SB-97 Health. (2017-2018)

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Senate Bill No. 97

CHAPTER 52

An act to add and repeal Section 15438.11 of the Government Code, to amend Sections 1276.5, 1276.65, 1341.45, 1348.9, 100235, 101315, 101315.2, 101317, 101317.2, 104151, 120955, 120956, 120970, and 121025 of, to amend the heading of Article 6 (commencing with Section 101315) of Chapter 3 of Part 3 of Division 101 of, to add Chapter 6.1 (commencing with Section 120972) to Part 4 of Division 105 of, and to add and repeal Chapter 1.6 (commencing with Section 103870) of Part 2 of Division 102 of, the Health and Safety Code, to amend Sections 14005.30, 14105.45, 14105.456, 14124.70, 14124.71, 14124.72, 14124.73, 14124.74, 14124.785, 14124.82, 14124.83, 14126.022, 14131.10, 14132.99, 14132.100, 14132.276, 14132.277, 14148.8, 14154, 14166.61, 14182.16, 14182.17, 14182.18, 14186, 14186.1, 14186.2, 14186.3, 14186.4, 14301.2, 15893, and 15894 of, to amend and repeal Sections 12302.6, 14132.24, 14183.6, 14186.35, 14301.1, and 14593 of, to add Sections 14043.1, 14105.29, 14124.13, and 14132.991 to, to add Article 4.11 (commencing with Section 14149.9) to Chapter 7 of Part 3 of Division 9 of, to add and repeal Section 14042.1 of, to repeal Sections 12330, 14124.80, 14124.85, 14124.88, 14148.65, 14148.67, 14186.11, 14186.36, 15893.5, and 15895.5 of, to repeal and amend Section 14132.275 of, and to repeal and add Sections 14102, 14124.81, and 14124.86 of, the Welfare and Institutions Code, to repeal Section 166 of Chapter 717 of the Statutes of 2010, and to amend and repeal Section 34 of Chapter 37 of the Statutes of 2013, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor July 10, 2017. Filed with Secretary of State July 10, 2017.]

LEGISLATIVE COUNSEL'S DIGEST

SB 97, Committee on Budget and Fiscal Review. Health.

(1) The California Health Facilities Financing Authority Act authorizes the California Health Facilities Financing Authority to make grants from the continuously appropriated California Health Facilities Financing Authority Fund to participating health institutions for financing or refinancing the acquisition, construction, or remodeling of health facilities. Existing law authorizes the authority to award grants to any eligible health facility, as defined, for purposes of financing defined projects.

This bill would require the authority to award grants, not to exceed $250,000 each, to eligible health facilities that meet at least one of 3 specified requirements, including that the health facility is operated by a tax-exempt nonprofit corporation that is licensed to operate the health facility by the State of California, and the annual gross revenue of the health facility does not exceed $10,000,000. The bill would create the Lifeline Grant Program Subfund in the California Health Facilities Financing Authority Fund and would transfer and appropriate $20,000,000 that is not otherwise obligated or impressed with a trust for other purposes from a specified subfund within the California Health Facilities Financing Authority Fund to the Lifeline Grant Program Subfund for the authority to use for the grant program. The bill would make the moneys available for encumbrance or expenditure until June 30,

2020, and would revert any remaining moneys in the subfund to the originating subfund as of June 30, 2022. The bill would repeal the grant program as of January 1, 2023.

(2) Existing law provides for the licensure and regulation of health facilities, including skilled nursing facilities, by the State Department of Public Health. Among other requirements, these provisions require the department to develop regulations that establish staff-to-patient ratios for direct caregivers, as specified. These provisions define a direct caregiver to include, among other persons, a registered nurse and a certified nurse assistant. A violation of those provisions is a crime.

This bill would require, effective July 1, 2018, skilled nursing facilities, except those skilled nursing facilities that are a distinct part of a general acute care facility or a state-owned hospital or developmental center, to have a minimum number of direct care service hours, as defined, of 3.5 per patient day, except as specified. The bill would revise the definition of a direct caregiver to include a nursing assistant participating in an approved training program, as specified. The bill would also require the department to adopt regulations to create a waiver of the direct care service hour requirements and to evaluate the impact of these requirements, as specified. By changing the definition of crimes, the bill would impose a state-mandated local program.

Existing law requires the State Department of Public Health to develop the Skilled Nursing Facility Quality and Accountability Supplemental Payment System to provide supplemental payments to skilled nursing facilities that improve the quality and accountability of care rendered to residents in skilled nursing facilities. Existing law establishes the Skilled Nursing Facility Quality and Accountability Special Fund in the State Treasury, which is a continuously appropriated fund that contains moneys from the assessment of specified administrative penalties and set asides of General Fund moneys, for the purposes of making quality and accountability payments. Existing law requires the State Department of Public Health to assess a skilled nursing facility an administrative penalty if the department determines that the skilled nursing facility fails to meet specified nursing hours per patient per day requirements.

This bill would additionally require, beginning in the 2019–20 fiscal year, as specified, the department to assess a skilled nursing facility an administrative penalty if the department determines that the skilled nursing facility fails to meet the direct care service hours per patient per day requirements. By providing a new source of funds for a continuously appropriated fund, the bill would make an appropriation.

(3) Existing law, until January 1, 2018, authorizes the Director of the Department of Managed Health Care to establish, by regulation, the Consumer Participation Program, which allows the director to award reasonable advocacy and witness fees to any person or organization that represents consumers and has made a substantial contribution on behalf of consumers to the adoption of a regulation or with regard to an order or decision impacting a significant number of enrollees.

This bill would extend the sunset date for the Consumer Participation Program until January 1, 2024.

(4) Existing law establishes procedures and requirements to govern the allocation to, and expenditure by, local health jurisdictions, hospitals, long-term health care facilities, clinics, emergency medical systems, and poison control centers of federal funding received for the prevention of, and response to, bioterrorist attacks and other public health emergencies. Existing law requires, of the $16,000,000 appropriated in the Budget Act of 2006 for local health jurisdictions for the purpose of preparing California for public health emergencies, a baseline allocation of $125,000 to be provided to each local health jurisdiction first. Existing law requires a local health jurisdiction that receives funds pursuant to these provisions to deposit them in a special local public health preparedness trust fund, and requires the interest earned on moneys in the fund to accrue to the benefit of the fund and to be expended for the same purposes as other moneys in the fund.

This bill would instead require, of the funds appropriated in the annual Budget Act for local health jurisdictions for the purpose of preparing California for public health emergencies, a baseline allocation of $60,000 to be provided to each local jurisdiction first, subject to the availability of funds appropriated in the annual Budget Act or another statute. The bill would require the local health jurisdiction to deposit the funds received pursuant to these provisions in a specified account and would require these funds to be tracked and managed according to the specified account name. The bill would prohibit local health jurisdictions from retaining more than $500 in interest earned on moneys in the account and would require that interest to be returned to the department on an annual basis.

(5) Existing law, until January 1, 2021, requires the State Department of Health Care Services to annually reimburse the Robert F. Kennedy Farm Workers Medical Plan up to $3,000,000 per year for claim payments that exceed $70,000 made by the plan on behalf of an eligible employee or dependent for a single episode of care on or after September 1, 2016. The Robert F. Kennedy Farm Workers Medical Plan is a nonprofit voluntary employees beneficiary association, organized under federal law, that provides payments for health care and other benefits to its members.

This bill would extend that annual reimbursement requirement for an additional 5 years until January 1, 2026.

(6) Existing law requires the State Department of Public Health to conduct a program of epidemiological assessments of the incidence of Parkinson’s disease, as specified. Under existing law, these provisions may be implemented only to the extent funds

from federal or private sources are made available for this purpose. Existing law requires the director of the department to establish a statewide system for the collection of data regarding Parkinson's disease.

This bill additionally would establish the Richard Paul Hemann Parkinson's Disease Program, which, among other things, would require the department to collect data on the incidence of Parkinson's disease in California, as specified. Beginning July 1, 2018, the bill would require a hospital, facility, physician and surgeon, or other health care provider diagnosing or providing treatment to Parkinson's disease patients to report each case of Parkinson's disease to the department, as prescribed.

The bill would be implemented only to the extent funds are made available for its purposes. The bill would repeal these provisions on January 1, 2020.

(7) Existing law requires, under the Every Woman Counts Program, the State Department of Health Care Services to provide breast cancer and cervical cancer screening services for qualified low-income individuals. Existing law requires the department to provide the fiscal and appropriate policy committees of the Legislature with quarterly updates on caseload, estimated expenditures, and related program monitoring data for the program, as specified.

This bill would instead require the department to provide biannual updates, as specified, and would require, commencing with the 2017–18 fiscal year, expenditures for the program included in the department's budget for services provided on or after July 1, 2017, to be charged against the appropriation for the fiscal year in which the billing is paid.

(8) Existing law requires the State Department of Public Health, to the extent funding is appropriated in the annual Budget Act, to establish a program to provide drug treatments to persons infected with human immunodeficiency virus (HIV) and to persons who are HIV-negative who have been prescribed preexposure prophylaxis included on the AIDS Drug Assistance Program (ADAP) formulary for the prevention of HIV infection, as provided. Existing law also makes, if the department uses a contractor or subcontractor to administer any aspect of the program, all types of information, whether written or oral, concerning a client, made or kept in connection with the administration of the program confidential, and not subject to disclosure except for purposes directly connected with the administration of the program.

This bill would, among other things, also allow those contractors and subcontractors to disclose information for the purposes of coordinating client eligibility with programs funded by the federal Ryan White HIV/AIDS Program, if disclosure is otherwise authorized by law, and pursuant to written authorization by the person who is the subject of the record or by his or her guardian or conservator.

Existing law requires public health records related to HIV or acquired immunodeficiency syndrome (AIDS), containing personally identifying information, that were developed or acquired by a state or local public health agency, or an agent of that agency, to be confidential and not disclosed, except as otherwise provided by law for public health purposes or pursuant to a written authorization by the person who is the subject of the record or by his or her guardian or conservator. Existing law authorizes certain state public health officials to disclose those records for the purpose of facilitating appropriate HIV/AIDS medical care and treatment, as specified.

This bill would include HIV prevention staff and HIV surveillance staff, as provided, among those state public health officials authorized to disclose those records for the purpose of facilitating appropriate HIV/AIDS medical care and treatment.

Existing law requires the State Public Health Officer, to the extent that state and federal funds are appropriated, to establish, and authorizes him or her to administer, a program to provide drug treatments to persons who are HIV-negative who have been prescribed pre-exposure prophylaxis (PrEP) included on the AIDS Drug Assistance Program (ADAP) formulary for the prevention of HIV infection. Existing law authorizes the State Public Health Officer, to the extent allowable under federal law, and as appropriated in the annual Budget Act, to expend money from the AIDS Drug Assistance Program Rebate Fund, a continuously appropriated fund, for this HIV infection prevention program to cover the costs of prescribed ADAP formulary medications for the prevention of HIV infection and other specified costs.

This bill would revise and recast the above provisions regarding the HIV infection prevention program by deleting the above provisions and instead authorizing the State Public Health Officer, to the extent that funds are available for these purposes, to establish and administer a program within the State Department of Public Health's Office of AIDS to subsidize certain costs of medications on the ADAP formulary for the prevention of HIV infection and other related medical services, as provided. The bill would require all types of information concerning a client of the program to be kept confidential and not disclosed, except as provided. The bill would authorize the State Public Health Officer, to the extent allowable under federal law, and upon the availability of funds, to expend money from the AIDS Drug Assistance Program Rebate Fund for this HIV infection prevention program to cover the costs of prescribed ADAP formulary medications for the prevention of HIV infection and other specified costs. Because the bill would authorize a new purpose for a continuously appropriated fund, the bill would create an appropriation.

(9) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

This bill, until January 1, 2021, or as otherwise specified, would require the State Department of Health Care Services to establish a 3-year pilot program in specified counties to provide medically tailored meals, as defined, to Medi-Cal participants with specified health conditions.

Comprehensive perinatal services are a covered benefit under the Medi-Cal program. Existing law requires the department to provide Medi-Cal reimbursements to alternative birth centers for facility-related delivery costs at a statewide all-inclusive rate per delivery that does not exceed 80% of the average Medi-Cal reimbursement received by general acute care hospitals with Medi-Cal contracts.

This bill would require the department, no earlier than July 1, 2017, to reimburse facility-related Medi-Cal delivery costs of eligible alternative birth centers based on a statewide all-inclusive rate per delivery that does not exceed 80% of the average diagnosis-related groups Level 1 rates received by general acute care hospitals pursuant to a specified provision and the applicable provisions of the Medi-Cal State Plan, as specified. The bill would revise eligibility requirements for reimbursements to alternative birth centers, including applicable certification requirements.

Existing law requires the State Department of Health Care Services to provide the Legislature an annual report summarizing data reported by alternative birth centers, as specified.

This bill would delete those reporting requirements.

Existing law excludes certain optional Medi-Cal benefits, including, among others, adult dental services and optometric and optician services from coverage under the Medi-Cal program, except for specified beneficiaries.

This bill would make the exclusion of adult dental services effective only through December 31, 2017, as specified. The bill would make optometric and optician services a covered benefit under the Medi-Cal program, contingent upon the Legislature including funding for these services in the state budget process, as specified.

Existing federal law prohibits federal financial participation for full-scope Medi-Cal services provided to qualified, nonexempt immigrants who have resided in the United States for less than 5 years. These individuals are known as New Qualified Immigrants (NQI). Existing state law grants full-scope Medi-Cal coverage for these NQI individuals, and requires these services to be provided with state-only funds if federal financial participation is not available.

Existing law provides that an NQI individual who is 21 years of age or older, who does not have minor children, and who is enrolled in coverage through the California Health Benefit Exchange (Exchange) with an advanced premium tax credit shall be eligible for certain Medi-Cal benefits only to the extent those benefits are not available through his or her individual health plan offered through the Exchange, instead of full-scope, state-funded Medi-Cal benefits. Existing law requires the department to pay on behalf of the beneficiary his or her insurance premium costs and cost-sharing payments for an individual health plan offered through the Exchange, as specified.

This bill would repeal those provisions that provide for the transition of NQI individuals over 21 years of age without children into an individual health plan offered through the Exchange.

Existing law requires the department to implement a specified option for women eligible for Medi-Cal pregnancy-related and postpartum services who are enrolled or will be enrolled in individual health care coverage through the Exchange and who also opt to enroll in Medi-Cal, and requires the department to provide beneficiaries who are receiving benefits under this provision with only those Medi-Cal benefits for pregnancy-related and postpartum services that are covered under the Medi-Cal program and that are not available through the beneficiary's qualified health plan offered though the Exchange. Existing law, except as provided, requires the department to pay the beneficiary's insurance premium costs and the beneficiary's cost sharing for benefits and services during the beneficiary's period of eligibility for pregnancy-related and postpartum services under the Medi-Cal program.

This bill would repeal those provisions.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that took effect January 1, 2014. Among other things, PPACA requires applicable individuals to maintain minimum essential coverage, and imposes a shared responsibility penalty on any applicable individual, as defined, who does not maintain minimum essential coverage. Existing federal law defines "minimum essential coverage" to include the coverage under the Medicaid program, however certain health care coverage options under Medicaid, such as coverage limited to treatment of emergency medical conditions, do not qualify as minimum essential coverage. Existing federal regulations authorize the United

States Secretary of Health and Human Services to recognize “other coverage” as minimum essential coverage provided that the United States Department of Health and Human Services determines that the coverage meets specified substantive and procedural requirements.

This bill would require the State Department of Health Care Services to apply to the United States Secretary of Health and Human Services for any program under the Medi-Cal program that provides full-scope Medi-Cal benefits to an applicable individual, as defined, and that otherwise does not qualify as minimum essential coverage, as specified, to be recognized as minimum essential coverage. The bill would make this provision inoperative, and on the following January 1 would repeal it, if the requirement to maintain minimum essential coverage under the PPACA is repealed and no similar provision that would subject Medi-Cal beneficiaries to a tax penalty for the failure to maintain minimum essential coverage is implemented.

Existing law expands eligibility for health care services under Medi-Cal to individuals eligible for aid under the California Work Opportunity and Responsibility to Kids (CalWORKs) program with family incomes that do not exceed 109% of the federal poverty level. When determining eligibility under this provision, existing law requires an applicant’s or beneficiary’s income and resources to be determined based on modified adjusted gross income, as specified.

This bill would require the State Department of Health Care Services to seek federal approval to use the determination of eligibility for the CalWORKs program as a determination of eligibility for Medi-Cal benefits under the provision described above, and would require, thereafter, the department’s use of the CalWORKs eligibility determination to determine eligibility for Medi-Cal benefits under this provision to be consistent, and in conformity, with the terms of the federal approval.

Because counties are required to make eligibility determinations under the Medi-Cal program, and because this bill would affect Medi-Cal eligibility determinations under that program, this bill would impose a state-mandated local program.

Existing law requires the department to establish and maintain a plan, known as the County Administrative Cost Control Plan, for the purpose of effectively controlling costs relating to the county administration of the determination of eligibility for benefits under the Medi-Cal program within the amounts annually appropriated for that administration.

Existing law authorizes the Director of Health Care Services, as well as the Attorney General, and other specified officials, to bring an action to recover the reasonable value of benefits provided or that will be provided to a Medi-Cal recipient against a 3rd party, including an insurance carrier, because of any injury for which the 3rd party is liable. Existing law contains procedures for the recovery of these amounts, some of which were originally exercised under a specified pilot project.

This bill would delete references to the pilot project and would revise the department’s procedures, including authorizing the department to execute one or more at-risk performance contracts to identify, quantify, and recover Medi-Cal payments from responsible 3rd parties and carriers that may be subject to a claim for reimbursement.

Under the Nursing Facility/Acute Hospital Transition and Diversion Waiver (NF/AH waiver), a home- and community-based services waiver authorized under federal law until March 31, 2017, home- and community-based services, such as case management and coordination, habilitation services, and community transition services, are provided to eligible Medi-Cal beneficiaries with long-term medical conditions who would otherwise receive care in a skilled nursing facility.

This bill would authorize the Director of Health Care Services, when renewing the NF/AH waiver, to seek additional increases in the scope of the home- and community-based NF/AH waiver.

Existing law requires the department to develop and implement a program to provide a community-living support benefit to eligible Medi-Cal beneficiaries, to submit any federal documentation that is necessary to provide this benefit, and to implement the benefit only to the extent that federal financial participation is available. Existing law requires the program to include reimbursement for an array of health-related and psychosocial services provided or coordinated at community-based housing sites, and access to certain community-living support services provided or coordinated at those sites, as specified.

This bill would discontinue the community-living support benefit program, effective July 1, 2017, and would require the department to assist participants in transitioning to other services, including, but not limited to, other ongoing waiver programs.

Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans.

This bill, to the extent that any necessary federal approvals are obtained and federal financial participation is available, would require the State Department of Health Care Services to make graduate medical education (GME) payments, in recognition of the Medi-Cal managed care share of direct and indirect GME costs, to designated public hospital systems and their affiliated government entities, as defined, in accordance with a methodology developed in consultation with the designated public hospitals, as specified. The bill would require any intergovernmental funds that a designated public hospital or affiliated government entity or other public entity elects to transfer to the department to be deposited into the Designated Public Hospital

Graduate Medical Education Special Fund, which the bill would establish in the State Treasury, to be continuously appropriated, thereby making an appropriation, to the department to be used as the nonfederal share of graduate medical education payments, to reimburse the department's administrative costs in implementing this program, and to otherwise support the Medi-Cal program.

Existing law establishes a demonstration project under the Medi-Cal program that maximizes the use of federal funds consistent with federal Medicaid law for distribution to specified hospitals that provide care to Medi-Cal beneficiaries and uninsured patients, in supplementation of Medi-Cal reimbursements. Under existing law, for the period of November 1, 2010, through October 31, 2015, a designated public hospital, as defined, receives federal disproportionate share hospital funds under this project, subject to interim reconciliation of payments, adjustments, and final audits, as specified.

This bill would require the department to follow specified calculations if the determinations pursuant to the interim reconciliation of payments, adjustments, and final audits result in total federal disproportionate share hospital funds claimable for distribution that, in combination with the payment adjustments made to nondesignated public hospitals, as defined, for the same year, are less than the applicable federal disproportionate share hospital allotment. The bill would also require the department to perform specified revised distribution calculations under designated circumstances. This bill would require the department, if the affiliated governmental entity for the designated public hospital is a county subject to specified provisions relating to redirection of funds for services to indigent persons, to determine how to account for whether any additional payment amount distributed to the hospital would otherwise have affected, if at all, the county's redirection obligation for the 2014–15 fiscal year, as specified, and to determine any necessary adjustments. The bill would require the department to consult with the affected designated public hospitals for these purposes, as specified. By creating new duties for county officials for purposes of consulting the department, the bill would impose a state-mandated local program.

Existing law prohibits the reimbursement to Medi-Cal pharmacy providers for legend and nonlegend drugs, as defined, from exceeding the lowest of either the estimated acquisition cost of the drug plus a professional dispensing fee or the pharmacy's usual and customary charge, as defined. Existing law, commencing April 1, 2017, requires the department to implement a new professional dispensing fee or fees consistent with a specified provision of federal law. Existing law requires the department to establish a list of maximum allowable ingredient costs (MAIC), as defined, for generically equivalent drugs, and requires these MAICs to be updated at least every 3 months.

This bill, among other things, would modify the way in which reimbursement to Medi-Cal pharmacy providers is calculated by, in part, requiring the department to implement a drug ingredient cost reimbursement methodology based on actual acquisition cost, as defined, and, effective for dates of service on or after April 1, 2017, a dispensing fee that is based upon a pharmacy's total annual claim volume of the previous year, as specified, and would require the department to reimburse physician-administered drugs that are blood factors, as defined, at an amount that does not exceed 120% of the average sales prices of the last quarter reported.

Existing federal law, the 21st Century Cures Act, authorizes the United States Secretary of Health and Human Services to award grants to states for the purpose of addressing the opioid abuse crisis, as specified, and requires grants awarded to a state under this program, the Opioid Grant Program, to be used for carrying out activities that supplement activities pertaining to opioids undertaken by the state agency responsible for administering the substance abuse prevention and treatment block grant.

This bill would authorize the State Department of Health Care Services to enter into exclusive or nonexclusive contracts, or to amend existing contracts, on a bid or negotiated basis for the purpose of administering or implementing any federal grant awarded pursuant to the federal 21st Century Cures Act, such as the Opioid Grant Program, as specified.

Existing law authorizes the department to create a program to provide health home services to Medi-Cal beneficiaries with chronic conditions, and provides that diabetic testing supplies are a covered benefit.

This bill would, to the extent federal financial participation is available and any necessary federal approvals have been obtained, require the department to establish the Diabetes Prevention Program, an evidence-based, lifestyle change program designed to prevent or delay the onset of type 2 diabetes within the Medi-Cal fee-for-service and managed care delivery systems.

Existing law authorizes the State Department of Health Care Services to enter into nonexclusive contracts with entities to provide fiscal intermediary services in order to administer and disburse funds available for Medi-Cal services to health care providers in accordance with the provisions of the contract and any schedule of charges or formula for determining payments established pursuant to the contract.

Existing law requires the department to provide the appropriate fiscal and policy committees of the Legislature, the Legislative Analyst's Office, the Department of Technology, and the California State Auditor's Office with quarterly reports on the transition and takeover process efforts of the Medi-Cal fiscal intermediary contract, as specified, including copies of any oversight reports developed by contractors of the department for the California Medicaid Management Information System (CA-MMIS) project.

Existing law requires the California State Auditor's Office to review the appropriate project documents and quarterly reports and make specified recommendations.

This bill would repeal those provisions.

Existing regulations authorize the department to designate a Medi-Cal Managed Care Ombudsman to provide Medi-Cal beneficiaries access to services that investigate and resolve complaints about managed care plans by, or on behalf of, Medi-Cal beneficiaries.

This bill would require the department to prepare and post on its Internet Web site quarterly reports on calls received by the Medi-Cal Managed Care Ombudsman, as specified.

(10) Existing federal law provides for the federal Medicare program, which is a public health insurance program for persons who are 65 years of age or older and specified persons with disabilities who are under 65 years of age.

Existing law requires the department to seek federal approval pursuant to a Medicare or Medicaid demonstration project or waiver, or a combination thereof, to establish a demonstration project, known as the Coordinated Care Initiative (CCI), that enables beneficiaries who are dually eligible for the Medi-Cal program and the Medicare program to receive a continuum of services that maximizes access to, and coordination of, benefits between these programs. Existing law conditions the implementation of the CCI on whether the Director of Finance estimates that the CCI will generate net General Fund savings, as specified. Existing law requires that Medi-Cal beneficiaries who have dual eligibility in the Medi-Cal and Medicare programs to be assigned as mandatory enrollees into managed care health plans in counties participating in the CCI, and requires that no later than December 31, 2017, or the date the managed care health plans and MSSP providers jointly satisfy certain readiness criteria, whichever is earlier, Multipurpose Senior Services Program (MSSP) services to be covered under managed care health contracts and only available through managed care health plans in counties participating in the CCI.

This bill would provide that the provision conditioning implementation of the CCI on the above-described estimation by the Director of Finance is inoperative on January 2, 2018, and, as of July 1, 2018, is repealed. The bill would make conforming changes in various provisions relating to the CCI to provide that those provisions continue to be operative.

Existing law provides that a person meeting participation requirements for the Program of All-Inclusive Care for the Elderly (PACE) may select a PACE plan if one is available in that person's county. Existing law as part of the CCI also requires specified Medi-Cal long-term services to be covered under managed health care plan contracts and to be available only though managed care health plans to beneficiaries residing in counties participating in the CCI.

This bill would provide that, except in counties with county organized health systems, a beneficiary who has dual eligibility in the Medi-Cal program and the Medicare Program or who is required to receive long-term services and supports through a managed care plan under the CCI, and who is also potentially eligible for PACE shall be informed by the department or its enrollment contractor that the beneficiary may request to be assessed for eligibility for PACE, and, if eligible, may enroll in PACE. The bill would prohibit enrollment of that beneficiary into a managed care plan until the earlier of 60 days or the time that he or she is assessed and determined to be ineligible for a PACE plan, unless the beneficiary subsequently chooses to enroll in a managed care plan. The bill would provide that while a beneficiary required to receive long-term services and supports is being assessed he or she shall remain in fee-for-service Medi-Cal, or, if applicable, the managed care plan in which he or she is enrolled.

(11) Existing law establishes the county-administered In-Home Supportive Services (IHSS) program, under which qualified aged, blind, and disabled persons are provided with services in order to permit them to remain in their own homes and avoid institutionalization. Existing law requires Medi-Cal long-term services and supports, including IHSS, Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP) services, and certain skilled nursing facility and subacute care services, to be covered services under managed care health plan contracts and to be available only through managed care health plans to beneficiaries residing in the CCI counties, except as specified.

This bill would provide that the above-described long-term services and supports continue to be covered services, as specified above, and would provide that IHSS are part of the covered long-term services and supports only through December 31, 2017. The bill would repeal, as of January 1, 2018, other provisions relating to IHSS as a Medi-Cal benefit available through managed care health plans in participating counties. The bill would make conforming changes in related provisions.

(12) Existing law requires, no later than December 31, 2017, or on the date the managed care health plans and MSSP providers jointly satisfy specified readiness criteria, whichever is earlier, MSSP services to transition from a federal waiver, as specified, to a benefit administered and allocated by managed care health plans in CCI counties.

This bill would instead require the above transition of MSSP services to take place no sooner than December 31, 2019, or as specified or on the date the above entities jointly satisfy the readiness criteria, whichever is earlier.

(13) Existing law establishes the Major Risk Medical Insurance Fund in the State Treasury and continuously appropriates moneys in the fund, except as specified, to the State Department of Health Care Services for purposes of the California Major Risk Medical Insurance Program. Existing law also establishes the Managed Care Administrative Fines and Penalties Fund, from which certain amounts are transferred into the Major Risk Medical Insurance Fund and, upon appropriation by the Legislature, used for the program, including to cover expenses of providing major risk medical coverage to eligible persons.

This bill would repeal the Major Risk Medical Insurance Fund, effective July 1, 2017, and replace it with the Health Care Services Plan Fines and Penalties Fund. The bill would require the moneys previously transferred to the Major Risk Medical Insurance Fund to instead be transferred to the Health Care Services Plan Fines and Penalties Fund, effective January 1, 2017. The bill would require those moneys to be continuously appropriated to the department, to be used, in addition to the purposes described above, to cover expenses of providing health care services for eligible individuals in the Medi-Cal program, subject to specified criteria.

This bill would authorize the Controller to use the funds in the Health Care Services Plan Fines and Penalties Fund for cashflow loans to the General Fund as authorized in specified provisions of the Government Code.

(14) Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

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

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

(16) This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.
Vote: majority Appropriation: yes Fiscal Committee: yes Local Program: yes

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 15438.11 is added to the Government Code, to read:

15438.11. (a) This section shall be known, and may be cited, as the Clinic Lifeline Act of 2017.

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

(1) Small and rural health facilities, including community-based clinics, may be adversely financially affected by a reduction or elimination of federal government assistance. Working capital is necessary for these health facilities, which provide health care regardless of the ability to pay for services, to continue to support the health care needs of vulnerable populations in California.

(2) The failure to adequately fund small and rural health facilities may result in significant costs to the state in the form of unnecessary emergency room visits. The lack of preventive care results in significant costs when patients become severely ill.

(3) The lack of access to working capital threatens the quality, accessibility, and availability of the services provided by health care facilities.

(4) The state's health care system is reliant upon those health care facilities that serve vulnerable populations, such as the indigent, underinsured, uninsured, underserved, and undocumented immigrant populations.

(5) It is the intent of the Legislature to assist those small or rural health facilities that may be adversely financially affected by a reduction or elimination of federal government assistance and that have little to no access to working capital.

(c) The authority shall award grants to eligible health facilities, as defined in subdivision (d) of Section 15432, that meet at least one of the following requirements:

(1) The health facility is operated by a tax-exempt nonprofit corporation that is licensed to operate the health facility by the State of California, and the annual gross revenue of the health facility does not exceed ten million dollars ($10,000,000).

(2) The health facility is operated by a tax-exempt nonprofit corporation that is licensed to operate the health facility by the State of California, and the health facility is located in a rural medical service study area, as defined by the California Healthcare Workforce Policy Commission.

(3) The health facility is a clinic operated by a district hospital or health care district.

(d) Grants under this section may be used for working capital for core operating support.

(e) The authority shall develop selection criteria and a process for awarding grants under this section. The authority may consider the following factors when selecting grant recipients and determining grant amounts:

(1) The percentage of total expenditures attributable to uncompensated care provided by an applicant.

(2) The extent to which the grant will contribute toward continuation of health care access by indigent, underinsured, uninsured, underserved, and undocumented immigrant populations.

(3) The need for the grant based on the applicant's total net assets.

(4) The adverse financial impact to the applicant as a result of any reduction or elimination of federal government assistance.

(5) The applicant's lack of access to working capital.

(6) The geographic location of the applicant, in order to maximize broad geographic distribution of funding or assist health facilities in underserved areas.

(7) Other factors, as determined by the authority.

(f) A grant to a health facility shall not exceed two hundred fifty thousand dollars ($250,000).

(g) The Lifeline Grant Program Subfund is hereby created within the California Health Facilities Financing Authority Fund. Twenty million dollars ($20,000,000) shall be transferred to the Lifeline Grant Program Subfund from the subfund within the California Health Facilities Financing Authority Fund that is used to fund the Health Expansion Loan Program II. Only moneys that are not otherwise obligated or impressed with a trust for other purposes may be transferred into the Lifeline Grant Program Subfund. Twenty million dollars ($20,000,000) in the Lifeline Grant Program Subfund is hereby appropriated to the authority to use for the purposes of this section, and shall be available for encumbrance or expenditure until June 30, 2020. Moneys remaining in the subfund as of June 30, 2022, shall revert to the originating subfund.

(h) (1) The authority shall adopt regulations as it deems necessary to implement this section.

(2) The authority may adopt regulations to implement this section as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1). 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.

(i) This section shall remain in effect only until January 1, 2023, and as of that date is repealed.

SEC. 2. Section 1276.5 of the Health and Safety Code is amended to read:

1276.5. (a) The department shall adopt regulations setting forth the minimum number of equivalent nursing hours per patient required in skilled nursing and intermediate care facilities, subject to the specific requirements of Section 14110.7 of the Welfare and Institutions Code. However, notwithstanding Section 14110.7 or any other law, commencing January 1, 2000, the minimum number of actual nursing hours per patient required in a skilled nursing facility shall be 3.2 hours, except as provided in Section 1276.9.

