) The circumstances under which updated or corrected data may be accepted and used by the department.

(b) The initial adoption of the emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations, and shall remain in effect for no more than 180 days. Before adopting any emergency regulations pursuant to this section, the department shall seek input from representatives of the hospital industry, including, but not limited to, the California Healthcare Association.

(Added by Stats. 2000, Ch. 48, Sec. 2. Effective June 29, 2000.)

14105.985. (a) (1) Disproportionate share payment augmentation programs shall be maintained for eligible providers pursuant to Section 14087.5, 14088, 14089, 14093, or 14200.

(2) The department shall make payment augmentations directly to eligible providers.

(b) (1) Inpatient days provided by licensed hospitals to Medi-Cal beneficiaries under contract to managed care contractors who are contracting with the department under Section 14087.5, 14088, 14093, 14200, or 14490 shall be included in the department's calculation of annualized Medi-Cal inpatient paid days for use in determining the hospital's medicaid inpatient hospitalization rate under Section 14105.98.

(2) Managed care contractors subject to paragraph (1) shall report inpatient days subject to paragraph (1) to the department.

(c) Revenue for inpatient services provided for Medi-Cal beneficiaries received by hospitals under contract to managed care contractors who are contracting with the department under Section 14087.5, 14088, 14093, 14200, or 14490 shall be included in the percentage rate calculations for the determination of the low-income utilization rate under Section 14105.98.

(Added by Stats. 1992, Ch. 722, Sec. 107.5. Effective September 15, 1992.)

14105.986. (a) Any children's hospital as defined in Section 10727 that holds a consolidated license issued pursuant to subparagraph (C) of paragraph (4) of subdivision (b) of Section 1250.8 of the Health and Safety Code may be evaluated for eligibility for payments under subdivision (c) of Section 14105.98 no earlier than January 1, 2000, using data related to all physical plants appearing on the consolidated license. For purposes of calculating the appropriate amount of the payment adjustment under subdivision (l) of Section 14105.98 for these children's hospitals, the department shall use data relating only to the children's hospital or any other physical plant appearing on the consolidated license which is not more than 15 miles from the children's hospital and shall exclude data relating to any physical plant added to the consolidated license pursuant to subparagraph (C) of paragraph (4) of subdivision (b) of Section 1250.8 of the Health and Safety Code.

(b) The department shall not implement this section unless all of the following occur:

(1) Federal financial participation is available.

(2) The federal Health Care Financing Administration approves a state plan amendment to implement this section.

(3) All data necessary to complete the evaluations and calculations required by subdivision (a) are provided to the department from the same sources described in Section 14105.98 and in the approved state plan existing on July 1, 1998. In no event shall data directly provided by a children's hospital be utilized for these evaluations and calculations.

(Added by Stats. 1998, Ch. 982, Sec. 2. Effective January 1, 1999.)

14105.99. (a) For purposes of this section, "Attachment 4.19-A" means the Medi-Cal payment adjustment system for acute inpatient hospital services set forth in Attachment 4.19-A of the Medi-Cal State Plan which became effective on or about July 1, 1990.

(b) (1) It is the intent of the Legislature that the annual appropriation for, and distribution of, payments pursuant to Attachment 4.19-A shall be reduced as a result of the payment adjustment program set forth in Section 14105.98, but only when federal approval, as described in paragraph (2) of subdivision (d) of Section 14105.98, is gained for that payment adjustment program.

(2) When the payment adjustment program set forth in Section 14105.98 gains federal approval, Attachment 4.19-A shall become inoperative and any appropriated amount for Attachment 4.19-A that is unexpended shall revert to the Health Care Deposit Fund for use in support of the Medi-Cal program.

(Amended by Stats. 1991, Ch. 1046, Sec. 4. Effective October 14, 1991.)

14106. If a Medi-Cal provider negotiates a rate of payment for inpatient, outpatient, or ancillary services with a prepaid health plan under contract with the department pursuant to Chapter 8 (commencing with Section 14200) of this part which is lower than or equal

to the lesser of reasonable costs, customary charges, or the schedule of maximum allowances, the rate shall not affect the director's determination of reasonable costs, customary charges, or schedule of maximum allowances.

(Amended by Stats. 1982, Ch. 328, Sec. 27. Effective June 30, 1982.)

14106.2. Insofar as permitted by federal law, for purposes of determining the reasonable costs of any service reimbursable under the provisions of this chapter, or determining prospective per capita rates of payment or cost-basis reimbursement under Chapter 8 (commencing with Section 14200) or Chapter 8.7 (commencing with Section 14520), any gifts, grants, or endowments received by the provider of such services or prepaid health plan, and any income earned by the investment or deposit thereof, shall not be deducted from the operating costs of such provider or plan.

It is the intent of the Legislature, in enacting this section, to encourage philanthropic support of health facilities and other providers of services to Medi-Cal beneficiaries.

(Added by Stats. 1980, Ch. 887, Sec. 2.)

14106.6. The director shall establish and update annually a rate schedule of reimbursement for paramedic services which provides reimbursement based upon reasonable cost standards of the department.

Notwithstanding any other provision of law, and to the extent federal financial participation is available, any city, county, or special district providing paramedic services as set forth in subdivision (s) of Section 14132, shall reimburse the Health Care Deposit Fund for the state costs of paying such medical claims. Funds allocated to the county from the County Health Services Fund pursuant to Part 4.5 (commencing with Section 16700) of Division 9 of the Welfare and Institutions Code may be utilized by the county or city to make such reimbursement. Nothing in this chapter shall be construed to require a city, county, or special district providing, or contracting for, paramedic services as part of a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code, to seek Medi-Cal reimbursement for services rendered to eligible Medi-Cal recipients.

This section shall be in effect only to the extent federal financial participation is available.

(Added by Stats. 1980, Ch. 1322, Sec. 2. Effective September 30, 1980.)

14107. (a) Any person, including any applicant or provider as defined in Section 14043.1, or billing agent, as defined in Section 14040.1, who engages in any of the activities identified in subdivision (b) is punishable by imprisonment as set forth in subdivisions (c) , (d), and (e), by a fine not exceeding three times the amount of the fraud or improper reimbursement or value of the scheme or artifice, or by both this fine and imprisonment.

(b) The following activities are subject to subdivision (a):

(1) A person, with intent to defraud, presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise under this chapter or Chapter 8 (commencing with Section 14200).

(2) A person knowingly submits false information for the purpose of obtaining greater compensation than that to which he or she is legally entitled for furnishing services or merchandise under this chapter or Chapter 8 (commencing with Section 14200).

(3) A person knowingly submits false information for the purpose of obtaining authorization for furnishing services or merchandise under this chapter or Chapter 8 (commencing with Section 14200).

(4) A person knowingly and willfully executes, or attempts to execute, a scheme or artifice to do either of the following:

(A) Defraud the Medi-Cal program or any other health care program administered by the department or its agents or contractors.

(B) Obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, the Medi-Cal program or any other health care program administered by the department or its agents or contractors, in connection with the delivery of or payment for health care benefits, services, goods, supplies, or merchandise.

(c) A violation of subdivision (a) is punishable by imprisonment in a county jail, or in the state prison for two, three, or five years.

(d) If the execution of a scheme or artifice to defraud as defined in paragraph (4) of subdivision (b) is committed under circumstances likely to cause or that do cause two or more persons great bodily injury, as defined in Section 12022.7 of the Penal Code, or serious bodily injury, as defined in paragraph (4) of subdivision (f) of Section 243 of the Penal Code, a term of four years, in addition and consecutive to the term of imprisonment imposed in subdivision (c), shall be imposed for each person who suffers great bodily injury or serious bodily injury.

The additional terms provided in this subdivision shall not be imposed unless the facts showing the circumstances that were likely to cause or that did cause great bodily injury or serious bodily injury to two or more persons are charged in the accusatory pleading and admitted or found to be true by the trier of fact.

(e) If the execution of a scheme or artifice to defraud, as defined in paragraph (4) of subdivision (b) results in a death which constitutes a second degree murder, as defined in Section 189 of the Penal Code, the offense shall be punishable, upon conviction, pursuant to subdivision (a) of Section 190 of the Penal Code.

(f) Any person, including an applicant or provider as defined in Section 14043.1, or billing agent, as defined in Section 14040.1, who has engaged in any of the activities subject to fine or imprisonment under this section, shall be subject to the asset forfeiture provisions for criminal profiteering.

(g) Pursuant to Section 923 of the Penal Code, the Attorney General may convene a grand jury to investigate and indict for any of the activities subject to fine, imprisonment, or asset forfeiture under this section.

(h) The enforcement remedies provided under this section are not exclusive and shall not preclude the use of any other criminal or civil remedy. However, an act or omission punishable in different ways by this section and other provisions of law shall not be punished under more than one provision, but the penalty to be imposed shall be determined as set forth in Section 654 of the Penal Code.

(Amended by Stats. 2000, Ch. 322, Sec. 27. Effective January 1, 2001.)

14107.1. Any provider on whose behalf improper claims are submitted for authorization or payment under this chapter may be required to submit all such claims over the provider's own signature for whatever time period the department determines appropriate.

(Added by Stats. 1976, Ch. 965.)

14107.11. (a) Upon receipt of a credible allegation of fraud as defined in subdivision (d) and for which an investigation is pending under the Medi-Cal program against a provider as defined in Section 14043.1, or the commencement of a suspension under Section 14123, the provider shall be temporarily placed under payment suspension, unless it is determined there is a good cause exception, as defined in subdivision (g), not to suspend the payments or to suspend them only in part, and the department may do any of the following:

(1) Collect any Medi-Cal program overpayment identified through an audit or examination, or any portion thereof from any provider. Notwithstanding Section 100171 of the Health and Safety Code, a provider may appeal the collection of overpayments under this section pursuant to procedures established in Article 5.3 (commencing with Section 14170). Overpayments collected under this section shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings if the findings are against the provider. Overpayments will be returned to a provider with interest if findings are in favor of the provider.

(2) Give notification of the payment suspension for any goods, services, supplies, or merchandise, or any portion thereof. The department shall notify the provider within five days of any payment suspension under this section. The department may delay notification to the provider by 30 days if it is requested to do so in writing by any law enforcement agency, which may be renewed in writing up to two times and in no event may exceed 90 days. The notice to the provider shall do all of the following:

(A) State that the payment suspension is being imposed in accordance with this subdivision and that the payment suspension is for a temporary period and will not continue if it is determined that no credible allegation of fraud remains against the provider or when legal proceedings relating to the allegation are complete.

(B) Cite the circumstances under which the payment suspension will be terminated.

(C) Specify, when appropriate, the type or types of claims for which payment is being suspended.

(D) Inform the provider of the right to submit written evidence that would be admissible under the administrative adjudication provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, for consideration by the department.

(b) Notwithstanding Section 100171 of the Health and Safety Code, a provider may appeal a payment suspension pursuant to Section 14043.65. Payments suspended under this section shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings.

(c) A payment suspension may be lifted when a resolution of an investigation for fraud or abuse occurs as defined in subdivision (p) of Section 14043.1.

(d) An allegation of fraud shall be considered credible if it exhibits indicia of reliability as recognized by state or federal courts or by other law sufficient to meet the constitutional prerequisite to a law enforcement search or seizure of comparable business assets. The department shall carefully consider the allegations, facts, data, and evidence with the same thoroughness as a state or federal court would use in approving a warrant for a search or seizure.

(e) (1) On a quarterly basis, the Department of Justice, and any other law enforcement agency that has accepted referrals for investigation from the department, shall submit a report to the department listing each referral and stating whether the referral continues to be under investigation and whether it involves a credible allegation of fraud. If the Department of Justice or a law enforcement agency fails to submit a report under this subdivision, the department may request the report from the Department of Justice or the law enforcement agency on no more than a quarterly basis. The Department of Justice or the law enforcement agency, as applicable, shall provide the report within 30 days of the request.

(2) Notwithstanding paragraph (1), no quarterly report shall be required from a law enforcement agency, unless that law enforcement agency has either received a referral from the department or reported an open case to the department and has not yet reported rejection or closure of that referral or open case.

(f) A report, request, or notification submitted under this section shall be exempt from the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code). These records may be disclosed to law enforcement agencies or other government entities that execute an agreement conforming to paragraph (5) of subdivision (c) of Section 7921.505 of the Government Code.

(g) For purposes of this section, all of the following apply:

(1) “Provider” has the same meaning as that term is defined in Section 14043.1.

(2) “Good cause exception” means a reason determined by the department that falls under Section 455.23(e) or (f) of Title 42 of the Code of Federal Regulations.

(3) “Law enforcement agency” includes any agency employing peace officers, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code.

(h) The director may, in consultation with interested parties, adopt regulations to implement this section as necessary. These regulations may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) and the adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The director shall transmit these emergency regulations directly to the Secretary of State for filing and the regulations shall become effective immediately upon filing. Upon completion of the formal regulation adoption process and prior to the expiration of the 120-day duration period of emergency regulations, the director shall transmit directly to the Secretary of State the adopted regulations, the rulemaking file, and the certification of compliance as required by subdivision (e) of Section 11346.1 of the Government Code.

(Amended by Stats. 2021, Ch. 615, Sec. 452. (AB 474) Effective January 1, 2022. Operative January 1, 2023, pursuant to Sec. 463 of Stats. 2021, Ch. 615.)

14107.115. (a) The Medi-Cal Anti-Fraud Special Deposit Fund is hereby created in the State Treasury.