(b) (1) For the purposes of this section, "nursing hours" means the number of hours of work performed per patient day by aides, nursing assistants, or orderlies plus two times the number of hours worked per patient day by registered nurses and licensed vocational nurses (except directors of nursing in facilities of 60 or larger capacity) and, in the distinct part of facilities and freestanding facilities providing care for persons with developmental disabilities or mental health disorders by licensed psychiatric technicians who perform direct nursing services for patients in skilled nursing and intermediate care facilities, except when the skilled nursing and intermediate care facility is licensed as a part of a state-owned hospital or developmental center, and except that nursing hours for skilled nursing facilities means the actual hours of work, without doubling the hours performed per patient day by registered nurses and licensed vocational nurses.

(2) Concurrent with implementation of the first year of rates established under the Medi-Cal Long Term Care Reimbursement Act of 1990 (Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code), for the purposes of this section, "nursing hours" means the number of hours of work performed per patient day by aides,

nursing assistants, registered nurses, and licensed vocational nurses (except directors of nursing in facilities of 60 or larger capacity) and, in the distinct part of facilities and freestanding facilities providing care for persons with developmental disabilities or mental health disorders, by licensed psychiatric technicians who performed direct nursing services for patients in skilled nursing and intermediate care facilities, except when the skilled nursing and intermediate care facility is licensed as a part of a state-owned hospital or developmental center.

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

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

(2) To qualify as an administrator for an intermediate care facility for the developmentally disabled, a qualified intellectual disability professional shall complete at least six months of administrative training or demonstrate six months of experience in an administrative capacity in a licensed health facility, as defined in Section 1250, excluding those facilities specified in subdivisions (e), (h), and (i).

SEC. 3. Section 1276.65 of the Health and Safety Code is amended to read:

1276.65. (a) For purposes of this section, the following definitions shall apply:

(1) “Direct care service hours” means the actual hours of work performed per patient day by a direct caregiver, as defined in paragraph (2). Until final regulations are promulgated to implement this section as amended by the act that added this paragraph, the department shall recognize the hours performed by direct caregivers, to the same extent as those hours are recognized by the department pursuant to Section 1276.5 on July 1, 2017.

(2) “Direct caregiver” means a registered nurse, as referred to in Section 2732 of the Business and Professions Code, a licensed vocational nurse, as referred to in Section 2864 of the Business and Professions Code, a psychiatric technician, as referred to in Section 4516 of the Business and Professions Code, and a certified nurse assistant, or a nursing assistant participating in an approved training program, as defined in Section 1337, while performing nursing services as described in Sections 72309, 72311, and 72315 of Title 22 of the California Code of Regulations, as those sections read on July 1, 2017.

(3) “Skilled nursing facility” means a skilled nursing facility as defined in subdivision (c) of Section 1250.

(b) A person employed to provide services such as food preparation, housekeeping, laundry, or maintenance services shall not provide nursing care to residents and shall not be counted in determining ratios under this section.

(c) (1) (A) Notwithstanding any other law, the department shall develop regulations that become effective August 1, 2003, that establish staff-to-patient ratios for direct caregivers working in a skilled nursing facility.

(B) Effective July 1, 2018, skilled nursing facilities, except those skilled nursing facilities that are a distinct part of a general acute care facility or a state-owned hospital or developmental center, shall have a minimum number of direct care services hours of 3.5 per patient day, except as set forth in Section 1276.9.

(C) Skilled nursing facilities shall have a minimum of 2.4 hours per patient day for certified nurse assistants in order to meet the requirements in subparagraph (B).

(D) The department shall repeal and amend existing regulations and adopt emergency regulations to implement the amendments made by the act that added this subparagraph. The department shall consult stakeholders prior to promulgation of regulations and shall provide a 90-day notice to stakeholders prior to adopting regulations. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

(2) The department, in developing staff-to-patient ratios for direct caregivers and licensed nurses required by this section, shall convert the existing requirement under Section 1276.5 of this code and Section 14110.7 of the Welfare and Institutions Code for direct care service hours per patient day of care and shall verify that no less care is given than is required pursuant to Section 1276.5 of this code and Section 14110.7 of the Welfare and Institutions Code. Further, the department shall develop the ratios in a manner that minimizes additional state costs, maximizes resident quality of care, and takes into account the length of the shift worked. In developing the regulations, the department shall develop a procedure for facilities to apply for a waiver that addresses individual patient needs except that in no instance shall the minimum staff-to-patient ratios be less than the 3.5 direct care service hours per patient day required pursuant to subparagraph (B) of paragraph (1).

(d) The direct care service hour requirements to be developed pursuant to this section shall be minimum standards only. Skilled nursing facilities shall employ and schedule additional staff as needed to ensure quality resident care based on the needs of individual residents and to ensure compliance with all relevant state and federal staffing requirements.

(e) No later than January 1, 2006, and every five years thereafter, the department shall consult with consumers, consumer advocates, recognized collective bargaining agents, and providers to determine the sufficiency of the staffing standards provided in this section and may adopt regulations to increase the minimum staffing ratios to adequate levels.

(f) In a manner pursuant to federal requirements, every skilled nursing facility shall post information about staffing levels that includes the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. This posting shall include staffing requirements developed pursuant to this section.

(g) (1) Notwithstanding any other law, the department shall inspect for compliance with this section during state and federal periodic inspections, including, but not limited to, those inspections required under Section 1422. This inspection requirement shall not limit the department's authority in other circumstances to cite for violations of this section or to inspect for compliance with this section.

(2) A violation of the regulations developed pursuant to this section may constitute a class "B," "A," or "AA" violation pursuant to the standards set forth in Section 1424. The department shall set a timeline for phase-in of penalties pursuant to this section through all-facility letters or other similar instructions.

(h) The requirements of this section are in addition to any requirement set forth in Section 1276.5 of this code and Section 14110.7 of the Welfare and Institutions Code.

(i) Implementation of the staffing standard developed pursuant to requirements set forth in this section shall be contingent on an appropriation in the annual Budget Act and continued federal approval of the Skilled Nursing Facility Quality Assurance Fee pursuant to Article 7.6 (commencing with Section 1324.20).

(j) 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 skilled nursing facility, with demonstrated expertise in long-term care. This subdivision establishes an accelerated process for issuing contracts pursuant to this section and contracts entered into pursuant to this section 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.

(k) This section shall not apply to facilities defined in Section 1276.9.

(l) The department shall adopt emergency regulations or all-facility letters, or other similar instructions, to create a waiver of the direct care service hour requirements established in this section for skilled nursing facilities by July 1, 2018, to address a shortage of available and appropriate health care professionals and direct caregivers. Waivers granted pursuant to these provisions shall be reviewed annually and either renewed or revoked. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

(m) The department shall evaluate the impact of the changes made to this section by the act that added this subdivision regarding patient quality of care and shall work with other state departments, as necessary, to evaluate the workforce available to meet these requirements, including an evaluation of the effectiveness of the minimum requirements of 2.4 hours per patient day for certified nursing assistants specified in subparagraph (C) of paragraph (1) of subdivision (c). The department may contract with a vendor for purposes of conducting this evaluation.

SEC. 4. Section 1341.45 of the Health and Safety Code is amended to read:

1341.45. (a) There is hereby created in the State Treasury the Managed Care Administrative Fines and Penalties Fund.

(b) The fines and administrative penalties collected pursuant to this chapter, on and after September 30, 2008, shall be deposited into the Managed Care Administrative Fines and Penalties Fund.

(c) The fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department, beginning September 1, 2009, and annually thereafter, as follows:

(1) The first one million dollars ($1,000,000) shall be transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) or Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(2) Any amount over the first one million dollars ($1,000,000), including accrued interest, in the fund shall be transferred to the Health Care Services Plan Fines and Penalties Fund created pursuant to Section 15893 of the Welfare and Institutions Code and, notwithstanding Section 13340 of the Government Code, shall be continuously appropriated for the purposes specified in Section 15894 of the Welfare and Institutions Code.

(d) Notwithstanding subdivision (b) of Section 1356 and Section 1356.1, the fines and administrative penalties authorized pursuant to this chapter shall not be used to reduce the assessments imposed on health care service plans pursuant to Section 1356.

(e) The amendments made to this section by the act adding this subdivision shall become operative on July 1, 2014.

(f) The amendments made to this section by the act adding this subdivision shall become operative on July 1, 2017.

SEC. 5. Section 1348.9 of the Health and Safety Code is amended to read:

1348.9. (a) On or before July 1, 2003, the director shall adopt regulations to establish the Consumer Participation Program, which shall allow for the director to award reasonable advocacy and witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of any regulation or to an order or decision made by the director if the order or decision has the potential to impact a significant number of enrollees.

(b) The regulations adopted by the director shall include specifications for eligibility of participation, rates of compensation, and procedures for seeking compensation. The regulations shall require that the person or organization demonstrate a record of advocacy on behalf of health care consumers in administrative or legislative proceedings in order to determine whether the person or organization represents the interests of consumers.

(c) This section shall apply to all proceedings of the department, but shall not apply to resolution of individual grievances, complaints, or cases.

(d) Fees awarded pursuant to this section may not exceed three hundred fifty thousand dollars ($350,000) each fiscal year.

(e) The fees awarded pursuant to this section shall be considered costs and expenses pursuant to Section 1356 and shall be paid from the assessment made under that section. Notwithstanding the provisions of this subdivision, the amount of the assessment shall not be increased to pay the fees awarded under this section.

(f) The department shall report to the appropriate policy and fiscal committees of the Legislature before March 1, 2004, and annually thereafter, the following information:

(1) The amount of reasonable advocacy and witness fees awarded each fiscal year.

(2) The individuals or organization to whom advocacy and witness fees were awarded pursuant to this section.

(3) The orders, decisions, and regulations pursuant to which the advocacy and witness fees were awarded.

(g) This section shall remain in effect only until January 1, 2024, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2024, deletes or extends that date.

SEC. 6. Section 100235 of the Health and Safety Code is amended to read:

100235. (a) The department shall annually reimburse the Robert F. Kennedy Farm Workers Medical Plan for claim payments that exceed seventy thousand dollars ($70,000) made by the plan on behalf of an eligible employee or dependent for a single episode of care on or after September 1, 2016. This reimbursement shall not exceed three million dollars ($3,000,000) per year.

(b) To seek reimbursement, commencing after September 1, 2017, and annually thereafter, the plan shall submit to the department completed data, verified by an independent certified public accountant, for claims paid by the plan for services during the preceding year from September 1 to August 31, inclusive.

(c) (1) If the department receives claims data from the plan pursuant to subdivision (b), the department shall analyze that data to determine the aggregate amount of claims that exceed seventy thousand dollars ($70,000) paid by the plan on behalf of an eligible employee or dependent for any single episode of care.

(2) No later than 60 days after the department receives claims data submitted by the plan, the department shall reimburse the plan the amount determined pursuant to paragraph (1), up to the amount of three million dollars ($3,000,000) per year.

(d) This section shall remain in effect only until January 1, 2026, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2026, deletes or extends that date.

SEC. 7. The heading of Article 6 (commencing with Section 101315) of Chapter 3 of Part 3 of Division 101 of the Health and Safety Code is amended to read:

Article 6. Federal Funding for Public Health Emergency Preparedness and Response

SEC. 8. Section 101315 of the Health and Safety Code is amended to read:

101315. (a) Federal funding received by the State Department of Public Health for public health emergency preparedness and response is subject to appropriation in the annual Budget Act or other statute, commencing with the 2003–04 fiscal year.

(b) This article governs those instances when federal funding is allocated and expended for public health emergency preparedness and response by local health jurisdictions, hospitals, long-term health care facilities, clinics, emergency medical systems, and poison control centers, or their trade associations, for the prevention of, and response to, bioterrorist attacks and other public health emergencies pursuant to the federally approved collaborative state-local plan.

(c) A local health jurisdiction shall be ineligible to receive funding from appropriations made for purposes of this article when that local health jurisdiction receives directly or through another local jurisdiction federal funding for the same purposes. Moneys appropriated for purposes of this article that would have been allocated to a local health jurisdiction that is ineligible, pursuant to this subdivision, to receive funding shall be allocated, as provided in Section 101317, among the remaining local health jurisdictions that are eligible.

(d) Funds appropriated for the purposes of this article shall not be used to supplant funding for existing levels of service and shall only be used for purposes specified in Section 101317.

(e) This article shall apply only when local health jurisdictions, hospitals, long-term health care facilities, clinics, emergency medical systems, and poison control centers, or their trade associations are designated by a federal or state agency to manage the funds for public health emergency preparedness and response to bioterrorist attacks and other public health emergencies, pursuant to the federally approved collaborative state-local plan.

SEC. 9. Section 101315.2 of the Health and Safety Code is amended to read:

101315.2. Of the funds appropriated in the annual Budget Act for local health jurisdictions for the purpose of preparing California for public health emergencies, including a potential pandemic influenza event, a baseline allocation of sixty thousand dollars ($60,000) shall be provided to each local health jurisdiction first, with the remaining amount allocated on a per population basis using the population information possessed by the Department of Finance, subject to the availability of funds appropriated in the annual Budget Act or another statute.

SEC. 10. Section 101317 of the Health and Safety Code is amended to read:

101317. (a) For purposes of this article, allocations shall be made to the administrative bodies of qualifying local health jurisdictions described as public health administrative organizations in Section 101185, and pursuant to Section 101315, in the following manner:

(1) (A) For the 2003–04 fiscal year and subsequent fiscal years, to the administrative bodies of each local health jurisdiction, a basic allotment of one hundred thousand dollars ($100,000), subject to the availability of funds appropriated in the annual Budget Act or another act.

(B) For the 2002–03 fiscal year, the basic allotment of one hundred thousand dollars ($100,000) shall be reduced by the amount of federal funding allocated as part of a basic allotment for the purposes of this article to local health jurisdictions in the 2001–02 fiscal year.

(2) (A) Except as provided in subdivision (c), after determining the amount allowed for the basic allotment as provided in paragraph (1), the balance of the annual appropriation for purposes of this article, if any, shall be allotted on a per capita basis to the administrative bodies of each local health jurisdiction in the proportion that the population of that local health jurisdiction bears to the population of all eligible local health jurisdictions of the state.

(B) The population estimates used for the calculation of the per capita allotment pursuant to subparagraph (A) shall be based on the Department of Finance's E-1 Report, "City/County Population Estimates with Annual Percentage Change," as of January 1 of the previous year. However, if within a local health jurisdiction there are one or more city health jurisdictions, the local health jurisdiction shall subtract the population of the city or cities from the local health jurisdiction total population for purposes of calculating the per capita total.

(b) If the amounts appropriated are insufficient to fully fund the allocations specified in subdivision (a), the department shall prorate and adjust each local health jurisdiction's allocation so that the total amount allocated equals the amount appropriated.

(c) For the 2002–03 fiscal year and subsequent fiscal years in which the federally approved collaborative state-local plan identifies an allocation method, other than the basic allotment and per capita method described in subdivision (a), for specific funding to a local public health jurisdiction, including, but not limited to, funding laboratory training, chemical and nuclear terrorism preparedness, smallpox preparedness, and information technology approaches, that funding shall be paid to the administrative bodies of those local health jurisdictions in accordance with the federally approved collaborative state-local plan for public health emergency preparedness and response in the state.

(d) Funds appropriated pursuant to the annual Budget Act or another act for allocation to local health jurisdictions pursuant to this article shall be disbursed quarterly, or upon the submission of an invoice with supporting documentation, to local health jurisdictions beginning July 1, 2002, using the following process:

(1) Each fiscal year, upon the approval of an application for funding by the administrative body of a local health jurisdiction, the department shall make the first quarterly payment to each eligible local health jurisdiction. Initially, that application shall include a plan and budget for the local program that is in accordance with the department's plans and priorities for public health emergency preparedness and response, and a certification by the chairperson of the board of supervisors or the mayor of a city with a local health department, or a designee authorized by the chairperson or mayor, that the funds received pursuant to this article will not be used to supplant other funding sources in violation of subdivision (d) of Section 101315. In subsequent years, the department shall develop a streamlined process for continuation of funding that will address new federal requirements and will assure the continuity of local plan activities.

(2) The department shall establish procedures and a format for the submission of the local health jurisdiction's plan and budget. The local health jurisdiction's plan shall be consistent with the department's plans and priorities for public health emergency preparedness and response in accordance with requirements specified in the department's federal grant award. Payments to local health jurisdictions beyond the first quarter shall be contingent upon the approval of the department of the local health jurisdiction's plan and the local health jurisdiction's progress in implementing the provisions of the local health jurisdiction's plan, as determined by the department.

(3) If a local health jurisdiction does not apply or submits a noncompliant application for its allocation, those funds provided under this article may be redistributed according to subdivision (a) to the remaining local health jurisdictions.

(e) Funds shall be used for activities to improve and enhance local health jurisdictions' preparedness for and response to public health threats and emergencies, and for other purposes, as determined by the department, that are consistent with the purposes for which the funds were appropriated.

(f) A local health jurisdiction that receives funds pursuant to this article shall deposit them in a special local public health preparedness account, in accordance with Section 75.305 of Title 45 of the Code of Federal Regulations, that is established solely for this purpose before transferring or expending the funds for any of the uses allowed pursuant to this article. Funds received pursuant to this article shall be tracked and managed according to the account name as identified by the department. Local health jurisdictions shall not retain more than five hundred dollars ($500) in interest earned on moneys in the account and any interest earned over five hundred dollars ($500) shall be returned to the department on an annual basis.

(g) (1) A local health jurisdiction that receives funding pursuant to this article shall submit reports that display cost data and the activities funded by moneys deposited in its local public health preparedness account to the department on a regular basis in a form and according to procedures prescribed by the department.

(2) The department, in consultation with local health jurisdictions, shall develop required content for the reports required under paragraph (1), which shall include, but not be limited to, data and information needed to implement this article and to satisfy federal reporting requirements. The chairperson of the board of supervisors or the mayor of a city with a local health department, or a designee authorized by the chairperson or mayor, shall certify the accuracy of the reports and that the moneys appropriated for the purposes of this article have not been used to supplant other funding sources.

(3) It is the intent of the Legislature that the department shall audit the cost reports every three years, commencing in January 2007, to determine compliance with federal requirements and consistency with local health jurisdiction budgets, contingent upon the availability of federal funds for this activity, and contingent upon the continuation of federal funding for public health emergency preparedness and response. All cost-compliance reports and audit exceptions or related analyses or reports issued by the State Department of Public Health regarding the expenditure of funding for public health emergency and response by local health jurisdictions shall be made available to the Legislature upon request.

(h) The administrative body of a local health jurisdiction may enter into a contract with the department and the department may enter into a contract with that local health jurisdiction for the department to administer all or a portion of the moneys allocated to

the local health jurisdiction pursuant to this article. The department may use funds retained on behalf of a local health jurisdiction pursuant to this subdivision solely for purposes of administering the jurisdiction's public health emergency preparedness and response activities. The funds appropriated pursuant to this article and retained by the department pursuant to this subdivision are available for expenditure and encumbrance for purposes of support or local assistance.

(i) The department may recoup from a local health jurisdiction moneys allocated pursuant to this article that are unspent or that are not expended for purposes specified in subdivision (d). The department may also recoup funds expended by a local health jurisdiction in violation of subdivision (d) of Section 101315. The department may withhold quarterly payments of moneys to a local health jurisdiction if the local health jurisdiction is not in compliance with this article or the terms of that local health jurisdiction's plan as approved by the department. Before any funds are recouped or withheld from a local health jurisdiction, the department shall meet with local health officials to discuss the status of the unspent moneys or the disputed use of the funds, or both.

(j) Notwithstanding any other law, moneys made available for public health emergency preparedness and response pursuant to this article in the 2001–02 fiscal year shall be available for expenditure and encumbrance until June 30, 2003. Moneys made available for public health emergency preparedness and response pursuant to this article from July 1, 2002, to August 30, 2003, inclusive, shall be available for expenditure and encumbrance until August 30, 2004. Moneys made available in the 2003–04 Budget Act for public health emergency preparedness and response shall be available for expenditure and encumbrance until August 30, 2005.

SEC. 11. Section 101317.2 of the Health and Safety Code is amended to read:

101317.2. Notwithstanding any other law, moneys made available in the 2004–05 Budget Act for public health emergency preparedness and response shall be available for expenditure and encumbrance until August 30, 2006.

SEC. 12. Chapter 1.6 (commencing with Section 103870) is added to Part 2 of Division 102 of the Health and Safety Code, to read:

CHAPTER 1.6. Richard Paul Hemann Parkinson's Disease Program

103870. (a) Beginning January 1, 2018, the department shall collect data on the incidence of Parkinson's disease in California. The program shall be known, and may be cited, as the Richard Paul Hemann Parkinson's Disease Program.

(b) The department shall establish a system for the collection of information determining the incidence and prevalence of Parkinson's disease. The department shall designate Parkinson's disease as a disease required to be reported in the state or any part of the state. All cases of Parkinson's disease diagnosed or treated in California shall be reported to the department.

(c) The department shall provide notification of the mandatory reporting of Parkinson's disease on its Internet Web site and shall also provide that information to associations representing physicians and hospitals and directly to the Medical Board of California at least 90 days prior to requiring information be reported.

(d) Beginning July 1, 2018, a hospital, facility, physician and surgeon, or other health care provider diagnosing or providing treatment to Parkinson's disease patients shall report each case of Parkinson's disease to the department in a format prescribed by the department.

(e) If the hospital or other facility fails to report in a format prescribed by the department, the department's authorized representative may access the information from the hospital or the facility and report it in the appropriate format. In these cases, the hospital or other facility shall reimburse the department or the authorized representative for its costs to access and report the information.

(f) All physicians, hospitals, outpatient clinics, and all other facilities, individuals, or agencies providing diagnostic or treatment services to patients with Parkinson's disease shall grant to the department or the authorized representative access to all records that would identify cases of Parkinson's disease or would establish characteristics of Parkinson's disease, treatment of Parkinson's disease, or medical status of any identified Parkinson's disease patient. Willful failure to grant access to those records shall be punishable by a civil penalty of up to five hundred dollars ($500) each day access is refused. Any civil penalties collected pursuant to this subdivision shall be deposited by the department in the General Fund.

(g) Except as otherwise provided in this section, all information collected pursuant to this section shall be confidential. For purposes of this section, this information shall be referred to as "confidential information."

(h) The program shall be under the direction of the director, who may enter into contracts, grants, or other agreements as are necessary for the conduct of the program. The award of these contracts, grants, or funding agreements shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code. This chapter shall be implemented only to the extent funds are made available for its purposes.

103870.1. (a) Persons with a valid scientific interest who are engaged in demographic, epidemiological, or other similar studies related to health who meet qualifications as determined by the department, and who agree, in writing, to maintain confidentiality, may be authorized access to confidential information collected by the department pursuant to Section 103870.

(b) The department may enter into agreements to furnish confidential information to other states' Parkinson's disease registries, federal Parkinson's disease control agencies, local health officers, or health researchers for the study of Parkinson's disease. Before confidential information is disclosed to those agencies, officers, researchers, or out-of-state registries, the requesting entity shall agree in writing to maintain the confidentiality of the information, and in the case of researchers, shall also do both of the following:

(1) Obtain approval of their committee for the protection of human subjects established in accordance with Part 46 (commencing with Section 46.101) of Title 45 of the Code of Federal Regulations.

(2) Provide documentation to the department that demonstrates to the department's satisfaction that the entity has established the procedures and ability to maintain the confidentiality of the information.

(c) Notwithstanding any other law, a disclosure authorized by this section shall include only the information necessary for the stated purpose of the requested disclosure, used for the approved purpose, and not be further disclosed.

(d) The furnishing of confidential information to the department or its authorized representative in accordance with this section shall not expose any person, agency, or entity furnishing information to liability, and shall not be considered a waiver of any privilege or a violation of a confidential relationship.

(e) The department shall maintain an accurate record of all persons who are given access to confidential information. The record shall include: the name of the person authorizing access; name, title, address, and organizational affiliation of persons given access; dates of access; and the specific purpose for which information is to be used. The record of access shall be open to public inspection during normal operating hours of the department.

(f) Notwithstanding any other law, the confidential information shall not be available for subpoena, shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding. The confidential information shall not be deemed admissible as evidence in any civil, criminal, administrative, or other tribunal or court for any reason.

(1) This subdivision does not prohibit the publication by the department of reports and statistical compilations that do not in any way identify individual cases or individual sources of information.

(2) Notwithstanding the restrictions in this subdivision, the individual to whom the information pertains shall have access to his or her own information in accordance with Chapter 1 (commencing with Section 1798) of Title 1.8 of the Civil Code.

(g) For the purposes of this section, "Parkinson's disease" means a chronic and progressive neurologic disorder resulting from deficiency of the neurotransmitter dopamine as the consequence of degenerative, vascular, or inflammatory changes in the area of the brain called the basal ganglia. It is characterized by tremor at rest, slow movements, rigidity of movement, droopy posture, muscle weakness, and unsteady or shuffling gait.

(h) This section does not preempt the authority of facilities or individuals providing diagnostic or treatment services to patients with Parkinson's disease to maintain their own facility-based Parkinson's disease registries.

103870.2. This chapter shall remain in effect only until January 1, 2020, and as of that date is repealed.

SEC. 13. Section 104151 of the Health and Safety Code is amended to read:

104151. (a) Notwithstanding Section 10231.5 of the Government Code, 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 the fiscal committees of the Legislature with an estimate package for the Every Woman Counts Program. This estimate package shall include all significant assumptions underlying the estimate for the Every Woman Counts Program's current-year and budget-year proposals, and shall contain concise information identifying applicable estimate components, such as caseload; a breakout of costs, including, but not limited to, clinical service activities, including office visits and consults, screening mammograms, diagnostic mammograms, diagnostic breast procedures, case management, and other clinical services; policy changes; contractor information; General Fund, special fund, and federal fund information; and other assumptions necessary to support the estimate.

(b) Notwithstanding Section 10231.5 of the Government Code, each year, the State Department of Health Care Services shall provide the fiscal and appropriate policy committees of the Legislature with biannual updates on caseload, estimated expenditures, and related program monitoring data for the Every Woman Counts Program. These updates shall be provided no later than February 28 and August 31 of each year. The purpose of the updates is to provide the Legislature with the most recent

information on the program, and shall include a breakdown of expenditures for each six-month period for clinical service activities, including, but not limited to, office visits and consults, screening mammograms, diagnostic mammograms, diagnostic breast procedures, case management, and other clinical services. This subdivision supersedes the requirements of Section 169 of Chapter 717 of the Statutes of 2010 (SB 853).

(c) Commencing with the 2017–18 fiscal year, expenditures for the Every Woman Counts Program included in the department's budget for services provided on or after July 1, 2017, shall be charged against the appropriation for the fiscal year in which the billing is paid.

SEC. 14. Section 120955 of the Health and Safety Code is amended to read:

120955. (a) (1) To the extent that state and federal funds are appropriated in the annual Budget Act for these purposes, the director shall establish and may administer a program to provide drug treatments to persons infected with human immunodeficiency virus (HIV), the etiologic agent of acquired immunodeficiency syndrome (AIDS). If the director makes a formal determination that, in any fiscal year, funds appropriated for the program will be insufficient to provide all of those drug treatments to existing eligible persons for the fiscal year and that a suspension of the implementation of the program is necessary, the director may suspend eligibility determinations and enrollment in the program for the period of time necessary to meet the needs of existing eligible persons in the program.

(2) The director, in consultation with the AIDS Drug Assistance Program Medical Advisory Committee, shall develop, maintain, and update as necessary a list of drugs to be provided under this program. The list 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.

(b) The director may grant funds to a county public health department through standard agreements to administer this program in that county. To maximize the recipients' access to drugs covered by this program, the director shall urge the county health department in counties granted these funds to decentralize distribution of the drugs to the recipients.

(c) The director shall establish a rate structure for reimbursement for the cost of each drug included in the program. Rates shall not be less than the actual cost of the drug. However, the director may purchase a listed drug directly from the manufacturer and negotiate the most favorable bulk price for that drug.

(d) Manufacturers of the drugs on the list shall pay the department a rebate equal to the rebate that would be applicable to the drug under Section 1927(c) of the federal Social Security Act (42 U.S.C. Sec. 1396r-8(c)) plus an additional rebate to be negotiated by each manufacturer with the department, except that no rebates shall be paid to the department under this section on drugs for which the department has received a rebate under Section 1927(c) of the federal Social Security Act (42 U.S.C. Sec. 1396r-8(c)) or that have been purchased on behalf of county health departments or other eligible entities at discount prices made available under Section 256b of Title 42 of the United States Code.

(e) The department shall submit an invoice, not less than two times per year, to each manufacturer for the amount of the rebate required by subdivision (d).

(f) Drugs may be removed from the list for failure to pay the rebate required by subdivision (d), unless the department determines that removal of the drug from the list would cause substantial medical hardship to beneficiaries.

(g) The department may adopt emergency regulations to implement amendments to this chapter made during the 1997–98 Regular Session, in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The initial adoption of emergency regulations shall be deemed to be an emergency and considered by the Office of Administrative Law as necessary for the immediate preservation of the public peace, health and safety, or general welfare. Emergency regulations adopted pursuant to this section shall remain in effect for no more than 180 days.

(h) Reimbursement under this chapter shall not be made for any drugs that are available to the recipient under any other private, state, or federal programs, or under any other contractual or legal entitlements, except that the director may authorize an exemption from this subdivision where exemption would represent a cost savings to the state.

(i) The department may also subsidize certain cost-sharing requirements for persons otherwise eligible for the AIDS Drug Assistance Program (ADAP) with existing non-ADAP drug coverage by paying for prescription drugs included on the ADAP formulary within the existing ADAP operational structure up to, but not exceeding, the amount of that cost-sharing obligation. This cost sharing may only be applied in circumstances in which the other payer recognizes the ADAP payment as counting toward the individual's cost-sharing obligation. The department may subsidize, using available federal funds and moneys from the AIDS

Drug Assistance Program Rebate Fund, costs associated with a health care service plan or health insurance policy, including medical copayments and deductibles for outpatient care, and premiums to purchase or maintain health insurance coverage.

SEC. 15. Section 120956 of the Health and Safety Code is amended to read:

120956. (a) The AIDS Drug Assistance Program Rebate Fund is hereby created as a special fund in the State Treasury.

(b) All rebates collected from drug manufacturers on drugs purchased through the AIDS Drugs Assistance Program (ADAP) implemented pursuant to this chapter and, notwithstanding Section 16305.7 of the Government Code, interest earned on these moneys shall be deposited in the fund exclusively to cover costs related to the purchase of drugs and services provided through ADAP and the HIV prevention program as described in Section 120972.

(c) Notwithstanding Section 13340 of the Government Code, moneys in the fund are continuously appropriated without regard to fiscal year to State Department of Public Health and available for expenditure for those purposes specified under this section.

SEC. 16. Section 120970 of the Health and Safety Code is amended to read:

120970. If the department utilizes a contractor or subcontractor to administer any aspect of the program provided for under this chapter, the following additional client assistance provisions shall apply:

(a) The contractor shall, either directly or through subcontracted pharmacy outlets, obtain and dispense the necessary drugs, in their approved forms according to the program formulary, and shall comply with all applicable provisions of the California Pharmacy Law (Chapter 9 (commencing with Section 4000) of Division 2 of the Business and Professions Code) and regulations adopted thereunder.

(b) Upon receipt of notification by the department, the contractor shall be able to accommodate additions or changes in the formulary within 10 business days.

(c) Clients shall receive drugs from a participating pharmacy either directly, through the client's designated representative, or mailed or delivered to the client's place of residence by the contractor or subcontractor, whichever the client prefers. Proof of delivery of the prescription to the client's designated address, by signature acknowledging receipt thereof, shall be required for all mail order prescriptions.

(d) Clients shall have their prescriptions filled within 24 hours of submission of prescription requests, and mail order prescriptions shall be shipped by the contractor within 48 hours of receipt of client prescription requests.

(e) The contractor shall provide 24-hour free telephone and fax machine access for physicians and surgeons, or medical care providers as authorized under state law, to call in or transmit prescriptions for mail order pharmacy.

(f) Clients shall have toll-free telephone access during business hours to speak with licensed pharmacists for medication counseling and for mail order prescription requests. The contractor shall provide consultation in the prevention of potentially harmful drug interactions in connection with prescriptions filled for clients.

(g) The contractor shall have the ability to subcontract with any willing provider, including independent and sole proprietorship pharmacies, provided the subcontractor accepts the rates offered by the contractor, supplies the contractor with timely information, and complies with necessary contract terms and conditions and other needs of the program as determined by the contractor or the department.

(h) It is the intent of the Legislature that the contractor subcontract with all willing providers accepting the terms and conditions provided for in subdivisions (a) to (g), inclusive, in order to facilitate continuity of care for clients under this chapter.

(i) All types of information, whether written or oral, concerning a client, made or kept in connection with the administration of ADAP services, which includes subsidizing costs associated with health care service plan contracts and health insurance premium payment assistance, shall be confidential, and shall not be used or disclosed except for any of the following:

(1) For purposes directly connected with the administration of the program.

(2) For coordinating client eligibility with programs funded by the federal Ryan White HIV/AIDS Program (Ryan White HIV/AIDS Treatment Extension Act of 2009, (Public Law 111-87, 42 U.S.C. Sec. 201, et seq.)).

(3) If disclosure is otherwise authorized by law.

(4) Pursuant to a written authorization by the person who is the subject of the record or by his or her guardian or conservator.

(j) Information regarding program policies and procedures, including enrollment procedures, eligibility guidelines, and lists of drugs covered, shall be made available to clients in appropriate literacy levels in English, Spanish, Mandarin/Cantonese, Tagalog, and in other languages, as determined by the department.

(k) The contractor shall develop and maintain a timely and accessible grievance procedure for clients to resolve problems regarding all components of the delivery of drugs under this chapter.

SEC. 17. Chapter 6.1 (commencing with Section 120972) is added to Part 4 of Division 105 of the Health and Safety Code, to read:

CHAPTER 6.1. Human Immunodeficiency Virus (HIV) Prevention

120972. (a) To the extent that funds are available for these purposes, the director may establish and administer a program within the department's Office of AIDS to subsidize certain costs of medications for the prevention of HIV infection and other related medical services, as authorized by this section, to persons who meet all of the following requirements:

(1) Are residents of California who are at least 18 years of age.

(2) Are HIV negative.

(3) Meet the financial eligibility requirements identified in Section 120960.

(4) Have been prescribed medication listed on the AIDS Drug Assistance Program (ADAP) formulary as provided in paragraph (2) of subdivision (a) of Section 120955.

(b) To the extent allowable under federal law, and upon available funds, the director may expend funding for this program from the AIDS Drug Assistance Program Rebate Fund as implemented pursuant to Section 120956.

(c) To the extent that funding is made available for this purpose, the program may subsidize all of the following costs of medication for the prevention of HIV infection and related medical services for eligible individuals:

(1) Costs for HIV pre-exposure prophylaxis (PrEP)-related medical services for uninsured individuals who are enrolled in a drug manufacturer's PrEP medication assistance program.

(2) For insured individuals, both of the following:

(A) The cost of medication copays, coinsurance, and deductibles for the prevention of HIV infection after the individual's insurance is applied and, if eligible, after the drug manufacturer's medication assistance program's contributions are applied.

(B) Medical copays, coinsurance, and deductibles for PrEP-related medical services.

(d) If the director makes a formal determination that, in any fiscal year, funds appropriated for the program will be insufficient to provide medications for the prevention of HIV infection or related medical costs to existing eligible persons for the fiscal year and that a suspension of the implementation of the program is necessary, the director may suspend either of the following:

(1) The program.

(2) The eligibility determinations and enrollment in the program for the period of time necessary to meet the needs of existing eligible persons in the program.

(e) Reimbursement under the program shall not be made for any drugs or related services that are available to the recipient under any other private, state, or federal programs, or under any other contractual or legal entitlements, except that the director may authorize an exemption from this subdivision if it would result in cost savings to the state.

(f) If the department utilizes a contractor or subcontractor to administer any aspect of the program, the provisions of Section 120970, except subdivision (i) of that section, shall apply.

(g) All types of information, whether written or oral, concerning a client, made or maintained in connection with the administration of this program, shall be confidential, and shall not be used or disclosed except for any of the following:

(1) For purposes directly connected with the administration of the program.

(2) If disclosure is otherwise authorized by law.

(3) Pursuant to a written authorization by the person who is the subject of the record or by his or her guardian or conservator.

(h) For purposes of verifying financial eligibility for the program, the department shall verify the accuracy of the modified adjusted gross income reported by an applicant or recipient of the program, with data, if available, from the Franchise Tax Board. The Franchise Tax Board and the department are authorized to disclose personally identifiable data to one another, solely for this purpose, and in accordance with the data exchange process identified in Section 120962.

SEC. 18. Section 121025 of the Health and Safety Code is amended to read:

121025. (a) Public health records relating to human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), containing personally identifying information, that were developed or acquired by a state or local public health agency, or an agent of that agency, are confidential and shall not be disclosed, except as otherwise provided by law for public health purposes or pursuant to a written authorization by the person who is the subject of the record or by his or her guardian or conservator.

(b) In accordance with subdivision (g) of Section 121022, a state or local public health agency, or an agent of that agency, may disclose personally identifying information in public health records, as described in subdivision (a), to other local, state, or federal public health agencies or to corroborating medical researchers, when the confidential information is necessary to carry out the duties of the agency or researcher in the investigation, control, or surveillance of disease, as determined by the state or local public health agency.

(c) Any disclosures authorized by subdivision (a), (b), or this subdivision shall include only the information necessary for the purpose of that disclosure and shall be made only upon the agreement that the information will be kept confidential as described in subdivision (a). Except as provided in paragraphs (1) to (3), inclusive, or as otherwise provided by law, any disclosure authorized by subdivision (a) or (b) shall not be made without written authorization as described in subdivision (a). Any unauthorized further disclosure shall be subject to the penalties described in subdivision (e).

(1) Notwithstanding any other law, the following disclosures are authorized for the purpose of enhancing the completeness of reporting to the federal Centers for Disease Control and Prevention (CDC) of HIV/AIDS and coinfection with tuberculosis, syphilis, gonorrhea, chlamydia, hepatitis B, hepatitis C, and meningococcal infection:

(A) The local public health agency HIV surveillance staff may further disclose the information to the health care provider who provides HIV care to the HIV-positive person who is the subject of the record for the purpose of assisting in compliance with subdivision (a) of Section 121022.

(B) Local public health agency tuberculosis control staff may further disclose the information to state public health agency tuberculosis control staff, who may further disclose the information, without disclosing patient identifying information, to the CDC, to the extent the information is requested by the CDC and permitted by subdivision (b), for purposes of the investigation, control, or surveillance of HIV and tuberculosis coinfections.

(C) Local public health agency sexually transmitted disease control staff may further disclose the information to state public health agency sexually transmitted disease control staff, who may further disclose the information, without disclosing patient identifying information, to the CDC, to the extent it is requested by the CDC and permitted by subdivision (b), for the purposes of the investigation, control, or surveillance of HIV and syphilis, gonorrhea, or chlamydia coinfection.

(D) For purposes of the investigation, control, or surveillance of HIV and its coinfection with hepatitis B, hepatitis C, and meningococcal infection, local public health agency communicable disease staff may further disclose the information to state public health agency staff, who may further disclose the information, without disclosing patient identifying information, to the CDC to the extent the information is requested by the CDC and permitted by subdivision (b).

(2) Notwithstanding any other law, the following disclosures are authorized for the purpose of facilitating appropriate HIV/AIDS medical care and treatment:

(A) State public health agency HIV surveillance staff, HIV prevention staff, AIDS Drug Assistance Program staff, and care services staff may further disclose the information to local public health agency staff, who may further disclose the information to the HIV-positive person who is the subject of the record, or the health care provider who provides his or her HIV care, for the purpose of proactively offering and coordinating care and treatment services to him or her.

(B) HIV surveillance staff, HIV prevention staff, AIDS Drug Assistance Program staff, and care services staff in the State Department of Public Health may further disclose the information directly to the HIV-positive person who is the subject of the record or the health care provider who provides his or her HIV care, for the purpose of proactively offering and coordinating care and treatment services to him or her.

(C) Local public health agency staff may further disclose acquired or developed information to the HIV-positive person who is the subject of the record or the health care provider who provides his or her HIV care for the purpose of proactively offering and coordinating care and treatment services to him or her.

(3) Notwithstanding any other law, for the purpose of facilitating appropriate medical care and treatment of persons coinfected with HIV and tuberculosis, syphilis, gonorrhea, chlamydia, hepatitis B, hepatitis C, or meningococcal infection, local public health agency sexually transmitted disease control, communicable disease control, and tuberculosis control staff may further disclose the information to state or local public health agency sexually transmitted disease control, communicable disease control, and tuberculosis control staff, the HIV-positive person who is the subject of the record, or the health care provider who provides his or her HIV, tuberculosis, hepatitis B, hepatitis C, meningococcal infection, and sexually transmitted disease care.

(4) For the purposes of paragraphs (2) and (3), "staff" does not include nongovernmental entities, but shall include state and local contracted employees who work within state and local public health departments.

(d) A confidential public health record, as defined in subdivision (c) of Section 121035, shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding.

(e) (1) A person who negligently discloses the content of a confidential public health record, as defined in subdivision (c) of Section 121035, to a third party, except pursuant to a written authorization, as described in subdivision (a), or as otherwise authorized by law, shall be subject to a civil penalty in an amount not to exceed five thousand dollars ($5,000), plus court costs, as determined by the court. The penalty and costs shall be paid to the person whose record was disclosed.

(2) A person who willfully or maliciously discloses the content of any confidential public health record, as defined in subdivision (c) of Section 121035, to a third party, except pursuant to a written authorization, or as otherwise authorized by law, shall be subject to a civil penalty in an amount not less than five thousand dollars ($5,000) and not more than twenty-five thousand dollars ($25,000), plus court costs, as determined by the court. The penalty and costs shall be paid to the person whose confidential public health record was disclosed.

(3) A person who willfully, maliciously, or negligently discloses the content of a confidential public health record, as defined in subdivision (c) of Section 121035, to a third party, except pursuant to a written authorization, or as otherwise authorized by law, that results in economic, bodily, or psychological harm to the person whose confidential public health record was disclosed, is guilty of a misdemeanor, punishable by imprisonment in a county jail for a period not to exceed one year, or a fine of not to exceed twenty-five thousand dollars ($25,000), or both, plus court costs, as determined by the court. The penalty and costs shall be paid to the person whose confidential public health record was disclosed.

(4) A person who commits an act described in paragraph (1), (2), or (3) is liable to the person whose confidential public health record was disclosed for all actual damages for economic, bodily, or psychological harm that is a proximate result of the act.

(5) Each violation of this section is a separate and actionable offense.

(6) This section does not limit or expand the right of an injured person whose confidential public health record was disclosed to recover damages under any other applicable law.

(f) If a confidential public health record, as defined in subdivision (c) of Section 121035, is disclosed, the information shall not be used to determine employability or insurability of a person.

SEC. 19. Section 12302.6 of the Welfare and Institutions Code is amended to read:

12302.6. (a) A managed care health plan may enter into contracts pursuant to paragraph (14) of subdivision (a) of Section 14186.35 solely in the manner prescribed in this section.

(b) For purposes of this section:

(1) "Agency" means a city, county, city and county agency, local health district, proprietary agency, or an entity that has or seeks a contract to provide in-home supportive services pursuant to Section 12301.6 or 12302 or this article.

(2) "Contract provider" means any person employed by an agency for the provision of services listed in this section.

(3) "County" means a political unit, unless otherwise indicated.

(4) "Department" means the State Department of Social Services.

(5) "Individual provider" means any person authorized to provide in-home supportive services under this article and Sections 14132.95, 14132.952, and 14132.956, pursuant to the individual provider mode referenced in Section 12302.2. As used in this paragraph, "individual provider" shall not include any person providing in-home supportive services pursuant to a county-employed homemaker mode or a contract provider.

(6) "Individual provider rate" means the combined total rate for wages and benefits for individual providers, as approved by the Statewide Authority or its delegate.

(7) “Managed care health plan” shall have the same meaning as set forth in Section 14186.1.

(8) “Qualified agency” means an agency that has been certified by the department.

(9) “Responsible party” means an officer or director of the applicant, a shareholder with a beneficial interest in the applicant exceeding 10 percent, or the person who will be primarily responsible for any contract with the managed care health plan.

(10) “Statewide Authority” means the California In-Home Supportive Services Authority established pursuant to Section 6531.5 of the Government Code.

(c) Managed care health plans shall assume the authority granted to counties pursuant to Section 12302 to contract for the provision of in-home supportive services with an agency.

(1) (A) Managed care health plans shall assume the authority as described in subdivision (a) only upon the integration of the In-Home Supportive Services Program into Medi-Cal managed care pursuant to Article 5.7 (commencing with Section 14186) of Chapter 7 in the counties participating in the demonstration project authorized under Section 14132.275. For individuals exempt from the provisions of Article 5.7 (commencing with Section 14186) of Chapter 7, as specified in subdivision (c) of Section 14186.2, this section shall not apply, and Section 12302 shall apply.

(B) If, at the time a managed care health plan assumes contracting authority pursuant to this subdivision with respect to a particular geographic area, there is an existing contract between the county and an agency for the provision of in-home supportive services, the managed care health plan shall enter into a contract with the county to continue providing the services, and the county shall maintain its existing contract with the agency for the provision of in-home supportive services until such time as that contract is due to expire. Agencies that have these existing contracts with a county at the time a managed care health plan assumes contracting authority pursuant to this subdivision shall automatically be certified as qualified agencies.

(2) An agency that is a county, or has an existing contract with a county, as of the date that the managed care health plan in the corresponding geographic area assumes contracting authority with respect to agencies, shall be deemed to be certified as a qualified agency with respect to the geographic area in which the agency has a contract to provide in-home supportive services with respect to the type of in-home supportive services provided pursuant to that contract. Where a county has an existing contract with an agency, the certification provided for in this subdivision shall remain in effect until the triennial deadline established by paragraph (3) of subdivision (d) that occurs no less than one year after the expiration of the contract in effect at the time that the managed care health plan assumes contracting authority with respect to agencies. However, if an agency that is party to such a contract seeks to expand the geographic area in which it is certified to provide services or seeks to expand the types of services for which it is certified, it must submit an application in accordance with subdivision (d).

(d) An agency contracting with a managed care health plan for the provision of in-home supportive services shall be certified as a qualified agency by the department in consultation with the State Department of Health Care Services.

(1) The certification of an agency as a qualified agency shall be with respect to a specific geographic area and an identified category of services.

(2) The department shall develop an application form and establish the conditions to be met for certification as a qualified agency.

(3) An agency seeking certification as a qualified agency shall submit to the department a verified application showing that it satisfies the conditions established by the department, pursuant to this subdivision, and shall provide the information specified, which shall include all of the following:

(A) The three most recent audited financial statements or other independently verified documentation showing that the applicant maintains liquid assets sufficient to cover 180 days of in-home supportive services’ operating expenses. A nonprofit or public entity applicant may instead satisfy this requirement by providing a letter of support signed by a representative of the public entity or managed care organization responsible for the majority of the applicant’s revenue stating its intent to continue to provide funding for IHSS in the event there is a disruption in the applicant’s revenue.

(B) Evidence of liability and workers’ compensation insurance.

(C) Evidence that the applicant has not been the subject of bankruptcy proceedings in the last five years.

(4) The department shall establish an annual deadline for submitting applications for certification pursuant to this subdivision. The department shall also establish a triennial deadline for submitting renewals of certification pursuant to this subdivision. The department shall process and approve or deny applications within 120 days of receipt of a completed application.

(5) In determining whether an agency may be certified as a qualified agency, the department, in consultation with the State Department of Health Care Services, shall consider documents and evidence to ensure that, among other things identified by the department, the agency:

(A) Guarantees the continuity and reliability of services to recipients.

(B) Guarantees the supervision of contract providers.

(C) Guarantees that each contract provider has been screened in accordance with Sections 12305.81 and 12305.87.

(D) Guarantees that each contract provider is capable of and is providing the service authorized.

(E) Complies with applicable rules and regulations regarding civil rights.

(F) Is capable of providing high-quality and reliable in-home supportive services.

(G) Is capable of complying with this section, any rules or regulations promulgated under this section, and any applicable federal rules and regulations.

(H) Has not demonstrated a pattern and practice of violations of state or federal laws and regulations based on any available information.

(6) An application for certification under this subdivision may be denied by the department if the department determines that the applying agency or a responsible party has violated a law or regulation that is substantially related to the qualifications or duties of the applying agency or is substantially related to the functions of the business for which certification was, or is to be, issued, or on the ground that an applying agency knowingly made a false statement of fact required to be revealed in an application for certification.

(7) The department shall develop a written appeal process for any agency dissatisfied with the decision of the department regarding certification.

(e) (1) A qualified agency shall submit verified cost reports to the department documenting that the qualified agency is in compliance with subdivision (i). The cost reports shall be verified by the responsible party and by a representative of a certified public accounting firm.

(2) The verified cost reports required by paragraph (1) shall be submitted within 90 calendar days after the end of each year and within 60 calendar days after any change in compensation negotiated by the Statewide Authority for individual providers has gone into effect.

(f) A managed care health plan that has entered into a contract in the manner prescribed in this section shall notify the department within 30 days if the contract between the managed care health plan and the qualified agency is suspended or terminated for any reason.

(g) A recipient of in-home supportive services may only be referred to a qualified agency by the county, managed care health plan, or care coordination teams. Qualified agencies, counties, and managed care health plans shall establish procedures to ensure contract limitations on caseload specified in subdivision (k) are being met and there is coordination of information between managed care health plans, qualified agencies, counties, and the department. When a recipient has been referred by the managed care health plan, the qualified agency may provide services in the following circumstances:

(1) It has been determined that the recipient is unable to function as the employer of the provider due to dementia, cognitive impairment, or other similar issues.

(2) The recipient has been identified to need services under this mode by the care coordination team created pursuant to paragraph (3) of subdivision (b) of Section 14186.

(3) The recipient is unable to retain a provider due to geographic isolation and distance, authorized hours, or other reasons.

(h) When a recipient who is severely impaired, as described in subdivision (b) of Section 12303.4, is referred to a qualified agency by a managed care health plan, the county, or the care coordination team, the qualified agency may provide emergency backup services, as needed, when a provider is unavailable due to vacation, illness, or other extraordinary circumstances, or the recipient is in the process of hiring or replacing a provider. Qualified agencies shall establish procedures to ensure contract limitations on caseload are being met and there is coordination of information between managed care health plans, qualified agencies, counties, and the department.

(i) Service hours provided under this section shall be deducted from the in-home supportive services recipient's current authorized hours of services and on an hour-to-hour basis coordinated with the county and the department to ensure hours are accurately captured and not duplicated per in-home supportive services program requirements.

(j) Wages and benefits for contract providers for their provision of in-home supportive services shall not be less than the individual provider rate negotiated by the Statewide Authority for the county where services are provided.

(k) Any contract entered into between a managed care health plan and a qualified agency shall provide for a minimum amount of service utilization and shall be approved by the department. In no case, however, shall in-home supportive services recipients referred for services exceed 5 percent of the in-home supportive services caseload in the county where services are provided.

(l) The department shall establish reasonable fees to be paid by agencies and qualified agencies for administering the provisions of this section, including, but not limited to, fees associated with processing applications for certification and renewals of certification, and fees associated with monitoring and enforcing compliance, including any fees reflecting the costs associated with investigating complaints, to the extent permissible by law. These fees shall be sufficient to cover the department's reasonable costs incurred in administering the provisions of this section.

(m) The state shall be immune from liability resulting from the state's implementation of this section or from the negligence or intentional torts of a contract provider providing services pursuant to this section.

(n) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may implement, interpret, or make specific this section by means of all-county letters, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including beneficiaries, providers, and advocates.

(o) This section shall remain in effect only until January 1, 2018, and as of that date is repealed.

SEC. 20. Section 12330 of the Welfare and Institutions Code is repealed.

SEC. 21. Section 14005.30 of the Welfare and Institutions Code is amended to read:

14005.30. (a) Medi-Cal benefits under this chapter shall be provided to individuals eligible for services under Section 1396u-1 of Title 42 of the United States Code with family incomes that do not exceed 109 percent of the federal poverty level.

(b) (1) Except as provided for in paragraph (3), when determining eligibility under this section, an applicant's or beneficiary's income and resources shall be determined, counted, and valued in accordance with the requirements of Section 1396a(e)(14) of Title 42 of the United States Code, as added by the ACA.

(2) When determining eligibility under this section, an applicant's or beneficiary's assets shall not be considered and deprivation shall not be a requirement for eligibility.

(3) The department shall seek federal approval to use the determination of eligibility for the CalWORKs program as a determination of eligibility for Medi-Cal benefits under this section. The department's use of the CalWORKs eligibility determination to determine eligibility for Medi-Cal benefits under this section shall be consistent, and in conformity, with the terms of the federal approval.

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

(d) The MAGI-based income eligibility standard applied under this section shall conform with the maintenance of effort requirements of Sections 1396a(e)(14) and 1396a(gg) of Title 42 of the United States Code, as added by the ACA.

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

(1) "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.

(2) "MAGI-based income" means income calculated using the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code, as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148)

and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(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 all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2018, 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. Commencing six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, 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.

(g) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 22. Section 14042.1 is added to the Welfare and Institutions Code, to read:

14042.1. (a) No earlier than January 1, 2018, the State Department of Health Care Services shall establish a Medically Tailored Meals Pilot Program to operate for a period of three years, or until funding is no longer available for the program, whichever date is earlier.

(1) The department shall determine the number of eligible participants and providers in the program and shall use Medi-Cal data to identify eligible members for participation in the program.

(2) The program shall provide medically tailored meal intervention services to Medi-Cal participants with one or more of the following health conditions: congestive heart failure, cancer, diabetes, chronic obstructive pulmonary disease, or renal disease.

(3) The department may establish additional eligibility requirements based on acuity and other selection criteria. Each participant in the program shall receive a standard intervention as determined by the department, of up to 21 meals per week for 12 to 24 weeks. All meals provided shall be medically tailored and designed to meet the specific nutritional needs of the participant's specific illness.

(4) The program shall be conducted in the following counties: Alameda, Los Angeles, Marin, San Diego, San Francisco, San Mateo, Santa Clara, and Sonoma.

(5) (A) At the conclusion of the program, the department shall use Medi-Cal data on the program participants to evaluate what impact, to the extent it can be determined, the program had on hospital readmissions, decreased admissions to long term care facilities, and emergency room utilization.

(B) The department shall send a report containing its evaluation to the Legislature on or before January 1, 2021, or within 12 months after the end of the three-year program.

(C) The legislative report submitted pursuant to subparagraph (B) shall be submitted in compliance with Section 9795 of the Government Code.

(b) For the purposes of this section, "medically tailored meals" means a specifically tailored diet to address the participant's specific medical condition and associated symptoms.

(c) The department shall develop a methodology for reimbursing contractors, or other entities as applicable, for services or activities provided pursuant to this section based on, and not to exceed, the aggregate amount of funds allocated per year for purposes of the program. The department may use up to 20 percent of the funds allocated per year for the program to support its administration and evaluation.

(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 policy letters, all-county letters, plan letters, or other similar instructions, without taking regulatory action.

(e) 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 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.

(f) The department shall seek any federal approvals necessary to implement this section, including any waivers it deems necessary to obtain federal financial participation for the program, and shall claim federal financial participation to the full extent

permitted by law. In the event federal financial participation is not available, the department shall implement the program using available state-only funds, subject to annual appropriation by the Legislature.

(g) This section shall remain in effect until the earlier of January 1, 2021, or six months following the end of the program, and as of that date is repealed.

SEC. 23. Section 14043.1 is added to the Welfare and Institutions Code, to read:

14043.1. (a) The Legislature finds and declares the following:

(1) The Medi-Cal Managed Care Ombudsman helps resolve issues between Medi-Cal managed care members and health plans, assists members with managed care related questions and problems, and answers questions from members.

(2) A pattern of inquiries, complaints, and grievances may be indicators of systemic problems regarding coverage and problems with access to care and warrant consideration.

(b) On a quarterly basis, the State Department of Health Care Services shall report on calls received by the Medi-Cal Managed Care Ombudsman. At a minimum, the report shall include the following:

(1) The number of contacts received, separated by inquiries and complaints.

(2) The average wait time for callers to answer.

(3) The number of calls abandoned.

(4) The result of contacts, including destination of referred calls, when possible.

(5) The average call time.

(6) Complaints, by issue type.

(7) The number of calls referred to another area of the department or to the Department of Managed Health Care for resolution.

(c) All data collected and reported shall include demographic information of beneficiaries, including race, ethnicity, age, gender, preferred language, language members were assisted in, and county of residence, and health plans of beneficiaries, to the extent known to the department at the time of the call. The department shall request, but not require, this information from members during the calls.

(d) The quarterly report shall include contacts from county mental health plan beneficiaries, as defined in Section 14700, including the requirements of subdivisions (a) and (b).

(e) The quarterly report shall be posted on the department's Internet Web site.

(f) The fourth quarterly report issued each year also shall include information pertaining to the following:

(1) Training protocols for staff, including cultural and linguistic competency.

(2) Assessment of contacts trends and actions taken by the State Department of Health Care Services as a result of contacts received.

(3) Consumer assistance protocols, procedures, and referral tools.

SEC. 24. Section 14102 of the Welfare and Institutions Code is repealed.

SEC. 25. Section 14102 is added to the Welfare and Institutions Code, to read:

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)).

SEC. 26. Section 14105.29 is added to the Welfare and Institutions Code, to read:

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.

SEC. 27. Section 14105.45 of the Welfare and Institutions Code is amended to read:

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 (Chapter 3.5 (commencing with Section 6250) of Division 7 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 (Chapter 3.5 (commencing with Section 6250) of Division 7 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.

SEC. 28. Section 14105.456 of the Welfare and Institutions Code is amended to read:

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.

SEC. 29. Section 14124.13 is added to the Welfare and Institutions Code, immediately following Section 14124.12, to read:

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.

SEC. 30. Section 14124.70 of the Welfare and Institutions Code is amended to read:

14124.70. As used in this article:

(a) “Carrier” includes any insurer as defined in Section 23 of the Insurance Code, including any private company, corporation, mutual association, trust fund, reciprocal or interinsurance exchange authorized under the laws of this state to insure persons against liability for injuries caused to another, and also any insurer providing benefits under a policy of bodily injury liability insurance covering liability arising out of the ownership, maintenance or use of a motor vehicle which provides uninsured motorist endorsement or coverage, pursuant to Section 11580.2 of the Insurance Code.

(b) “Beneficiary” means any person who has received benefits or will be provided benefits under this chapter because of an injury for which another person or party may be liable. It includes such beneficiary’s guardian, conservator or other personal representative, his estate or survivors.

(c) “Reasonable value of benefits” means both of the following:

(1) Except in a case in which services were provided to a beneficiary under a managed care arrangement or contract, “reasonable value of benefits” means the Medi-Cal rate of payment, for the type of services rendered, under the schedule of maximum allowances authorized by Section 14106 or, the Medi-Cal rate of payment, for the type of services rendered, under regulations adopted pursuant to this chapter, including but not limited, to Section 14105.

(2) If services were provided to a beneficiary under a managed care arrangement or contract, “reasonable value of benefits” means the rate of payment to the provider by the plan for the services rendered to the beneficiary, except in cases where the plan pays the provider on a capitated or risk sharing basis, in which case it means the value of the services rendered to the beneficiary calculated by the plan as the usual customary and reasonable charge made to the general public by the provider for similar services.

(d) “Lien” means the director’s claim for recovery, from a beneficiary’s tort action or claim, of the reasonable value of benefits provided on behalf of the beneficiary.

SEC. 31. Section 14124.71 of the Welfare and Institutions Code is amended to read:

14124.71. (a) When benefits are provided or will be provided to a beneficiary under this chapter because of an injury for which another party is liable, or for which a carrier is liable in accordance with the provisions of any policy of insurance issued pursuant to Section 11580.2 of the Insurance Code, the director shall have a right to recover from such a party or carrier the reasonable value of benefits so provided. The Attorney General, or counsel for the fiscal intermediary under the Medi-Cal program with the permission of the Attorney General, or a contractor pursuant to Section 14124.80, or a county through its civil legal adviser, may, to enforce such right, institute and prosecute legal proceedings against the third party or carrier who may be liable for the injury in

an appropriate court, either in the name of the director or in the name of the injured person, his guardian, conservator, personal representative, estate, or survivors.

(b) The director may:

(1) Compromise, or settle and release any such claim in whole or in part with any such party or carrier, or

(2) Waive any such claim, in whole or in part, for the convenience of the director, or if the director determines that collection would result in undue hardship upon the person who suffered the injury, or in a wrongful death action upon the heirs of the deceased.

(c) No action taken on behalf of the director pursuant to this section or any judgment rendered in such action shall be a bar to any action upon the claim or cause of action of the beneficiary, his guardian, conservator, personal representative, estate, dependents, or survivors against the third party who may be liable for the injury, or shall operate to deny to the beneficiary the recovery for that portion of any damages not covered hereunder.

(d) The cost of a service provided to an eligible developmentally disabled Medi-Cal beneficiary under Section 14132.44 may be recovered by the director from a liable third party or carrier.

SEC. 32. Section 14124.72 of the Welfare and Institutions Code is amended to read:

14124.72. (a) If an action is brought by the director pursuant to Section 14124.71, it shall be commenced within the period prescribed in Section 338 of the Code of Civil Procedure.

(b) The death of the beneficiary does not abate any right of action established by Section 14124.71.

(c) When an action or claim is brought by persons entitled to bring such actions or assert such claims against a third party who may be liable for causing the death of a beneficiary, any settlement, judgment or award obtained is subject to the director's right to recover from that party the reasonable value of the benefits provided to the beneficiary under the Medi-Cal program, as provided in subdivision (d).

(d) The director's claim for reimbursement of the benefits provided to the beneficiary shall be limited to the amount of the director's lien, as defined in subdivision (d) of Section 14124.70. If the action or claim is brought by the beneficiary alone and the beneficiary incurs a personal liability to pay attorney's fees and costs of litigation, the amount of the director's lien that is reimbursed shall be reduced by 25 percent, which represents the director's reasonable share of attorney's fees paid by the beneficiary, and that portion of the cost of litigation expenses determined by multiplying the actual litigation expenses by the ratio of the amount reimbursed to the director as satisfaction of the director's lien, prior to deducting reasonable attorney's fees and litigation expenses, to the full amount of the settlement, judgment, or award.

SEC. 33. Section 14124.73 of the Welfare and Institutions Code is amended to read:

14124.73. (a) If either the beneficiary or the director brings an action or claim against such third party or carrier, the beneficiary or the director shall within 30 calendar days of filing the action give to the other written notice by personal service, registered mail, or other means of communication deemed appropriate by the department of the action or claim, and of the name of the court or state or local agency in which the action or claim is brought. The purpose of the notice is to provide the beneficiary and the director, as applicable, the opportunity to ensure their interests are adequately represented in an action or claim against a liable third party or carrier. Proof of such notice shall be filed in such action or claim. If an action or claim is brought by either the director or the beneficiary, the other may, at any time before trial on the facts, become a party to, or shall consolidate his action or claim with the other if brought independently.

(b) If an action or claim is brought by the director pursuant to subdivision (a) of Section 14124.71, written notice to the beneficiary, guardian, conservator, personal representative, estate or survivor given pursuant to this section shall advise him of his right to intervene in the proceeding, his right to obtain a private attorney of his choice, and the director's right to recover the amount of the director's lien, as defined in subdivision (d) of Section 14124.70.

(c) Notification of either the beneficiary or the director of an action or claim against a third party or carrier shall include, at a minimum, the following information:

(1) The date of the beneficiary's injury.

(2) The beneficiary's Medi-Cal identification number.

(3) The name and contact information of the liable third party or carrier against whom the action or claim has been filed.

(4) The name and contact information of the carrier for the party identified in paragraph (3) against which a claim has been or will be filed for the beneficiary's injury, the carrier's unique claim identifier for the claim, and the name and contact information of the party responsible for adjudicating the claim on the carrier's behalf, to the extent these are known by the party providing notice under subdivision (a) at the time such notice is provided.

(d) If any information required pursuant to paragraph (4) of subdivision (c) is not known to the party at the time notice pursuant to subdivision (a) is provided, the party providing such notice shall provide such information to the notice recipient within 15 calendar days of obtaining the information.

SEC. 34. Section 14124.74 of the Welfare and Institutions Code is amended to read:

14124.74. In the event of a settlement, judgment, or award in a suit or claim against a third party or carrier:

(a) If the action or claim is prosecuted by the beneficiary alone, the court or agency shall first order paid from any settlement, judgment, or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees, when an attorney has been retained. After payment of these expenses and attorney's fees the court or agency shall, on the application of the director, allow as a first lien against the amount of the settlement, judgment, or award the amount that the director is entitled to recover as satisfaction of the director's lien, as provided in subdivision (d) of Section 14124.72, and as a second lien, the amount of any claims, pursuant to Section 14019.3, owed to a provider, as provided in Section 14124.791.