(b) All outstanding Medi-Cal payments intercepted by the State Controller’s Office at the direction of the department, as a result of a payment suspension imposed on a Medi-Cal provider pursuant to Section 14107.11, shall be deposited into the Medi-Cal Anti-Fraud Special Deposit Fund.

(c) All moneys deposited into the Medi-Cal Anti-Fraud Special Deposit Fund shall be continuously appropriated and allocated in accordance with subdivision (d), but shall remain in the fund until the department lifts the suspension pursuant to subdivision (c) of Section 14107.11.

(d) Upon the lifting of a suspension, the department may return the intercepted Medi-Cal payments to the Medi-Cal provider or may offset the payments against any liabilities or restitution owed by the Medi-Cal provider to the department, including, but not limited to, any liabilities described in paragraph (1) of subdivision (a) of Section 14107.11.

(Added by Stats. 2025, Ch. 21, Sec. 98. (AB 116) Effective June 30, 2025.)

14107.12. (a) The Department of Justice may pay, pursuant to subdivision (d), from funds recovered by the Department of Justice, and only to the extent that the money may be used for this purpose, a reward to any person who furnishes information leading to the recovery of not less than one hundred dollars ($100) of public funds paid for services or goods rendered under the Medi-Cal program due to an act or omission by an individual or entity from which recovery is sought and that is the basis of a conviction of a Medi-Cal provider of services or goods in violation of any statutory criminal prohibition within the jurisdiction of the Division of Medi-Cal Fraud and Elder Abuse pursuant to Section 12528 of the Government Code.

(b) A reward shall not be paid for information under this section unless the information relates to the specific activities of a specific individual or entity, and specifies the time period during which the prohibited activities occurred.

(c) A reward shall not be paid under this section to a federal, state, or local public employee or any individual contracting with a state or local agency for information discovered by the employee during the course of their duties as a federal, state, or local agency employee or pursuant to a contract with that agency.

(d) The amount of a reward under this section shall be determined by the Department of Justice, and shall not exceed 10 percent of the restitution recovered or one thousand dollars ($1,000), whichever is less. A reward shall not be paid until all recoverable funds have been collected from the individual or entity convicted of a violation of statutory prohibitions listed in subdivision (a).

(e) A determination by the Department of Justice of the eligibility of an individual to receive a reward, the amount and appropriateness of a reward under this section, and the timing of the payment of the reward shall be deemed to be final and shall not be subject to administrative appeal or judicial review.

(f) Subject to subdivision (g), payments made under authority of this section shall be disregarded for purposes of determining eligibility for any Medi-Cal program, the CalWORKs program, the CalFresh program, the County Medical Services Program, and any other means-tested public benefit program for which California has authority to establish the rules for determining eligibility.

(g) The income disregard described in subdivision (f) shall not be effective, with respect to an identified program, until the first day of the third month from the month in which any necessary federal approval is obtained. The income disregard provided for in subdivision (f) shall only be implemented to the extent that federal financial participation is obtained.

(Amended by Stats. 2021, Ch. 554, Sec. 11. (SB 823) Effective January 1, 2022.)

14107.13. (a) (1) The department, in conjunction with the Department of Justice, shall identify those areas of the fee-for-service Medi-Cal program that are at greatest risk of fraud or abuse.

(2) In an effort to curb the fraud and abuse, the department shall do one or both of the following:

(A) Request confirmation of service from beneficiaries that services or goods were actually received.

(B) Request confirmation of service from referring and rendering providers that the referring providers actually authorized and the rendering providers actually delivered services or goods underlying claims for reimbursement.

(3) For purposes of this section, “areas” includes, but is not limited to, provider types, services, aid code categories, and geographic areas.

(b) For any fee-for-service benefit, the department shall provide a notice to confirm service to the following:

(1) The recipient of the benefits.

(A) Notices under this paragraph shall be provided no more frequently than once per calendar month and shall detail all benefits reportedly received that are relevant to the suspected fraudulent or abusive activity identified in paragraph (1) of subdivision (a).

(B) Notwithstanding subparagraph (A), a notice shall not be provided to a beneficiary who has not received benefits that are relevant to the suspected fraudulent or abusive activity identified in paragraph (1) of subdivision (a).

(2) The referring and rendering providers of benefits.

(A) Notices under this paragraph shall be provided no more frequently than one per calendar month and shall detail all referrals for benefits and all benefits rendered that are relevant to the suspected fraudulent or abusive activity identified in paragraph (1) of subdivision (a).

(B) Notwithstanding subparagraph (A), a notice shall not be sent to a provider who has made no referrals for benefits nor rendered benefits that are relevant to the suspected fraudulent or abusive activity identified in paragraph (1) of subdivision (a).

(C) Notwithstanding subparagraph (A), a notice shall not be sent to a provider who receives a remittance advice from the state.

(D) Subject to subdivision (e), notices under this paragraph shall be sent to the provider’s mailing address, facsimile number, or electronic mail address, of record with the appropriate licensing agency.

(c) The notices required by this section shall be sent for as long as the department, in conjunction with the Department of Justice, deems it necessary for fraud control purposes.

(d) The notices required by this section shall be adopted jointly by the department and the Department of Justice.

(e) The notices required by this section shall be transmitted electronically, via facsimile, or by mail, whichever is most cost-effective, practicable, and consistent with state and federal privacy laws and regulations.

(f) Notices sent to beneficiaries pursuant to paragraph (1) of subdivision (b) shall comply with the Medi-Cal threshold language requirements that apply to Medi-Cal managed care plans.

(Added by Stats. 2004, Ch. 394, Sec. 1. Effective January 1, 2005.)

14107.2. (a) Any person who solicits or receives any remuneration, including, but not restricted to, any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in valuable consideration of any kind, either:

(1) In return for the referral, or promised referral, of any individual to a person for the furnishing or arranging for the furnishing of any service or merchandise for which payment may be made, in whole or in part, under this chapter or Chapter 8 (commencing with Section 14200); or

(2) In return for the purchasing, leasing, ordering, or arranging for or recommending the purchasing, leasing, or ordering of any goods, facility, service or merchandise for which payment may be made, in whole or in part, under this chapter or Chapter 8 (commencing with Section 14200), is punishable upon a first conviction by imprisonment in a county jail for not longer than one year or imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by a fine not exceeding ten thousand dollars ($10,000), or by both that imprisonment and fine. A second or subsequent conviction shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code.

(b) Any person who offers or pays any remuneration, including, but not restricted to, any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in valuable consideration of any kind, either:

(1) To refer any individual to a person for the furnishing or arranging for furnishing of any service or merchandise for which payment may be made, in whole or in part, under this chapter or Chapter 8 (commencing with Section 14200); or

(2) To purchase, lease, order, or arrange for or recommend the purchasing, leasing, or ordering of any goods, facility, service, or merchandise for which payment may be made, in whole or in part, under this chapter or Chapter 8 (commencing with Section 14200), is punishable upon a first conviction by imprisonment in a county jail for not longer than one year or pursuant to subdivision (h) of Section 1170 of the Penal Code, or by a fine not exceeding ten thousand dollars ($10,000), or by both that imprisonment and fine. A second or subsequent conviction shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code.

(c) Subdivisions (a) and (b) shall not apply to the following:

(1) Any amount paid by an employer to an employee, who has a bona fide employment relationship with that employer, for employment with provision of covered items or services.

(2) A discount or other reduction in price obtained by a provider of services or other entity under this chapter or Chapter 8 (commencing with Section 14200), if the reduction in price is properly disclosed and reflected in the costs claimed or charges made by the provider or entity under this chapter or Chapter 8 (commencing with Section 14200). This paragraph shall not apply to consultant pharmaceutical services rendered to nursing facilities nor to all categories of intermediate care facilities for the developmentally disabled.

(3) The practices or transactions between a federally qualified health center, as defined in Section 1396d(l)(2)(B) of Title 42 of the United States Code, and any individual or entity shall be permitted only to the extent sanctioned or permitted by federal law.

(4) The provision of nonmonetary remuneration in the form of hardware, software, or information technology and training services, as described in subsections (x) and (y) of Section 1001.952 of Title 42 of the Code of Federal Regulations, as amended October 4, 2007, as published in the Federal Register (72 Fed. Reg. 56631, 56644), and subsequently amended versions.

(d) For purposes of this section, “kickback” means a rebate or anything of value or advantage, present or prospective, or any promise or undertaking to give any rebate or thing of value or advantage, with a corrupt intent to unlawfully influence the person to whom it is given in actions undertaken by that person in his or her public, professional, or official capacity.

(e) The enforcement remedies provided under this section are not exclusive and shall not preclude the use of any other criminal or civil remedy.

(Amended by Stats. 2011, Ch. 15, Sec. 630. (AB 109) Effective April 4, 2011. Operative October 1, 2011, by Sec. 636 of Ch. 15, as amended by Stats. 2011, Ch. 39, Sec. 68.)

14107.3. Any person who knowingly and willfully charges, solicits, accepts, or receives, in addition to any amount payable under this chapter, any gift, money, contribution, donation, or other consideration as a precondition to providing services or merchandise to a Medi-Cal beneficiary for any service or merchandise in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program under this chapter or Chapter 8 (commencing with Section 14200), except either:

(1) To collect payments due under a contractual or legal entitlement pursuant to subdivision (b) of Section 14000; or

(2) To bill a long-term care patient or representative for the amount of the patient's share of the cost; or

(3) As provided under Section 14019.3, is punishable upon a first conviction by imprisonment in the county jail for not longer than one year or pursuant to subdivision (h) of Section 1170 of the Penal Code, or by a fine not to exceed ten thousand dollars ($10,000), or both such imprisonment and fine. A second or subsequent conviction shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code.

(Amended by Stats. 2011, Ch. 15, Sec. 631. (AB 109) Effective April 4, 2011. Operative October 1, 2011, by Sec. 636 of Ch. 15, as amended by Stats. 2011, Ch. 39, Sec. 68.)

14107.4. (a) Any person who, with the intent to defraud, certifies as true and correct any cost report, submitted by a hospital to a state agency for reimbursement pursuant to Section 14170, who knowingly fails to disclose in writing on the cost report any significant beneficial interest, as defined in subdivision (d), which the owners of the provider, or members of the provider governing board, or employees of the provider, or independent contractor of the provider, have in the contractors or vendors to the providers, is guilty of a public offense.

(b) Any person who, with the intent to defraud, knowingly causes any material false information to be included in any cost report submitted by a hospital to a state agency for reimbursement pursuant to Section 14170 shall be guilty of an offense punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by a fine not exceeding ten thousand dollars ($10,000), or by a fine and imprisonment, or by imprisonment in the county jail not exceeding one year, or by a fine not exceeding five thousand dollars ($5,000), or by both a fine and imprisonment.

(c) The provider's chief executive officer shall certify that any cost report submitted by a hospital to a state agency for reimbursement pursuant to Section 14170 shall be true and correct. In the case of a hospital which is operated as a unit of a coordinated group of health facilities and under common management, either the hospital's chief executive officer or administrator, or the chief financial officer of the operating region of which the hospital is a part, shall certify to the accuracy of the report.

(d) As used in this section, "significant beneficial interest" means any financial interest that is equal to or greater than twenty-five thousand dollars ($25,000) of ownership interest or 5 percent of the whole ownership or any other contractual or compensatory arrangement with vendors or contractors or immediate family members of vendors or contractors. "Immediate family" means spouse, son, daughter, father, mother, father-in-law, mother-in-law, daughter-in-law, or son-in-law. Interests held by these persons specified in subdivision (a) and members of these person's immediate family should be combined and included as a single interest.

(e) Any person who violates the provisions of subdivision (a) is punishable by imprisonment in the county jail for a period not to exceed one year or pursuant to subdivision (h) of Section 1170 of the Penal Code, or by fine not to exceed five thousand dollars ($5,000), or by both such fine and imprisonment.

(Amended by Stats. 2011, Ch. 15, Sec. 632. (AB 109) Effective April 4, 2011. Operative October 1, 2011, by Sec. 636 of Ch. 15, as amended by Stats. 2011, Ch. 39, Sec. 68.)

14107.5. (a) The department may, pursuant to regulations adopted pursuant to subdivision (b), rescind the privileges of a provider of durable medical equipment or incontinence supplies who fails to satisfy the requirements of this section to bill and receive payment for services provided under this chapter.

(b) The department shall adopt regulations to define the specific causes for which the authority of a Medi-Cal provider of durable medical equipment or incontinence supplies to bill and receive payment for services provided under this chapter may be rescinded for violation of this section.

(c) The department shall not rescind the authority of a Medi-Cal provider of durable medical equipment or incontinence supplies to bill and receive payment under this chapter without a prior hearing, unless any of the following conditions exist:

(1) The provider has failed to provide material information to the department pursuant to Section 14125.8.

(2) The provider has knowingly furnished false information on any application for provider enrollment.

(3) The provider has knowingly filed false claims for reimbursement under this chapter.

(Added by Stats. 1991, Ch. 560, Sec. 3.)

14108. Any developmentally disabled recipient under this chapter receiving care in a nursing facility or any category of intermediate care facility for the developmentally disabled is entitled as a part of the therapeutic and rehabilitative program, to be temporarily absent from the facilities. The State Department of Health Services shall, with consultation from the State Department of Developmental Services, adopt regulations establishing the periods of time and conditions under which temporary absences shall be permitted. The regulations shall require that absences be in accordance with an individual program plan and provide for absences due to hospitalization for an acute condition. The limits on temporary leaves of absence established by the Department of Health Services by regulation shall not be less than 30 days per year.