(b) If the action or claim is prosecuted both by the beneficiary and the director, the court or agency shall first order paid from any settlement, judgment, or award, the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the beneficiary. After payment of these expenses and attorney's fees, the court or agency shall first apply out of the balance of the settlement, judgment, or award an amount sufficient to reimburse the amount that the director is entitled to recover as satisfaction of the director's lien, as provided under subdivision (d) of Section 14124.72, and then an amount sufficient to reimburse a provider who has filed a lien for any claims for services rendered to the beneficiary, as provided under Section 14124.791.

SEC. 35. Section 14124.785 of the Welfare and Institutions Code is amended to read:

14124.785. The director's recovery is limited to the amount derived from applying Section 14124.72, 14124.76, or 14124.78, whichever is less, to the total settlement, judgment, or award amount upon resolution of all actions or claims associated with the injury with regard to each and every defendant. All statutes of limitations related to the recovery of the director's lien are tolled until the director receives notification of the resolution of all actions or claims associated with the injury with regard to each and every defendant.

SEC. 36. Section 14124.80 of the Welfare and Institutions Code is repealed.

SEC. 37. Section 14124.81 of the Welfare and Institutions Code is repealed.

SEC. 38. Section 14124.81 is added to the Welfare and Institutions Code, to read:

14124.81. (a) The department shall administer the provisions of Sections 14124.82 to 14124.86, inclusive, pertaining to the State Department of Health Care Services' administration of the personal injury and workers' compensation recovery programs.

(b) An attorney or the beneficiary, guardian, personal representative, estate, or survivors of any of those, who are mandated under Section 14124.79 to report Medi-Cal involvement are excluded from any further remuneration benefits under Sections 14124.82 to 14124.86, inclusive.

SEC. 39. Section 14124.82 of the Welfare and Institutions Code is amended to read:

14124.82. (a) The department, in its reasonable discretion, may execute one or more at-risk performance contracts to identify, quantify, or recover, or any combination thereof, Medi-Cal payments from responsible third parties and carriers that may be subject to a claim for reimbursement.

(b) Priority, by the terms of the contract or contracts, shall be given to the identification and recovery of claims nearing the statute of limitation, prior adjudicated claims, and prior existing injury claims. However, all claims that are older, in whole or part, than 12 months, at the time of discovery and notification by the contractor to the department, shall be subject to contractual lien recovery unless departmental personnel have previously identified these claims and have filed appropriate liens, notices, or other payment demands. A claim arises and the 12-month period begins when the department or its fiscal agent has first made payment for

medical services related to the personal or workers' compensation action on behalf of a given recipient. The department may waive any time requirement, if it concludes that it will not otherwise discover the claim and be able to effect recovery.

(c) To implement this section, the department may contract with public or private entities. Contracts or amendments entered into under this section may be on an exclusive or nonexclusive basis, and on a noncompetitive bid basis. The contracts and amendments shall be exempt from all of the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code.

(3) Review or approval of contracts by the Department of General Services.

SEC. 40. Section 14124.83 of the Welfare and Institutions Code is amended to read:

14124.83. The agreement shall include, but is not limited to, the following provisions:

(a) The agreement shall stipulate when the contractor may identify, quantify, or recover amounts owing by third parties that may be subject to a claim for reimbursement.

(b) Payment to the contractor shall be based upon a no cost percentage of recovery formula, which shall not exceed 25 percent of the gross recovery upon the claim. It is the intent of the Legislature that "no cost" include all considerations for court costs, legal fees, and the universe of the case processing activity, not including, however, departmental processing.

(c) Payment for amounts determined to be owed to the state by third parties and carriers shall be made directly to the state.

(d) A bond in the amount required by the state for collection agencies shall be sufficient.

(e) Contractor's files shall be subject to audit, pursuant to the contract, but shall remain the property of the contractor. At the request of the department, the contractor shall provide copies of any claims related to a particular recovery.

(f) The contractor shall report periodically to the department concerning its progress in the discovery of cases and the recovery of amounts subject to claim, and shall provide other information as the department may require, and at a reasonable frequency, to adequately monitor the progress of the contractor.

SEC. 41. Section 14124.85 of the Welfare and Institutions Code is repealed.

SEC. 42. Section 14124.86 of the Welfare and Institutions Code is repealed.

SEC. 43. Section 14124.86 is added to the Welfare and Institutions Code, to read:

14124.86. The contractor shall retain its rights to compensation upon recovery for completed duties under the contract with respect to any claims or liens processed in whole or in part prior to the termination date of the agreement.

SEC. 44. Section 14124.88 of the Welfare and Institutions Code is repealed.

SEC. 45. Section 14126.022 of the Welfare and Institutions Code is amended to read:

14126.022. (a) (1) By August 1, 2011, the department shall develop the Skilled Nursing Facility Quality and Accountability Supplemental Payment System, subject to approval by the federal Centers for Medicare and Medicaid Services, and the availability of federal, state, or other funds.

(2) (A) The system shall be utilized to provide supplemental payments to skilled nursing facilities that improve the quality and accountability of care rendered to residents in skilled nursing facilities, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, and to penalize those facilities that do not meet measurable standards.

(B) A freestanding pediatric subacute care facility, as defined in Section 51215.8 of Title 22 of the California Code of Regulations, shall be exempt from the Skilled Nursing Facility Quality and Accountability Supplemental Payment System.

(3) The system shall be phased in, beginning with the 2010–11 rate year.

(4) The department may utilize the system to do all of the following:

(A) Assess overall facility quality of care and quality of care improvement, and assign quality and accountability payments to skilled nursing facilities pursuant to performance measures described in subdivision (i).

(B) Assign quality and accountability payments or penalties relating to quality of care, or direct care staffing levels, wages, and benefits, or both.

(C) Limit the reimbursement of legal fees incurred by skilled nursing facilities engaged in the defense of governmental legal actions filed against the facilities.

(D) Publish each facility's quality assessment and quality and accountability payments in a manner and form determined by the director, or his or her designee.

(E) Beginning with the 2011–12 fiscal year, establish a base year to collect performance measures described in subdivision (i).

(F) Beginning with the 2011–12 fiscal year, in coordination with the State Department of Public Health, publish the direct care staffing level data and the performance measures required pursuant to subdivision (i).

(5) The department, in coordination with the State Department of Public Health, shall report to the relevant Assembly and Senate budget subcommittees by May 1, 2016, information regarding the quality and accountability supplemental payments, including, but not limited to, its assessment of whether the payments are adequate to incentivize quality care and to sustain the program.

(b) (1) There is hereby created in the State Treasury, the Skilled Nursing Facility Quality and Accountability Special Fund. The fund shall contain moneys deposited pursuant to subdivisions (g) and (j) to (m), inclusive. Notwithstanding Section 16305.7 of the Government Code, the fund shall contain all interest and dividends earned on moneys in the fund.

(2) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated without regard to fiscal year to the department for making quality and accountability payments, in accordance with subdivision (n), to facilities that meet or exceed predefined measures as established by this section.

(3) Upon appropriation by the Legislature, moneys in the fund may also be used for any of the following purposes:

(A) To cover the administrative costs incurred by the State Department of Public Health for positions and contract funding required to implement this section.

(B) To cover the administrative costs incurred by the State Department of Health Care Services for positions and contract funding required to implement this section.

(C) To provide funding assistance for the Long-Term Care Ombudsman Program activities pursuant to Chapter 11 (commencing with Section 9700) of Division 8.5.

(c) No appropriation associated with Chapter 717 of the Statutes of 2010 is intended to implement the provisions of Section 1276.65 of the Health and Safety Code.

(d) (1) There is hereby appropriated for the 2010–11 fiscal year, one million nine hundred thousand dollars ($1,900,000) from the Skilled Nursing Facility Quality and Accountability Special Fund to the California Department of Aging for the Long-Term Care Ombudsman Program activities pursuant to Chapter 11 (commencing with Section 9700) of Division 8.5. It is the intent of the Legislature for the one million nine hundred thousand dollars ($1,900,000) from the fund to be in addition to the four million one hundred sixty-eight thousand dollars ($4,168,000) proposed in the Governor's May Revision for the 2010–11 Budget. It is further the intent of the Legislature to increase this level of appropriation in subsequent years to provide support sufficient to carry out the mandates and activities pursuant to Chapter 11 (commencing with Section 9700) of Division 8.5.

(2) The department, in partnership with the California Department of Aging, shall seek approval from the federal Centers for Medicare and Medicaid Services to obtain federal Medicaid reimbursement for activities conducted by the Long-Term Care Ombudsman Program. The department shall report to the fiscal committees of the Legislature during budget hearings on progress being made and any unresolved issues during the 2011–12 budget deliberations.

(e) There is hereby created in the Special Deposit Fund established pursuant to Section 16370 of the Government Code, the Skilled Nursing Facility Minimum Staffing Penalty Account. The account shall contain all moneys deposited pursuant to subdivision (f).

(f) (1) Beginning with the 2010–11 fiscal year, the State Department of Public Health shall use the direct care staffing level data it collects to determine whether a skilled nursing facility has met the nursing hours or direct care service hours per patient per day requirements pursuant to Section 1276.5 or 1276.65, as applicable, of the Health and Safety Code.

(2) (A) Beginning with the 2010–11 fiscal year, the State Department of Public Health shall assess a skilled nursing facility, licensed pursuant to subdivision (c) of Section 1250 of the Health and Safety Code, an administrative penalty if the State

Department of Public Health determines that the skilled nursing facility fails to meet the nursing hours or direct care service hours per patient per day requirements pursuant to Section 1276.5 or 1276.65, as applicable, of the Health and Safety Code, as follows:

(i) Fifteen thousand dollars ($15,000) if the facility fails to meet the requirements for 5 percent or more of the audited days up to 49 percent.

(ii) Thirty thousand dollars ($30,000) if the facility fails to meet the requirements for over 49 percent or more of the audited days.

(B) (i) If the skilled nursing facility does not dispute the determination or assessment, the penalties shall be paid in full by the licensee to the State Department of Public Health within 30 days of the facility's receipt of the notice of penalty and deposited into the Skilled Nursing Facility Minimum Staffing Penalty Account.

(ii) The State Department of Public Health may, upon written notification to the licensee, request that the department offset any moneys owed to the licensee by the Medi-Cal program or any other payment program administered by the department to recoup the penalty provided for in this section.

(C) (i) If a facility disputes the determination or assessment made pursuant to this paragraph, the facility shall, within 15 days of the facility's receipt of the determination and assessment, simultaneously submit a request for appeal to both the department and the State Department of Public Health. The request shall include a detailed statement describing the reason for appeal and include all supporting documents the facility will present at the hearing.

(ii) Within 10 days of the State Department of Public Health's receipt of the facility's request for appeal, the State Department of Public Health shall submit, to both the facility and the department, all supporting documents that will be presented at the hearing.

(D) The department shall hear a timely appeal and issue a decision as follows:

(i) The hearing shall commence within 60 days from the date of receipt by the department of the facility's timely request for appeal.

(ii) The department shall issue a decision within 120 days from the date of receipt by the department of the facility's timely request for appeal.

(iii) The decision of the department's hearing officer, when issued, shall be the final decision of the State Department of Public Health.

(E) The appeals process set forth in this paragraph shall be exempt from Chapter 4.5 (commencing with Section 11400) and Chapter 5 (commencing with Section 11500), of Part 1 of Division 3 of Title 2 of the Government Code. The provisions of Sections 100171 and 131071 of the Health and Safety Code do not apply to appeals under this paragraph.

(F) If a hearing decision issued pursuant to subparagraph (D) is in favor of the State Department of Public Health, the skilled nursing facility shall pay the penalties to the State Department of Public Health within 30 days of the facility's receipt of the decision. The penalties collected shall be deposited into the Skilled Nursing Facility Minimum Staffing Penalty Account.

(G) The assessment of a penalty under this subdivision does not supplant the State Department of Public Health's investigation process or issuance of deficiencies or citations under Chapter 2.4 (commencing with Section 1417) of Division 2 of the Health and Safety Code.

(g) The State Department of Public Health shall transfer, on a monthly basis, all penalty payments collected pursuant to subdivision (f) into the Skilled Nursing Facility Quality and Accountability Special Fund.

(h) This section does not impact the effectiveness or utilization of Section 1278.5 or 1432 of the Health and Safety Code relating to whistleblower protections, or Section 1420 of the Health and Safety Code relating to complaints.

(i) (1) Beginning in the 2010–11 fiscal year, the department, in consultation with representatives from the long-term care industry, organized labor, and consumers, shall establish and publish quality and accountability measures, benchmarks, and data submission deadlines by November 30, 2010.

(2) The methodology developed pursuant to this section shall include, but not be limited to, the following requirements and performance measures:

(A) Beginning in the 2011–12 fiscal year:

(i) Immunization rates.

(ii) Facility acquired pressure ulcer incidence.

(iii) The use of physical restraints.

(iv) Compliance with the nursing hours or direct care service hours per patient per day requirements pursuant to Section 1276.5 or 1276.65, as applicable, of the Health and Safety Code.

(v) Resident and family satisfaction.

(vi) Direct care staff retention, if sufficient data is available.

(B) If this act is extended beyond the dates on which it becomes inoperative and is repealed, in accordance with Section 14126.033, the department, in consultation with representatives from the long-term care industry, organized labor, and consumers, beginning in the 2013–14 rate year, shall incorporate additional measures into the system, including, but not limited to, quality and accountability measures required by federal health care reform that are identified by the federal Centers for Medicare and Medicaid Services.

(C) The department, in consultation with representatives from the long-term care industry, organized labor, and consumers, may incorporate additional performance measures, including, but not limited to, the following:

(i) Compliance with state policy associated with the United States Supreme Court decision in Olmstead v. L.C. ex rel. Zimring (1999) 527 U.S. 581.

(ii) Direct care staff retention, if not addressed in the 2012–13 rate year.

(iii) The use of chemical restraints.

(D) Beginning with the 2015–16 fiscal year, the department, in consultation with representatives from the long-term care industry, organized labor, and consumers, shall incorporate direct care staff retention as a performance measure in the methodology developed pursuant to this section.

(j) (1) Beginning with the 2010–11 rate year, and pursuant to subparagraph (B) of paragraph (5) of subdivision (a) of Section 14126.023, the department shall set aside savings achieved from setting the professional liability insurance cost category, including any insurance deductible costs paid by the facility, at the 75th percentile. From this amount, the department shall transfer the General Fund portion into the Skilled Nursing Facility Quality and Accountability Special Fund. A skilled nursing facility shall provide supplemental data on insurance deductible costs to facilitate this adjustment, in the format and by the deadlines determined by the department. If this data is not provided, a facility's insurance deductible costs will remain in the administrative costs category.

(2) Notwithstanding paragraph (1), for the 2012–13 rate year only, savings from capping the professional liability insurance cost category pursuant to paragraph (1) shall remain in the General Fund and shall not be transferred to the Skilled Nursing Facility Quality and Accountability Special Fund.

(k) For the 2013–14 rate year, if there is a rate increase in the weighted average Medi-Cal reimbursement rate, the department shall set aside the first 1 percent of the weighted average Medi-Cal reimbursement rate increase for the Skilled Nursing Facility Quality and Accountability Special Fund.

(l) If this act is extended beyond the dates on which it becomes inoperative and is repealed, for the 2014–15 rate year, in addition to the amount set aside pursuant to subdivision (k), if there is a rate increase in the weighted average Medi-Cal reimbursement rate, the department shall set aside at least one-third of the weighted average Medi-Cal reimbursement rate increase, up to a maximum of 1 percent, from which the department shall transfer the General Fund portion of this amount into the Skilled Nursing Facility Quality and Accountability Special Fund.

(m) Beginning with the 2015–16 rate year, and each subsequent rate year thereafter for which this article is operative, an amount equal to the amount deposited in the fund pursuant to subdivisions (k) and (l) for the 2014–15 rate year shall be deposited into the Skilled Nursing Facility Quality and Accountability Special Fund, for the purposes specified in this section.

(n) (1) (A) Beginning with the 2013–14 rate year, the department shall pay a supplemental payment, by April 30, 2014, to skilled nursing facilities based on all of the criteria in subdivision (i), as published by the department, and according to performance measure benchmarks determined by the department in consultation with stakeholders.

(B) (i) The department may convene a diverse stakeholder group, including, but not limited to, representatives from consumer groups and organizations, labor, nursing home providers, advocacy organizations involved with the aging

community, staff from the Legislature, and other interested parties, to discuss and analyze alternative mechanisms to implement the quality and accountability payments provided to nursing homes for reimbursement.

(ii) The department shall articulate in a report to the fiscal and appropriate policy committees of the Legislature the implementation of an alternative mechanism as described in clause (i) at least 90 days prior to any policy or budgetary changes, and seek subsequent legislation in order to enact the proposed changes.

(2) Skilled nursing facilities that do not submit required performance data by the department's specified data submission deadlines pursuant to subdivision (i) are not eligible to receive supplemental payments.

(3) Notwithstanding paragraph (1), if a facility appeals the performance measure of compliance with the nursing hours or direct care service hours per patient per day requirements, pursuant to Section 1276.5 or 1276.65, as applicable, of the Health and Safety Code, to the State Department of Public Health, and it is unresolved by the department's published due date, the department shall not use that performance measure when determining the facility's supplemental payment.

(4) Notwithstanding paragraph (1), if the department is unable to pay the supplemental payments by April 30, 2014, then on May 1, 2014, the department shall use the funds available in the Skilled Nursing Facility Quality and Accountability Special Fund as a result of savings identified in subdivisions (k) and (l), less the administrative costs required to implement subparagraphs (A) and (B) of paragraph (3) of subdivision (b), in addition to any Medicaid funds that are available as of December 31, 2013, to increase provider rates retroactively to August 1, 2013.

(o) The department shall seek 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 approval is obtained from the federal Centers for Medicare and Medicaid Services and federal financial participation is available.

(p) In implementing this section, the department and the State Department of Public Health may contract as necessary, with California's Medicare Quality Improvement Organization, or other entities deemed qualified by the department or the State Department of Public Health, not associated with a skilled nursing facility, to assist with development, collection, analysis, and reporting of the performance data pursuant to subdivision (i), and with demonstrated expertise in long-term care quality, data collection or analysis, and accountability performance measurement models pursuant to subdivision (i). This subdivision establishes an accelerated process for issuing any contract pursuant to this section. Any contract entered into pursuant to this subdivision is exempt from the requirements of the Public Contract Code, through December 31, 2020.

(q) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the following apply:

(1) The director shall implement this section, in whole or in part, by means of provider bulletins, or other similar instructions without taking regulatory action.

(2) The State Public Health Officer may implement this section by means of all-facility letters, or other similar instructions without taking regulatory action.

(r) Notwithstanding paragraph (1) of subdivision (n), if a final judicial determination is made by any state or federal court that is not appealed, in any action by any party, or a final determination is made by the administrator of the federal Centers for Medicare and Medicaid Services, that any payments pursuant to subdivisions (a) and (n), are invalid, unlawful, or contrary to any provision of federal law or regulations, or of state law, these subdivisions shall become inoperative, and for the 2011–12 rate year, the rate increase provided under subparagraph (A) of paragraph (4) of subdivision (c) of Section 14126.033 shall be reduced by the amounts described in subdivision (j). For the 2013–14 and 2014–15 rate years, any rate increase shall be reduced by the amounts described in subdivisions (j) to (l), inclusive.

(s) Notwithstanding any other provision of this section, but only to the extent the department determines federal financial participation is available and not otherwise jeopardized, a skilled nursing facility shall remain eligible to participate in the supplemental payment program pursuant to this section so long as the facility meets the applicable nursing hours per patient per day requirements pursuant to Section 1276.5 of the Health and Safety Code that would have applied in the absence of the act that added this subdivision.

(t) Notwithstanding any provision of this section, but only to the extent the department determines federal financial participation is available and not otherwise jeopardized, compliance with the provisions of subdivision (c) of Section 1276.65 of the Health and Safety Code amended by the act that added this subdivision shall not be used to determine facility qualification for the supplemental payments provided for in this section until the performance period beginning in the 2019–20 fiscal year. This limitation shall also apply to the issuance of citations pursuant to subdivisions (c) and (d) of Section 1424 of the Health and Safety Code based upon the failure to comply with the provisions of subdivision (c) of Section 1276.65 of the Health and Safety Code as

amended by the act that added this subdivision. Until the performance period beginning in the 2019–20 fiscal year, the department shall apply the provisions of Section 1276.5 of the Health and Safety Code for purposes of administering the supplemental payments pursuant to this section.

SEC. 46. Section 14131.10 of the Welfare and Institutions Code is amended to read:

14131.10. (a) Notwithstanding any other provision of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591), in order to implement changes in the level of funding for health care services, specific optional benefits are excluded from coverage under the Medi-Cal program.

(b) (1) The following optional benefits are excluded from coverage under the Medi-Cal program:

(A) Adult dental services, except as specified in paragraph (2).

(i) This exclusion shall be in effect only through December 31, 2017, and adult dental services shall be covered under the Medi-Cal program as of January 1, 2018, or the effective date of any necessary federal approvals, whichever is later.

(ii) The restoration of adult dental services pursuant to clause (i) shall be effective only to the extent any necessary federal approvals are obtained as required by subdivision (f).

(B) Audiology services and speech therapy services.

(C) Chiropractic services.

(D) Optometric and optician services, including services provided by a fabricating optical laboratory, except as provided in subdivision (g).

(E) Podiatric services.

(F) Psychology services.

(G) Incontinence creams and washes.

(2) (A) Medical and surgical services provided by a doctor of dental medicine or dental surgery, which, if provided by a physician, would be considered physician services, and which services may be provided by either a physician or a dentist in this state, are covered.

(B) Emergency procedures are also covered in the categories of service specified in subparagraph (A). The director may adopt regulations for any of the services specified in subparagraph (A).

(C) Effective May 1, 2014, or the effective date of any necessary federal approvals as required by subdivision (f), whichever is later, for persons 21 years of age or older, adult dental benefits, subject to utilization controls, are limited to all the following medically necessary services:

(i) Examinations, radiographs/photographic images, prophylaxis, and fluoride treatments.

(ii) Amalgam and composite restorations.

(iii) Stainless steel, resin, and resin window crowns.

(iv) Anterior root canal therapy.

(v) Complete dentures, including immediate dentures.

(vi) Complete denture adjustments, repairs, and relines.

(D) Services specified in this paragraph shall be included as a covered medical benefit under the Medi-Cal program pursuant to Section 14132.89.

(3) Pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy are not excluded from coverage under this section.

(c) The optional benefit exclusions do not apply to either of the following:

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

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

(A) A skilled nursing facility or intermediate care facility as defined in subdivisions (c) and (d) of Section 1250 of the Health and Safety Code.

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

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

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

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

(g) (1) Effective no sooner than January 1, 2020, or January 1 of the subsequent calendar year following the legislative action pursuant to paragraph (2), whichever is later, and subject to paragraph (2) and subdivision (f), optometric and optician services, including services provided by a fabricating optical laboratory, shall be covered benefits under the Medi-Cal program.

(2) The restoration of optometric and optician services pursuant to this subdivision is contingent upon the Legislature including funding for these services in the state budget process.

SEC. 47. Section 14132.24 of the Welfare and Institutions Code is amended to read:

14132.24. (a) The department shall develop and implement a program to provide a community-living support benefit to eligible Medi-Cal beneficiaries. The department shall submit any waiver application, modification of any existing waiver, or amendment to the Medicaid state plan, that is necessary to provide this benefit, and shall implement the benefit only to the extent that federal financial participation is available.

(b) The community-living support benefit shall include both of the following:

(1) (A) Reimbursement for an array of health-related and psychosocial services provided or coordinated at community-based housing sites that enable beneficiaries to remain in the least restrictive and most homelike environment while receiving the health-related services, including personal care and psychosocial services, necessary to protect their health and well-being. These community-based housing units may include, but are not limited to, the living area or unit within a facility that is specifically designed to provide ongoing assisted living services, licensed residential care facilities for the elderly, publicly funded senior and disabled housing projects, or supportive housing sites that serve chronically homeless individuals with chronic or disabling health conditions.

(B) For purposes of this section, “assisted living services” includes, but is not limited to, assistance with personal activities of daily living, including dressing, feeding, toileting, bathing, grooming, mobility, and associated tasks, to help provide for and maintain physical and psychological comfort.

(2) Access to community-living support services provided or coordinated at the community-based housing site, including, but not limited to, the personal care and health services specified in paragraph (8) of subdivision (a) of Section 1788 of the Health and Safety Code, and the health related support services specified in Section 53290 of the Health and Safety Code.

(c) Services available through the community-living support benefit shall not duplicate services available through the Medi-Cal state plan, other Medi-Cal waivers, or other programs financed by the state.

(d) An individual shall be eligible for the community-living support benefit if he or she is eligible for the Medi-Cal program, is a resident of San Francisco who would otherwise be homeless, living in shelters, or institutionalized, and meets one or both of the following criteria:

(1) The department determines that he or she would benefit from supportive housing, as defined in subdivision (c) of Section 53260 of the Health and Safety Code.

(2) The department determines that he or she is eligible for placement in a skilled nursing facility, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, or an intermediate care facility, as defined in subdivision (d) of that section.

(e) The department may modify the eligibility criteria specified in subdivision (d), if needed, to qualify the community-living support benefit for federal financial participation.

(f) The department shall seek to maximize resources for community-based housing by coordinating the community-living support benefit with existing efforts to coordinate care, improve health outcomes, and reduce long-term care costs for the targeted population.

(g) This section shall be implemented only upon adoption of a resolution by the Board of Supervisors of the City and County of San Francisco providing county funds for use by the state to match federal Medicaid funds to receive federal funds for services provided under the waiver specified in this section, and for any costs associated with implementing and monitoring the waiver, to limit additional state costs.

(h) The program described in this section shall be discontinued effective July 1, 2017.

(1) Commencing on or after January 1, 2017, the department shall do the following:

(A) Notify program stakeholders and program participants that the program will be discontinued effective July 1, 2017, and that program participants will be assisted in transitioning to other services, including, but not limited to, other ongoing waiver programs.

(B) Discontinue enrolling new participants in the program.

(C) Begin transitioning all existing program participants to other services, including, but not limited to, other ongoing waiver programs.

(2) Subparagraph (C) of paragraph (1) shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available for the other programs and services into which the existing program participants will be transferred.

(i) This section shall become inoperative on July 1, 2018, and, as of January 1, 2019, is repealed.

SEC. 48. Section 14132.99 of the Welfare and Institutions Code is amended to read:

14132.99. (a) For the purposes of this section, “facility residents” means individuals who are currently residing in a nursing facility and whose care is paid for by Medi-Cal either with or without a share of cost. The term “facility residents” also includes individuals who are hospitalized and who are or will be waiting for transfer to a nursing facility.

(b) For those patients who are in acute care hospitals and who are pending placement in a nursing facility, the department shall expedite the processing of waiver applications in order to divert hospital discharges from nursing facilities into the community.

(c) The Nursing Facility/Acute Hospital Transition and Diversion Waiver shall include the following services:

(1) One-time community transition services as defined and allowed by the federal Centers for Medicare and Medicaid Services, including, but not limited to, security deposits that are required to obtain a lease on an apartment or home, essential furnishings, and moving expenses required to occupy and use a community domicile, set-up fees, or deposits for utility or service access, including, but not limited to, telephone, electricity, and heating, and health and safety assurances, including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy. These costs shall not exceed five thousand dollars ($5,000).

(2) Habilitation services, as defined in Section 1915(c)(5) of the federal Social Security Act (42 U.S.C. Sec. 1396n(c)(5)), and in attachment 3-d to the July 25, 2003, State Medicaid Directors Letter re Olmstead Update No. 3, to mean services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home- and community-based settings.

(d) The department shall implement this section only to the extent it can demonstrate fiscal neutrality within the overall department budget, and federal fiscal neutrality as required under the terms of the federal waiver, and only if the department has obtained the necessary approvals and receives federal financial participation from the federal Centers for Medicare and Medicaid Services.

SEC. 49. Section 14132.991 is added to the Welfare and Institutions Code, immediately following Section 14132.99, to read:

14132.991. (a) When renewing the Nursing Facility/Acute Hospital Transition and Diversion Waiver, as authorized by subdivision (t) of Section 14132, the director may take the following actions, among others:

(1) Contract with one or more organizations, referred to as a care management contractor, qualified to provide or arrange for delivery of care management and waiver services, including, but not limited to, personal needs assessments, and arranging for services available through public and private agencies, including services available under the waiver, for the waiver participants and applicants. The contract with the care management contractor, the care management contract, may require the care management contractor or their subcontractor, or both, to do all of the following, among other things:

(A) Provide, arrange for, or subcontract with community-based providers for the provision of, waiver services to waiver participants.

(B) Recognize program and service linkages, coordinate service delivery mechanisms and promote prevention of avoidable institutional placement, emergency room visits or inpatient hospital stays, or both, and coordination between health, social, and long-term services and supports by person-centered care planning.

(C) Provide or arrange for, care management to each waiver participant to stabilize their health care, and provide access to home- and community-based services, including managing and anticipating episodes of medical crisis in which transitional care management is needed.

(D) Carry out the waiver's person-centered model of care, pursuant to the requirements set forth in Sections 441.720, 441.725, and 441.540 of Title 42 of the Code of Federal Regulations.

(E) Submit all information and reports required by the department, including, but not limited to, annual financial statements in the timeframe specified by the department.

(F) Pay any providers of waiver services who are not directly employed by or contracted with the care management contractor no less than the rates specified in the waiver or the department's fee schedule, whichever is less, for the provider type.

(G) Bill the department, at the rate established by the state, for all services the care management contractor provides to waiver participants, directly or through a subcontractor or other direct service provider.

(H) Comply with the requirements of the waiver, including any other requirements established by the department regarding waiver operations, including, but not limited to, requirements regarding care coordination. These requirements may be set forth in the care management contract, care management manual, all-county letters, plan letters, plan or provider bulletins or policy letters, or similar instructions.

(2) Propose that the waiver provide for achievement of annual cost neutrality in the aggregate to allow enrollment and authorization of waiver services based on the medical necessity of the waiver services on a case-by-case basis.

(3) Expand the number of waiver slots up to 5,000 additional slots, the director may seek federal approval to amend the waiver to add additional slots or make changes to the waiver model with approval from the Department of Finance.

(4) Require care management contractors to enroll at least 60 percent of all total annual enrollments from either of the following:

(A) Hospital, nursing facility, or other institutional settings assisting members with transitions back to the home or community, or both, setting.

(B) Individuals who had been continuously receiving in home care services, of the type offered under the waiver, under the Early and Periodic Screening, Diagnosis, and Treatment State Plan benefit, California Children Services or Pediatric Palliative Care programs for children, for at least the prior three months but have at the time of transition exceeded the age limit for that benefit.

(5) If the director determines that the care management contractor is not fiscally solvent, or is in danger of becoming fiscally insolvent, the director has the option to immediately terminate the contract with the care management contractor.

(6) Terminate or refuse to renew, in whole or in part, a care management contract when the director determines that the action is necessary to protect the health of the beneficiaries or funds appropriated to the Medi-Cal program.

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

(c) 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 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.

(d) The department shall implement this section only to the extent it can demonstrate federal cost neutrality as required under the terms of the waiver, and only to the extent any necessary federal approvals are obtained and federal financial participation is available.

SEC. 50. Section 14132.100 of the Welfare and Institutions Code is amended to read:

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d(a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accordance with the definition of “visit” set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1 thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accordance with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(F) Any changes in any of the services described in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites.

(G) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in subdivision (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

(I) Any changes in the scope of a project approved by the federal Health Resources and Services Administration (HRSA).

(3) No change in costs shall, in and of itself, be considered a scope-of-service change unless all of the following apply:

(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of services defined in subdivisions (a) and (b), as applicable.

(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section 413) of Subchapter B of Chapter 4 of Title 42 of the Code of Federal Regulations, or its successor.

(C) The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

(D) The net change in the FQHC’s or RHC’s rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75-percent threshold shall be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. “Net change” means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

(4) An FQHC or RHC may submit requests for scope-of-service changes once per fiscal year, only within 90 days following the beginning of the FQHC’s or RHC’s fiscal year. Any approved increase or decrease in the provider’s rate shall be retroactive to

the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(5) An FQHC or RHC shall submit a scope-of-service rate change request within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a scope-of-service rate change request within 90 days of the beginning of the following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change shall be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to "fiscal year" shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision (l). These supplemental payments shall be determined separately from the scope-of-service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include both of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant, two hundred thousand dollars ($200,000) or 1 percent of a facility's total costs, whichever is less.

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) (1) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this section, "physician" shall be interpreted in a manner consistent with the Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a physician and surgeon, osteopath, podiatrist, dentist, optometrist, and chiropractor. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal practitioner, as defined in Section 51179.7 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a four-hour day of attendance at an adult day health care center, and any other provider identified in the state plan's definition of an FQHC or RHC visit.

(2) (A) A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist.

(B) Notwithstanding subdivision (e), if an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice, or a marriage and family therapist for the purposes of establishing its FQHC or RHC rate chooses to bill these services as a separate visit, the FQHC or RHC shall apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, shall bill these services as a separate visit. However, multiple encounters with dental professionals or marriage and family therapists that take place on the same day shall constitute a single visit. The department shall develop the appropriate forms to determine which FQHC's or RHC's rates shall be adjusted and to facilitate the calculation of the adjusted rates. An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this subparagraph shall not constitute a change in scope of service within the meaning of subdivision (e). An FQHC or RHC that applies for an adjustment to its rate pursuant to this subparagraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment for visits between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist has been approved. Any approved increase or decrease in the provider's rate shall be made within six months after the date of receipt of the department's rate adjustment forms pursuant to this subparagraph and shall be retroactive to the beginning of the fiscal year in which the FQHC or RHC submits the request, but in no case shall the effective date be earlier than January 1, 2008.

(C) An FQHC or RHC that does not provide dental hygienist, dental hygienist in alternative practice, or marriage and family therapist services, and later elects to add these services and bill these services as a separate visit, shall process the addition of these services as a change in scope of service pursuant to subdivision (e).

(3) Notwithstanding any other provision of this section, no later than July 1, 2018, a visit shall include a marriage and family therapist.

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity (as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code), the Medicare Program, or the Child Health and Disability Prevention (CHDP) Program, the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) An entity that first qualifies as an FQHC or RHC in the year 2001 or later, a newly licensed facility at a new location added to an existing FQHC or RHC, and any entity that is an existing FQHC or RHC that is relocated to a new site shall each have its reimbursement rate established in accordance with one of the following methods, as selected by the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(2) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously submitted an annual utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs.

(3) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location

was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its FQHC or RHC enrollment approval, and the department shall reconcile the difference between the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

(j) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, or in a mobile unit as defined by paragraph (2) of subdivision (b) of Section 1765.105 of the Health and Safety Code, shall be billed by and reimbursed at the same rate as the FQHC or RHC establishing the intermittent clinic site or the mobile unit, subject to the right of the FQHC or RHC to request a scope-of-service adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes. An FQHC or RHC that reverses its election under this subdivision shall revert to its prior rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable scope-of-service adjustments as provided in subdivision (e).

(l) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, scope-of-service changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under all other provisions of law of this state.

(m) The department shall, no later than March 30, 2008, promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

(n) The department shall implement this section only to the extent that federal financial participation is obtained.

SEC. 51. Section 14132.275 of the Welfare and Institutions Code, as added by Section 14 of Chapter 37 of the Statutes of 2013, is repealed.

SEC. 52. Section 14132.275 of the Welfare and Institutions Code, as amended by Section 321 of Chapter 86 of the Statutes of 2016, is amended to read:

14132.275. (a) The department shall seek federal approval to establish the demonstration project described in this section pursuant to a Medicare or a Medicaid demonstration project or waiver, or a combination of those. Under a Medicare demonstration, the department may contract with the federal Centers for Medicare and Medicaid Services (CMS) and demonstration sites to operate the Medicare and Medicaid benefits in a demonstration project that is overseen by the state as a delegated Medicare benefit administrator, and may enter into financing arrangements with CMS to share in any Medicare Program savings generated by the demonstration project.

(b) After federal approval is obtained, the department shall establish the demonstration project that enables dual eligible beneficiaries to receive a continuum of services that maximizes access to, and coordination of, benefits between the Medi-Cal and Medicare programs and access to the continuum of long-term services and supports and behavioral health services, including mental health and substance use disorder treatment services. The purpose of the demonstration project is to integrate services authorized under the federal Medicaid Program (Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.)) and the federal Medicare Program (Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.)). The demonstration project may also include additional services as approved through a demonstration project or waiver, or a combination of those.

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

(1) "Behavioral health" means Medi-Cal services provided pursuant to Section 51341 of Title 22 of the California Code of Regulations and Drug Medi-Cal substance abuse services provided pursuant to Section 51341.1 of Title 22 of the California Code of Regulations, and any mental health benefits available under the Medicare Program.

(2) "Capitated payment model" means an agreement entered into between CMS, the state, and a managed care health plan, in which the managed care health plan receives a capitation payment for the comprehensive, coordinated provision of Medi-Cal services and benefits under Medicare Part C (42 U.S.C. Sec. 1395w-21 et seq.) and Medicare Part D (42 U.S.C. Sec. 1395w-101 et seq.), and CMS shares the savings with the state from improved provision of Medi-Cal and Medicare services that reduces the cost of those services. Medi-Cal services include long-term services and supports as defined in Section 14186.1, behavioral health services, and any additional services offered by the demonstration site.

(3) "Demonstration site" means a managed care health plan that is selected to participate in the demonstration project under the capitated payment model.

(4) “Dual eligible beneficiary” means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) and Medicare Part B (42 U.S.C. Sec. 1395j et seq.) and is eligible for medical assistance under the Medi-Cal State Plan.

(d) No sooner than March 1, 2011, the department shall identify health care models that may be included in the demonstration project, shall develop a timeline and process for selecting, financing, monitoring, and evaluating the demonstration sites, and shall provide this timeline and process to the appropriate fiscal and policy committees of the Legislature. The department may implement these demonstration sites in phases.

(e) The department shall provide the fiscal and appropriate policy committees of the Legislature with a copy of any report submitted to CMS to meet the requirements under the demonstration project.

(f) Goals for the demonstration project shall include all of the following:

(1) Coordinate Medi-Cal and Medicare benefits across health care settings and improve the continuity of care across acute care, long-term care, behavioral health, including mental health and substance use disorder services, and home- and community-based services settings using a person-centered approach.

(2) Coordinate access to acute and long-term care services for dual eligible beneficiaries.

(3) Maximize the ability of dual eligible beneficiaries to remain in their homes and communities with appropriate services and supports in lieu of institutional care.

(4) Increase the availability of and access to home- and community-based services.

(5) Coordinate access to necessary and appropriate behavioral health services, including mental health and substance use disorder services.

(6) Improve the quality of care for dual eligible beneficiaries.

(7) Promote a system that is both sustainable and person and family centered by providing dual eligible beneficiaries with timely access to appropriate, coordinated health care services and community resources that enable them to attain or maintain personal health goals.

(g) No sooner than March 1, 2013, demonstration sites shall be established in up to eight counties, and shall include at least one county that provides Medi-Cal services through a two-plan model pursuant to Article 2.7 (commencing with Section 14087.3) and at least one county that provides Medi-Cal services under a county organized health system pursuant to Article 2.8 (commencing with Section 14087.5). The director shall consult with the Legislature, CMS, and stakeholders when determining the implementation date for this section. In determining the counties in which to establish a demonstration site, the director shall consider both of the following:

(1) Local support for integrating medical care, long-term care, and home- and community-based services networks.

(2) A local stakeholder process that includes health plans, providers, mental health representatives, community programs, consumers, designated representatives of in-home supportive services personnel, and other interested stakeholders in the development, implementation, and continued operation of the demonstration site.

(h) In developing the process for selecting, financing, monitoring, and evaluating the health care models for the demonstration project, the department shall enter into a memorandum of understanding with CMS. Upon completion, the memorandum of understanding shall be provided to the fiscal and appropriate policy committees of the Legislature and posted on the department’s Internet Web site.

(i) The department shall negotiate the terms and conditions of the memorandum of understanding, which shall address, but are not limited to, the following:

(1) Reimbursement methods for a capitated payment model. Under the capitated payment model, the demonstration sites shall meet all of the following requirements:

(A) Have Medi-Cal managed care health plan and Medicare dual eligible-special needs plan contract experience, or evidence of the ability to meet these contracting requirements.

(B) Be in good financial standing and meet licensure requirements under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), except for county organized health system plans that are exempt from licensure pursuant to Section 14087.95.

(C) Meet quality measures, which may include Medi-Cal and Medicare Healthcare Effectiveness Data and Information Set measures and other quality measures determined or developed by the department or CMS.

(D) Demonstrate a local stakeholder process that includes dual eligible beneficiaries, managed care health plans, providers, mental health representatives, county health and human services agencies, designated representatives of in-home supportive services personnel, and other interested stakeholders that advise and consult with the demonstration site in the development, implementation, and continued operation of the demonstration project.

(E) Pay providers reimbursement rates sufficient to maintain an adequate provider network and ensure access to care for beneficiaries.

(F) Follow final policy guidance determined by CMS and the department with regard to reimbursement rates for providers pursuant to paragraphs (4) to (7), inclusive, of subdivision (o).

(G) To the extent permitted under the demonstration, pay noncontracted hospitals prevailing Medicare fee-for-service rates for traditionally Medicare covered benefits and prevailing Medi-Cal fee-for-service rates for traditionally Medi-Cal covered benefits.

(2) Encounter data reporting requirements for both Medi-Cal and Medicare services provided to beneficiaries enrolling in the demonstration project.

(3) Quality assurance withholding from the demonstration site payment, to be paid only if quality measures developed as part of the memorandum of understanding and plan contracts are met.

(4) Provider network adequacy standards developed by the department and CMS, in consultation with the Department of Managed Health Care, the demonstration site, and stakeholders.

(5) Medicare and Medi-Cal appeals and hearing process.

(6) Unified marketing requirements and combined review process by the department and CMS.

(7) Combined quality management and consolidated reporting process by the department and CMS.

(8) Procedures related to combined federal and state contract management to ensure access, quality, program integrity, and financial solvency of the demonstration site.

(9) To the extent permissible under federal requirements, implementation of the provisions of Sections 14182.16 and 14182.17 that are applicable to beneficiaries simultaneously eligible for full-scope benefits under Medi-Cal and the Medicare Program.

(10) (A) In consultation with the hospital industry, CMS approval to ensure that Medicare supplemental payments for direct graduate medical education and Medicare add-on payments, including indirect medical education and disproportionate share hospital adjustments continue to be made available to hospitals for services provided under the demonstration.

(B) The department shall seek CMS approval for CMS to continue these payments either outside the capitation rates or, if contained within the capitation rates, and to the extent permitted under the demonstration project, shall require demonstration sites to provide this reimbursement to hospitals.

(11) To the extent permitted under the demonstration project, the default rate for noncontracting providers of physician services shall be the prevailing Medicare fee schedule for services covered by the Medicare Program and the prevailing Medi-Cal fee schedule for services covered by the Medi-Cal program.

(j) (1) The department shall comply with and enforce the terms and conditions of the memorandum of understanding with CMS, as specified in subdivision (i). To the extent that the terms and conditions do not address the specific selection, financing, monitoring, and evaluation criteria listed in subdivision (i), the department:

(A) Shall require the demonstration site to do all of the following:

(i) Comply with additional site readiness criteria specified by the department.

(ii) Comply with long-term services and supports requirements in accordance with Article 5.7 (commencing with Section 14186).

(iii) To the extent permissible under federal requirements, comply with the provisions of Sections 14182.16 and 14182.17 that are applicable to beneficiaries simultaneously eligible for full-scope benefits under both Medi-Cal and the Medicare Program.

(iv) Comply with all transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS, including transition timeframes, notices, and emergency supplies.

(B) May require the demonstration site to forgo charging premiums, coinsurance, copayments, and deductibles for Medicare Part C and Medicare Part D services.

(2) The department shall notify the Legislature within 30 days of the implementation of each provision in paragraph (1).

(k) The director may enter into exclusive or nonexclusive contracts on a bid or negotiated basis and may amend existing managed care contracts to provide or arrange for services provided under this section. Contracts entered into or amended pursuant to this section shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code.

(l) (1) (A) Except for the exemptions provided for in this section and in Section 14132.277, the department shall enroll dual eligible beneficiaries into a demonstration site unless the beneficiary makes an affirmative choice to opt out of enrollment or is already enrolled on or before June 1, 2013, in a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS or in any entity with a contract with the department pursuant to Chapter 8.75 (commencing with Section 14591).

(B) Dual eligible beneficiaries who opt out of enrollment into a demonstration site may choose to remain enrolled in fee-for-service Medicare or a Medicare Advantage plan for their Medicare benefits, but shall be mandatorily enrolled into a Medi-Cal managed care health plan pursuant to Section 14182.16, except as exempted under subdivision (c) of Section 14182.16.

(C) (i) Persons meeting requirements for the Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14591) or a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS may select either of these managed care health plans for their Medicare and Medi-Cal benefits if one is available in that county.

(ii) In areas where a PACE plan is available, the PACE plan shall be presented as an enrollment option, included in all enrollment materials, enrollment assistance programs, and outreach programs related to the demonstration project, and made available to beneficiaries whenever enrollment choices and options are presented. Persons meeting the age qualifications for PACE and who choose PACE shall remain in the fee-for-service Medi-Cal and Medicare programs, and shall not be assigned to a managed care health plan for the lesser of 60 days or until they are assessed for eligibility for PACE and determined not to be eligible for a PACE plan. Persons enrolled in a PACE plan shall receive all Medicare and Medi-Cal services from the PACE program pursuant to the three-way agreement between the PACE program, the department, and the Centers for Medicare and Medicaid Services.

(2) To the extent that federal approval is obtained, the department may require that any beneficiary, upon enrollment in a demonstration site, remain enrolled in the Medicare portion of the demonstration project on a mandatory basis for six months from the date of initial enrollment. After the sixth month, a dual eligible beneficiary may elect to enroll in a different demonstration site, a different Medicare Advantage plan, fee-for-service Medicare, PACE, or a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS, for his or her Medicare benefits.

(A) During the six-month mandatory enrollment in a demonstration site, a beneficiary may continue receiving services from an out-of-network Medicare provider for primary and specialty care services only if all of the following criteria are met:

(i) The dual eligible beneficiary demonstrates an existing relationship with the provider prior to enrollment in a demonstration site.

(ii) The provider is willing to accept payment from the demonstration site based on the current Medicare fee schedule.

(iii) The demonstration site would not otherwise exclude the provider from its provider network due to documented quality of care concerns.

(B) The department shall develop a process to inform providers and beneficiaries of the availability of continuity of services from an existing provider and ensure that the beneficiary continues to receive services without interruption.

(3) (A) Notwithstanding subparagraph (A) of paragraph (1), a dual eligible beneficiary shall be excluded from enrollment in the demonstration project if the beneficiary meets any of the following:

(i) The beneficiary has a prior diagnosis of end-stage renal disease. This clause does not apply to beneficiaries diagnosed with end-stage renal disease subsequent to enrollment in the demonstration project. The director may, with stakeholder input and federal approval, authorize beneficiaries with a prior diagnosis of end-stage renal disease in specified counties to voluntarily enroll in the demonstration project.

(ii) The beneficiary has other health coverage, as defined in paragraph (5) of subdivision (b) of Section 14182.16.

(iii) The beneficiary is enrolled in a home- and community-based waiver that is a Medi-Cal benefit under Section 1915(c) of the federal Social Security Act (42 U.S.C. Sec. 1396n et seq.), except for persons enrolled in Multipurpose Senior Services Program services or beneficiaries receiving services through a regional center who resides in the County of San Mateo.

(iv) The beneficiary is receiving services through a regional center or state developmental center. However, a beneficiary receiving services through a regional center who resides in the County of San Mateo, by making an affirmative choice to opt in, may voluntarily enroll in the demonstration project, upon receipt of all legal notifications required pursuant to this section and applicable federal requirements.

(v) The beneficiary resides in a geographic area or ZIP Code not included in managed care, as determined by the department and CMS.

(vi) The beneficiary resides in one of the Veterans' Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(B) (i) Beneficiaries who have been diagnosed with HIV/AIDS may opt out of the demonstration project at the beginning of any month. The State Department of Public Health may share relevant data relating to a beneficiary's enrollment in the AIDS Drug Assistance Program with the department, and the department may share relevant data relating to HIV-positive beneficiaries with the State Department of Public Health.

(ii) The information provided by the State Department of Public Health pursuant to this subparagraph shall not be further disclosed by the State Department of Health Care Services, and shall be subject to the confidentiality protections of subdivisions (d) and (e) of Section 121025 of the Health and Safety Code, except this information may be further disclosed as follows:

(I) To the person to whom the information pertains or the designated representative of that person.

(II) To the Office of AIDS within the State Department of Public Health.

(C) Beneficiaries who are Indians receiving Medi-Cal services in accordance with Section 55110 of Title 22 of the California Code of Regulations may opt out of the demonstration project at the beginning of any month.

(D) The department, with stakeholder input, may exempt specific categories of dual eligible beneficiaries from enrollment requirements in this section based on extraordinary medical needs of specific patient groups or to meet federal requirements.

(4) For the 2013 calendar year, the department shall offer federal Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275) compliant contracts to existing Medicare Advantage Dual Special Needs Plans (D-SNP) to continue to provide Medicare benefits to their enrollees in their service areas as approved on January 1, 2012. In the 2013 calendar year, beneficiaries in Medicare Advantage and D-SNP plans shall be exempt from the enrollment provisions of subparagraph (A) of paragraph (1), but may voluntarily choose to enroll in the demonstration project. Enrollment into the demonstration project's managed care health plans shall be reassessed in 2014 depending on federal reauthorization of the D-SNP model and the department's assessment of the demonstration plans.

(5) For the 2013 calendar year, demonstration sites shall not offer to enroll dual eligible beneficiaries eligible for the demonstration project into the demonstration site's D-SNP.

(6) The department shall not terminate contracts in a demonstration site with a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to

Article 2.9 (commencing with Section 14088) to provide services to beneficiaries who are HIV positive beneficiaries or who have been diagnosed with AIDS and with any entity with a contract pursuant to Chapter 8.75 (commencing with Section 14591), except as provided in the contract or pursuant to state or federal law.

(m) Notwithstanding Section 10231.5 of the Government Code, the department shall conduct an evaluation, in partnership with CMS, to assess outcomes and the experience of dual eligibles in these demonstration sites and shall provide a report to the Legislature after the first full year of demonstration operation, and annually thereafter. A report submitted to the Legislature pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code. The department shall consult with stakeholders regarding the scope and structure of the evaluation.

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

(o) It is the intent of the Legislature that:

(1) In order to maintain adequate provider networks, demonstration sites shall reimburse providers at rates sufficient to ensure access to care for beneficiaries.

(2) Savings under the demonstration project are intended to be achieved through shifts in utilization, and not through reduced reimbursement rates to providers.

(3) Reimbursement policies shall not prevent demonstration sites and providers from entering into payment arrangements that allow for the alignment of financial incentives and provide opportunities for shared risk and shared savings in order to promote appropriate utilization shifts, which encourage the use of home- and community-based services and quality of care for dual eligible beneficiaries enrolled in the demonstration sites.

(4) To the extent permitted under the demonstration project, and to the extent that a public entity voluntarily provides an intergovernmental transfer for this purpose, both of the following shall apply:

(A) The department shall work with CMS in ensuring that the capitation rates under the demonstration project are inclusive of funding currently provided through certified public expenditures supplemental payment programs that would otherwise be impacted by the demonstration project.

(B) Demonstration sites shall pay to a public entity voluntarily providing intergovernmental transfers that previously received reimbursement under a certified public expenditures supplemental payment program, rates that include the additional funding under the capitation rates that are funded by the public entity's intergovernmental transfer.

(5) The department shall work with CMS in developing other reimbursement policies and shall inform demonstration sites, providers, and the Legislature of the final policy guidance.

(6) The department shall seek approval from CMS to permit the provider payment requirements contained in subparagraph (G) of paragraph (1) and paragraphs (10) and (11) of subdivision (i), and Section 14132.276.

(7) Demonstration sites that contract with hospitals for hospital services on a fee-for-service basis that otherwise would have been traditionally Medicare services will achieve savings through utilization changes and not by paying hospitals at rates lower than prevailing Medicare fee-for-service rates.

(p) The department shall enter into an interagency agreement with the Department of Managed Health Care to perform some or all of the department's oversight and readiness review activities specified in this section. These activities may include providing consumer assistance to beneficiaries affected by this section and conducting financial audits, medical surveys, and a review of the adequacy of provider networks of the managed care health plans participating in this section. The interagency agreement shall be updated, as necessary, on an annual basis in order to maintain functional clarity regarding the roles and responsibilities of the Department of Managed Health Care and the department. The department shall not delegate its authority under this section as the single state Medicaid agency to the Department of Managed Health Care. Notwithstanding any other law, this subdivision shall be operative only through June 30, 2017.

(q) (1) Beginning with the May Revision to the 2013–14 Governor's Budget, and annually thereafter, the department shall report to the Legislature on the enrollment status, quality measures, and state costs of the actions taken pursuant to this section.

(2) (A) By January 1, 2013, or as soon thereafter as practicable, the department shall develop, in consultation with CMS and stakeholders, quality and fiscal measures for health plans to reflect the short- and long-term results of the implementation of this section. The department shall also develop quality thresholds and milestones for these measures. The department shall update these measures periodically to reflect changes in this program due to implementation factors and the structure and design of the benefits and services being coordinated by managed care health plans.

(B) The department shall require health plans to submit Medicare and Medi-Cal data to determine the results of these measures. If the department finds that a health plan is not in compliance with one or more of the measures set forth in this section, the health plan shall, within 60 days, submit a corrective action plan to the department for approval. The corrective action plan shall, at a minimum, include steps that the health plan shall take to improve its performance based on the standard or standards with which the health plan is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the health plan in order to avoid a sanction pursuant to Section 14304. This subparagraph is not intended to limit Section 14304.

(C) The department shall publish the results of these measures, including by posting on the department's Internet Web site, on a quarterly basis.

(r) 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 and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

SEC. 53. Section 14132.276 of the Welfare and Institutions Code is amended to read:

14132.276. For nursing facility services provided under the demonstration project as established in Section 14132.275, to the extent these provisions are authorized under the memorandum of understanding specified in subdivision (j) of Section 14132.275, the following shall apply:

(a) The demonstration site shall not combine the rates of payment for post-acute skilled and rehabilitation care provided by a nursing facility and long-term and chronic care provided by a nursing facility in order to establish a single payment rate for dual eligible beneficiaries requiring skilled nursing services.

(b) The demonstration site shall pay nursing facilities providing post-acute skilled and rehabilitation care or long-term and chronic care rates that reflect the different level of services and intensity required to provide these services.

(c) For the purposes of determining the appropriate rate for the type of care identified in subdivision (b), the demonstration site shall pay no less than the recognized rates under Medicare and Medi-Cal for these service types.

(d) With respect to services under this section, the demonstration site shall not offer, and the nursing facility shall not accept, any discounts, rebates, or refunds as compensation or inducements for the referral of patients or residents.

(e) It is the intent of the Legislature that savings under the demonstration project be achieved through shifts in utilization, and not through reduced reimbursement rates to providers.

(f) In order to encourage quality improvement and promote appropriate utilization incentives, including reduced rehospitalization and shorter lengths of stay, for nursing facilities providing the services under this section, the demonstration sites may do any of the following:

(1) Utilize incentive or bonus payment programs that are in addition to the rates identified in subdivisions (b) and (c).

(2) Opt to direct beneficiaries to facilities that demonstrate better performance on quality or appropriate utilization factors.

(g) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

SEC. 54. Section 14132.277 of the Welfare and Institutions Code is amended to read:

14132.277. (a) For purposes of this section, the following definitions apply:

(1) "Alternate health care service plan" means a prepaid health plan that is a nonprofit health care service plan with at least 3.5 million enrollees statewide, that owns or operates its own pharmacies, and that provides medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each specific geographic region in which it operates to provide services to enrollees.

(2) "Cal MediConnect plan" means a health plan or other qualified entity jointly selected by the state and CMS for participation in the demonstration project.

(3) "CMS" means the federal Centers for Medicare and Medicaid Services.

(4) “Coordinated Care Initiative county” means the Counties of Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara, and any other county identified in Appendix 3 of the Memorandum of Understanding Between the Centers for Medicare and Medicaid Services and the State of California, Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees, inclusive of all amendments, as authorized by Section 14132.275.

(5) “D-SNP plan” means a Medicare Advantage Dual Special Needs Plan.

(6) “D-SNP contract” means a federal Medicare Improvements for Patients and Provider Act of 2008 (Public Law 110-275) compliant contract between the department and a D-SNP plan.

(7) “Demonstration project” means the demonstration project authorized by Section 14132.275.

(8) “Excluded beneficiaries” means those beneficiaries who are not eligible to participate in the demonstration project pursuant to subdivision (l) of Section 14132.275.

(9) “FIDE-SNP plan” means a Medicare Advantage Fully-Integrated Dual Eligible Special Needs Plan.

(10) “Non-Coordinated Care Initiative counties” means counties not participating in the demonstration project.

(b) For the 2014 calendar year, the department shall offer D-SNP contracts to existing D-SNP plans to continue to provide benefits to their enrollees in their service areas as approved on January 1, 2013. The director may include in any D-SNP contract provisions requiring that the D-SNP plan do the following:

(1) Submit to the department a complete and accurate copy of the bid submitted by the plan to CMS for its D-SNP contract.

(2) Submit to the department copies of all utilization and quality management reports submitted to CMS.

(c) In Coordinated Care Initiative counties, Medicare Advantage plans and D-SNP plans may continue to enroll beneficiaries in 2014. In the 2014 calendar year, beneficiaries enrolled in a Medicare Advantage or D-SNP plan operating in a Coordinated Care Initiative county shall be exempt from the enrollment provisions of subparagraph (A) of paragraph (1) of subdivision (l) of Section 14132.275. Those beneficiaries may at any time voluntarily choose to disenroll from their Medicare Advantage or D-SNP plan and enroll in a demonstration site operating pursuant to subdivision (g) of Section 14132.275. If a beneficiary chooses to do so, that beneficiary may subsequently disenroll from the demonstration site and return to fee-for-service Medicare or to a D-SNP plan or Medicare Advantage plan.

(d) For the 2015 calendar year and the remainder of the demonstration project, in Coordinated Care Initiative counties, the department shall offer D-SNP contracts to D-SNP plans that were approved for the D-SNP plan’s service areas as of January 1, 2013. In Coordinated Care Initiative counties, the department shall enter into D-SNP contracts with D-SNP plans only for excluded beneficiaries and for those beneficiaries identified in paragraphs (2) and (5) of subdivision (g).

(e) For the 2015 calendar year and the remainder of the demonstration project, in non-Coordinated Care Initiative counties, the department shall offer D-SNP contracts to D-SNP plans.

(f) The director may include in a D-SNP contract offered pursuant to subdivision (d) or (e) provisions requiring that the D-SNP plan do the following:

(1) Submit to the department a complete and accurate copy of the bid submitted by the plan to CMS for its D-SNP contract.

(2) Submit to the department copies of all utilization and quality management reports submitted to CMS.

(g) For the 2015 calendar year and the remainder of the demonstration project, in Coordinated Care Initiative counties, the enrollment provisions of subdivision (l) of Section 14132.275 shall apply subject to the following:

(1) Beneficiaries enrolled in a FIDE-SNP plan or a Medicare Advantage plan, other than a D-SNP plan, shall be exempt from the enrollment provisions of subparagraph (A) of paragraph (1) of subdivision (l) of Section 14132.275.

(2) If the D-SNP plan is not a Cal MediConnect plan, beneficiaries enrolled as of December 31, 2014, in a D-SNP plan shall be exempt from the enrollment provisions of subparagraph (A) of paragraph (1) of subdivision (l) of Section 14132.275. Those beneficiaries may at any time voluntarily choose to disenroll from their D-SNP plan and enroll in a demonstration site operating pursuant to subdivision (g) of Section 14132.275. A dual eligible beneficiary who is enrolled as of December 31, 2014, in a D-SNP plan that is not a Cal MediConnect plan and who opts out of a demonstration site during the course of the demonstration project may choose to reenroll in that D-SNP plan.

(3) If the D-SNP is a Cal MediConnect plan, beneficiaries enrolled in a D-SNP plan who are eligible for the demonstration project shall be subject to the enrollment provisions of subparagraph (A) of paragraph (1) of subdivision (l) of Section 14132.275.

(4) For FIDE-SNP plans serving beneficiaries in Coordinated Care Initiative counties, the department shall require the following provisions:

(A) After December 31, 2014, enrollment in the County of Los Angeles shall not exceed 6,000 additional beneficiaries at any point during the term of the demonstration project. After December 31, 2014, enrollment in the combined Counties of Riverside and San Bernardino shall not exceed 1,500 additional beneficiaries at any point during the term of the demonstration project.

(B) Any necessary data or information requirements provided by the FIDE-SNP to ensure contract compliance.

(5) Beneficiaries enrolled in an alternate health care service plan (AHCSP) who become dually eligible for Medicare and Medicaid benefits while enrolled in that AHCSP may elect to enroll in the AHCSP's D-SNP plan subject to the following requirements:

(A) The beneficiary was a member of the AHCSP immediately prior to becoming dually eligible for Medicare and Medicaid benefits.

(B) Upon mutual agreement between a Cal MediConnect Plan operated by a health authority or commission contracting with the department and the AHCSP, the AHCSP shall take full financial and programmatic responsibility for certain long-term supports and services of the D-SNP enrollee, including, but not limited to, certain long-term skilled nursing care, community-based adult services, multipurpose senior services program services, and other applicable Medi-Cal benefits offered in the demonstration project.

(6) Prior to assigning a beneficiary in a Medi-Cal managed care health plan pursuant to Section 14182.16, the department shall determine whether the beneficiary is already a member of the AHCSP. If so, the beneficiary shall be assigned to a Medi-Cal managed care health plan operated by a health authority or commission contracting with the department and subcontracting with the AHCSP.

(h) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

SEC. 55. Section 14148.65 of the Welfare and Institutions Code is repealed.

SEC. 56. Section 14148.67 of the Welfare and Institutions Code is repealed.

SEC. 57. Section 14148.8 of the Welfare and Institutions Code is amended to read:

14148.8. (a) (1) The State Department of Health Care Services shall provide Medi-Cal reimbursements to alternative birth centers for facility-related delivery costs at a statewide all-inclusive rate per delivery that shall not exceed 80 percent of the average Medi-Cal reimbursement received by general acute care hospitals with Medi-Cal contracts and shall be based on an average hospital length of stay of 1.7 days. The reimbursement rate shall be updated annually and shall be based on the California Medical Assistance Commission's annually published legislative report of average contract rates for general acute care hospitals with Medi-Cal contracts. However, the reimbursement shall not exceed the alternative birth center's charges to any non-Medi-Cal patient for similar services. This paragraph shall apply to Medi-Cal reimbursement for facility-related delivery costs of alternative birth centers until the effective date of any necessary federal approval obtained by the department pursuant to paragraph (2).

(2) Effective no earlier than July 1, 2017, the department shall reimburse facility-related Medi-Cal delivery costs of eligible alternative birth centers based on a statewide all-inclusive rate per delivery that shall not exceed 80 percent of the average diagnosis-related groups (DRG) Level 1 rates received by general acute care hospitals pursuant to Section 14105.28 and the applicable provisions of the Medi-Cal State Plan. Reimbursement pursuant to this paragraph shall not exceed the alternative birth center's charges to any non-Medi-Cal patient for similar services. The department shall seek any federal approvals necessary to implement this paragraph. This paragraph shall not be implemented until any necessary federal approvals are obtained. This paragraph shall not be construed to make inoperative any existing payment reductions that are applicable to alternative birth center services, including, but not limited to, the payment reductions imposed pursuant to Section 14105.192.

(b) In order to be eligible for reimbursement pursuant to this section, an alternative birth center shall satisfy the following criteria as determined by the state department:

(1) The facility shall meet all applicable requirements of Section 1204.3 of the Health and Safety Code.

(2) The facility shall be currently certified as a Comprehensive Perinatal Services Program (CPSP) provider pursuant to Section 14134.5.

(3) The facility may utilize licensed midwives, certified nurse midwives, certified nurse practitioners, and clinical nurse specialists when appropriate.

(4) The facility shall meet the standards for certification established by the National Association of Childbearing Centers, or at least equivalent standards as determined by the department, including those relating to the proximity and involvement of hospitals, obstetricians, and pediatricians.