During these temporary absences the State Department of Health Services shall reimburse the facility for the cost of maintaining the vacant accommodations at a rate determined by the department which shall be less than the regular rate.

(Amended by Stats. 1990, Ch. 1329, Sec. 18. Effective September 26, 1990.)

14108.1. Any recipient receiving care in a nursing facility under this chapter, as part of a certified special treatment program for persons with mental illnesses, or as a part of a mental health therapeutic and rehabilitative program approved and certified by a local mental health director, is entitled to be temporarily absent from those facilities. The department may develop regulations establishing the periods of time and conditions under which temporary absences shall be permitted. These regulations shall require that absences be in accordance with an individual patient care plan and also provide for absences due to hospitalization for an acute condition. The limits on temporary leaves of absence established by the department by regulation shall not be less than 30 days per year.

During these temporary absences, the department shall reimburse the facility for the cost of maintaining the vacant accommodations at a rate to be determined by the department which shall be less than the normal reimbursement rate.

(Amended by Stats. 2012, Ch. 34, Sec. 226. (SB 1009) Effective June 27, 2012. Operative July 1, 2012, by Sec. 254 of Ch. 34.)

14108.2. Except as provided by Section 14108 and Section 14108.1, any recipient of services under this chapter who is residing in a long-term care facility shall be permitted to be temporarily absent from such facilities for up to 18 days per year, not including days of bed hold for acute hospitalization. The department may approve additional days of leave on an individual basis, not to exceed 12 days per year, exclusive of days of bed hold for acute hospitalization.

All such leaves of absence shall be in accordance with an individual patient care plan as approved by the attending physician. The director shall adopt regulations establishing the conditions under which additional leave days shall be authorized. The director may establish reasonable limits on the duration of any period of absence.

(Added by Stats. 1982, Ch. 857, Sec. 1.)

14109. In determining the medical needs of any person eligible under this chapter, and the amount of health care such person is entitled to receive, the department shall include the cost of any deductibles or, cost sharing or similar charge imposed in connection with benefits to which such person may be entitled under the federal program of health insurance for the aged and disabled, except that for those individuals 65 years of age or over, who prior to July 1, 1973, were ineligible under the federal program of health insurance for the aged, the director may include such costs.

(Amended by Stats. 1973, Ch. 1216.)

14109.5. Notwithstanding the provisions of Section 14109, effective January 1, 1982, the reimbursement rate for costs specified in Section 14109 for all services, including, but not limited to, hospital inpatient services, shall, to the extent feasible, not exceed the reimbursement rate for similar services established under this chapter. For purposes of this section, effective October 1, 1992, the reimbursement rates established under this chapter for hospital inpatient services shall be no greater than the amounts paid by the Medicare program for similar services.

The fiscal intermediary shall expedite the implementation of any change order resulting only from this section. The department shall provide sufficient funding for any such change order to enable the fiscal intermediary to implement such change order expeditiously and to not have to divert staff or other resources from existing contract tasks, including but not limited to those resources dedicated to the implementation of all other change orders.

(Amended by Stats. 1992, Ch. 722, Sec. 108. Effective September 15, 1992.)

14109.6. Notwithstanding Section 14109, effective September 1, 1997, and pursuant to Section 1396a(n) of Title 42 of the United States Code, as amended by Section 4714 of the federal Balanced Budget Act of 1997, the reimbursement rate for costs specified in Section 14109 for all services, including, but not limited to, hospital inpatient services, shall, to the extent feasible, not exceed the reimbursement rate for similar services established under this chapter. Effective for dates of service on or after September 1, 1997, the reimbursement rates established under this chapter for hospital inpatient services shall be no greater than the amounts paid by the Medicare program for similar services. Notwithstanding the provisions of this section, Section 14109.5 shall remain in effect for

dates of service prior to September 1, 1997. It is the intent of the Legislature that regulations and the amendments to the medicaid state plan previously adopted pursuant to Section 14109.5 shall remain in effect for purposes of this section until amended or otherwise modified by the department.

(Added by Stats. 1997, Ch. 294, Sec. 70. Effective August 18, 1997.)

14110. No payment for care or services shall be made under Medi-Cal to a medical or health care facility unless it has been certified by the department for participation, and it meets one of the following:

(a) It is licensed by the department.

(b) It is licensed by a comparable agency in another state.

(c) It is exempt from licensure.

(d) It is operated by the Regents of the University of California.

(e) It meets the utilization review plan criteria for certification or is certified as an institutional provider of services under Title XVIII of the Federal Social Security Act and regulations issued thereunder.

Nothing in this section shall preclude payments for care for aged patients in medical facilities or institutions operated or licensed by the department, or the State Department of State Hospitals, State Department of Developmental Services, State Department of Social Services, or Department of Rehabilitation.

The department shall certify facilities licensed pursuant to subdivision (e) of Section 1250 of the Health and Safety Code for participation in the program within 30 calendar days of receipt of a complete application or date of licensure, whichever is greater, if the facility meets all the requirements for certification. The department for claims purposes only, shall enroll facilities which meet all certification requirements within 30 calendar days of the date of certification or 60 calendar days of licensure, whichever is greater.

(Amended by Stats. 2012, Ch. 440, Sec. 79. (AB 1488) Effective September 22, 2012.)

14110.05. (a) The department shall ensure that nursing facility applicants have access to assistance in identifying and securing the information necessary to complete the Medi-Cal application and to make the eligibility determination.

(b) The department shall ensure that Medi-Cal applications for nursing facility residents are processed in a timely manner in accordance with state and federal laws and regulations.

(Added by Stats. 1992, Ch. 84, Sec. 3. Effective January 1, 1993.)

14110.1. Medi-Cal reimbursements for long-term care in any hospital shall be at a rate not to exceed the maximum rate paid for long-term care in nursing facilities which are distinct parts of acute care hospitals, except for patients whose medical or nursing needs exceed the level of care provided in nursing facilities.

(Amended by Stats. 1989, Ch. 731, Sec. 13.)

14110.15. (a) The department shall develop, collect, and maintain, in an electronic format, all data elements in the minimum data set specified by the federal government. The data base shall incorporate the data required for preadmission screening and annual resident reviews, and Medi-Cal treatment authorization requests. The department shall make the format of this new data base available to the public.

(b) All skilled nursing facilities and nursing facilities required by federal law to complete the minimum data set form shall provide the data to the department in a manner and form prescribed by the director. The director may require that the submission of that data shall be in an electronic format.

(c) The department shall design the minimum data set data base in a manner that maintains resident confidentiality and that allows the use of the data by other authorized state agencies, including, but not limited to, the Office of Statewide Health Planning and Development. To the extent possible, those other state agencies shall obtain the minimum data set and preadmission screening and annual resident review data from the department's database established and maintained pursuant to this section.

(d) To the fullest extent possible, the department shall use the minimum data set database to meet the requirements of the current treatment authorization request review process and shall automate use of the minimum data set information for that purpose.

(e) This section shall not be construed to prohibit the department or any other state agency from requiring additional information that is not available from the minimum data set database in order to meet other data needs.

(f) The department shall implement this section no later than the date specified by the federal government for facility completion of automation of the minimum data set data. The department shall, within a reasonable time, make necessary system changes to begin the use of the automated minimum data set data to meet its treatment authorization and preadmission screening and annual resident review data requirements. To the fullest extent possible, these system changes shall be anticipated and commenced in advance of the federal government's final implementation date.

(g) The system shall be developed and implemented in consultation with representatives of the long-term care industry and other interested parties, such as physicians and other health care professionals.

(h) The department shall implement the development of the minimum data set database only if federal funds are available for that purpose. Development of the data system applications for use of the automated minimum data set database by the department are subject to federal approval and federal financial participation for the affected systems.

(Amended by Stats. 2012, Ch. 34, Sec. 227. (SB 1009) Effective June 27, 2012. Operative July 1, 2012, by Sec. 254 of Ch. 34.)

14110.2. The director shall, unless precluded by federal law or regulation, amend the state plan under Title XIX of the Social Security Act to conform to the policy directions and budgetary decisions of the Legislature, as reflected in the Budget Act for each fiscal year.

(Added by Stats. 1982, Ch. 328, Sec. 29. Effective June 30, 1982.)

14110.3. Until the Secretary of Health, Education and Welfare establishes, by regulation, standards in accordance with Title XIX of the Federal Social Security Act for intermediate care facilities, there shall be no requirement for the provision of intermediate care in nursing homes; however, a nursing home may elect to waive the provisions of this section and voluntarily apply to the department to provide intermediate care in its facility.

(Added by Stats. 1976, Ch. 504.)

14110.4. (a) All laundry services for all apparel, linen, garments, towels, and hospital gowns shall be provided by a nursing facility or any category of intermediate care facility for the developmentally disabled at no cost to a recipient under this chapter. These laundry services shall be considered as part of the basic care provided by the facility under the daily rate provided for pursuant to this chapter. The director shall, if necessary, adjust the daily rate to provide for the costs of these services. A facility may, however, charge the patient a fee to provide special drycleaning or treatment for a garment needing this care, when the garment is owned by the patient and when the regular laundry service is not appropriate.

(b) A facility shall provide a periodic hair trim as part of its care for all patients who are recipients under this chapter. This service shall be included as part of the daily rate provided for pursuant to this chapter. The director shall, if necessary, adjust the daily rate to provide for the costs of these services. A facility may, however, charge a fee for beauty shop services for patients who request special treatments or styling of their hair.

(c) The director shall seek all federal funds available for implementation of this section.

(Amended by Stats. 1990, Ch. 1329, Sec. 19. Effective September 26, 1990.)

14110.5. Effective January 1, 1977, no payment for any prescription ophthalmic device shall be made under Medi-Cal if that device does not meet the standards adopted by the department, the State Board of Optometry or the Division of Licensing of the Medical Board of California under Section 2541.3 of the Business and Professions Code.

(Amended by Stats. 1995, Ch. 279, Sec. 26. Effective January 1, 1996.)

14110.55. For the purposes of the pilot program established under Section 14495.10, or, if Section 14495.10 is repealed and replaced by Section 14132.20, then under the program implemented pursuant to Section 14132.20, the department shall develop a reimbursement rate for continuous skilled nursing care services provided by a participating health facility to developmentally disabled individuals who meet the federal waiver eligibility criteria or Medi-Cal State Plan amendment criteria. The reimbursement rate shall be determined in accordance with a methodology that shall be developed by the department. The department may elect to establish individual patient-specific rates.

(Amended by Stats. 2009, 4th Ex. Sess., Ch. 5, Sec. 41. Effective July 28, 2009.)

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

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

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

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

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

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

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

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

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

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

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

(e) The department shall, commencing August 1, 1999, increase the Medi-Cal reimbursement for level A and level B nursing facilities solely to provide funds for salaries, wages, and benefits increases for direct care staff. For the purposes of this subdivision, "direct care staff" means registered nurses, licensed vocational nurses, and nurse assistants, who provide direct patient care. The amount of funds to be provided to each level A and level B facility pursuant to this subdivision shall be calculated on a per-patient-day basis, and shall be added to the per diem rate paid to each facility. The amount of funds provided under this subdivision to each nursing facility peer group shall be published in a Medi-Cal provider bulletin. Level A and level B facilities shall compensate their registered nurses, licensed vocational nurses, and nurse assistants that portion of the rate increase provided under this subdivision in the form of salaries, wages, and benefits increases for their direct care staff. The total amount to be passed through by each facility shall be the per diem amount received by the facility pursuant to this subdivision times the facility's number of Medi-Cal patient days.

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

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

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

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

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

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

(A) A qualified intellectual disability professional employed in the performance of direct care to patients.

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

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

(D) Other nonsupervisory staff providing direct patient care.

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

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

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

(A) Linen and laundry staff.

(B) Plant operations and maintenance staff.

(C) Housekeeping staff.

(D) Dietary staff.

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

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

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

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

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

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

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

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

(9) Each facility receiving funds from the department, or from a county organized health system described in paragraph (10) pursuant to this subdivision shall certify on the form provided by the department that these funds were expended for increased direct care and other staff salary, wages, and benefits increases in accordance with this subdivision. The facility shall return the form to the department by October 1, 2001. The facility shall submit a copy of the completed form to all collective bargaining agents with whom the facility has collective bargaining agreements for direct care and other staff at the facility.

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

(g) Any facility which is paid under the rate provided for in subdivision (a), (e), or (f) which the director finds has not made the wage and benefit increases provided for shall be liable for the amount of funds paid to the facility based upon the wage and benefit requirements provided for by this section but not distributed to employees for wages and benefits, plus a penalty equal to 10 percent of the funds not so distributed. The facility shall be subject to Section 14107.

(Amended by Stats. 2023, Ch. 797, Sec. 6. (AB 248) Effective January 1, 2024.)

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

(b) (1) The director shall adopt regulations that shall establish the minimum number of equivalent nursing hours per patient required in the following, for the first year of implementation of the first year of rates established pursuant to this article:

(A) 2.6 hours for skilled nursing facilities.

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

(C) 0.9 hours for intermediate care facilities.

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

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

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

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

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

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

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

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

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

(e) Notwithstanding paragraph (1) of subdivision (d), commencing January 1, 2000, the minimum number of nursing hours per patient day required in skilled nursing facilities shall be 3.2, without regard to the doubling of nursing hours as described in paragraph (1) of subdivision (b) of Section 1276.5 of the Health and Safety Code, and except as set forth in Section 1276.9 of the Health and Safety Code.