(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, interpret, or make specific this section, in whole or in part, by means of provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action.

(d) This section does not alter the scope of practice for any health care professional or authorize the delivery of health care services in a setting or in a manner not authorized by the Health and Safety Code or the Business and Professions Code.

(e) 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.

SEC. 58. Article 4.11 (commencing with Section 14149.9) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 4.11. Diabetes Prevention Program

14149.9. (a) It is the intent of the Legislature that the department pursue policies and programs to assist Medi-Cal beneficiaries in preventing or delaying the onset of type 2 diabetes.

(b) (1) The department shall establish the Diabetes Prevention Program (DPP) within the Medi-Cal fee-for-service and managed care delivery systems.

(2) A Medi-Cal managed care plan shall make the DPP available to enrolled beneficiaries in accordance with this article.

(c) In implementing the DPP, the department shall require that Medi-Cal providers offering DPP services comply with guidelines issued by the federal Centers for Disease Control and Prevention (CDC) and obtain CDC recognition in connection with the National Diabetes Prevention Program.

(d) The DPP shall be an evidence-based, lifestyle change program designed to prevent or delay the onset of type 2 diabetes among individuals with prediabetes.

(e) The DPP shall be made available to Medi-Cal beneficiaries no sooner than July 1, 2018.

(f) A Medi-Cal provider may identify and recommend participation in the DPP to a beneficiary who meets all of the following requirements:

(1) The beneficiary is at least 18 years of age.

(2) As of the date of the provider recommendation, the beneficiary has a body mass index (BMI) of at least 25 if the beneficiary is not self-identified as Asian, or a BMI of at least 23 if the beneficiary is self-identified as Asian.

(3) Within the 12-month period prior to the provider recommendation, the beneficiary has had one of the following:

(A) A hemoglobin A1c test with a value between 5.7 and 6.4 percent.

(B) A fasting plasma glucose of 110-125 mg/dL.

(C) A two-hour plasma glucose of 140-199 mg/dL.

(4) The beneficiary has no previous diagnosis of type 1 diabetes or type 2 diabetes, with the exception of gestational diabetes.

(5) The beneficiary does not have end-stage renal disease.

(g) In implementing the DPP, the department shall require Medi-Cal providers offering DPP services to use a CDC-approved lifestyle change curriculum that does all of the following:

(1) Emphasizes self-monitoring, self-efficacy, and problem solving.

(2) Provides for coach feedback.

(3) Includes participant materials to support program goals.

(4) Requires participant weigh-ins to track and achieve program goals.

(h) DPP services shall be provided by peer coaches, who promote realistic lifestyle changes, emphasize weight loss through healthy eating and physical activity, and implement the DPP curriculum. A trained peer coach may be a physician, a nonphysician practitioner, or an unlicensed person who has been trained to deliver the required curriculum content and possesses the skills, knowledge, and qualities specified in the National Diabetes Prevention Program guidelines.

(i) A beneficiary who participates in the DPP shall be allowed to participate in 22 peer coaching sessions over a period of at least one year. Thereafter, the department shall provide a participating beneficiary who achieves and maintains a required minimum weight loss of 5 percent from the first core session, in accordance with CDC standards, with less intensive, ongoing maintenance sessions to help the beneficiary continue healthy behaviors.

(j) (1) The department shall develop payment methodologies, or adjust existing methodologies, for reimbursing DPP services and activities in the Medi-Cal fee-for-service delivery system, not to exceed 80 percent of the federal Medicare Program reimbursement for comparable service, billing, and diagnosis codes under the federal Medicare Program.

(2) For purposes of reimbursement under the Medi-Cal fee-for-service delivery system, an unlicensed peer coach shall have an arrangement with an enrolled Medi-Cal provider for purposes of reimbursement for rendered DPP services.

(k) This article shall be implemented only to the extent that the department obtains federal financial participation to the extent permitted by federal law, and obtains any necessary federal approvals.

(l) For the purposes of implementing this article, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including contracts for the purpose of obtaining subject matter expertise or other technical assistance. A contract may be statewide or on a more limited geographic basis. A contract entered into or amended pursuant to this subdivision shall be exempt from all of the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

(2) Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code.

(3) Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code.

(4) Review or approval of any division of the Department of General Services.

(m) 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 this article, policies and procedures pertaining to the DPP, and applicable waivers and state plan amendments, by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. Thereafter, the department, by July 1, 2020, shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this article, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

SEC. 59. Section 14154 of the Welfare and Institutions Code is amended to read:

14154. (a) (1) The department shall establish and maintain a plan whereby costs for county administration of the determination of eligibility for benefits under this chapter will be effectively controlled within the amounts annually appropriated for that administration. The plan, to be known as the County Administrative Cost Control Plan, shall establish standards and performance criteria, including workload, productivity, and support services standards, to which counties shall adhere. The plan shall include standards for controlling eligibility determination costs that are incurred by performing eligibility determinations at county hospitals, or that are incurred due to the outstationing of any other eligibility function. Except as provided in Section 14154.15, reimbursement to a county for outstationed eligibility functions shall be based solely on productivity standards applied to that county's welfare department office.

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

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

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

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

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

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

(5) The department shall provide a clear narrative description along with fiscal detail in the Medi-Cal estimate package, submitted to the Legislature in January and May of each year, of each component of the county administrative funding for the Medi-Cal program. This shall describe how the information obtained from the county budget survey documents was utilized and, if applicable, modified and the rationale for the changes.

(6) Notwithstanding any other law, the department shall develop and implement, in consultation with county program and fiscal representatives, a new budgeting methodology for Medi-Cal county administrative costs that reflects the impact of PPACA implementation on county administrative work. The new budgeting methodology shall be used to reimburse counties for eligibility processing and case maintenance for applicants and beneficiaries.

(A) The budgeting methodology may include, but is not limited to, identification of the costs of eligibility determinations for applicants, and the costs of eligibility redeterminations and case maintenance activities for recipients, for different groupings of cases, based on variations in time and resources needed to conduct eligibility determinations. The calculation of time and resources shall be based on the following factors: complexity of eligibility rules, ongoing eligibility requirements, and other factors as determined appropriate by the department. The development of the new budgeting methodology may include, but is not limited to, county survey of costs, time and motion studies, in-person observations by department staff, data reporting, and other factors deemed appropriate by the department.

(B) The new budgeting methodology shall be clearly described, state the necessary data elements to be collected from the counties, and establish the timeframes for counties to provide the data to the state.

(C) The new budgeting methodology developed pursuant to this paragraph shall be implemented no sooner than the 2015–16 fiscal year. The department may develop a process for counties to phase in the requirements of the new budgeting methodology.

(D) The department shall provide the new budgeting methodology to the legislative fiscal committees by March 1 of the fiscal year immediately preceding the first fiscal year of implementation of the new budgeting methodology.

(E) To the extent that the funding for the county budgets developed pursuant to the new budget methodology is not fully appropriated in any given fiscal year, the department, with input from the counties, shall identify and consider options to align funding and workload responsibilities.

(F) For purposes of this paragraph, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(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 paragraph by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 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. Beginning six months after the implementation of the new budgeting methodology pursuant to this paragraph, and notwithstanding Section 10231.5 of the Government Code, 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.

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

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

(2) It is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2008–09, 2009–10, 2010–11, 2011–12, 2012–13, 2014–15, 2015–16, 2016–17, and 2017–18 fiscal years.

(d) The department is responsible for the Medi-Cal program in accordance with state and federal law. A county shall determine Medi-Cal eligibility in accordance with state and federal law. If in the course of its duties the department becomes aware of accuracy problems in any county, the department shall, within available resources, provide training and technical assistance as appropriate. This section shall not be interpreted to eliminate any remedy otherwise available to the department to enforce accurate county administration of the program. In administering the Medi-Cal eligibility process, each county shall meet the following performance standards each fiscal year:

(1) Complete eligibility determinations as follows:

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

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

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

(B) Upon the development and implementation of the best-practice guidelines and expedited processes, the department and the counties may develop an expedited enrollment timeframe for newborns that is separate from the standards for all other applications, to the extent that the timeframe is consistent with these guidelines and processes.

(3) Perform timely annual redeterminations, as follows:

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

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

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

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

(f) On January 1 of each year, each applicable county, as determined by the department, shall report to the department on the county's results in meeting the performance standards specified in this section. The report shall be subject to verification by the department. County reports shall be provided to the public upon written request.

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

is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the county in order to avoid a sanction.

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

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

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and except as provided in subparagraph (G) of paragraph (6) of subdivision (a), the department shall, without taking any further regulatory action, implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters or similar instructions.

SEC. 60. Section 14166.61 of the Welfare and Institutions Code is amended to read:

14166.61. (a) For successor demonstration year 6 and subsequent successor demonstration years, each designated public hospital described in subdivision (c) of Section 14166.3 shall be eligible to receive an allocation of federal Medicaid funding from the applicable federal disproportionate share hospital allotment pursuant to this section. The department shall establish the allocations and claim the federal funding in a manner that maximizes federal Medicaid funding to the state during the term of the successor demonstration project, and shall consider, at a minimum, all of the following factors:

(1) The optimal use of intergovernmental transfer-funded payments described in subdivision (d).

(2) Minimizing the need to redistribute federal funds that are based on the certified public expenditures of designated public hospitals as described in paragraph (1) of subdivision (c).

(b) Disproportionate share hospital allocations for designated public hospitals shall be determined for each successor demonstration year as set forth below. With respect to successor demonstration year 10, allocations shall be determined separately for each of the periods of July 1, 2014, through June 30, 2015, and July 1, 2015, through October 31, 2015.

(1) The department shall determine the maximum federal disproportionate share hospital allotment that is available under this section for the successor demonstration year.

(2) An initial allocation shall be made to Kern Medical Center for the periods and in the amounts specified below:

(A) For successor demonstration year 6, the amount of eight million dollars ($8,000,000).

(B) For successor demonstration years 7 through 9, the amount of twelve million dollars ($12,000,000).

(C) For the period of July 1, 2014, through June 30, 2015, the amount of twelve million dollars ($12,000,000).

(D) For the period of July 1, 2015, through October 31, 2015, the amount of four million dollars ($4,000,000).

(3) Each designated public hospital shall be allocated an amount per hospital discharge as specified in this paragraph. The number of discharges per category occurring in the relevant period shall be derived from each hospital's data as reported pursuant to Section 14166.8. The reported discharges shall relate to the same hospital services for which costs are calculated for purposes of this section.

(A) One thousand one hundred dollars ($1,100) per hospital discharge with respect to an uninsured individual.

(B) Nine hundred dollars ($900) per hospital discharge with respect to an individual enrolled in the Low Income Health Program.

(C) Seven hundred fifty dollars ($750) per hospital discharge with respect to a Medi-Cal beneficiary, excluding discharges for which Medicare payments were received.

(4) The remaining available federal disproportionate share hospital allotment, after the allocations are made pursuant to paragraphs (2) and (3), shall be allocated to designated public hospitals as follows:

(A) The department shall calculate for each designated public hospital an initial DSH claiming ability amount. For the purposes of this article, the “initial DSH claiming ability amount” means the total sum of the hospital’s uncompensated Medi-Cal, Low Income Health Program, and uninsured costs of hospital services that are reported as eligible certified public expenditures for disproportionate share hospital payments pursuant to Section 14166.8. For hospitals described in subdivision (d), the total sum shall be multiplied by 175 percent.

(B) The remaining available federal disproportionate share hospital allotment shall be allocated pro rata among the designated public hospitals based upon each hospital’s initial DSH claiming ability amount as determined pursuant to subparagraph (A).

(c) Each designated public hospital shall receive its allocation of federal disproportionate share hospital payments in one or both of the following forms:

(1) Distributions from the Demonstration Disproportionate Share Hospital Fund established pursuant to subdivision (d) of Section 14166.9, consisting of federal funds claimed and received by the department, pursuant to clauses (ii) and (iii) of subparagraph (A) of paragraph (2) of subdivision (a) of Section 14166.9 based on designated public hospitals’ certified public expenditures up to 100 percent of uncompensated Medi-Cal and uninsured costs. These distributions may be made to a designated public hospital independent of the amount of uncompensated Medi-Cal and uninsured costs certified as public expenditures by that hospital pursuant to Section 14166.8.

(2) Intergovernmental transfer-funded payments, as described in subdivision (d). For purposes of determining whether the hospital has received its allocation of federal disproportionate share hospital payments established under this section, only the federal share of intergovernmental transfer-funded payments shall be considered.

(d) Designated public hospitals that meet the requirements of Section 1396r-4(b)(1)(A) of Title 42 of the United States Code regarding the Medicaid inpatient utilization rate or Section 1396r-4(b)(1)(B) of Title 42 of the United States Code regarding the low-income utilization rate, may receive intergovernmental transfer-funded disproportionate share hospital payments as follows:

(1) The department shall establish the amount of the hospital’s intergovernmental transfer-funded disproportionate share hospital payment. The total amount of that payment, consisting of the federal and nonfederal components, shall in no case exceed an amount equal to 75 percent of the hospital’s uncompensated Medi-Cal, Low Income Health Program, and uninsured costs of hospital services, determined in accordance with the Special Terms and Conditions for the successor demonstration project and the applicable provisions of the Medi-Cal State Plan.

(2) A transfer amount shall be determined for each hospital that is subject to this subdivision, equal to the nonfederal share of the payment amount established for the hospital pursuant to paragraph (1). The transfer amount determined shall be paid by the hospital, or the public entity with which the hospital is affiliated, and deposited into the Medi-Cal Inpatient Payment Adjustment Fund established pursuant to subdivision (b) of Section 14163. The sources of funds utilized for the transfer amount shall not include impermissible provider taxes or donations as defined under Section 1396b(w) of Title 42 of the United States Code or other federal funds. For this purpose, federal funds do not include delivery system reform incentive pool payments or patient care revenue received as payment for services rendered under programs such as designated state health programs, the Low Income Health Program, Medicare, or Medicaid.

(3) The department shall pay the amounts established pursuant to paragraph (1) to each hospital using the transfer amounts deposited pursuant to paragraph (2) as the nonfederal share of those payments.

(e) The total federal disproportionate share hospital funds allocated under this section to designated public hospitals with respect to each successor demonstration year, in combination with the federal share of disproportionate share hospital payment adjustments made to nondesignated public hospitals pursuant to Section 14166.16 and applicable provisions of the Medi-Cal State Plan for the same successor demonstration year, shall not exceed the applicable federal disproportionate share hospital allotment.

(f) (1) Each designated public hospital shall receive quarterly interim payments of its disproportionate share hospital allocation during the successor demonstration year, except that, with respect to the period of July 1, 2015, through October 31, 2015, the interim payment shall be made in October 2015. The determinations set forth in subdivisions (a) to (e), inclusive, shall be made on an interim basis prior to the start of each successor demonstration year. The department shall use the same cost and statistical data used in determining the interim payments for Medi-Cal inpatient hospital services under Section 14166.4, and available payments and uncompensated and uninsured cost data, including data from the Medi-Cal paid claims file and the hospital’s books and records, for the corresponding period.

(2) Prior to the distribution of payments in accordance with paragraph (1) and subdivisions (g) and (h) to a designated public hospital that is part of a hospital system containing multiple designated public hospitals licensed to the same governmental entity, the department shall consult with the applicable governmental entity. The department shall implement any adjustments to

the payment distributions for the hospitals in that hospital system as requested by the governmental entity if the net effect of the requested adjustments for those hospitals is zero. These payment redistributions shall recognize the level of care provided to Medi-Cal and uninsured patients and shall maintain the viability and effectiveness of the hospital system.

(3) If the determinations pursuant to subdivision (g) or (h) for a successor demonstration year result in total federal disproportionate share hospital funds claimable for distribution to designated public hospitals under this section that, in combination with the federal share of disproportionate share hospital payment adjustments made to nondesignated public hospitals for the same successor demonstration year as described in subdivision (e), are less than the applicable federal disproportionate share hospital allotment, the department shall follow the steps described in subparagraphs (A) to (C), inclusive. For purposes of this paragraph, the determinations for successor demonstration year 10 shall be made for the period of July 1, 2014, through June 30, 2015.

(A) The maximum available federal disproportionate share hospital funds for designated public hospitals for the successor demonstration year shall be determined by subtracting the federal share of disproportionate share hospital payment adjustments payable to nondesignated public hospitals pursuant to Section 14166.16 and applicable provisions of the Medi-Cal State Plan for the same successor demonstration year from the applicable federal disproportionate share hospital allotment.

(B) A reduction factor shall be calculated by dividing the total federal disproportionate share hospital funds that are claimable for distributions to designated public hospitals pursuant to subdivision (g) or (h), as applicable, by the maximum available federal disproportionate share hospital funds determined under subparagraph (A).

(C) The reduction factor calculated under subparagraph (B) shall be multiplied by the applicable allocation amount specified in paragraph (2) of subdivision (b), by the applicable amount per discharge specified in paragraph (3) of subdivision (b), and by the remaining available allotment otherwise allocable under paragraph (4) of subdivision (b). The total of these allocation amounts shall be incorporated as the payment distributions to be made pursuant to subdivision (g) or (h), as applicable.

(4) With respect to the period of July 1, 2014, through June 30, 2015, and notwithstanding subdivision (e) of Section 14184.30, if a final audit, reconciliation, or judicial or administrative determination is made or implemented subsequent to the applicable finalization date set forth in paragraph (1) of subdivision (e) of Section 14184.30 and results in federal disproportionate share hospital funds distributable to designated public hospitals in addition to the aggregate amount distributed pursuant to paragraph (3), the department shall proceed as follows:

(A) The department shall perform revised distribution calculations pursuant to subdivision (b) and, if applicable, paragraph (3).

(B) The amounts that would be allocated to each designated public hospital under the revised distribution calculations in subparagraph (A) shall be compared to the amounts previously distributed to the hospital for the same successor demonstration year.

(C) The additional federal disproportionate share hospital funds shall be distributed to those designated public hospitals to which additional amounts would be due under the revised distribution calculations.

(D) The timing of the adjustments under this paragraph shall be determined by the department in consultation with the affected designated public hospitals.

(E) Notwithstanding any other law, if the affiliated governmental entity for the designated public hospital is a county subject to Article 12 (commencing with Section 17612.1) of Chapter 6 of Part 5, the department, in consultation with the affected designated public hospital and the Department of Finance, shall determine how to account for whether any additional payment amount distributed to the designated public hospital pursuant to subparagraph (C) would otherwise have affected, if at all, the applicable county's redirection obligation for the 2014–15 fiscal year pursuant to paragraphs (4) and (5) of subdivision (a) of Section 17612.3 and shall determine which adjustments, if any, are necessary to either the repayment amount or the applicable county's redirection obligation. For purposes of this subparagraph, subdivision (f) of Section 17612.2 of this code and paragraph (7) of subdivision (e) of Section 101853 of the Health and Safety Code shall apply.

(g) No later than April 1 following the end of the relevant reporting period for the successor demonstration year, the department shall undertake an interim reconciliation of payments based on Medicare and other cost, payment, discharge, and statistical data submitted by the hospital for the successor demonstration year, and shall adjust payments to the hospital accordingly.

(h) Each designated public hospital shall receive its disproportionate share hospital allocation, as computed pursuant to subdivisions (a) to (e), inclusive, subject to final audits of all applicable Medicare and other cost, payment, discharge, and statistical data for the successor demonstration year.

SEC. 61. Section 14182.16 of the Welfare and Institutions Code is amended to read:

14182.16. (a) The department shall require Medi-Cal beneficiaries who have dual eligibility in Medi-Cal and the Medicare Program to be assigned as mandatory enrollees into new or existing Medi-Cal managed care health plans for their Medi-Cal benefits in Coordinated Care Initiative counties.

(b) For the purposes of this section and Section 14182.17, the following definitions shall apply:

(1) “Coordinated Care Initiative counties” means the Counties of Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

(2) “Dual eligible beneficiary” means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or both, and is eligible for medical assistance under the Medi-Cal State Plan.

(3) “Full-benefit dual eligible beneficiary” means an individual 21 years of age or older who is eligible for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), Medicare Part B (42 U.S.C. Sec. 1395j et seq.), and Medicare Part D (42 U.S.C. Sec. 1395w-101), and is eligible for medical assistance under the Medi-Cal State Plan.

(4) “Managed care health plan” means an individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.81 (commencing with Section 14087.96), or Article 2.91 (commencing with Section 14089), of this chapter, or Chapter 8 (commencing with Section 14200).

(5) “Other health coverage” means health coverage providing the same full or partial benefits as the Medi-Cal program, health coverage under another state or federal medical care program except for the Medicare Program (Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.)), or health coverage under a contractual or legal entitlement, including, but not limited to, a private group or indemnification insurance program.

(6) “Out-of-network Medi-Cal provider” means a health care provider that does not have an existing contract with the beneficiary’s managed care health plan or its subcontractors.

(7) “Partial-benefit dual eligible beneficiary” means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.), but not Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or who is eligible for Medicare Part B (42 U.S.C. Sec. 1395j et seq.), but not Medicare Part A (42 U.S.C. Sec. 1395c et seq.), and is eligible for medical assistance under the Medi-Cal State Plan.

(c) (1) Notwithstanding subdivision (a), a dual eligible beneficiary is exempt from mandatory enrollment in a managed care health plan if the dual eligible beneficiary meets any of the following:

(A) Except in counties with county organized health systems operating pursuant to Article 2.8 (commencing with Section 14087.5), the beneficiary has other health coverage.

(B) The beneficiary receives services through a foster care program, including the program described in Article 5 (commencing with Section 11400) of Chapter 2.

(C) The beneficiary is under 21 years of age.

(D) The beneficiary is not eligible for enrollment in managed care health plans for medically necessary reasons determined by the department.

(E) The beneficiary resides in one of the Veterans Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(F) The beneficiary is enrolled in any entity with a contract with the department pursuant to Chapter 8.75 (commencing with Section 14591).

(G) The beneficiary is enrolled in a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7.

(2) A beneficiary who has been diagnosed with HIV/AIDS is not exempt from mandatory enrollment, but may opt out of managed care enrollment at the beginning of any month.

(d) Implementation of this section shall incorporate the provisions of Section 14182.17 that are applicable to beneficiaries eligible for benefits under Medi-Cal and the Medicare Program.

(e) At the director's sole discretion, in consultation with stakeholders, the department may determine and implement a phased-in enrollment approach that may include Medi-Cal beneficiary enrollment into managed care health plans immediately upon implementation of this section in a specific county, over a 12-month period, or other phased approach. The phased-in enrollment shall commence no sooner than March 1, 2013, and not until all necessary federal approvals have been obtained.

(f) To the extent that mandatory enrollment is required by the department, an enrollee's access to fee-for-service Medi-Cal shall not be terminated until the enrollee has selected or been assigned to a managed care health plan.

(g) Except in a county where Medi-Cal services are provided by a county organized health system, and notwithstanding any other law, in any county in which fewer than two existing managed health care plans contract with the department to provide Medi-Cal services under this chapter that are available to dual eligible beneficiaries, including long-term services and supports, the department may contract with additional managed care health plans to provide Medi-Cal services.

(h) For partial-benefit dual eligible beneficiaries, the department shall inform these beneficiaries of their rights to continuity of care from out-of-network Medi-Cal providers pursuant to subparagraph (G) of paragraph (5) of subdivision (d) of Section 14182.17, and that the need for medical exemption criteria applied to counties operating under Chapter 4.1 (commencing with Section 53800) of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations may not be necessary to continue receiving Medi-Cal services from an out-of-network provider.

(i) The department may contract with existing managed care health plans to provide or arrange for services under this section. Notwithstanding any other law, the department may enter into the contract without the need for a competitive bid process or other contract proposal process, provided that the managed care health plan provides written documentation that it meets all of the qualifications and requirements of this section and Section 14182.17.

(j) The development of capitation rates for managed care health plan contracts shall include the analysis of data specific to the dual eligible population. For the purposes of developing capitation rates for payments to managed care health plans, the department shall require all managed care health plans, including existing managed care health plans, to submit financial, encounter, and utilization data in a form, at a time, and including substance as deemed necessary by the department. Failure to submit the required data shall result in the imposition of penalties pursuant to Section 14182.1.

(k) Persons meeting participation requirements for the Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14591) may select a PACE plan if one is available in that county. Except in counties with county organized health systems operating pursuant to Article 2.8 (commencing with Section 14087.5), the department or its enrollment contractor shall notify a dual eligible beneficiary who is subject to mandatory enrollment in a managed care plan and who is potentially eligible for PACE that he or she may alternatively request to be assessed for eligibility for PACE, and, if eligible, may enroll in a PACE plan. The department or its enrollment contractor shall not enroll a dual eligible beneficiary who requests to be assessed for PACE in a managed care plan until the earlier of 60 days or the time that he or she is assessed and determined to be ineligible for a PACE plan, unless the beneficiary subsequently chooses to enroll in a managed care plan.

(l) Except for dual eligible beneficiaries participating in the demonstration project pursuant to Section 14132.275, persons meeting the participation requirements in effect on January 1, 2010, for a Medi-Cal primary case management plan in operation on that date, may select that primary care case management plan or a successor health care plan that is licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) to provide services within the same geographic area that the primary care case management plan served on January 1, 2010.

(m) The department may implement an intergovernmental transfer arrangement with a public entity that elects to transfer public funds to the state to be used solely as the nonfederal share of Medi-Cal payments to managed care health plans for the provision of services to dual eligible beneficiaries pursuant to Section 14182.15.

(n) To implement this section, the department may contract with public or private entities. Contracts or amendments entered into under this section may be on an exclusive or nonexclusive basis and on a noncompetitive bid basis and shall be exempt from all of the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code.

(3) Review or approval of contracts by the Department of General Services.

(o) Any otherwise applicable provisions of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) not in conflict with this section or with the Special Terms and Conditions of the waiver shall

apply to this section.

(p) The department shall, in coordination with and consistent with an interagency agreement with the Department of Managed Health Care, at a minimum, monitor on a quarterly basis the adequacy of provider networks of the managed care health plans. Notwithstanding any other law, this subdivision shall remain operative only through June 30, 2017.

(q) The department shall suspend new enrollment of dual eligible beneficiaries into a managed care health plan if it determines that the managed care health plan does not have sufficient primary or specialty care providers and long-term service and supports to meet the needs of its enrollees.

(r) Managed care health plans shall pay providers in accordance with Medicare and Medi-Cal coordination of benefits.

(s) This section shall be implemented only to the extent that all federal approvals and waivers are obtained and only if and to the extent that federal financial participation is available.

(t) 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 and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

(u) A managed care health plan that contracts with the department for the provision of services under this section shall ensure that beneficiaries have access to the same categories of licensed providers that are available under fee-for-service Medicare. Nothing in this section shall prevent a managed care health plan from contracting with selected providers within a category of licensure.

(v) The department shall, commencing August 1, 2013, convene stakeholders, at least quarterly, to review progress on the Coordinated Care Initiative and make recommendations to the department and the Legislature for the duration of the Coordinated Care Initiative. The stakeholders shall include beneficiaries, counties, and health plans, and representatives from primary care providers, specialists, hospitals, nursing facilities, MSSP programs, CBAS programs, other social service providers, the IHSS program, behavioral health providers, and substance use disorders stakeholders.

(w) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

SEC. 62. Section 14182.17 of the Welfare and Institutions Code is amended to read:

14182.17. (a) For the purposes of this section, the definitions in subdivision (b) of Section 14182.16 shall apply.

(b) The department shall ensure and improve the care coordination and integration of health care services for Medi-Cal beneficiaries residing in Coordinated Care Initiative counties who are either of the following:

(1) Dual eligible beneficiaries, as defined in subdivision (b) of Section 14182.16, who receive Medi-Cal benefits and services through the demonstration project established pursuant to Section 14132.275 or through mandatory enrollment in managed care health plans pursuant to Section 14182.16.

(2) Medi-Cal beneficiaries who receive long-term services and supports pursuant to Article 5.7 (commencing with Section 14186).

(c) The department shall develop an enrollment process to be used in Coordinated Care Initiative counties to do the following:

(1) Except in a county that provides Medi-Cal services under a county organized health system pursuant to Article 2.8 (commencing with Section 14087.5), provide a choice of Medi-Cal managed care plans to a dual eligible beneficiary who has opted for Medicare fee-for-service, and establish an algorithm to assign beneficiaries who do not make a choice.

(2) Ensure that only beneficiaries required to make a choice or affirmatively opt out are sent enrollment materials.

(3) Establish enrollment timelines, developed in consultation with health plans and stakeholders, and approved by CMS, for each demonstration site. The timeline may provide for combining or phasing in enrollment for Medicare and Medi-Cal benefits.

(d) Before the department contracts with managed care health plans or Medi-Cal providers to furnish Medi-Cal benefits and services pursuant to subdivision (b), the department shall do all of the following:

(1) Ensure timely and appropriate communications with beneficiaries as follows:

(A) At least 90 days prior to enrollment, inform dual eligible beneficiaries through a notice written at not more than a sixth-grade reading level that includes, at a minimum, how the Medi-Cal system of care will change, when the changes will occur, and who they can contact for assistance with choosing a managed care health plan or with problems they encounter.

(B) Develop and implement an outreach and education program for beneficiaries to inform them of their enrollment options and rights, including specific steps to work with consumer and beneficiary community groups.

(C) Develop, in consultation with consumers, beneficiaries, and other stakeholders, an overall communications plan that includes all aspects of developing beneficiary notices.

(D) Ensure that managed care health plans and their provider networks are able to provide communication and services to dual eligible beneficiaries in alternative formats that are culturally, linguistically, and physically appropriate through means, including, but not limited to, assistive listening systems, sign language interpreters, captioning, written communication, plain language, and written translations.

(E) Ensure that managed care health plans have prepared materials to inform beneficiaries of procedures for obtaining Medi-Cal benefits, including grievance and appeals procedures, that are offered by the plan or are available through the Medi-Cal program.

(F) Ensure that managed care health plans have policies and procedures in effect to address the effective transition of beneficiaries from Medicare Part D plans not participating in the demonstration project. These policies shall include, but not be limited to, the transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS, including a determination of which beneficiaries require information about their transition supply, and, within the first 90 days of coverage under a new plan, provide for a temporary fill when the beneficiary requests a refill of a nonformulary drug.

(G) Contingent upon available private or public funds other than moneys from the General Fund, contract with community-based, nonprofit consumer, or health insurance assistance organizations with expertise and experience in assisting dual eligible beneficiaries in understanding their health care coverage options.

(H) Develop, with stakeholder input, informing and enrollment materials and an enrollment process in the demonstration site counties. The department shall ensure all of the following prior to implementing enrollment:

(i) Enrollment materials shall be made public at least 60 days prior to the first mailing of notices to dual eligible beneficiaries, and the department shall work with stakeholders to incorporate public comment into the materials.

(ii) The materials shall be in a not more than sixth grade reading level and shall be available in all the Medi-Cal threshold languages, as well as in alternative formats that are culturally, linguistically, and physically appropriate. For in-person enrollment assistance, disability accommodation shall be provided, when appropriate, through means including, but not limited to, assistive listening systems, sign language interpreters, captioning, and written communication.

(iii) The materials shall plainly state that the beneficiary may choose fee-for-service Medicare or Medicare Advantage, but must return the form to indicate this choice, and that if the beneficiary does not return the form, the state shall assign the beneficiary to a plan and all Medicare and Medi-Cal benefits shall only be available through that plan.

(iv) The materials shall plainly state that the beneficiary shall be enrolled in a Medi-Cal managed care health plan even if he or she chooses to stay in fee-for-service Medicare.

(v) The materials shall plainly explain all of the following:

(I) The plan choices.

(II) Continuity of care provisions.

(III) How to determine which providers are enrolled in each plan.

(IV) How to obtain assistance with the choice forms.

(vi) The enrollment contractor recognizes, in compliance with existing statutes and regulations, authorized representatives, including, but not limited to, a caregiver, family member, conservator, or a legal services advocate, who is recognized by any of the services or programs that the person is already receiving or participating in.

(I) Make available to the public and to all Medi-Cal providers copies of all beneficiary notices in advance of the date the notices are sent to beneficiaries. These copies shall be available on the department’s Internet Web site.

(2) Require that managed care health plans perform an assessment process that, at a minimum, does all of the following:

(A) Assesses each new enrollee's risk level and needs by performing a risk assessment process using means such as telephonic, Web-based, or in-person communication, or review of utilization and claims processing data, or by other means as determined by the department, with a particular focus on identifying those enrollees who may need long-term services and supports. The risk assessment process shall be performed in accordance with all applicable federal and state laws.