(Amended by Stats. 2001, Ch. 685, Sec. 23. Effective January 1, 2002.)

14110.8. (a) For the purposes of this section:

(1) “Facility” means any long-term health care facility as defined in subdivisions (c), (d), (e), (g), and (h) of Section 1250 of the Health and Safety Code.

(2) “Resident” means a person who is a facility resident or patient and a Medi-Cal beneficiary and whose facility care is being paid for in whole or in part by Medi-Cal.

(3) “Agent” means a person who manages, uses, or controls those funds or assets of the resident that legally are required to be used to pay the resident’s long-term care patient liability and other charges not paid for by the Medi-Cal program.

(4) “Responsible party” means a person other than the resident or potential resident, who, by virtue of signing or cosigning an admissions agreement of a facility, either together with, or on behalf of, a potential resident, becomes personally responsible or liable for payment of any portion of the charges incurred by the resident while in the facility. A person who signs or cosigns a facility’s admissions agreement by virtue of being an agent under a power of attorney for health care or an attorney-in-fact under a durable power of attorney executed by the potential resident, a conservator of the person or estate of the potential resident, or a representative payee, is not a responsible party under this section, and does not thereby assume personal responsibility or liability for payment of any charges incurred by the resident, except to the extent that the person, or the resident’s conservator or representative payee is an agent as defined in paragraph (3).

(b) No facility may require or solicit, as a condition of admission into the facility, that a Medi-Cal beneficiary have a responsible party sign or cosign the admissions agreement. No facility may accept or receive, as a condition of admission into the facility, the signature or cosignature of a responsible party for a Medi-Cal beneficiary.

(c) A facility may require, as a condition of admission, where a resident has an agent, that the resident’s agent sign or cosign the admissions agreement and agree to distribute to the facility promptly when due, the long-term care patient liability and any other charges not paid for by the Medi-Cal program that the resident or their agent has agreed to pay. The financial obligation of the agent shall be limited to the amount of the resident’s funds received but not distributed to the facility. A new agent who did not sign or cosign the admissions agreement shall be held responsible to distribute funds in accordance with this section.

(d) When a resident on non-Medi-Cal status converts to Medi-Cal coverage, any security deposit paid to the facility by the resident or on the resident’s behalf as a condition of admission to the facility shall be returned and the obligations and responsibilities of the resident or responsible party during the time period when the resident is covered by Medi-Cal shall be limited to the obligations and responsibilities provided for under the Medi-Cal program. In the event that the resident becomes ineligible for Medi-Cal coverage at any time subsequent to converting to Medi-Cal coverage, the resident and responsible party shall be bound by the terms of the original admission agreement, or any admission agreement in effect at the time the Medi-Cal coverage commenced.

(e) When a resident on non-Medi-Cal status converts to Medi-Cal coverage, the facility shall make a reasonable attempt to assist the resident in contacting the county to obtain an estimate of the resident’s long-term care patient liability.

(f) A resident and their agent shall pay to the facility the long-term care patient liability, for which they are responsible under the Medi-Cal program, unless otherwise exempted by law.

(g) If a resident or their agent disputes the amount of the long-term care patient liability owed to a facility, the resident or agent may apply for a state hearing pursuant to Section 10950 for a determination of the amount owed to the facility.

(h) Any agent who willfully violates the requirements of this section is guilty of a misdemeanor, and upon conviction thereof, shall be punished by a fine not to exceed two thousand five hundred dollars ($2,500) or by imprisonment in the county jail not to exceed 180 days, or both.

(Amended by Stats. 2023, Ch. 42, Sec. 142. (AB 118) Effective July 10, 2023.)

14110.9. No nursing facility or any category of intermediate care facility for the developmentally disabled may require a security deposit from a Medi-Cal beneficiary who applies for admission to the facility.

(Amended by Stats. 1990, Ch. 1329, Sec. 21. Effective September 26, 1990.)

14111. (a) As permitted by federal law or regulations, for health care services provided in a long-term health care facility that are reimbursed by Medicare, a physician and surgeon may delegate any of the following to a nurse practitioner:

(1) Alternating visits required by federal law and regulations with a physician and surgeon.

(2) Any duties consistent with federal law and regulations within the scope of practice of nurse practitioners, so long as all of the following conditions are met:

(A) A physician and surgeon approves, in writing, the admission of the individual to the facility.

(B) The medical care of each resident is supervised by a physician and surgeon.

(C) A physician and surgeon performs the initial visit and alternate required visits.

(b) This section does not authorize benefits not otherwise authorized by federal law or regulation.

(c) All responsibilities delegated to a nurse practitioner pursuant to this section shall be performed under the supervision of the physician and surgeon and pursuant to a standardized procedure among the physician and surgeon, nurse practitioner, and facility.

(d) No task that is required by federal law or regulation to be performed personally by a physician may be delegated to a nurse practitioner.

(e) Nothing in this section shall be construed as limiting the authority of a long-term health care facility to hire and employ nurse practitioners so long as that employment is consistent with federal law and within the scope of practice of a nurse practitioner.

(Amended by Stats. 1994, Ch. 646, Sec. 1. Effective January 1, 1995.)

14111.5. (a) As permitted by federal law or regulations, for health care services provided in a long-term health care facility that are reimbursed under this chapter, a nurse practitioner may, to the extent consistent with his or her scope of practice, perform any of the following tasks otherwise required of a physician and surgeon:

(1) With respect to visits required by federal law or regulations, making alternating visits, or more frequent visits if the physician and surgeon is not available.

(2) Any duty or task that is consistent with federal and state law or regulation within the scope of practice of nurse practitioners, so long as all of the following conditions are met:

(A) A physician and surgeon approves, in writing, the admission of the individual to the facility.

(B) The medical care of each resident is supervised by a physician and surgeon.

(C) A physician and surgeon performs the initial visit and alternate required visits.

(b) This section does not authorize benefits not otherwise authorized by federal or state law or regulation.

(c) All responsibilities undertaken by a nurse practitioner pursuant to this section shall be performed in collaboration with the physician and surgeon and pursuant to a standardized procedure among the physician and surgeon, nurse practitioner, and facility.

(d) Except as provided in subdivisions (a) to (c), inclusive, any task that is required by federal law or regulation to be performed personally by a physician may be delegated to a nurse practitioner who is not an employee of the long-term health care facility.

(e) Nothing in this section shall be construed as limiting the authority of a long-term health care facility to hire and employ nurse practitioners so long as that employment is consistent with federal law and with the scope of practice of a nurse practitioner.

(Amended by Stats. 1995, Ch. 91, Sec. 186. Effective January 1, 1996.)

14112. Health care provided pursuant to this chapter shall not constitute a lien against the property of any recipient or medically indigent or other person eligible under this chapter.

(Amended by Stats. 1969, Ch. 21.)

14113. The department shall enter into cooperative arrangements with the Department of Rehabilitation and any other state agency or department responsible for health or vocational rehabilitation services in the state to insure the appropriate utilization of such services in the provision of health care and related remedial services under this chapter.

(Amended by Stats. 1973, Ch. 142.)

14114. (a) This section shall be known, and may be cited, as Medi-Cal Physicians and Dentists Loan Repayment Program Act.

(b) Notwithstanding any other law, the department shall develop and administer the Medi-Cal Physicians and Dentists Loan Repayment Program to provide loan assistance payments to qualifying, recent graduate physicians and dentists that serve beneficiaries of existing health care programs described in Chapter 7 (commencing with Section 14000) to Chapter 8.9 (commencing with Section 14700), inclusive. To implement this section, the department shall consult with other state entities, including the Department of Health Care Access and Information, and with affected stakeholders.

(c) (1) The Medi-Cal Physicians and Dentists Loan Repayment Program shall be funded using moneys appropriated to the department for this purpose.

(2) The Loan Repayment Program Account is hereby continued in the State Treasury within the Healthcare Treatment Fund established pursuant to Section 30130.55 of the Revenue and Taxation Code. The Loan Repayment Program Account shall contain funds appropriated by the Legislature from the Healthcare Treatment Fund to the Medi-Cal Physicians and Dentists Loan Repayment Program. Notwithstanding Section 13340 of the Government Code, the Loan Repayment Program Account is hereby continuously appropriated, without regard to fiscal year, to implement the Medi-Cal Physicians and Dentists Loan Repayment Program.

(3) The Medi-Cal Loan Repayment Program Special Fund is hereby established in the State Treasury. The Medi-Cal Loan Repayment Program Special Fund shall contain funds transferred from the California Electronic Cigarette Excise Tax Fund pursuant to Section 31005 of the Revenue and Taxation Code, funds transferred pursuant to paragraph (2) of subdivision (c) of Section 14197.2, and any other moneys appropriated to the Medi-Cal Physicians and Dentists Loan Repayment Program other than funds appropriated from the Health Care Treatment Fund described in paragraph (2). The department and the State Controller's office shall maintain separate subaccounts for funds appropriated or transferred from each funding source. Notwithstanding Section 13340 of the Government Code, the Medi-Cal Loan Repayment Program Special Fund is hereby continuously appropriated, without regard to fiscal year, to implement the Medi-Cal Physicians and Dentists Loan Repayment Program.

(4) The department shall expend all funds available in the Loan Repayment Program Account of the Healthcare Treatment Fund prior to expending any funds from the Medi-Cal Loan Repayment Program Special Fund.

(5) Within each fund and subaccount, the department shall administer two separate payment pools for participating physicians and dentists, respectively, consistent with the allocations provided for in Item 4260-102-3305 of the Budget Act of 2018, Item 4260-102-3305 of the Budget Act of 2019, Section 31005 of the Revenue and Taxation Code, and paragraph (2) of subdivision (c) of Section 14197.2.

(6) Moneys appropriated to the department to implement this section shall be available to fund the administrative costs incurred by the department and any entity contracted with pursuant to subdivision (g). Administrative costs from the Loan Repayment Program Account of the Healthcare Treatment Fund are limited by subdivision (f) of Section 30130.57 of the Revenue and Taxation Code.

(d) The department shall develop the eligibility criteria to be used to evaluate physician and dentist participation in the Medi-Cal Physicians and Dentists Loan Repayment Program. In developing these criteria, the department shall prioritize ensuring timely access, limiting geographic shortages of services, and ensuring quality care in the Medi-Cal program. The department shall develop separate criteria for distribution of payments from the physician and dentist payment pools. At a minimum, the department shall establish the maximum number of years a physician or dentist may be in practice to qualify for payments pursuant to this section, and the minimum number of years a participating physician or dentist receiving payments pursuant to this section shall agree to participate as an enrolled provider in the Medi-Cal program.

(e) The selection of physicians and dentists for participation in the Medi-Cal Physicians and Dentists Loan Repayment Program and the amount of loan repayment assistance awarded to a participating physician or dentist shall be at the discretion of the department and any entity contracted with pursuant to subdivision (g), and shall be based on the criteria developed pursuant to subdivision (d). An exercise of discretion by the department and its contractors pursuant to this subdivision shall not be subject to judicial review, except that an applicant physician or dentist who is not selected for participation in the program may file for a writ of mandate pursuant to Section 1085 of the Code of Civil Procedure to rectify an abuse of discretion by the department and its contractors.

(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, interpret, or make specific this section, in whole or in part, by means of policy letters, provider bulletins, or other similar instructions, without taking regulatory action. The department shall consult with affected stakeholders before taking action pursuant to this subdivision.

(g) To implement this section, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the review or approval of a division of the Department of General Services.

(h) This section shall be implemented only to the extent that the department determines that federal financial participation under the Medi-Cal program is not jeopardized. If the department determines there is a reasonable likelihood that federal financial participation is available for expenditures pursuant to this section, it may seek the federal approvals necessary to obtain federal financial participation.

(i) The Legislature finds and declares that the expenditures authorized by paragraph (2) of subdivision (c) are all of the following:

(1) Made in accordance with the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Article 2 (commencing with Section 30121) of Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code).

(2) Based on criteria developed and periodically updated as part of the annual budget process in accordance with subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(3) Consistent with the purposes and conditions for expenditures described in subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(j) The Legislature finds and declares that this section is a state law within the meaning of Section 1621(d) of Title 8 of the United States Code.

(Amended by Stats. 2022, Ch. 46, Sec. 6. (AB 186) Effective June 30, 2022. Conditionally inoperative as prescribed by Stats. 2018, Ch. 47, Sec. 4.)

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

(b) The director may, where he or she finds that delay in the submission of bills was caused by circumstances beyond the control of the provider, extend the period for submission of bills for a period not to exceed one year.

(c) (1) Reimbursement for an original claim, submitted for payment between 6 and 12 months after the month of service, that does not meet any of the exceptions allowing billing after six months as specified in subdivisions (a) and (b), or the exception specified in subdivision (f), shall be reduced as follows:

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

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

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

(3) The reductions specified in paragraph (1) shall not apply to a Medi-Cal program for which there is no state General Fund match, including, but not limited to, the Local Educational Agency (LEA) Medi-Cal Billing Option program and the Targeted Case Management (TCM) program.

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

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

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

(Amended by Stats. 2007, Ch. 130, Sec. 248. Effective January 1, 2008.)

14115.1. The department may not require that any hospital based physician submit a combined charge, which includes the physician and hospital charge, if it is not the customary practice of such physician to submit a combined charge. The physician's right to bill independently shall be respected by the department; provided, however, this shall not prevent the department from

enacting reasonable regulations to insure that the total charges, when a hospital and physician bill separately, do not exceed the total charge when both bill for the same services in a combined charge.

(Amended by Stats. 1974, Ch. 546.)

14115.2. (a) The department shall not require nursing facilities or any category of intermediate care facility for the developmentally disabled, as defined in Section 1250 of the Health and Safety Code to originate monthly bills for beneficiaries if the following conditions are met:

(1) A claim on which inpatient per diem days have been billed by the provider is received by the fiscal intermediary by the fifth working day of the month following the month being billed; and

(2) The claim received by the fiscal intermediary does not show a patient status code that indicates discharge or death on the last day billed for the recipient for that month.

(b) When the conditions listed above are met, the fiscal intermediary shall, by the 20th of the month, mail to the provider a preimprinted claim to cover the current month's services to those beneficiaries.

(c) The provider shall be required to check the preimprinted claim for accuracy, to make corrections, and to certify that the beneficiaries who are listed on the claim received the services listed.

(d) The preimprinted claim shall be returned in the manner required by Section 14115; provided, the preimprinted claim shall be deemed a late submission no earlier than six months following the end of the month of service being billed.

(e) Except as otherwise provided in this section, the rights and duties of providers and the department with respect to the billing procedures hereby established shall be governed by the provisions of this chapter.

(Amended by Stats. 1990, Ch. 1329, Sec. 22. Effective September 26, 1990.)

14115.3. The department shall permit a nurse anesthetist to bill independently for services rendered by such nurse anesthetist. If a nurse anesthetist chooses to bill independently for such services, the department shall make the payment for the services directly to the nurse anesthetist.

(Added by Stats. 1974, Ch. 1374.)

14115.4. If the Budget Act should in any budget year restrict payment for pathology services under the Medi-Cal program to only the provider who actually performs those services, this restriction shall not prohibit any of the following:

(a) Reimbursement of a hospital for pathology services performed by an outside reference laboratory for hospital patients.

(b) Reimbursement of a clinical laboratory for performance of pathology services that are referred to another clinical laboratory.

(c) Reimbursement of a clinical laboratory when pathology services are performed at a different testing location owned and operated by the same clinical laboratory.

Services provided pursuant to subdivision (a), (b), or (c) shall be reimbursed in accordance with the rules and regulations of the department.

(Added by Stats. 1983, Ch. 960, Sec. 5.)

14115.41. (a) For services that are performed at a central laboratory as authorized pursuant to Section 1241.1 of the Business and Professions Code, the department shall provide reimbursement directly to the laboratory performing the services and submitting the claim for reimbursement. Nothing in this section shall prohibit a primary care clinic network that utilizes centralized billing from submitting claims on the behalf of the network's central laboratory, if the claims are submitted with the central laboratory's provider number. The department shall not deny payment to a laboratory created pursuant to Section 1241.1 of the Business and Professions Code, for either of the following reasons:

(1) The clinic and the licensed central laboratory performing the services are owned and operated by the same nonprofit corporation with the same board of directors and the same corporate officers.

(2) The laboratory services are performed on a specimen collected at the clinic for a clinic patient.

(b) Nothing in this section shall be construed to allow a primary care clinic to submit a separate claim for central laboratory services currently reimbursed under the Medi-Cal program, utilizing the primary care clinic's provider number.

(c) The department may implement utilization controls or other cost-control measures to ensure that medically necessary services are appropriately rendered.

(d) (1) A primary care clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code that is affiliated with a network of primary care clinics may continue to submit claims for the laboratory services provided until such time that the primary care clinic receives a provider number for the central laboratory pursuant to this section, if all of the following requirements are met:

(A) The network of primary care clinics is operated by the same nonprofit corporation with the same board of directors and corporate officers.

(B) The primary care clinic operates under the same procedures and protocols as the affiliated clinics in the network, and the laboratory holds a valid Clinical Laboratory Improvement Amendments of 1988 (42 U.S.C. 263a) (CLIA) certificate and state laboratory license to perform moderate and high complexity laboratory services.

(C) The of primary care clinic has been providing laboratory testing services for the patients of the primary care clinic within the clinic network prior to August 1, 2006, and has been authorized by Medi-Cal to submit claims for those services.

(2) This subdivision shall remain operative until June 30, 2007.

(Added by Stats. 2006, Ch. 795, Sec. 3. Effective January 1, 2007.)

14115.5. Moneys payable or rights existing under this chapter shall be subject to any claim, lien or offset of the State of California, and any claim of the United States of America made pursuant to federal statute, but shall not otherwise be subject to enforcement of a money judgment or other legal process, and no transfer or assignment, at law or in equity, of any right of a provider of health care to any payment shall be enforceable against the state, a fiscal intermediary or carrier.

(Amended by Stats. 1982, Ch. 497, Sec. 183. Operative July 1, 1983, by Sec. 185 of Ch. 497.)

14115.7. (a) The department, with the assistance of the Controller, shall develop a procedure by which approved claims for services rendered may be reimbursed through a means of electronic transfer of funds to designated providers of services.

(b) The department shall make the electronic transfer of funds for the payment of approved claims for services rendered pursuant to this chapter available to all interested parties for a reasonable initial fee, and an annual subscription fee for system updating, maintenance, and support services provided to users.

(c) The department shall charge fees pursuant to subdivision (b) in an amount which shall recover, as nearly as possible, the cost of provider enrollment, bank transaction charges, and ongoing net support costs for maintenance of the electronic transfer system.

(d) The department shall, in charging fees pursuant to subdivision (b), adjust those fees by the amount of any administrative savings due to the implementation of this section.

(Added by Stats. 1990, Ch. 374, Sec. 1.)

14115.75. (a) As a condition of payment for goods, supplies, and merchandise provided to Medi-Cal beneficiaries by a provider that receives or makes annual payments of at least five million dollars ($5,000,000) under the Medi-Cal program, the provider shall comply with the federal False Claims Act employee training and policy requirements contained in Section 1902(a) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(68)), and with any requirements that the United States Secretary of Health and Human Services may specify. The calculation of the five million dollar ($5,000,000) threshold shall be based on federal law and regulations and guidance from the United States Secretary of Health and Human Services.

(b) For purposes of this section, “provider” has the same meaning as that term is defined in Section 14043.1, and also includes any Medi-Cal managed care plan authorized under this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591).

(Amended by Stats. 2011, Ch. 367, Sec. 13. (AB 574) Effective January 1, 2012.)

14115.8. (a) (1) The department shall amend the Medicaid state plan with respect to the billing option for services by local educational agencies (LEAs), to ensure that schools shall be reimbursed for all eligible services that they provide that are not precluded by federal requirements.

(2) The department shall examine methodologies for increasing school participation in the Medi-Cal Billing Option for LEAs so that schools can meet the health care needs of their students.

(3) The department, to the extent possible, shall simplify claiming processes for LEA billing.

(4) The department shall eliminate and modify state plan and regulatory requirements that exceed federal requirements when they are unnecessary.

(5) (A) The department shall, in consultation with the LEA Ad Hoc Workgroup established pursuant to subdivision (c), and consistent with any applicable federal requirements, issue and regularly maintain a program guide for the LEA Medi-Cal Billing Option program. The program guide shall contain a billing manual that includes, but is not limited to, an explanation of billing, auditing, costs reporting, time studies, federal and state compliance rules, fiscal and programmatic compliance information regarding processes, documentation, and guidance necessary for the proper submission of claims, and auditing of LEAs, charter schools, and community colleges, as required under the LEA Medi-Cal Billing Option program.

(B) The program guide described in subparagraph (A) shall include, but not be limited to, state plan amendments, Frequently Asked Questions, policy and procedure letters, a plain language explanation of the certified public expenditure processes used to report and reconcile program costs from interim reimbursement to final cost settlement, trainings, provider manuals, and all other types of instructional materials relevant to the LEA Medi-Cal Billing Option program.

(C) (i) The department shall distribute the program guide to all participating LEAs, charter schools, and community colleges by January 1, 2020. Distribution of the program guide may occur by electronic mail or by notification by electronic mail of the posting of the guide on the department's internet website.

(ii) The department shall distribute an updated program guide to all participating LEAs, including charter schools and community colleges, by July 1, 2024, that includes the requirements described in subparagraphs (A) and (B). The department may distribute the program guide by electronic mail or by notification by electronic mail of the posting of the guide on the department's internet website.

(D) The department shall only adopt a revision of the program guide after providing 30 calendar days' written notification of the revision, including a statement of justification, to the LEA Ad Hoc Workgroup and all other participating LEAs, charter schools, and community colleges. The department may provide written notice by electronic mail. Under extraordinary circumstances, when revisions are necessary to reflect changes required by state or federal law or otherwise mandated by the federal Centers for Medicare and Medicaid Services and those changes require immediate action, the department may provide less than 30 calendar days' written notice.

(b) The department shall conduct an audit of a Medi-Cal Billing Option claim consistent with, but not limited to, all of the following:

(1) (A) The program guide and any revisions made pursuant to paragraph (5) of subdivision (a), including any revisions that are necessary to reflect changes required by state or federal law or otherwise mandated by the federal Centers for Medicare and Medicaid Services, that are in effect at the time the service was provided.

(B) Generally accepted accounting principles.

(C) Federal audit regulations, as set forth in Part 200 (commencing with Section 200.0) of Title 2 of the Code of Federal Regulations (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards), or its successor.

(D) Reasonable cost principles under the federal Medicare Program, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(E) The federal Centers for Medicare and Medicaid Services Provider Reimbursement Manual Part 1 (CMS Publication 15-1).

(F) Any and all applicable federal or state statutes and regulations.

(2) (A) The department shall complete an audit and notify an LEA of the audit findings within 18 months of the date that the Cost and Reimbursement Comparison Schedule (CRCS) is submitted. This timeline may be extended by no more than three months upon a determination that the LEA has not provided sufficient documentation as requested by the auditor.

(B) The department shall provide an interim settlement or final settlement of the Medi-Cal share of each LEA's costs within 12 months of the March 1 due date of the CRCS.

(C) When a final settlement is not issued within 12 months of the March 1 due date, the department shall complete final settlement no later than 18 months after the date that the CRCS is submitted.

(D) LEAs shall be reimbursed for all eligible services that meet federal requirements.

(3) For purposes of this subdivision, an audit shall refer to the audit and cost recovery process described in Section 14170.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may issue and regularly maintain the program guide described in this section without taking regulatory action.

(d) If a rate study for the LEA Medi-Cal Billing Option is completed pursuant to Section 52 of Chapter 171 of the Statutes of 2001, the department, in consultation with the entities named in paragraph (1) of subdivision (e), shall implement the recommendations from

the study, to the extent feasible and appropriate.

(e) (1) In order to assist the department in formulating the state plan amendments required to implement this section, the department shall regularly consult with the LEA Ad Hoc Workgroup, consisting of, but not limited to, representatives of the State Department of Education, LEAs, including urban, rural, large and small school districts, and county offices of education, and local education consortia. It is the intent of the Legislature that the department also consult with staff from Region IX of the federal Centers for Medicare and Medicaid Services, experts from the fields of both health and education, and state legislative staff.

(2) The department shall ensure that any LEA participating in the Medi-Cal Billing Option program may participate virtually in any trainings or stakeholder meetings, including those meetings conducted pursuant to paragraph (1).

(f) Notwithstanding any other law, or any other contrary state requirement, the department shall take whatever action is necessary to ensure that, to the extent there is capacity in its certified match, an LEA shall be reimbursed retroactively for the maximum period allowed by the federal government for any department change that results in an increase in reimbursement to LEA providers.

(g) The department may undertake all necessary activities to recoup matching funds from the federal government for reimbursable services that have already been provided in the state's public schools. The department shall prepare and take whatever action is necessary to implement all regulations, policies, state plan amendments, and other requirements necessary to achieve this purpose.

(h) The department shall, on or before December 31 of each year, file with the Legislature, and publish on its internet website, an annual report that shall include at least all of the following:

(1) A copy of the annual comparison required by subdivision (m).

(2) A state-by-state comparison of school-based Medicaid total and per eligible child claims and federal revenues. The comparison shall include a review of the most recent two years for which completed data is available.

(3) A summary of department activities, including training for LEAs, and an explanation of how each activity contributed toward narrowing the gap between California's per eligible student federal fund recovery and the per student recovery of the top three states.

(4) A listing of all school-based services, activities, and providers approved for reimbursement by the federal Centers for Medicare and Medicaid Services in other state plans that are not yet approved for reimbursement in California's state plan and the service unit rates approved for reimbursement.

(5) The official recommendations made to the department by the entities named in subdivision (e) and the action taken by the department regarding each recommendation.

(6) A one-year timetable for state plan amendments and other actions necessary to obtain reimbursement for those items listed in paragraph (4).

(7) Identification of any barriers to LEA reimbursement, including those specified by the entities named in subdivision (e), that are not imposed by federal requirements, and a description of the actions that have been, and will be, taken to eliminate them.

(8) (A) A statewide summary of financial findings related to the process identified in the program guide for the most recently completed audited state fiscal year. The summary of findings shall be updated in subsequent years until all filed CRCS reports have been audited.

(B) For purposes of subparagraph (A), the "most recently completed audited state fiscal year" means the most recent state fiscal year where 70 percent or more of the filed CRCSs have been audited.

(C) A description of changes to the cost settlement process that shall include all of the following:

(i) A summary of the number of audits conducted of Medi-Cal Billing Option program CRCSs.

(ii) A summary of the difference between interim reimbursement and the CRCSs.