(B) Assesses the care needs of dual eligible beneficiaries and coordinates their Medi-Cal benefits across all settings, including coordination of necessary services within, and, when necessary, outside of the managed care health plan's provider network.

(C) Uses a mechanism or algorithm developed by the managed care health plan pursuant to paragraph (7) of subdivision (b) of Section 14182 for risk stratification of members.

(D) At the time of enrollment, applies the risk stratification mechanism or algorithm approved by the department to determine the health risk level of members.

(E) Reviews historical Medi-Cal fee-for-service utilization data and Medicare data, to the extent either is accessible to and provided by the department, for dual eligible beneficiaries upon enrollment in a managed care health plan so that the managed care health plans are better able to assist dual eligible beneficiaries and prioritize assessment and care planning.

(F) Analyzes Medicare claims data for dual eligible beneficiaries upon enrollment in a demonstration site pursuant to Section 14132.275 to provide an appropriate transition process for newly enrolled beneficiaries who are prescribed Medicare Part D drugs that are not on the demonstration site's formulary, as required under the transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS.

(G) Assesses each new enrollee's behavioral health needs and historical utilization, including mental health and substance use disorder treatment services.

(H) Follows timeframes for reassessment and, if necessary, circumstances or conditions that require redetermination of risk level, which shall be set by the department.

(3) Ensure that the managed care health plans arrange for primary care by doing all of the following:

(A) Except for beneficiaries enrolled in the demonstration project pursuant to Section 14132.275, forgo interference with a beneficiary's choice of primary care physician under Medicare, and not assign a full-benefit dual eligible beneficiary to a primary care physician unless it is determined through the risk stratification and assessment process that assignment is necessary, in order to properly coordinate the care of the beneficiary or upon the beneficiary's request.

(B) Assign a primary care physician to a partial-benefit dual eligible beneficiary receiving primary or specialty care through the Medi-Cal managed care plan.

(C) Provide a mechanism for partial-benefit dual eligible enrollees to request a specialist or clinic as a primary care provider if these services are being provided through the Medi-Cal managed care health plan. A specialist or clinic may serve as a primary care provider if the specialist or clinic agrees to serve in a primary care provider role and is qualified to treat the required range of conditions of the enrollees.

(4) Ensure that the managed care health plans perform, at a minimum, and in addition to, other statutory and contractual requirements, care coordination, and care management activities as follows:

(A) Reflect a member-centered, outcome-based approach to care planning, consistent with the CMS model of care approach and with federal Medicare requirements and guidance.

(B) Adhere to a beneficiary's determination about the appropriate involvement of his or her medical providers and caregivers, according to the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(C) Develop care management and care coordination for the beneficiary across the medical and long-term services and supports care system, including transitions among levels of care and between service locations.

(D) Develop individual care plans for higher risk beneficiaries based on the results of the risk assessment process with a particular focus on long-term services and supports.

(E) Use nurses, social workers, the beneficiary's primary care physician, if appropriate, and other medical professionals to provide care management and enhanced care management, as applicable, particularly for beneficiaries in need of or

receiving long-term services and supports.

(F) Consider behavioral health needs of beneficiaries and coordinate those services with the county mental health department as part of the beneficiary's care management plan when appropriate.

(G) Facilitate a beneficiary's ability to access appropriate community resources and other agencies, including referrals as necessary and appropriate for behavioral services, such as mental health and substance use disorders treatment services.

(H) Monitor skilled nursing facility utilization and develop care transition plans and programs that move beneficiaries back into the community to the extent possible. Plans shall monitor and support beneficiaries in the community to avoid further institutionalization.

(5) Ensure that the managed care health plans comply with, at a minimum, and in addition to other statutory and contractual requirements, network adequacy requirements as follows:

(A) Provide access to providers that comply with applicable state and federal law, including, but not limited to, physical accessibility and the provision of health plan information in alternative formats.

(B) Meet provider network adequacy standards for long-term services and supports that the department shall develop.

(C) Maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients, which shall be made available to beneficiaries, at a minimum, by phone, written material, and the Internet, and in accessible formats, upon request.

(D) Monitor an appropriate provider network that includes an adequate number of accessible facilities within each service area.

(E) Contract with and assign patients to safety net and traditional providers as defined in subdivisions (hh) and (jj), respectively, of Section 53810 of Title 22 of the California Code of Regulations, including small and private practice providers who have traditionally treated dual eligible patients, based on available medical history to ensure access to care and services. A managed care health plan shall establish participation standards to ensure participation and broad representation of traditional and safety net providers within a service area.

(F) Maintain a liaison to coordinate with each regional center operating within the plan's service area to assist dual eligible beneficiaries with developmental disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution.

(G) Maintain a liaison and provide access to out-of-network providers, for up to 12 months, for new members enrolled under Sections 14132.275 and 14182.16 who have an ongoing relationship with a provider, if the provider will accept the health plan's rate for the service offered, or for nursing facilities and Community-Based Adult Services, or the applicable Medi-Cal fee-for-service rate, whichever is higher, and the managed care health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues in accordance with guidance from the department, including all-plan letters. A partial-benefit dual eligible beneficiary enrolled in Medicare Part A who only receives primary and specialty care services through a Medi-Cal managed care health plan shall be able to receive these Medi-Cal services from an out-of-network Medi-Cal provider for 12 months after enrollment. This subparagraph shall not apply to out-of-network providers that furnish ancillary services.

(H) Assign a primary care physician who is the primary clinician for the beneficiary and who provides core clinical management functions for partial-benefit dual eligible beneficiaries who are receiving primary and specialty care through the Medi-Cal managed care health plan.

(I) Employ care managers directly or contract with nonprofit or proprietary organizations in sufficient numbers to provide coordinated care services for long-term services and supports as needed for all members.

(6) Ensure that the managed care health plans address medical and social needs as follows:

(A) Offer services beyond those required by Medicare and Medi-Cal at the managed care health plan's discretion.

(B) Refer beneficiaries to community resources or other agencies for needed medical or social services or items outside the managed care health plan's responsibilities.

(C) Facilitate communication among a beneficiary's health care and personal care providers, including long-term services and supports and behavioral health providers when appropriate.

(D) Engage in other activities or services needed to assist beneficiaries in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status.

(E) Facilitate timely access to primary care, specialty care, medications, and other health services needed by the beneficiary, including referrals to address any physical or cognitive barriers to access.

(F) Utilize the most recent common procedure terminology (CPT) codes, modifiers, and correct coding initiative edits.

(7) (A) Ensure that the managed care health plans provide, at a minimum, and in addition to other statutory and contractual requirements, a grievance and appeal process that does both of the following:

(i) Provides a clear, timely, and fair process for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits, as specified by the department. Each managed care health plan shall have a grievance process that complies with Section 14450, and Sections 1368 and 1368.01 of the Health and Safety Code.

(ii) Complies with a Medicare and Medi-Cal grievance and appeal process, as applicable. The appeals process shall not diminish the grievance and appeals rights of IHSS recipients pursuant to Section 10950.

(B) In no circumstance shall the process for appeals be more restrictive than what is required under the Medi-Cal program.

(e) The department shall do all of the following:

(1) Monitor the managed care health plans' performance and accountability for provision of services, in addition to all other statutory and contractual monitoring and oversight requirements, by doing all of the following:

(A) Develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the dual eligible subset of enrollees. These performance measures may include measures from the Healthcare Effectiveness Data and Information Set or measures indicative of performance in serving special needs populations, such as the National Committee for Quality Assurance structure and process measures, or other performance measures identified or developed by the department.

(B) Implement performance measures that are required as part of the contract to provide quality assurance indicators for long-term services and supports in quality assurance plans required under the plans' contracts. These indicators shall include factors such as affirmative member choice, increased independence, avoidance of institutional care, and positive health outcomes. The department shall develop these quality assurance indicators in consultation with stakeholder groups.

(C) Effective January 10, 2014, and for each subsequent year of the demonstration project authorized under Section 14132.275, provide a report to the Legislature describing the degree to which Medi-Cal managed care health plans in counties participating in the demonstration project have fulfilled the quality requirements, as set forth in the health plan contracts.

(D) Effective June 1, 2014, and for each subsequent year of the demonstration project authorized by Section 14132.275, provide a report from the department to the Legislature summarizing information from both of the following:

(i) The independent audit report required to be submitted annually to the department by managed care health plans participating in the demonstration project authorized by Section 14132.275.

(ii) Any routine financial examinations of managed care health plans operating in the demonstration project authorized by Section 14132.275 that have been conducted and completed for the previous calendar year by the department.

(2) Monitor on a quarterly basis the utilization of covered services of beneficiaries enrolled in the demonstration project pursuant to Section 14132.275 or receiving long-term services and supports pursuant to Article 5.7 (commencing with Section 14186).

(3) Develop requirements for managed care health plans to solicit stakeholder and member participation in advisory groups for the planning and development activities relating to the provision of services for dual eligible beneficiaries.

(4) Submit to the Legislature the following information:

(A) Provide, to the fiscal and appropriate policy committees of the Legislature, a copy of any report submitted to CMS pursuant to the approved federal waiver described in Section 14180.

(B) Together with the State Department of Social Services, the California Department of Aging, and the Department of Managed Health Care, in consultation with stakeholders, develop a programmatic transition plan, and submit that plan to

the Legislature within 90 days of the effective date of this section. The plan shall include, but is not limited to, the following components:

(i) A description of how access and quality of service shall be maintained during and immediately after implementation of these provisions, in order to prevent unnecessary disruption of services to beneficiaries.

(ii) Explanations of the operational steps, timelines, and key milestones for determining when and how the components of paragraphs (1) to (9), inclusive, shall be implemented.

(iii) The process for addressing consumer complaints, including the roles and responsibilities of the departments and health plans and how those roles and responsibilities shall be coordinated. The process shall outline required response times and the method for tracking the disposition of complaint cases. The process shall include the use of an ombudsman, liaison, and 24-hour hotline dedicated to assisting Medi-Cal beneficiaries navigate among the departments and health plans to help ensure timely resolution of complaints.

(iv) A description of how stakeholders were included in the various phases of the planning process to formulate the transition plan, and how their feedback shall be taken into consideration after transition activities begin.

(C) The department, together with the State Department of Social Services, the California Department of Aging, and the Department of Managed Health Care, convene and consult with stakeholders at least twice during the period following production of a draft of the implementation plan and before submission of the plan to the Legislature. Continued consultation with stakeholders shall occur on an ongoing basis for the implementation of the provisions of this section.

(D) No later than 90 days prior to the initial plan enrollment date of the demonstration project pursuant to the provisions of Sections 14132.275, 14182.16, and of Article 5.7 (commencing with Section 14186), assess and report to the fiscal and appropriate policy committees of the Legislature on the readiness of the managed care health plans to address the unique needs of dual eligible beneficiaries and Medi-Cal only seniors and persons with disabilities pursuant to the applicable readiness evaluation criteria and requirements set forth in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48. The report shall also include an assessment of the readiness of the managed care health plans in each county participating in the demonstration project to have met the requirements set forth in paragraphs (1) to (9), inclusive.

(E) The department shall submit two reports to the Legislature, with the first report submitted five months prior to the commencement date of enrollment and the second report submitted three months prior to the commencement date of enrollment, that describe the status of all of the following readiness criteria and activities that the department shall complete:

(i) Enter into contracts, either directly or by funding other agencies or community-based, nonprofit, consumer, or health insurance assistance organizations with expertise and experience in providing health plan counseling or other direct health consumer assistance to dual eligible beneficiaries, in order to assist these beneficiaries in understanding their options to participate in the demonstration project specified in Section 14132.275 and to exercise their rights and address barriers regarding access to benefits and services.

(ii) Develop a plan to ensure timely and appropriate communications with beneficiaries as follows:

(I) Develop a plan to inform beneficiaries of their enrollment options and rights, including specific steps to work with consumer and beneficiary community groups described in clause (i), consistent with the provisions of paragraph (1).

(II) Design, in consultation with consumers, beneficiaries, and stakeholders, all enrollment-related notices, including, but not limited to, summary of benefits, evidence of coverage, prescription formulary, and provider directory notices, as well as all appeals and grievance-related procedures and notices produced in coordination with existing federal Centers for Medicare and Medicaid Services (CMS) guidelines.

(III) Design a comprehensive plan for beneficiary and provider outreach, including specific materials for persons in nursing and group homes, family members, conservators, and authorized representatives of beneficiaries, as appropriate, and providers of services and supports.

(IV) Develop a description of the benefits package available to beneficiaries in order to assist them in plan selection and how they may select and access services in the demonstration project’s assessment and care planning process.

(V) Design uniform and plain language materials and a process to inform seniors and persons with disabilities of copays and covered services so that beneficiaries can make informed choices.

(VI) Develop a description of the process, except in those demonstration counties that have a county operated health system, of automatically assigning beneficiaries into managed care health plans that shall include a requirement to consider Medicare service utilization, provider data, and consideration of plan quality.

(iii) Finalize rates and comprehensive contracts between the department and participating health plans to facilitate effective outreach, enroll network providers, and establish benefit packages. To the extent permitted by CMS, the plan rates and contract structure shall be provided to the appropriate fiscal and policy committees of the Legislature and posted on the department's Internet Web site so that they are readily available to the public.

(iv) Ensure that contracts have been entered into between plans and providers including, but not limited to, agreements with county agencies as necessary.

(v) Develop network adequacy standards for medical care and long-term supports and services that reflect the provisions of paragraph (5).

(vi) Identify dedicated department or contractor staff with adequate training and availability during business hours to address and resolve issues between health plans and beneficiaries, and establish a requirement that health plans have similar points of contact and are required to respond to state inquiries when continuity of care issues arise.

(vii) Develop a tracking mechanism for inquiries and complaints for quality assessment purposes, and post publicly on the department's Internet Web site information on the types of issues that arise and data on the resolution of complaints.

(viii) Prepare scripts and training for the department and plan customer service representatives on all aspects of the program, including training for enrollment brokers and community-based organizations on rules of enrollment and counseling of beneficiaries.

(ix) Develop continuity of care procedures.

(x) Adopt quality measures to be used to evaluate the demonstration projects. Quality measures shall be detailed enough to enable measurement of the impact of automatic plan assignment on quality of care.

(xi) Develop reporting requirements for the plans to report to the department, including data on enrollments and disenrollments, appeals and grievances, and information necessary to evaluate quality measures and care coordination models. The department shall report this information to the appropriate fiscal and policy committees of the Legislature, and this information shall be posted on the department's Internet Web site.

(f) This section shall be implemented only to the extent that all federal approvals and waivers are obtained and only if and to the extent that federal financial participation is available.

(g) To implement this section, the department may contract with public or private entities. Contracts or amendments entered into under this section may be on an exclusive or nonexclusive basis and a noncompetitive bid basis and shall be exempt from the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code.

(3) Review or approval of contracts by the Department of General Services.

(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 and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries. The department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

(i) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

SEC. 63. Section 14182.18 of the Welfare and Institutions Code is amended to read:

14182.18. (a) It is the intent of the Legislature that both the managed care plans participating in and providing long-term services and supports under Sections 14182.16 and 14186.2 and the state have protections against either significant overpayment or significant underpayments. Risk corridors are one method of risk sharing that may limit the financial risk of misaligning the payments associated with a contract to furnish long-term services and supports pursuant to a contract under the Coordinated Care Initiative on an at-risk basis.

(b) In Coordinated Care Initiative counties, as defined in paragraph (1) of subdivision (b) of Section 14182.16, for managed care health plans providing long-term services and supports, the department shall include in its contract with those plans risk corridors designed with the following parameters:

(1) Risk corridors shall apply only to the costs of the individuals and services identified below:

(A) Health care service costs for full-benefit dual eligible beneficiaries, as defined in paragraph (3) of subdivision (b) of Section 14182.16, for whom both of the following are true:

(i) The beneficiary is enrolled in the managed care health plan and the plan's contract covers all Medi-Cal long-term services and supports.

(ii) The beneficiary is not enrolled in the demonstration project.

(B) Long-term services and supports costs for partial-benefit dual eligible beneficiaries, as defined in paragraph (7) of subdivision (b) of Section 14182.16, and non-dual-eligible beneficiaries who are enrolled in the managed care health plan if the plan's contract covers all Medi-Cal long-term services and supports.

(2) Risk corridors applied to costs of beneficiary services identified in subparagraph (A) of paragraph (1) shall only be in place for a period of 24 months starting with the first month in which both mandatory enrollment of full-benefit dual eligible beneficiaries pursuant to Section 14182.16 and mandatory coverage of all Medi-Cal long-term services and supports pursuant to Section 14186.2 have occurred.

(3) Risk corridors applied to costs of beneficiary services identified in subparagraph (B) of paragraph (1) shall only be in place for a period of 24 months starting with the first month in which mandatory coverage of all Medi-Cal long-term services and supports pursuant to Section 14186.2 has occurred.

(4) The risk sharing of the costs of the individuals and services under this subdivision shall be constructed by the department so that it is symmetrical with respect to risk and profit, and so that all of the following apply:

(A) The managed care health plan is fully responsible for all costs in excess of the capitated rate of the plan up to 1 percent.

(B) The managed care health plan shall fully retain the revenues paid through the capitated rate in excess of the costs incurred up to 1 percent.

(C) The managed care health plan and the department shall share responsibility for costs in excess of the capitated rate of the plan that are greater than 1 percent above the rate but less than 2.5 percent above the rate.

(D) The managed care health plan and the department shall share the benefit of revenues in excess of the costs incurred that are greater than 1 percent below the capitated rate of the plan but less than 2.5 percent below the capitated rate of the plan.

(E) The department shall be fully responsible for all costs in excess of the capitated rate of the plan that are more than 2.5 percent above the capitated rate of the plan.

(F) The department shall fully retain the revenues paid through the capitated rate in excess of the costs incurred greater than 2.5 percent below the capitated rate of the plan.

(c) The department shall develop specific contractual language implementing the requirements of this section and corresponding details that shall be incorporated into the managed care health plan's contract.

(d) This section shall be implemented only to the extent that any necessary federal approvals or waivers are obtained.

(e) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

SEC. 64. Section 14183.6 of the Welfare and Institutions Code, as amended by Section 19 of Chapter 37 of the Statutes of 2013, is amended to read:

14183.6. (a) The department shall enter into an interagency agreement with the Department of Managed Health Care to have the Department of Managed Health Care, on behalf of the department, conduct financial audits, medical surveys, and a review of the provider networks of the managed care health plans participating in the demonstration project and the Medi-Cal managed care expansion into rural counties, and to provide consumer assistance to beneficiaries affected by the provisions of Sections 14182.16 and 14182.17. The interagency agreement shall be updated, as necessary, on an annual basis in order to maintain

functional clarity regarding the roles and responsibilities of these core activities. The department shall not delegate its authority under this division as the single state Medicaid agency to the Department of Managed Health Care.

This section shall become inoperative on June 30, 2017, and, as of January 1, 2018, is repealed.

SEC. 65. Section 14183.6 of the Welfare and Institutions Code, as added by Section 20 of Chapter 37 of the Statutes of 2013, is repealed.

SEC. 66. Section 14186 of the Welfare and Institutions Code is amended to read:

14186. (a) It is the intent of the Legislature that long-term services and supports (LTSS) be covered through managed care health plans in Coordinated Care Initiative counties.

(b) It is further the intent of the Legislature that all of the following occur:

(1) Persons receiving health care services through Medi-Cal receive these services through a coordinated health care system that reduces the unnecessary use of emergency and hospital services.

(2) Coordinated health care services, including medical, long-term services and supports, and enhanced care management be covered through Medi-Cal managed care health plans in order to eliminate system inefficiencies and align incentives with positive health care outcomes.

(3) Managed care health plans shall, in coordination with LTSS care management providers, develop and expand care coordination practices in consultation with counties, nursing facilities, area agencies on aging, and other home- and community-based providers, and share best practices. Unless the consumer objects, managed care health plans may establish care coordination teams as needed. If the consumer is an IHSS recipient, his or her participation and the participation of his or her provider shall be subject to the consumer's consent. These care coordination teams shall include the consumer, and his or her authorized representative, health plan, Community-Based Adult Services (CBAS) case manager for CBAS clients, Multipurpose Senior Services Program (MSSP) case manager for MSSP clients, and, if an IHSS recipient, may include others, including, but not limited to, the recipient's IHSS provider or a representative of the county social services agency.

(4) To the extent possible, for Medi-Cal beneficiaries also enrolled in the Medicare program, that the department work with the federal government to coordinate financing and incentives and permit managed care health plans to coordinate health care provided under both health care systems.

(5) The health care choices made by Medi-Cal beneficiaries be considered with regard to all of the following:

(A) Receiving care in a home- and community-based setting to maintain independence and quality of life.

(B) Selecting their health care providers in the managed care plan network.

(C) Controlling care planning, decisionmaking, and coordination with their health care providers.

(D) Gaining access to services that are culturally, linguistically, and operationally sensitive to meet their needs or limitations and that improve their health outcomes, enhance independence, and promote living in home- and community-based settings.

(E) Self-directing their care by being able to hire, fire, and supervise their IHSS provider.

(F) Being assured by the department and coordinating departments of their oversight of the quality of these coordinated health care services.

(6) Counties continue to perform functions necessary for the administration of the IHSS program, including conducting assessments and determining authorized hours for recipients, pursuant to Article 7 (commencing with Section 12300) of Chapter 3. Counties and the State Department of Social Services may share recipient and provider data, as legally authorized, related to the IHSS program with managed care health plans for members who are receiving IHSS benefits to support care coordination when applicable.

(7) (A) No sooner than December 31, 2019, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of paragraph (4) of subdivision (b) of Section 14186.3, whichever is earlier, MSSP services shall transition from a federal waiver pursuant to Section 1915(c) under the federal Social Security Act (42 U.S.C. Sec. 1396n(c)) to a benefit administered and allocated by managed care health plans in Coordinated Care Initiative counties.

(B) Notwithstanding Chapter 8 (commencing with Section 9560) of Division 8.5, it is also the intent of the Legislature that the provisions of this article shall apply to dual eligible and Medi-Cal-only beneficiaries enrolled in MSSP. It is the further

intent of the Legislature that the department and managed care health plans shall work in collaboration with MSSP providers to begin development of standards that create a model of care of an integrated, person-centered care management and care coordination model that works within the context of managed care, and explore which portions of the MSSP program model may be adapted to managed care while maintaining the integrity and efficacy of the MSSP model to use as the basis of transition planning.

(C) At least 30 days before the MSSP services transition to a benefit administered and allocated by managed care health plans in Coordinated Care Initiative counties, the department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to transition the MSSP services to managed care health plans.

(8) In lieu of providing nursing facility services, managed care health plans may authorize home- and community-based services plan benefits, as defined in subdivision (d) of Section 14186.1, which managed care health plans shall be responsible for paying at no share of cost to the county.

(9) Managed care health plans shall share confidential beneficiary data as legally authorized and as appropriate to improve care coordination, promote shared understanding of the consumer's needs, and provide appropriate coordination to the IHSS program and other long-term services and supports.

(10) Managed care health plans may authorize Care Plan Option services, which may include assistance with activities of daily living and instrumental activities of daily living, for which managed care health plans shall be solely responsible for paying. The grievance process for these benefits shall be the same process as used for other benefits authorized by managed care health plans, and shall comply with Section 14450 of this code and Sections 1368 and 1368.1 of the Health and Safety Code.

(c) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

SEC. 67. Section 14186.1 of the Welfare and Institutions Code is amended to read:

14186.1. For purposes of this article, the following definitions shall apply unless otherwise specified:

(a) "Coordinated Care Initiative counties" has the same meaning as that term is defined in paragraph (1) of subdivision (b) of Section 14182.16.

(b) "Home- and community-based services" means services provided pursuant to paragraphs (1), (2), and (3) of subdivision (c).

(c) "Long-term services and supports" or "LTSS" means all of the following:

(1) In-home supportive services (IHSS) provided pursuant to Article 7 (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956. Notwithstanding any other law, this paragraph shall be operative only through December 31, 2017.

(2) Community-Based Adult Services (CBAS).

(3) Multipurpose Senior Services Program (MSSP) services, which include those services approved under a federal home- and community-based services waiver or, beginning no sooner than January 1, 2020, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of paragraph (4) of subdivision (b) of Section 14186.3, whichever is earlier, equivalent services.

(4) Skilled nursing facility services and subacute care services established under subdivision (c) of Section 14132, including those services described in Sections 51511 and 51511.5 of Title 22 of the California Code of Regulations, regardless of whether the service is included in the basic daily rate or billed separately, and any leave of absence or bed hold provided consistent with Section 72520 of Title 22 of the California Code of Regulations or the state plan. However, services provided by any category of intermediate care facility for the developmentally disabled shall not be considered long-term services and supports.

(d) "Home- and community-based services (HCBS) plan benefits" may include in-home and out-of-home respite, nutritional assessment, counseling, and supplements, minor home or environmental adaptations, habilitation, and other services that may be deemed necessary by the managed care health plan, including its care coordination team. The department, in consultation with stakeholders, may determine whether health plans shall be required to include these benefits in their scope of service, and may establish guidelines for the scope, duration, and intensity of these benefits. The grievance process for these benefits shall be the same process as used for other benefits authorized by managed care health plans, and shall comply with Section 14450, and Sections 1368 and 1368.1 of the Health and Safety Code.

(e) "Managed care health plan" means an individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81

(commencing with Section 14087.96), or Article 2.91 (commencing with Section 14089), of this chapter, or Chapter 8 (commencing with Section 14200). For purposes of this article, “managed care health plan” shall not include an individual, organization, or entity that enters into a contract with the department to provide services pursuant to Chapter 8.75 (commencing with Section 14591) or the Senior Care Action Network.

(f) “Other health coverage” means health coverage providing the same full or partial benefits as the Medi-Cal program, health coverage under another state or federal medical care program except for the Medicare Program (Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.)), or health coverage under a contractual or legal entitlement, including, but not limited to, a private group or indemnification insurance program.

(g) “Recipient” means a Medi-Cal beneficiary eligible for In-Home Supportive Services provided pursuant to Article 7 (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.

(h) “Stakeholder” shall include, but not be limited to, area agencies on aging and independent living centers.

(i) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

SEC. 68. Section 14186.11 of the Welfare and Institutions Code is repealed.

SEC. 69. Section 14186.2 of the Welfare and Institutions Code is amended to read:

14186.2. (a) (1) Not sooner than March 1, 2013, all Medi-Cal long-term services and supports (LTSS) described in subdivision (c) of Section 14186.1 shall be services that are covered under managed care health plan contracts and shall be available only through managed care health plans to beneficiaries residing in Coordinated Care Initiative counties, except for the exemptions provided for in subdivision (c). The director shall consult with the Legislature, CMS, and stakeholders when determining the implementation date for this section. The department shall pay managed care health plans using a capitation ratesetting methodology that pays for all Medi-Cal benefits and services, including all LTSS, covered under the managed care health plan contract. In order to receive any LTSS through Medi-Cal, Medi-Cal beneficiaries shall mandatorily enroll in a managed care health plan for the provision of Medi-Cal benefits.

(2) HCBS plan benefits may be covered services that are provided under managed care health plan contracts for beneficiaries residing in Coordinated Care Initiative counties, except for the exemptions provided for in subdivision (c).

(3) Beneficiaries who are not mandatorily enrolled in a managed care health plan pursuant to paragraph (15) of subdivision (b) of Section 14182 shall not be required to receive LTSS through a managed care health plan.

(4) The transition of the provision of LTSS through managed care health plans shall occur after the department obtains any federal approvals through necessary federal waivers or amendments, or state plan amendments.

(5) Counties where LTSS are not covered through managed care health plans shall not be subject to this article.

(6) Beneficiaries residing in counties not participating in the dual eligible demonstration project pursuant to Section 14132.275 shall not be subject to this article.

(b) (1) The provisions of this article shall be applicable to a Medi-Cal beneficiary enrolled in a managed care health plan in a county where this article is effective.

(2) At the director’s sole discretion, in consultation with coordinating departments and stakeholders, the department may determine and implement a phased-in enrollment approach that may include the addition of Medi-Cal long-term services and supports in a beneficiary’s Medi-Cal managed care benefits immediately upon implementation of this article in a specific county, over a 12-month period, or other phased approach, but no sooner than March 1, 2013.

(c) (1) The provisions of this article shall not apply to any of the following individuals:

(A) Medi-Cal beneficiaries who meet any of the following and shall, therefore, continue to receive any medically necessary Medi-Cal benefits, including LTSS, through fee-for-service Medi-Cal:

(i) Except in counties with county organized health systems operating pursuant to Article 2.8 (commencing with Section 14087.5), have other health coverage.

(ii) Receive services through any state foster care program including the program described in Article 5 (commencing with Section 11400) Chapter 2, unless the beneficiary is already receiving services through a managed care health plan.

(iii) Are not eligible for enrollment in managed care health plans for medically necessary reasons determined by the department.

(iv) Reside in one of the Veterans' Homes of California, as described in Chapter 1 (commencing with Section 1010) of Division 5 of the Military and Veterans Code.

(B) Persons enrolled in the Program of All-Inclusive Care for the Elderly (PACE) pursuant to Chapter 8.75 (commencing with Section 14591), or a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS.

(C) Persons who are under 21 years of age.

(D) Other specific categories of beneficiaries specified by the department based on extraordinary medical needs of specific patient groups or to meet federal requirements, in consultation with stakeholders.

(2) Beneficiaries who have been diagnosed with HIV/AIDS are not exempt from mandatory enrollment, but may opt out of managed care enrollment at the beginning of any month.

(d) Except in counties with county organized health systems operating pursuant to Article 2.8 (commencing with Section 14087.5), the department or its enrollment contractor shall notify a beneficiary who is required to receive Medi-Cal long-term care services and supports through a managed care plan and who is potentially eligible for PACE that he or she may alternatively request to be assessed for eligibility for PACE, and, if eligible, may enroll in PACE. The department or its enrollment contractor shall not enroll a beneficiary who requests to be assessed for PACE in a managed care plan until the earlier of 60 days or the time that he or she is assessed and determined to be ineligible for a PACE plan, unless the beneficiary subsequently chooses to enroll in a managed care plan. During the time that the beneficiary is being assessed, he or she shall remain in fee-for-service Medi-Cal, or, if applicable, the managed care plan in which he or she is enrolled.

(e) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

SEC. 70. Section 14186.3 of the Welfare and Institutions Code is amended to read:

14186.3. (a) (1) No sooner than July 1, 2012, Community-Based Adult Services (CBAS) shall be a Medi-Cal benefit covered under every managed care health plan contract and available only through managed care health plans. Medi-Cal beneficiaries who are eligible for CBAS shall enroll in a managed care health plan in order to receive those services, except for beneficiaries exempt under subdivision (c) of Section 14186.2 or in counties or geographic regions where Medi-Cal benefits are not covered through managed care health plans. Notwithstanding subdivision (a) of Section 14186.2 and pursuant to the provisions of an approved federal waiver or plan amendment, the provision of CBAS as a Medi-Cal benefit through a managed care health plan shall not be limited to Coordinated Care Initiative counties.

(2) Managed care health plans shall determine a member's medical need for CBAS using the assessment tool and eligibility criteria established pursuant to the provisions of an approved federal waiver or amendments and shall approve the number of days of attendance and monitor treatment plans of their members. Managed care health plans shall reauthorize CBAS in compliance with criteria established pursuant to the provisions of the approved federal waiver or amendment requirements.

(b) (1) Beginning in the 2012 calendar year, managed care health plans shall collaborate with MSSP providers to begin development of an integrated, person-centered care management and care coordination model and explore how the MSSP program model may be adapted to managed care while maintaining the efficacy of the MSSP model. The California Department of Aging and the department shall work with the MSSP site association and managed care health plans to develop a template contract to be used by managed care health plans contracting with MSSP sites in Coordinated Care Initiative counties.

(2) Notwithstanding the implementation date authorized in paragraph (1) of subdivision (a) of Section 14186.2, no later than December 31, 2017, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of paragraph (4), whichever is earlier:

(A) Multipurpose Senior Services Program (MSSP) services shall be a Medi-Cal benefit available only through managed care health plans, except for beneficiaries exempt under subdivision (c) of Section 14186.2 in Coordinated Care Initiative counties.

(B) Managed care health plans shall contract with all county and nonprofit organizations that are designated providers of MSSP services for the provision of MSSP case management and waiver services. These contracts shall provide for all of

the following:

(i) Managed care health plans shall allocate to the MSSP providers the same level of funding they would have otherwise received under their MSSP contract with the California Department of Aging.

(ii) MSSP providers shall continue to meet all existing federal waiver standards and program requirements, which include maintaining the contracted service levels.