(iii) A summary related to audit findings of noncompliance.

(i) The department shall provide semiannual Medi-Cal Billing Option billing forums to LEAs to provide guidance on appropriate billing practices.

(j) The department shall make targeted technical assistance available to LEAs that experience a 25 percent or greater difference between their submitted cost report and the final audited settlement, including assisting LEAs to understand the actions needed to reduce differences between submitted cost reports and the final audited settlement.

(k) (1) The department's administration of the LEA Medi-Cal Billing Option program shall be funded and staffed by proportionately reducing federal Medicaid payments allocable to LEAs for the provision of benefits funded by the federal Medicaid program under

the billing option for services by LEAs. Moneys collected as a result of the reduction in federal Medicaid payments allocable to LEAs shall be deposited into the Local Educational Agency Medi-Cal Recovery Fund, which is hereby established in the Special Deposit Fund established pursuant to Section 16370 of the Government Code. These funds shall be used, upon appropriation by the Legislature, only to support the department to meet all the requirements of administering the LEA Medi-Cal Billing Option program. If at any time this section is repealed, it is the intent of the Legislature that all funds in the Local Educational Agency Medi-Cal Recovery Fund be returned proportionally to all LEAs whose federal Medicaid funds were used to create this fund. The annual amount withheld pursuant to this paragraph shall not exceed 5 percent of total Medicaid payments allocable to LEAs for the provision of benefits funded by the federal Medicaid program under the billing option for services by LEAs.

(2) Moneys collected under paragraph (1) shall be proportionately reduced from federal Medicaid payments to all participating LEAs so that no one LEA loses a disproportionate share of its federal Medicaid payments.

(l) (1) The department may enter into a sole source contract to comply with the requirements of this section.

(2) The level of additional staff to comply with the requirements of this section, including, but not limited to, staff for which the department has contracted for pursuant to paragraph (1), shall be limited to that level that can be funded with revenues derived pursuant to subdivision (i).

(m) The activities of the department shall include all of the following:

(1) An annual comparison of the school-based Medicaid systems in comparable states.

(2) Efforts to improve communications with the federal government, the State Department of Education, and LEAs.

(3) The development and updating of written guidelines to LEAs regarding best practices to avoid audit exceptions, as needed.

(4) The establishment and maintenance of an LEA user-friendly, interactive internet website.

(5) Collaboration with the State Department of Education to help ensure LEA compliance with state and federal Medicaid requirements and to help improve LEA participation in the Medi-Cal Billing Option for LEAs.

(Amended by Stats. 2024, Ch. 492, Sec. 17. (SB 1511) Effective January 1, 2025.)

14116. The director of a county agency which administers the provisions of this chapter and also administers medical facilities may not delegate to an employee the decision to authorize or deny aid under this chapter, if he has also delegated authority to that employee to operate or participate in the operation of any such medical facility.

(Added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)

14117. Information relating to the medication provided to Medi-Cal recipients, shall be disclosed by the department or its agents, to physicians who are treating those same recipients as patients, upon request of the treating physician.

(Added by Stats. 1978, Ch. 1327.)

14119. The director shall employ sufficient consultants to assure compliance with the provisions of this code and the regulations, and the protection of the best interests of the state, and no county shall employ such consultants. However, if the director finds that it is not reasonable in specific cases to transfer to state employment a consultant employed by a county and that the consultant function is being performed according to statewide standards, he may authorize the county to continue to provide that particular consultant service.

As used in this section, a “consultant” means a person who reviews the procedures, charges and services of providers under this chapter, and who grants prior authorizations to providers.

(Amended by Stats. 1969, Ch. 21.)

14120. (a) At the beginning of each fiscal year, for the current fiscal year, the director shall establish a monthly schedule of anticipated total payments and anticipated payments for categories of services, according to the categories established in the Governor’s Budget. The schedule will be revised quarterly.

(b) The director shall report actual total payments and payments for categories of services, as set forth in subdivision (a), monthly to the Director of Finance and to the Joint Legislative Budget Committee.

(c) At any time during the fiscal year, if the director has reason to believe that the total cost of the program will exceed available funds, the director may first modify the method or amount of payment for services provided that no amount shall be reduced more than 10 percent and no modification will conflict with federal law. If such modification is not sufficient to bring the program within available funds, the director may postpone elective services in the schedule of benefits. Such postponement of elective services shall be accomplished by changing the standards for approval of requests for prior authorizations. Such changes shall be designed

to insure that those recipients most in need of elective services receive them first within the funds available, but that no particular service is completely eliminated.

(d) At any time during the fiscal year, if the total amounts paid since the beginning of the fiscal year exceed by 10 percent the amounts scheduled, the director shall immediately institute the action set forth in subdivision (c).

(e) At any time during the fiscal year, if the total amounts paid for any category of service exceeds by 10 percent the amounts scheduled (other than services for which the method or amount of payment is prescribed by the United States Secretary of Health and Human Services pursuant to Title XIX of the federal Social Security Act), the director shall modify the method or amount of payment for such category of service to assure that the total amount paid for such category of service in the fiscal year shall be less than 10 percent in excess of the total amount scheduled provided the total cost of the program to the State General Fund shall not exceed appropriated state general funds.

(f) Before any of the above actions are taken by the director, he or she shall consult with representatives of concerned provider groups.

(g) Notwithstanding subdivision (c) or (e), the director shall not reduce the amount of payment, under the circumstances described in subdivision (c) or (e), for the ingredient cost component of pharmaceutical services rendered by pharmacist providers in California.

(Amended by Stats. 1988, Ch. 1444, Sec. 1. Effective September 28, 1988.)

14122. The department may provide, by regulation and consistent with the requirements of the Federal Social Security Act, for the care and treatment, or both, of persons eligible for medical assistance pursuant to Sections 14005.1, 14005. 4, and 14005.7 by providers in another state in those cases where out-of-state care or treatment is rendered on an emergency basis or is otherwise in the best interests of the person under the circumstances.

(Amended by Stats. 1977, Ch. 1252.)

14123. Participation in the Medi-Cal program by a provider of service is subject to suspension in order to protect the health of the recipients and the funds appropriated to carry out this chapter.

(a) (1) The director may suspend a provider of service from further participation under the Medi-Cal program for violation of any provision of this chapter or Chapter 8 (commencing with Section 14200) or any rule or regulation promulgated by the director pursuant to those chapters. The suspension may be for an indefinite or specified period of time and with or without conditions, or may be imposed with the operation of the suspension stayed or probation granted. The director shall suspend a provider of service for conviction of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service.

(2) If the provider of service is a clinic, group, corporation, or other association, conviction of any officer, director, or shareholder with a 10 percent or greater interest in that organization, of a crime described in paragraph (1) shall result in the suspension of that organization and the individual convicted if the director believes that suspension would be in the best interest of the Medi-Cal program. If the provider of service is a political subdivision of the state or other government agency, the conviction of the person in charge of the facility of a crime described in paragraph (1) may result in the suspension of that facility. The record of conviction or a certified copy thereof, certified by the clerk of the court or by the judge in whose court the conviction is had, shall be conclusive evidence of the fact that the conviction occurred. A plea or verdict of guilty, or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section.

(3) After conviction, but before the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal, the director, if they believe that suspension would be in the best interests of the Medi-Cal program, may order the suspension of a provider of service. When the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence irrespective of any subsequent order under Section 1203.4 of the Penal Code allowing a person to withdraw their plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment, the director shall order the suspension of a provider of service. The suspension shall not take effect earlier than the date of the director's order. Suspension following a conviction is not subject to the proceedings required in subdivision (c). However, the director may grant an informal hearing at the request of the provider of service to determine in the director's sole discretion if the circumstances surrounding the conviction justify rescinding or otherwise modifying the suspension provided for in this subdivision.

(4) If the provider of service appeals the conviction and the conviction is reversed, the provider may apply for reinstatement to the Medi-Cal program after the conviction is reversed. Notwithstanding Section 14124.6, the application for reinstatement shall not be subject to the one-year waiting period for the filing of a reinstatement petition pursuant to Section 11522 of the Government Code.

(b) (1) Whenever the director receives written notification from the Secretary of the United States Department of Health and Human Services that a physician or other individual practitioner has been suspended from participation in the Medicare or Medicaid

programs, the director shall promptly suspend the practitioner from participation in the Medi-Cal program and notify the Administrative Director of the Division of Workers' Compensation of the suspension, in accordance with paragraph (2) of subdivision (e). This automatic suspension is not subject to the proceedings required in subdivision (c). No payment from state or federal funds may be made for any item or service rendered by the practitioner during the period of suspension.

(2) If the practitioner suspended from participation in the Medicare Program or Medicaid program is a participant in the Medi-Cal program, the director may request a waiver as permitted by federal law, including, but not limited to, Section 1320a-7(d)(3)(B)(i) of Title 42 of the United States Code if the suspension was based solely on conduct that is not deemed to be unprofessional conduct under California law. The department shall seek any federal approvals it deems necessary to implement this paragraph. This paragraph shall be implemented only to the extent that the department obtains any necessary federal approvals and federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

(3) 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 paragraph (2), in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or similar written instructions.

(c) The proceedings for suspension shall be conducted pursuant to Section 100171 of the Health and Safety Code. The director may temporarily suspend any provider of service prior to any hearing when in their opinion that action is necessary to protect the public welfare or the interests of the Medi-Cal program. The director shall notify the provider of service of the temporary suspension and the effective date thereof and at the same time serve the provider with an accusation. The accusation and all proceedings thereafter shall be in accordance with Section 100171 of the Health and Safety Code. Upon receipt of a notice of defense by the provider, the director shall set the matter for hearing within 30 days after receipt of the notice. The temporary suspension shall remain in effect until such time as the hearing is completed and the director has made a final determination on the merits. The temporary suspension shall, however, be deemed vacated if the director fails to make a final determination on the merits within 60 days after the original hearing has been completed. This subdivision does not apply where the suspension of a provider is based upon the conviction of any crime involving fraud, abuse of the Medi-Cal program, or suspension from the federal Medicare Program. In those instances, suspension shall be automatic.

(d) (1) The suspension by the director of any provider of service shall preclude the provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association to the Medi-Cal program for any services or supplies the provider has provided under the program, except for services or supplies provided prior to the suspension. No clinic, group, corporation, or other association which is a provider of service shall submit claims for payment to the Medi-Cal program for any services or supplies provided by a person within the organization who has been suspended or revoked by the director, except for services or supplies provided prior to the suspension.

(2) If the provisions of this chapter, Chapter 8 (commencing with Section 14200), or the regulations promulgated by the director are violated by a provider of service that is a clinic, group, corporation, or other association, the director may suspend the organization and any individual person within the organization who is responsible for the violation.

(e) (1) Notice of the suspension shall be sent by the director to the provider's state licensing, certifying, or registering authority, along with the evidence upon which the suspension was based.

(2) At the same time notice is provided pursuant to paragraph (1), the director shall provide written notification of the suspension to the Administrative Director of the Division of Workers' Compensation, for purposes of Section 139.21 of the Labor Code.

(f) In addition to the bases for suspension contained in subdivisions (a) and (b), the director may suspend a provider of service from further participation under the Medi-Cal dental program for the provision of services that are below or less than the standard of acceptable quality, as established by the California Dental Association Guidelines for the Assessment of Clinical Quality and Professional Performance, Copyright 1995, Third Edition, as periodically amended. The suspension shall be subject to the requirements contained in subdivisions (a) to (e), inclusive.

(Amended by Stats. 2023, Ch. 261, Sec. 5. (SB 487) Effective January 1, 2024.)

14123.05. The department shall develop, in consultation with provider representatives, including, but not limited to, physician, pharmacy, and medical supplies providers, a process that enables a provider to meet and confer with the appropriate department officials after the issuance of a letter notifying the provider of a payment suspension, pursuant to Section 14107.11, or a temporary suspension, pursuant to subdivision (a) of Section 14043.36, for the purpose of presenting and discussing information and evidence that may impact the department's decision to modify or terminate the sanction.

(Amended by Stats. 2012, Ch. 797, Sec. 25. (SB 1529) Effective January 1, 2013.)

14123.1. Subdivision (a) of Section 14123 as added by Section 2 of Chapter 994 of the Statutes of 1969 does not constitute a change in, but is declaratory of, the preexisting law, and shall be construed merely as providing a specific statutory basis for suspension.

(Added by Stats. 1976, Ch. 504.)

14123.2. Any provider or person that presents or causes to be presented a claim for services to an officer, employee, or agent of the state, or of any department or agency thereof as defined in appropriate state law, that the director determines is for a medical or other item or service that the person knows or has reason to know; (a) was not provided as claimed, or (b) payment for which may not be made under the program in the following instances: (1) when the person or provider has been suspended from participation in the program, or (2) when the department determines that the services or items claimed are substantially in excess of the needs of individuals or are of a quality that fails to meet professionally recognized standards of health care, or (3) when the department determines that a person has demonstrated a pattern of abusive overbilling of the program, or (4) when the department determines that a person has intentionally or negligently made a false statement or representation on any request for payment submitted to the Medi-Cal program; or (c) is submitted in violation of an agreement between the person and the state, shall be subject in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than three times the amount claimed for each item or service. For continuing intentional violations, a civil money penalty of not more than three times the amount claimed for each item or service may be imposed for each day the violation continues.

The director shall make the determination to assess civil money penalties and shall be responsible for the collection of the penalty amounts.

The provider or person subjected to a civil money penalty may appeal any decision by the director to assess the penalty pursuant to Section 100171 of the Health and Safety Code.

Notwithstanding any other provisions of law, all money collected pursuant to this section shall be deposited in the General Fund on a monthly basis.

(Amended by Stats. 1997, Ch. 220, Sec. 37. Effective August 4, 1997.)

14123.25. (a) In lieu of, or in addition to, the imposition of any other sanction available to it, including the sanctions and penalties authorized under Section 14123.2 or 14171.6, and as the “single state agency” for California vested with authority to administer the Medi-Cal program, the department shall exercise the authority granted to it in Section 1002.2 of Title 42 of the Code of Federal Regulations, and may also impose the mandatory and permissive exclusions identified in Section 1128 of the federal Social Security Act (42 U.S.C. Sec. 1320a-7), and its implementing regulations, and impose civil penalties identified in Section 1128A of the federal Social Security Act (42 U.S.C. Sec. 1320a-7a), and its implementing regulations, against applicants and providers, as defined in Section 14043.1, or against billing agents, as defined in Section 14040.1. The department may also terminate, or refuse to enter into, a provider agreement authorized under Section 14043.2 with an applicant or provider, as defined in Section 14043.1, upon the grounds specified in Section 1866(b)(2) of the federal Social Security Act (42 U.S.C. Sec. 1395cc(b)(2)). Notwithstanding Section 100171 of the Health and Safety Code or any other provision of law, any appeal by an applicant, provider, or billing agent of the imposition of a civil penalty, exclusion, or other sanction pursuant to this subdivision shall be in accordance with Section 14043.65, except that where the action is based upon a conviction for any crime involving fraud or abuse of the Medi-Cal, Medicaid, or Medicare programs, or an exclusion by the federal government from the Medicaid or Medicare programs, the action shall be automatic and not subject to appeal or hearing.

(b) In addition, the department may impose the intermediate sanctions identified in Section 1846 of the Social Security Act (42 U.S.C. Sec. 1395w-2), and its implementing regulations, against any provider that is a clinical laboratory, as defined in Section 1206 of the Business and Professions Code. The imposition and appeal of this intermediate sanction shall be in accordance with Article 8 (commencing with Section 1065) of Chapter 2 of Division 1 of Title 17 of the California Code of Regulations.

(c) (1) In addition, the department may issue a written warning notice of improper billing or improper cost report computation, which shall specifically identify the statute, regulation, or rule that is being violated, to a provider via certified mail, return receipt requested, whenever a review of the provider’s paid claims or a provider’s cost report demonstrates a pattern of improper billing or improper cost report computation. The review shall not take into account claims that were denied or payment reductions. The warning notice shall be in a format that specifically apprises the provider of the item or service improperly billed and, if applicable, the deficiencies in the manner in which provider costs were computed. The warning notice may be issued with annual cost report audit findings, or in addition to any audit or any other action that the department is authorized to take. The failure of the department to exercise its discretion to issue the warning notice shall not limit its authority to audit or take any action authorized by law. The warning notice shall provide the provider with the opportunity to contest the warning notice and explain to the department the correctness of the provider’s bill or cost report computation. If the department accepts the provider’s explanation, in whole or in part, no further action related to the notice or part of the notice that the department accepts as correct shall be taken pursuant to this section.

(2) Civil money penalties may be imposed in the following circumstances:

(A) If a provider presents or causes to be presented claims for payment by the Medi-Cal program that are:

(i) Billed improperly, and are for a service or item about which the provider has received two or more warning notices of improper billing, the provider may, in addition to any other penalties that may be prescribed by law, be subject to a civil

money penalty of one hundred dollars ($100) per claim, or up to two times the amount improperly claimed for each item or service, whichever is greater.

(ii) For a service or item for which the department solicits provider costs for use in calculating Medi-Cal reimbursement or in calculating and assigning Medi-Cal reimbursement rates, the cost reports relevant to the claims are improperly calculated, and the provider has received two or more warning notices of improper cost report computation regarding substantially similar errors, the provider may, in addition to any other penalties that may be prescribed by law, be subject to a civil money penalty of one hundred dollars ($100) per adjustment by the department to the costs submitted by the provider, or up to two times the amount improperly claimed for each item or service, whichever is greater.

(B) If a provider presents or causes to be presented claims for payment by the Medi-Cal program that are:

(i) Billed improperly, and are for a service or item about which the provider has received three or more warning notices of improper billing, or has been assessed a penalty under subparagraph (A), the provider may, in addition to any other penalties that may be prescribed by law, be subject to a civil money penalty of one thousand dollars ($1,000) per claim, or up to three times the amount improperly claimed for each item or service, whichever is greater.

(ii) For a service or item for which the department solicits provider costs for use in calculating Medi-Cal reimbursement or in calculating and assigning Medi-Cal reimbursement rates, and the cost reports relevant to the claims are improperly calculated, and the provider has received three or more warning notices of improper cost report computation regarding substantially similar errors, or has been assessed a penalty under subparagraph (A), the provider may, in addition to any other penalties that may be prescribed by law, be subject to a civil money penalty of one thousand dollars ($1,000) per adjustment by the department to the costs submitted by the provider, or three times the amount claimed for each item or service, whichever is greater.

(3) Any provider subjected to civil money penalties under paragraph (2) may appeal the decision to assess penalties pursuant to Section 100171 of the Health and Safety Code.

(Amended by Stats. 2005, Ch. 22, Sec. 227. Effective January 1, 2006.)

14124. Notice of any suspension under Section 14123, along with any information obtained as a result of the director's investigation shall be sent by the director to the appropriate state licensing, certifying or registering authority. The director may in any event provide information obtained as a result of its investigation to such appropriate state agency at any time.

Nothing contained in this section shall limit the state licensing, certifying or registering authority's power to conduct at any time independent investigations and proceedings concerning the revocation or suspension of any person's license, certificate or registration. No action taken by the state licensing, certifying, or registering authority shall have any effect upon a suspension under Section 14123.

The word "suspension" as used in this section shall mean a final suspension after all administrative and judicial remedies are exhausted.

(Added by Stats. 1969, Ch. 1386.)

14124.1. Each provider, as defined in Section 14043.1, of health care services rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, shall keep and maintain records of each service rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, the beneficiary or person to whom rendered, the date the service was rendered, and any additional information as the department may by regulation require. Records required to be kept and maintained under this section shall be retained by the provider for a period of 10 years from the final date of the contract period between the plan and the provider, from the date of completion of any audit, or from the date the service was rendered, whichever is later, in accordance with Section 438.3(u) of Title 42 of the Code of Federal Regulations.

(Amended by Stats. 2017, Ch. 511, Sec. 25. (AB 1688) Effective January 1, 2018.)

14124.2. (a) (1) During normal working hours, the department may make any examination of the books and records of, and may visit and inspect the premises or facilities of, those identified in paragraphs (2) and (3), that it may deem necessary to carry out the provisions of this chapter or Chapter 8 (commencing with Section 14200) and regulations adopted thereunder, or the law under which the department or its agents or contractors administer any other health care program.

(2) Any applicant or provider, as defined in Section 14043.1, pertaining to services, goods, supplies, or merchandise rendered or supplied, directly or indirectly, or to be rendered or supplied, directly or indirectly, to any beneficiary under this chapter or Chapter 8 (commencing with Section 14200).

(3) Any person or entity that provides services, goods, supplies, or merchandise, directly or indirectly, under, or seeks reimbursement from, any other health care program administered by the department or its agents or contractors.

(b) (1) Applicants, providers, or others receiving or seeking reimbursement under the Medi-Cal program or other health care programs administered by the department or its agents or contractors shall furnish information or copies of records and documentation upon request by the department. Unannounced visits to request this information shall be reserved for those exceptional situations where arrangement of an appointment beforehand is clearly not possible or is clearly inappropriate to the nature of the intended visit. Only those related books and records of each service rendered, the beneficiary to whom rendered, the date, and additional information as the department may by regulation require shall be subject to the requirement of furnishing copies. This information may include records to support and document the recipient's eligibility for services and, to the extent necessary, records to provide proof of the quantity and receipt of the services, and that the services were provided by proper personnel. Providers and others subject to this section shall be reimbursed for reasonable photocopying-related expenses as determined by the department. Failure to comply with the requests for information or records made pursuant to this section shall be grounds for immediate suspension of the provider or others subject to this section under subdivision (b) of Section 14123 or under the other health care programs administered by the department or its agents or contractors.

(2) Any copies furnished pursuant to this section shall be used only to investigate and pursue criminal, civil, or administrative sanctions for Medi-Cal fraud or abuse, including the provision of dental services that are below or less than the standard of acceptable quality as prescribed by subdivision (f) of Section 14123, or fraud or abuse under any other health care program administered by the department or its agents or contractors and the copies shall be destroyed when that purpose has been satisfied. This section shall not be construed to prohibit the referral of investigative findings, including copies of books and records, to the appropriate federal, state, or local licensing, certifying, regulatory, or prosecutorial authority.

(c) For purposes of this section and Section 14124.1, "provider" shall be defined as follows:

(1) "Provider" shall have the meaning contained in Section 14043.1.

(2) "Provider" shall also include any person or entity under contract with the provider, as defined in paragraph (1), to assist in the application process or eligibility determination.

(Amended by Stats. 2000, Ch. 322, Sec. 31. Effective January 1, 2001.)

14124.3. Notice of any act of the department required by law or department regulation to be given may be signed and given by the director or an authorized employee of the department and may be made personally or by mail. If made by mail, service shall be made in the manner prescribed by Section 1013 of the Code of Civil Procedure. In the case of service by mail, the service is complete at the time of deposit in the United States Post Office.

(Added by Stats. 1970, Ch. 1030.)

14124.4. The director may on his own motion at any time before a suspension is placed into effect and without further proceedings, review the penalty against a provider, but such review shall be limited to reduction of such penalty.

(Added by Stats. 1970, Ch. 1030.)

14124.5. (a) The director may, in accordance with Section 10725, adopt, amend, or repeal, in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, reasonable rules and regulations as may be necessary or proper to carry out the purposes and intent of this chapter, and to enable the department to exercise the powers and perform the duties conferred upon it by this chapter, not inconsistent with any statute of this state.

(b) All regulations previously adopted by the State Department of Health Care Services or any predecessor department pursuant to this chapter and in effect immediately preceding the operative date of this section, shall remain in effect and shall be fully enforceable unless and until readopted, amended, or repealed by the director in accordance with Section 10725.

(Amended by Stats. 2014, Ch. 442, Sec. 25. (SB 1465) Effective September 18, 2014.)

14124.6. In the event the director orders that oral argument or a hearing be held upon a petition for reinstatement or reduction of penalty filed pursuant to Section 11522 of the Government Code, he or she may hear and decide the matter himself or herself or may, in his or her discretion, either (1) sit and hear the matter with an administrative law judge assigned by the department or (2) assign the matter to an administrative law judge assigned by the department who shall proceed in accordance with Section 100171 of the Health and Safety Code, and who shall prepare a proposed decision for the department for action pursuant to Section 11517 of the Government Code.

(Amended by Stats. 1997, Ch. 220, Sec. 38. Effective August 4, 1997.)

14124.7. (a) No long-term health care facility participating as a provider under the Medi-Cal program shall seek to evict out of the facility or, effective January 1, 2002, transfer within the facility, any resident as a result of the resident changing his or her manner of purchasing the services from private payment or Medicare to Medi-Cal, except that a facility may transfer a resident from a private room to a semiprivate room if the resident changes to Medi-Cal payment status. This section also applies to residents who have made a timely and good faith application for Medi-Cal benefits and for whom an eligibility determination has not yet been made.

(b) This section does not apply to any resident of a skilled nursing facility or intermediate care facility, receiving respite care services, as defined in Section 1418.1 of the Health and Safety Code, unless it is already being provided through a Medicaid waiver program pursuant to Section 1396n of Title 42 of the United States Code, or is already allowed as a covered service by the Medi-Cal program.

(c) Nothing in this section shall limit a facility's ability to transfer a resident within a facility, as provided by law, because of a change in a resident's health care needs or if the bed retention would result in there being no available Medicare-designated beds within a facility.

(d) This section shall be implemented only to the extent it does not conflict with federal law.

(Amended by Stats. 2000, Ch. 451, Sec. 34. Effective January 1, 2001.)

14124.10. (a) No licensed long-term health care facility participating as a provider under the Medi-Cal program shall discriminate against a Medi-Cal patient on the basis of the source of payment for the facility's services that are required to be provided to individuals entitled to services under the Medi-Cal program. Nothing in this section shall be construed to prohibit a facility from charging private-pay patients for services required to be provided to Medi-Cal patients or which are in addition to those required under the Medi-Cal program.

(b) (1) A long-term health care facility participating as a provider under the Medi-Cal program shall provide aid, care, service, and other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public, regardless of payment source. This subdivision applies to, but is not limited to, admission practices, room selection and placements except as specified in subdivisions (a) and (c) of Section 14124.7, and meal provision.

(2) The Legislature hereby finds and declares that this subdivision does not constitute a change in law and policy, but is declaratory of existing law and the Medi-Cal Provider Agreement and therefore the requirements imposed by this subdivision shall not be considered a new state mandate for the purposes of reimbursement pursuant to Article 3.8 (commencing with Section 14126) of this chapter or any other Medi-Cal ratesetting provisions of any law, regulation, or the California Medicaid State Plan.