(iii) Managed care plans and MSSP providers shall share confidential beneficiary data with one another, as necessary to implement the provisions of this section.

(C) The California Department of Aging shall continue to contract with all designated MSSP sites, including those in the counties participating in the demonstration project, and perform MSSP waiver oversight and monitoring.

(D) The California Department of Aging and the department, in consultation with MSSP providers, managed care health plans, and stakeholders, shall develop service fee structures, services, and person-centered care coordination models that shall be effective June 2013, for the provision of care coordination and home- and community-based services to beneficiaries who are enrolled in managed care health plans but not enrolled in MSSP, and who may have care coordination and service needs that are similar to MSSP participants. The service fees for MSSP providers and MSSP services for any additional beneficiaries and additional services for existing MSSP beneficiaries shall be based upon, and consistent with, the rates and services delivered in MSSP.

(3) In the 2014 calendar year, the provisions of paragraph (2) shall continue. In addition, managed care health plans shall work in collaboration with MSSP providers to begin development of an integrated, person-centered care management and care coordination model that works within the context of managed care and explore which portions of the MSSP program model may be adapted to managed care while maintaining the integrity and efficacy of the MSSP model.

(4) (A) No sooner than December 31, 2019, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of this paragraph, whichever is earlier, MSSP services in Coordinated Care Initiative counties shall transition from a federal waiver pursuant to Section 1915(c) under the federal Social Security Act (42 U.S.C. Sec. 1396n(c)) to a benefit administered and allocated by managed care health plans.

(B) No later than January 1, 2014, the department, in consultation with the California Department of Aging and the Department of Managed Health Care, and with stakeholder input, shall submit a transition plan to the Legislature to describe how subparagraph (A) shall be implemented. The plan shall incorporate the principles of the MSSP in the managed care benefit, and shall include provisions to ensure seamless transitions and continuity of care. Managed care health plans shall, in partnership with local MSSP providers, conduct a local stakeholder process to develop recommendations that the department shall consider when developing the transition plan.

(C) No later than 90 days prior to implementation of subparagraph (A), the department, in consultation with the California Department of Aging and the Department of Managed Health Care, and with stakeholder input, shall submit a transition plan to the Legislature that includes steps to address concerns, if any, raised by stakeholders subsequent to the plan developed pursuant to subparagraph (B).

(D) Before MSSP services transition to a benefit administered and allocated by managed care health plans pursuant to subparagraph (A) of paragraph (2), the California Department of Aging and the department, in consultation with MSSP providers, managed care health plans, and stakeholders, shall develop readiness criteria for the transition. The readiness criteria shall include, but are not limited to, the mutual agreement of the affected managed care health plans and MSSP providers to the transition date. The department shall evaluate the readiness of the managed care health plans and MSSP providers to commence the transition of MSSP services to managed care health plans.

(E) At least 30 days before the MSSP services transition to a benefit administered and allocated by managed care health plans in Coordinated Care Initiative counties, the department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to transition the MSSP services to managed care health plans.

(c) (1) Not sooner than March 1, 2013, or on the date that any necessary federal approvals or waivers are obtained, whichever is later, nursing facility services and subacute facility services shall be Medi-Cal benefits available only through managed care health plans.

(2) Managed care health plans shall authorize utilization of nursing facility services or subacute facility services for their members when medically necessary. The managed care health plan shall maintain the standards for determining levels of care and authorization of services for both Medicare and Medi-Cal services that are consistent with policies established by the federal Centers for Medicare and Medicaid Services and consistent with the criteria for authorization of Medi-Cal services

specified in Section 51003 of Title 22 of the California Code of Regulations, which includes utilization of the “Manual of Criteria for Medi-Cal Authorization,” published by the department in January 1982, last revised April 11, 2011.

(3) The managed care health plan shall maintain continuity of care for beneficiaries by recognizing any prior treatment authorization made by the department for not less than six months following enrollment of a beneficiary into the health plan.

(4) When a managed care health plan has authorized services in a facility and there is a change in the beneficiary’s condition under which the facility determines that the facility may no longer meet the needs of the beneficiary, the beneficiary’s health has improved sufficiently so the resident no longer needs the services provided by the facility, or the health or safety of individuals in the facility is endangered by the beneficiary, the managed care health plan shall arrange and coordinate a discharge of the beneficiary and continue to pay the facility the applicable rate until the beneficiary is successfully discharged and transitioned into an appropriate setting.

(5) The managed care health plan shall pay providers, including institutional providers, in accordance with the prompt payment provisions contained in each health plan’s contracts with the department, including the ability to accept and pay electronic claims.

(d) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

SEC. 71. Section 14186.35 of the Welfare and Institutions Code is amended to read:

14186.35. (a) Not sooner than March 1, 2013, in-home supportive services (IHSS) shall be a Medi-Cal benefit available through managed care health plans in a county where this article is effective. Managed care health plans shall cover IHSS in accordance with the standards and requirements set forth in Article 7 (commencing with Section 12300) of Chapter 3. Specifically, managed care health plans shall do all of the following:

(1) Ensure access to, provision of, and payment for IHSS for individuals who meet the eligibility criteria for IHSS.

(2) Ensure recipients retain the right to be the employer, to select, engage, direct, supervise, schedule, and terminate IHSS providers in accordance with Section 12301.6.

(3) Assume all financial liability for payment of IHSS services for recipients receiving said services pursuant to managed care.

(4) Create a care coordination team, as needed, unless the consumer objects. If the consumer is an IHSS recipient, his or her participation and the participation of his or her provider shall be at the recipient’s option. The care coordination team shall include the consumer, his or her authorized representative, managed care health plan, county social services agency, Community Based Adult Services (CBAS) case manager for CBAS clients, Multipurpose Senior Services Program (MSSP) case manager for MSSP clients, and may include others as identified by the consumer.

(5) Maintain the paramedical role and function of providers as authorized pursuant to Sections 12300 and 12301.

(6) Ensure compliance with all requirements set forth in Section 14132.956 and any resulting state plan amendments.

(7) Adhere to quality assurance provisions and individual data and other standards and requirements as specified by the State Department of Social Services including state and federal quality assurance requirements.

(8) Share confidential beneficiary data with the contractors specified in this section to improve care coordination, promote shared understanding of the consumer’s needs, and ensure appropriate access to IHSS and other long-term services and supports.

(9) (A) Enter into a memorandum of understanding with a county agency and the county’s public authority or nonprofit consortium pursuant to Section 12301.6 to continue to perform their respective functions and responsibilities pursuant to the existing ordinance or contract until the Director of Health Care Services provides notification pursuant to subdivision (a) of Section 12300.7 for that county.

(B) Following the notification pursuant to subdivision (a) of Section 12300.7, enter into a memorandum of understanding with the county agencies to perform the following activities:

(i) Assess, approve, and authorize each recipient’s initial and continuing need for services pursuant to Article 7 (commencing with Section 12300) of Chapter 3. County agency assessments shall be shared with the care coordination teams established under paragraph (4), when applicable, and the county agency thereafter may receive and consider additional input from the care coordination team.

(ii) Plans may contract with counties for additional assessments for purposes of paragraph (6) of subdivision (b) of Section 14186.

(iii) Enroll providers, conduct provider orientation, and retain enrollment documentation pursuant to Sections 12301.24 and 12305.81.

(iv) Conduct criminal background checks on all potential providers and exclude providers consistent with the provisions set forth in Sections 12305.81, 12305.86, and 12305.87.

(v) Provide assistance to IHSS recipients in finding eligible providers through the establishment of a provider registry as well as provide training for providers and recipients as set forth in Section 12301.6.

(vi) Refer all providers to the California In-Home Supportive Services Authority or nonprofit consortium for the purposes of wages, benefits, and other terms and conditions of employment in accordance with subdivision (a) of Section 12300.7 and Title 23 (commencing with Section 110000) of the Government Code.

(vii) Pursue overpayment recovery pursuant to Section 12305.83.

(viii) Perform quality assurance activities including routine case reviews, home visits, and detecting and reporting suspected fraud pursuant to Section 12305.71.

(ix) Share confidential data necessary to implement the provisions of this section.

(x) Appoint an advisory committee of not more than 11 people, and no less than 50 percent of the membership of the advisory committee shall be individuals who are current or past users of personal assistance paid for through public or private funds or recipients of IHSS services.

(xi) Continue to perform other functions necessary for the administration of the IHSS program pursuant to Article 7 (commencing with Section 12300) of Chapter 3 and regulations promulgated by the State Department of Social Services pursuant to that article.

(C) A county may contract with an entity or may establish a public authority pursuant to Section 12301.6 for the performance of any or all of the activities set forth in a contract with a managed care health plan pursuant to this section.

(10) Enter into a contract with the State Department of Social Services to perform the following activities:

(A) Pay wages and benefits to IHSS providers in accordance with the wages and benefits negotiated pursuant to Title 23 (commencing with Section 110000) of the Government Code.

(B) Perform obligations on behalf of the IHSS recipient as the employer of his or her provider, including unemployment compensation, disability benefits, applicable federal and state taxes, and federal old age survivor's and disability insurance through the state's payroll system for IHSS in accordance with Sections 12302.2 and 12317.

(C) Provide technical assistance and support for all payroll-related activities involving the state's payroll system for IHSS, including, but not limited to, the monthly restaurant allowance as set forth in Section 12303.7, the monthly cash payment in advance as set forth in Section 12304, and the direct deposit program as set forth in Section 12304.4.

(D) Share recipient and provider data with managed care health plans for members who are receiving IHSS to support care coordination.

(E) Provide an option for managed care health plans to participate in quality monitoring activities conducted by the State Department of Social Services pursuant to subdivision (f) of Section 12305.7 for recipients who are plan members.

(11) In concert with the department, timely reimburse the state for payroll and other obligations of the beneficiary as the employer, including unemployment compensation, disability benefits, applicable federal and state taxes, and federal old age survivors and disability insurance benefits through the state's payroll system.

(12) In a county where services are provided in the homemaker mode, enter into a contract with the county to implement the provision of services pursuant to the homemaker mode as set forth in Section 12302.

(13) Retain the IHSS individual provider mode as a choice available to beneficiaries in all participating managed care health plans in each county.

(14) In a county where services are provided pursuant to a contract, and as needed, enter into a contract with a city, county, or city and county agency, a local health district, a voluntary nonprofit agency, or a proprietary agency as set forth in Section 12302 and in accordance with Section 12302.6.

(15) Assume the financial risk associated with the cost of payroll and associated activities set forth in paragraph (10).

(b) IHSS recipients receiving services through managed care health plans shall retain all of the following:

(1) The responsibilities as the employer of the IHSS provider for the purposes of hiring, firing, and supervising their provider of choice as set forth in Section 12301.6.

(2) The ability to appeal any action relating to his or her application for or receipt of services pursuant to Article 7 (commencing with Section 12300) of Chapter 3.

(3) The right to employ a provider applicant who has been convicted of an offense specified in Section 12305.87 by submitting a waiver of the exclusion.

(4) The ability to request a reassessment pursuant to Section 12301.1.

(c) The department and the State Department of Social Services, along with the counties, managed care health plans, consumers, advocates, and other stakeholders, shall develop a referral process and informational materials for the appeals process that is applicable to home- and community-based services plan benefits authorized by a managed care health plan. The process established by this paragraph shall ensure ease of access for consumers.

(d) For services provided through managed care health plans, the IHSS provider shall continue to adhere to the requirements set forth in subdivision (b) of Section 12301.24, subdivision (a) of Section 12301.25, subdivision (a) of Section 12305.81, and subdivision (a) of Section 12306.5.

(e) In accordance with Section 14186.2, as the provision of IHSS transitions to managed care health plans in a phased-in approach, the State Department of Social Services shall do all of the following:

(1) Retain program administration functions, in coordination with the department, including policy development, provider appeals and general exceptions, and quality assurance and program integrity for the IHSS program in accordance with Article 7 (commencing with Section 12300) of Chapter 3.

(2) Perform the obligations on behalf of the recipient as employer relating to workers' compensation as set forth in Section 12302.2 and Section 12302.21 for those entities that have entered into a contract with a managed care health plan pursuant to Section 12302.6.

(3) Retain responsibilities related to the hearing process for IHSS recipient appeals as set forth in Chapter 7 (commencing with Section 10950) of Part 2.

(4) Continue to have access to and provide confidential recipient data necessary for the administration of the program.

(f) A managed care health plan shall not be deemed be the employer of an individual in-home supportive services provider referred to recipients under this section for purposes of liability due to the negligence or intentional torts of the individual provider.

(g) This section shall remain in effect only until January 1, 2018, and as of that date is repealed.

SEC. 72. Section 14186.36 of the Welfare and Institutions Code is repealed.

SEC. 73. Section 14186.4 of the Welfare and Institutions Code is amended to read:

14186.4. (a) This article shall be implemented only to the extent that all necessary federal approvals and waivers have been obtained and only if and to the extent that federal financial participation is available.

(b) To implement this article, the department may contract with public or private entities. Contracts, or amendments to current contracts, entered into under this article may be on a noncompetitive bid basis and shall be exempt from all of the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code.

(3) Review or approval of contracts by the Department of General Services.

(4) Review or approval of feasibility study reports and the requirements of Sections 4819.35 to 4819.37, inclusive, and Sections 4920 to 4928, inclusive, of the State Administrative Manual.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services and State Department of Social Services may implement, interpret, or make specific

this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the departments shall notify and consult with stakeholders, including beneficiaries, providers, area agencies on aging, independent living centers, and advocates.

(d) Beginning July 1, 2012, the department shall provide the fiscal and appropriate policy committees of the Legislature with a copy of any report submitted to the federal Centers for Medicare and Medicaid Services (CMS) that is required under an approved federal waiver or waiver amendments or any state plan amendment for any LTSS.

(e) The department shall enter into an interagency agreement with the Department of Managed Health Care to perform some or all of the department's oversight and readiness review activities specified in this article. These activities may include providing consumer assistance to beneficiaries affected by this article, and conducting financial audits, medical surveys, and a review of the provider networks of the managed care health plans participating in this article. The interagency agreement shall be updated, as necessary, on an annual basis in order to maintain functional clarity regarding the roles and responsibilities of the Department of Managed Health Care and the department. The department shall not delegate its authority as the single state Medicaid agency under this article to the Department of Managed Health Care. Notwithstanding any other law, this subdivision shall be operative only through June 30, 2017.

(f) (1) Beginning with the May Revision to the 2013–14 Governor's Budget, and annually thereafter, the department shall report to the Legislature on the enrollment status, quality measures, and state costs of the actions taken pursuant to this article.

(2) (A) By January 1, 2013, or as soon thereafter as practicable, the department shall develop, in consultation with CMS and stakeholders, quality and fiscal measures for managed care health plans to reflect the short- and long-term results of the implementation of this article. The department shall also develop quality thresholds and milestones for these measures. The department shall update these measures periodically to reflect changes in this program due to implementation factors and the structure and design of the benefits and services being coordinated by the health plans.

(B) The department shall require managed care health plans to submit Medicare and Medi-Cal data to determine the results of these measures. If the department finds that a health plan is not in compliance with one or more of the measures set forth in this section, the health plan shall, within 60 days, submit a corrective action plan to the department for approval. The corrective action plan shall, at a minimum, include steps that the health plan shall take to improve its performance based on the standard or standards with which the health plan is out of compliance. The corrective action plan shall establish interim benchmarks for improvement that shall be expected to be met by the health plan in order to avoid a sanction pursuant to Section 14304. Nothing in this paragraph is intended to limit the application of Section 14304.

(C) The department shall publish the results of these measures, including via posting on the department's Internet Web site, on a quarterly basis.

(g) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

SEC. 74. Section 14301.1 of the Welfare and Institutions Code, as amended by Section 31 of Chapter 30 of the Statutes of 2016, is amended to read:

14301.1. (a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health-plan- and county-specific rates. Notwithstanding any other law, this section shall apply to any managed care organization, licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), that has contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS for rates established on or after July 1, 2012. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

(1) Health-plan-specific encounter and claims data.

(2) Supplemental utilization and cost data submitted by the health plans.

(3) Fee-for-service data for the underlying county of operation or other appropriate counties as deemed necessary by the department.

(4) Department of Managed Health Care financial statement data specific to Medi-Cal operations.

(5) Other demographic factors, such as age, gender, or diagnostic-based risk adjustments, as the department deems appropriate.

(b) To the extent that the department is unable to obtain sufficient actual plan data, it may substitute plan model, similar plan, or county-specific fee-for-service data.

(c) The department shall develop rates that include administrative costs, and may apply different administrative costs with respect to separate aid code groups.

(d) The department shall develop rates that shall include, but are not limited to, assumptions for underwriting, return on investment, risk, contingencies, changes in policy, and a detailed review of health plan financial statements to validate and reconcile costs for use in developing rates.

(e) The department may develop rates that pay plans based on performance incentives, including quality indicators, access to care, and data submission.

(f) The department may develop and adopt condition-specific payment rates for health conditions, including, but not limited to, childbirth delivery.

(g) (1) Prior to finalizing Medi-Cal managed care capitation rates, the department shall provide health plans with information on how the rates were developed, including rate sheets for that specific health plan, and provide the plans with the opportunity to provide additional supplemental information.

(2) For contracts entered into between the department and any entity pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7, the department, by June 30 of each year, or, if the budget has not passed by that date, no later than five working days after the budget is signed, shall provide preliminary rates for the upcoming fiscal year.

(h) For the purposes of developing capitation rates through implementation of this ratesetting methodology, Medi-Cal managed care health plans shall provide the department with financial and utilization data in a form and substance as deemed necessary by the department to establish rates. This data shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act (Division 7 (commencing with Section 6250) of Title 1 of the Government Code).

(i) Notwithstanding any other law, on and after the effective date of the act adding this subdivision, the department may apply this section to the capitation rates it pays under any managed care health plan contract.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may set and implement managed care capitation rates, and interpret or make specific this section and any applicable federal waivers and state plan amendments by means of plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

(k) The department shall report, upon request, to the fiscal and policy committees of the respective houses of the Legislature regarding implementation of this section.

(l) Prior to October 1, 2011, the risk-adjusted countywide capitation rate shall comprise no more than 20 percent of the total capitation rate paid to each Medi-Cal managed care plan.

(m) (1) It is the intent of the Legislature to preserve the policy goal to support and strengthen traditional safety net providers who treat high volumes of uninsured and Medi-Cal patients when Medi-Cal enrollees are defaulted into Medi-Cal managed care plans.

(2) As the department adds additional factors, such as managed care plan costs, to the Medi-Cal managed care plan default assignment algorithm, it shall consult with the Auto Assignment Performance Incentive Program stakeholder workgroup to develop cost factor disregards related to intergovernmental transfers and required wraparound payments that support safety net providers.

(n) (1) The department shall develop and pay capitation rates to entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), using actuarial methods and in a manner consistent with this section, except as provided in this subdivision.

(2) The department may develop capitation rates using a standardized rate methodology across managed care plan models for comparable populations. The specific rate methodology applied to PACE organizations shall address features of PACE that distinguishes it from other managed care plan models.

(3) The department may develop statewide rates and apply geographic adjustments, using available data sources deemed appropriate by the department. Consistent with actuarial methods, the primary source of data used to develop rates for each

PACE organization shall be its Medi-Cal cost and utilization data or other data sources as deemed necessary by the department.

(4) Rates developed pursuant to this subdivision shall reflect the level of care associated with the specific populations served under the contract.

(5) The rate methodology developed pursuant to this subdivision shall contain a mechanism to account for the costs of high-cost drugs and treatments.

(6) Rates developed pursuant to this subdivision shall be actuarially certified prior to implementation.

(7) The department shall consult with those entities contracted pursuant to Chapter 8.75 (commencing with Section 14591) in developing a rate methodology according to this subdivision.

(8) Consistent with the requirements of federal law, the department shall calculate an upper payment limit for payments to PACE organizations. In calculating the upper payment limit, the department shall correct the applicable data as necessary and shall consider the risk of nursing home placement for the comparable population when estimating the level of care and risk of PACE participants.

(9) During the first three rate years in which the methodology developed pursuant to this subdivision is used by the department to set rates for entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), the department shall pay the entity at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11), as necessary to mitigate the impact to the entity during the transition to the methodology developed pursuant to this subdivision.

(10) During the first two years in which a new PACE organization or existing PACE organization enters a previously unserved area, the department shall pay at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11).

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

(12) This subdivision shall apply for rates implemented no earlier than January 1, 2017.

SEC. 75. Section 14301.1 of the Welfare and Institutions Code, as amended by Section 32 of Chapter 30 of the Statutes of 2016, is repealed.

SEC. 76. Section 14301.2 of the Welfare and Institutions Code is amended to read:

14301.2. (a) The director may defer fee-for-service payments or payments to Medi-Cal managed care health plans contracting with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.9 (commencing with Section 14088), or Article 2.91 (commencing with Section 14089) of this chapter, or Chapter 8 (commencing with Section 14200) or Chapter 8.75 (commencing with Section 14591), the Senior Care Action Network Health Plan, and Medi-Cal managed care health plan providers, as applicable, which are payable during the final month of the state fiscal year. This section may be implemented only to the extent consistent with federal law.

(b) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

SEC. 77. Section 14593 of the Welfare and Institutions Code, as amended by Section 34 of Chapter 30 of the Statutes of 2016, is amended to read:

14593. (a) (1) The department may enter into contracts with public or private organizations for implementation of the PACE program, and also may enter into separate contracts with PACE organizations, to fully implement the single state agency responsibilities assumed by the department in those contracts, Section 14132.94, and any other state requirement found necessary by the department to provide comprehensive community-based, risk-based, and capitated long-term care services to California's frail elderly.

(2) The department may enter into separate contracts as specified in paragraph (1) with up to 15 PACE organizations. This paragraph shall become inoperative upon federal approval of a capitation rate methodology, pursuant to subdivision (n) of Section 14301.1.

(b) The requirements of the PACE model, as provided for pursuant to Section 1894 (42 U.S.C. Sec. 1395eee) and Section 1934 (42 U.S.C. Sec. 1396u-4) of the federal Social Security Act, shall not be waived or modified. The requirements that shall not be waived or modified include all of the following:

(1) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

(2) The delivery of comprehensive, integrated acute and long-term care services.

(3) The interdisciplinary team approach to care management and service delivery.

(4) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

(5) The assumption by the provider of full financial risk.

(6) The provision of a PACE benefit package for all participants, regardless of source of payment, that shall include all of the following:

(A) All Medicare-covered items and services.

(B) All Medicaid-covered items and services, as specified in the state's Medicaid plan.

(C) Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

(c) Sections 14002, 14005.12, 14005.17, and 14006 shall apply when determining the eligibility for Medi-Cal of a person receiving the services from an organization providing services under this chapter.

(d) Provisions governing the treatment of income and resources of a married couple, for the purposes of determining the eligibility of a nursing-facility certifiable or institutionalized spouse, shall be established so as to qualify for federal financial participation.

(e) (1) The department shall establish capitation rates paid to each PACE organization at no less than 95 percent of the fee-for-service equivalent cost, including the department's cost of administration, that the department estimates would be payable for all services covered under the PACE organization contract if all those services were to be furnished to Medi-Cal beneficiaries under the fee-for-service Medi-Cal program provided for pursuant to Chapter 7 (commencing with Section 14000).

(2) This subdivision shall be implemented only to the extent that federal financial participation is available.

(3) This subdivision shall become inoperative upon federal approval of a capitation rate methodology, pursuant to subdivision (n) of Section 14301.1.

(f) Contracts under this chapter may be on a nonbid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(g) (1) Notwithstanding subdivision (b), and only to the extent federal financial participation is available, the department, in consultation with PACE organizations, shall seek increased federal regulatory flexibility from the federal Centers for Medicare and Medicaid Services to modernize the PACE program, which may include, but is not limited to, addressing all of the following:

(A) Composition of PACE interdisciplinary teams (IDT).

(B) Use of community-based physicians.

(C) Marketing practices.

(D) Development of a streamlined PACE waiver process.

(2) This subdivision shall be operative upon federal approval of a capitation rate methodology pursuant to subdivision (n) of Section 14301.1.

SEC. 78. Section 14593 of the Welfare and Institutions Code, as added by Section 35 of Chapter 30 of the Statutes of 2016, is repealed.

SEC. 79. Section 15893 of the Welfare and Institutions Code is amended to read:

15893. (a) There is hereby continued in existence in the State Treasury a special fund known as the Major Risk Medical Insurance Fund that is, notwithstanding Section 13340 of the Government Code, continuously appropriated to the department for

the purposes specified in Section 15894, Section 10127.16 of the Insurance Code, and Section 1373.622 of the Health and Safety Code.

(b) Funds may be deposited in the Major Risk Medical Insurance Fund from one or more of the following accounts in the Cigarette and Tobacco Products Surtax Fund:

(1) The Hospital Services Account.

(2) The Physician Services Account.

(3) The Unallocated Account.

(c) Effective July 1, 2017, the Major Risk Medical Insurance Fund in the State Treasury is abolished and all moneys in the fund shall be transferred to the Health Care Services Plan Fines and Penalties Fund created pursuant to subdivision (d). Any remaining balance, assets, liabilities, and encumbrances of the Major Risk Medical Insurance Fund as of July 1, 2017, shall be transferred to, and become part of, the Health Care Services Plan Fines and Penalties Fund.

(d) There is hereby created in the State Treasury a special fund known as the Health Care Services Plan Fines and Penalties Fund that is, notwithstanding Section 13340 of the Government Code, continuously appropriated to the department for the purposes specified in Section 15894, Section 10127.16 of the Insurance Code, and Section 1373.622 of the Health and Safety Code.

(e) Any law that refers to the Major Risk Medical Insurance Fund, including, but not limited to, a reference in this chapter to the Major Risk Medical Insurance Fund or the "fund," shall be construed to refer to the Health Care Services Plan Fines and Penalties Fund, effective July 1, 2017.

(f) Notwithstanding any other law, the Controller may use the funds in the Health Care Services Plan Fines and Penalties Fund for cash flow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

SEC. 80. Section 15893.5 of the Welfare and Institutions Code is repealed.

SEC. 81. Section 15894 of the Welfare and Institutions Code is amended to read:

15894. (a) Except as provided in Section 15894.5, the department shall authorize the expenditure of money in the fund to cover program expenses, including program expenses that exceed subscriber contributions, and to cover expenses relating to Section 10127.16 of the Insurance Code, Section 1373.622 of the Health and Safety Code, and health care services for eligible individuals in the Medi-Cal program. The department shall determine the amount of funds expended for each of these purposes, taking into consideration the requirements of this chapter, Section 10127.16 of the Insurance Code, and Section 1373.622 of the Health and Safety Code. Funds may be expended for health care services for eligible individuals in the Medi-Cal program only after all costs for the administration and delivery of health care services under Section 1373.622 of the Health and Safety Code and Section 10127.16 of the Insurance Code have been fully funded.

(b) Following consultation with a health care service plan or health insurer, if the department and the health care service plan or health insurer have not agreed to a final reconciliation of the amount to be expended from the fund or to be reimbursed to the fund, the department shall give written notice of its determination to the health care service plan or health insurer of the final reconciliation amount, as determined by the department. The health care service plan or health insurer shall remit payment to the department within 60 days of the date of notice from the department. If payment is not received, interest shall accrue in the amount of 7 percent per annum. The department may offset the amount to be reimbursed to the fund against any other payments owed to the health care service plan or health insurer by the department, or may negotiate a payment plan with the health care service plan or health insurer for full payment, and in that case may waive interest accrual as long as payment from the health care service plan or health insurer is made in accordance with the payment plan. This subdivision shall control over any conflict or ambiguity between this subdivision and the provisions of Section 1373.622 of the Health and Safety Code, Section 10127.16 of the Insurance Code, Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code, or this chapter.

SEC. 82. Section 15895.5 of the Welfare and Institutions Code is repealed.

SEC. 83. Section 166 of Chapter 717 of the Statutes of 2010 is repealed.

SEC. 84. Section 34 of Chapter 37 of the Statutes of 2013 is amended to read:

Sec. 34. (a) At least 30 days prior to enrollment of beneficiaries into the Coordinated Care Initiative, the Director of Finance shall estimate the amount of net General Fund savings obtained from the implementation of the Coordinated Care Initiative. This estimate shall take into account any net savings to the General Fund achieved through the tax imposed pursuant to Article 5

(commencing with Section 6174) of Chapter 2 of Part 1 of Division 2 of the Revenue and Taxation Code Article 5 (commencing with Section 6174).

(b) (1) By January 10 for each fiscal year after implementation of the Coordinated Care Initiative, for as long as the Coordinated Care Initiative remains operative, the Director of Finance shall estimate the amount of net General Fund savings obtained from the implementation of the Coordinated Care Initiative.

(2) Savings shall be determined under this subdivision by comparing the estimated costs of the Coordinated Care Initiative, as approved by the federal government, and the estimated costs of the program if the Coordinated Care Initiative were not operative. The determination shall also include any net savings to the General Fund achieved through the tax imposed pursuant to Article 5 (commencing with Section 6174) of Chapter 2 of Part 1 of Division 2 of the Revenue and Taxation Code.

(3) The estimates prepared by the Director of Finance, in consultation with the Director of Health Care Services, shall be provided to the Legislature.

(c) (1) Notwithstanding any other law, if, at least 30 days prior to enrollment of beneficiaries into the Coordinated Care Initiative, the Director of Finance estimates pursuant to subdivision (a) that the Coordinated Care Initiative will not generate net General Fund savings, then the activities to implement the Coordinated Care Initiative shall be suspended immediately and the Coordinated Care Initiative shall become inoperative July 1, 2014.

(2) If the Coordinated Care Initiative becomes inoperative pursuant to this subdivision, the Director of Health Care Services shall provide any necessary notifications to any affected entities.

(3) For purposes of this subdivision and subdivision (d) only, “Coordinated Care Initiative” means all of the following statutes and any amendments to the following:

(A) Sections 14132.275, 14183.6, and 14301.1 of the Welfare and Institutions Code, as amended by this act.

(B) Sections 14132.276, 14132.277, 14182.16, 14182.17, 14182.18, and 14301.2 of the Welfare and Institutions Code.

(C) Article 5.7 (commencing with Section 14186) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(D) Title 23 (commencing with Section 110000) of the Government Code.

(E) Section 6531.5 of the Government Code.

(F) Section 6253.2 of the Government Code, as amended by this act.

(G) Sections 12300.5, 12300.6, 12300.7, 12302.6, 12306.15, 12330, 14186.35, and 14186.36 of the Welfare and Institutions Code.

(H) Sections 10101.1, 12306, and 12306.1 of the Welfare and Institutions Code, as amended by this act.

(I) The amendments made to Sections 12302.21 and 12302.25 of the Welfare and Institutions Code, as made by Chapter 439 of the Statutes of 2012.

(d) (1) Notwithstanding any other law, and beginning in 2015, if the Director of Finance estimates pursuant to subdivision (b) that the Coordinated Care Initiative will not generate net General Fund savings, the Coordinated Care Initiative shall become inoperative January 1 of the following calendar year, except as follows:

(A) Section 12306.15 of the Welfare and Institutions Code shall become inoperative as of July 1 of that same calendar year.

(B) For any agreement that has been negotiated and approved by the Statewide Authority, the Statewide Authority shall continue to retain its authority pursuant to Section 6531.5 and Title 23 (commencing with Section 110000) of the Government Code and Sections 12300.5, 12300.6, 12300.7, and 12302.6 of the Welfare and Institutions Code, and shall remain the employer of record for all individual providers covered by the agreement until the agreement expires or is subject to renegotiation, whereby the authority of the Statewide Authority shall terminate and the county shall be the employer of record in accordance with Section 12302.25 of the Welfare and Institutions Code and may establish an employer of record pursuant to Section 12301.6 of the Welfare and Institutions Code.

(C) For an agreement that has been assumed by the Statewide Authority that was negotiated and approved by a predecessor agency, the Statewide Authority shall cease being the employer of record and the county shall be reestablished as the employer of record for purposes of bargaining and in accordance with Section 12302.25 of the Welfare and Institutions Code, and may establish an employer of record pursuant to Section 12301.6 of the Welfare and Institutions Code.

(2) If the Coordinated Care Initiative becomes inoperative pursuant to this subdivision, the Director of Health Care Services shall provide any necessary notifications to any affected entities.

(e) This section shall become inoperative on January 2, 2018, and, as of July 1, 2018, is repealed.

SEC. 85. The Legislature finds and declares that this act, which adds Section 120972 to the Health and Safety Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to protect private and confidential medical information, it is necessary for that information to remain confidential.

SEC. 86. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 87. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.