(3) 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 Centers for Medicare and Medicaid Services, that reimbursement by the Medi-Cal program to long-term health care facilities for costs associated with this section is required by state or federal law or regulation, this subdivision shall become operative only upon appropriation by the Legislature.

(c) Nothing in this section shall limit a facility's ability to provide aid, care, service, and other benefits available under Medi-Cal in the manner, method, scope, and level appropriate based upon resident acuity and health care needs.

(d) This section shall be implemented only to the extent that it does not conflict with federal law and that any necessary federal approvals are obtained and federal financial participation for the Medi-Cal program is available and is not otherwise jeopardized.

(Amended by Stats. 2024, Ch. 339, Sec. 4. (SB 1354) Effective January 1, 2025.)

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.

(Added by Stats. 2008, Ch. 758, Sec. 48. Effective September 30, 2008.)

14124.12. (a) (1) Notwithstanding any other law, for the duration of the COVID-19 emergency period, the department shall implement any federal Medicaid program waiver or flexibility approved by the federal Centers for Medicare and Medicaid Services related to the COVID-19 public health emergency. This includes, but is not limited to, any waiver or flexibility approved pursuant to Sections 1315, 1320b-5, or 1396n of Title 42 of the United States Code, or the Medi-Cal state plan. Any request for a federal Medicaid program waiver or flexibility shall be subject to Department of Finance approval before the department submits that request to the federal Centers for Medicare and Medicaid Services.

(2) During the COVID-19 emergency period, and through December 31, 2022, for any extended waiver or flexibility described in subdivision (f), if there is a conflict between this chapter, Chapter 8 (commencing with Section 14200), Chapter 8.8 (commencing with Section 14600), or Chapter 8.9 (commencing with Section 14700), and any approved federal waiver or flexibility, as described in paragraph (1), the approved federal waiver or flexibility shall control over any conflict in the specified state law.

(b) (1) To the extent that federal financial participation is available, the department, subject to Department of Finance approval, shall exercise its option under Section 1396a(a)(10)(A)(ii)(XXIII) of Title 42 of the United States Code to extend the medical assistance, as described in Section 1396a(a)(10)(A)(ii)(XVIII) of Title 42 of the United States Code, to uninsured individuals, as defined in Section 1396a(ss) of Title 42 of the United States Code, for the duration of the COVID-19 emergency period.

(2) The department, subject to Department of Finance approval, may seek federal approval pursuant to Section 1315 of Title 42 of the United States Code to extend the medical assistance afforded to uninsured individuals pursuant to paragraph (1) to include COVID-19-related treatment services that are otherwise covered for full-scope Medi-Cal beneficiaries, as defined by the department. If federal financial participation is unavailable, the department, subject to Department of Finance approval, may elect to implement this paragraph on a state-only funding basis, and subject to an appropriation by the Legislature.

(c) Notwithstanding any other law, the department shall seek to maximize federal financial participation for Medi-Cal expenditures that it determines to be available for the COVID-19 public health emergency, and shall comply with any federal requirements and conditions for receipt of that federal financial participation. This includes, but is not limited to, the temporary increase in the federal medical assistance percentage made available pursuant to Section 6008 of the federal Families First Coronavirus Response Act (Public Law 116-127).

(d) Due to the impact of the COVID-19 public health emergency on the department's ongoing administration of the Medi-Cal program, the department may seek any federal approvals it deems necessary for any number of temporary extensions of all or select components of the California Medi-Cal 2020 Demonstration (No. 11-W-00193/9) pursuant to Article 5.5 (commencing with Section 14184), which is scheduled to expire on December 31, 2020. If the department elects to seek any extension, the department shall determine the length of time for the extension sought and whether to seek an extension for the entirety of the demonstration or select components of the demonstration. In implementing this subdivision, the department, to the extent practicable, shall consult with affected stakeholder entities before seeking a temporary extension.

(e) The department, subject to Department of Finance approval, shall seek any federal approvals it deems necessary to implement this section or to maintain sufficient access to covered benefits under the Medi-Cal program during the COVID-19 emergency period. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(f) (1) (A) The department shall seek any federal approvals it deems necessary to extend the approved waiver or flexibility implemented pursuant to subdivision (a), as of July 1, 2021, that are related to the delivery and reimbursement of services via telehealth modalities in the Medi-Cal program. Subject to subdivision (e), the department shall implement those extended waivers or

flexibilities for which federal approval is obtained, to commence on the first calendar day immediately following the last calendar day of the federal COVID-19 public health emergency period, and through December 31, 2022.

(B) Subject to subdivision (e), the department may authorize the use of remote patient monitoring as an allowable telehealth modality for covered health care services and provider types it deems appropriate for dates of service on or after July 1, 2021. The department may establish a fee schedule for applicable health care services delivered via remote patient monitoring.

(2) (A) For purposes of informing the 2022–23 proposed Governor's Budget, released in January 2022, the department shall convene an advisory group consisting of consultants, subject matter experts, and other affected stakeholders to provide recommendations to inform the department in establishing and adopting billing and utilization management protocols for telehealth modalities to increase access and equity and reduce disparities in the Medi-Cal program. The advisory group shall analyze the impact of telehealth in increased access for patients, changes in health quality outcomes and utilization, best practices for the appropriate mix of in-person visits and telehealth, and the benefits or liabilities of any practice or care model changes that have resulted from telephonic visits.

(B) The advisory group shall include representatives of the California Medical Association, the California Primary Care Association, the California Association of Public Hospitals, the County Behavioral Health Directors Association, Medi-Cal managed care plans, Planned Parenthood Affiliates of California, Essential Access Health, and other subject matter experts or other affected stakeholders as identified by the department.

(3) For purposes of implementing this subdivision, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this paragraph shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(4) Nothing in this subdivision shall be construed to limit coverage of, and reimbursement for, telehealth modalities that are the type authorized by the department prior to the COVID-19 emergency period and described in the Medi-Cal State Plan, the Medi-Cal provider manual, or other departmental guidance.

(g) (1) Notwithstanding any other law, subject to appropriation by the Legislature and Section 11.95 of the Budget Act of 2021, the department shall implement those activities and expenditures to enhance, expand, or strengthen home and community-based services (HCBS) under the Medi-Cal program that are approved by the federal Centers for Medicare and Medicaid Services pursuant to Section 9817 of the federal American Rescue Plan Act of 2021 (Public Law 117-2) and associated federal guidance.

(2) Notwithstanding any other law, the department shall comply with any federal requirements and conditions as necessary to claim the increased federal medical assistance percentage for eligible HCBS expenditures pursuant to Section 9817 of the federal American Rescue Plan Act of 2021 (Public Law 117-2) and associated federal guidance.

(3) Notwithstanding any other law, stipends or payments received by an individual from initiatives included in the approved HCBS spending plan described in this subdivision shall not be considered income or resources for purposes of determining the individual's, or any member of their household's, eligibility for benefits or assistance, or the amount or extent of benefits or assistance, under any state or local benefit or assistance program, to the extent permitted under federal law and, where applicable, to the extent any necessary federal approvals are obtained.

(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, the State Department of Social Services, the California Department of Aging, the State Department of Public Health, the State Department of Developmental Services, the State Department of Rehabilitation, and the Department of Health Care Access and Information, as applicable, may implement, interpret, or make specific this subdivision and any HCBS activity described in paragraph (1) by means of all-county letters, plan letters, provider bulletins, or other similar instructions, without taking any further regulatory action.

(5) For purposes of implementing this subdivision and any HCBS activity described in paragraph (1), the department, the State Department of Social Services, the California Department of Aging, the State Department of Public Health, the State Department of Developmental Services, the State Department of Rehabilitation, and the Department of Health Care Access and Information, as applicable, may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this paragraph, and the implementation of any HCBS activity described in paragraph (1), shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Chapters 7 (commencing with Section 9530) and 7.5 (commencing with Section 9540) of Division 8.5 of this code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(6) Any funding made available to the Traumatic Brain Injury Program in the State Department of Rehabilitation pursuant to paragraph (1) shall be exempted from subdivision (b) of Section 4355, subdivision (b) of Section 4357, and subdivision (c) of Section 4357.1.

(h) Notwithstanding any other law, subject to subdivision (e), the department shall align COVID-19 vaccine administration payments to payment reimbursement structures for vaccines administered in accordance with the Medi-Cal State Plan.

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

(j) For purposes of this section, the following definitions apply:

(1) “COVID-19 emergency period” has the same meaning as “emergency period” as defined in Section 1320b-5(g)(1)(B) of Title 42 of the United States Code, unless otherwise defined in federal law or any federal approval obtained pursuant to this section.

(2) “COVID-19 public health emergency” means the Public Health Emergency declared by the Secretary of the United States Department of Health and Human Services on January 31, 2020, pursuant to Section 247d of Title 42 of the United States Code, and entitled “Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus,” including any subsequent renewal of that declaration.

(Amended by Stats. 2024, Ch. 40, Sec. 62. (SB 159) Effective June 29, 2024.)

14124.13. (a) The department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis for purpose of administering or implementing any federal grant awarded pursuant to the federal 21st Century Cures Act (Public Law 114-255), any subsequent amendments to that federal act, or any associated federal regulation or policy guidance.

(b) Contracts entered into or amended pursuant to this section shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(Added by Stats. 2017, Ch. 52, Sec. 29. (SB 97) Effective July 10, 2017.)

14124.14. (a) The department shall develop and submit an application to solicit a grant authorized under Section 9007 of the federal 21st Century Cures Act (42 U.S.C. Sec. 290bb-37) to develop a community-based crisis response plan. To the extent consistent with federal grant application requirements, the grant application shall include, at a minimum, a plan for all of the following:

(1) Promoting integration and coordination between local public and private entities engaged in crisis response, including first responders, emergency health care providers, primary care providers, law enforcement, court systems, health care payers, social service providers, and behavioral health providers.

(2) Developing memoranda of understanding with public and private entities to implement crisis response services.

(3) Addressing gaps in community resources for crisis intervention and prevention.

(4) Developing models for minimizing hospital emergency department utilization and readmissions, including through appropriate discharge planning.

(b) The department shall confer with stakeholders during the development of the grant application. Stakeholders shall include, but not be limited to, representatives from organizations that have experience responding to crisis care, including hospitals, first responders, emergency health care providers, primary care providers, law enforcement, court systems, health care payers, social service providers, behavioral health providers, and organizations representing consumers of behavioral health services and their significant support persons.

(c) If the department receives a grant under Section 9007 of the federal 21st Century Cures Act (42 U.S.C. Sec. 290bb-37), the department shall submit to the United States Secretary of Health and Human Services, at the time and in the manner, and containing the information, as the secretary may reasonably require, a report, including an evaluation of the effect of the grant on all of the following:

(1) Local crisis response services and measures for individuals receiving crisis planning and early intervention supports.

(2) Individuals reporting improved functional outcomes.

(3) Individuals receiving regular followup care following a crisis.

(d) The department shall submit a copy of the report described in subdivision (c) to the Legislature. A report submitted pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(e) This section shall become operative only if Congress appropriates funds for purposes of Section 9007 of the federal 21st Century Cures Act (42 U.S.C. Sec. 290bb-37).

(Added by Stats. 2018, Ch. 315, Sec. 1. (AB 2112) Effective January 1, 2019. Conditionally operative as prescribed by its own provisions.)

14124.15. (a) Effective January 1, 2023, subject to appropriation by the Legislature, the department shall design and implement a supplemental payment program for emergency medical air transportation services to increase the Medi-Cal reimbursement in an amount not to exceed normal and customary charges charged by qualified emergency medical air transportation providers.

(b) 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, in whole or in part, and any applicable federal waivers and state plan amendments by means of plan letters, plan or provider bulletins, or similar instructions without taking any further regulatory action.

(c) In implementing this section, the department shall seek any federal approvals it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(d) This section shall become inoperative if any of the following occurs:

(1) The federal Centers for Medicare and Medicaid Services denies approval for the implementation of this section.

(2) The Legislature fails to appropriate moneys for the program in the annual Budget Act, or fails to appropriate such moneys in a separate bill enacted within 30 days following enactment of the annual Budget Act.

(3) A lawsuit related to this section is filed against the state and a preliminary injunction or other order has been issued that results in a financial disadvantage to the state, including, but not limited to, a loss of federal financial participation.

(Added by Stats. 2021, Ch. 476, Sec. 3. (AB 1104) Effective October 4, 2021. Conditionally inoperative as prescribed by its own provisions.)

14124.16. (a) (1) Upon appropriation by the Legislature for this purpose, the department shall complete an independent analysis to determine whether network adequacy exists to obtain federal approval for a covered Medi-Cal benefit that provides housing support services. The analysis shall take into consideration all of the following in assessing capacity to provide a covered housing support services benefit:

(A) Providers that are not certified Medi-Cal providers, but are receiving funding from the United States Department of Housing and Urban Development to provide housing support services.

(B) The number of providers in relation to each region's or county's number of people experiencing homelessness.

(C) A comparison of provider networks in states that have implemented Medicaid benefits to fund housing support services, including any similar Medicaid benefits in California serving different populations.

(D) Specific actions the department could take to develop a network of providers meeting the criteria of this section, and an estimated timeline for developing an adequate network, should the analysis conclude that the state's network is not yet adequate.

(2) The department shall report, in compliance with Section 9795 of the Government Code, the outcomes of the independent analysis to the Legislature by January 1, 2024, so long as an appropriation is made as described in paragraph (1).

(b) For purposes of implementing this section, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(Added by Stats. 2021, Ch. 263, Sec. 2. (SB 171) Effective September 23, 2021.)