## Senate Bill No. 853

CHAPTER 717

An act to amend Section 56.30 of the Civil Code, to amend Section 854.1 of the Government Code, to amend Sections 1324.20, 1324.21, 1324.22, 1324.23, 1324.27, 1324.28, 1324.30, 1567.50, 120917, 130251, 130500, 130507, 130509, and 130543 of, to amend and repeal Section 1324.29 of, and to add Sections 1356.2, 1417.5, 120971, 130250.1, 130251.15, 130252, 130253, and 130254 to, the Health and Safety Code, to amend Sections 12693.21 and 12693.26 of, and to add Section 12693.23 to, the Insurance Code, to amend Sections 12009, 12204, 12207, 12242, 12251, 12253, 12254, 12257, 12258, 12260, 12301, 12302, 12303, 12304, 12305, 12307, 12412, 12413, 12421, 12422, 12423, 12427, 12428, 12429, 12431, 12433, 12434, 12491, 12493, 12494, 12601, 12602, 12631, 12632, 12636, 12636.5, 12679, 12681, 12801, 12951, 12977, 12983, 12984, and 13108 of, and to amend, add, and repeal Section 12201 of, the Revenue and Taxation Code, to amend Sections 4474.2, 4474.3, 4474.4, 4474.5, 4474.8, 4684.50, 4684.53, 4684.55, 4684.58, 4684.60, 4684.63, 4684.65, 4684.70, 4684.75, 5370.2, 10022, 14005.11, 14089, 14089.05, 14089.4, 14091.3, 14126.023, 14126.027, 14126.033, 14132, 14154, 14165.4, 14301.1, and 14301.11 of, to amend the heading of Article 3.5 (commencing with Section 4684.50) of Chapter 6 of Division 4.5 of, to add Sections 4101.5, 4646.55, 4701.1, 4791, 5813.6, 14105.08, 14105.28, 14105.281, 14105.456, 14126.022, 14132.925, 14167.351, and 14183.6 to, to repeal Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9 of, to repeal and amend Section 14005.25 of, and to repeal and add Section 4684.74 of, the Welfare and Institutions Code, and to amend Section 10 of Chapter 13 of the Third Extraordinary Session of the Statutes of 2009, relating to health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor October 19, 2010. Filed with Secretary of State October 19, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

SB 853, Committee on Budget and Fiscal Review. Health.

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

Pursuant to a federal waiver, the Medi-Cal program administers a program known as the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program, under which comprehensive clinical family planning services, as defined, are provided to any person who has a family income

at or below 200% of the federal poverty level and who is eligible to receive those services pursuant to the terms of the waiver. Existing law requires the program to be operated only in accordance with the waiver and certain statutes and regulations and subject to the terms, conditions, and duration of the waiver.

This bill would rename the program as the Family PACT Program. The bill would provide that in addition to being operated in accordance with the waiver, the program may be operated in accordance with a state plan amendment adopted pursuant to federal law, as specified, known as the Family PACT successor state plan amendment and would make conforming changes. The bill would expand the definition of comprehensive clinical family planning services to include services, drugs, devices, and supplies deemed by the federal Centers for Medicare and Medicaid Services to be appropriate for the Family PACT Program. The bill would permit the Director of Health Care Services to implement the state plan amendment retroactively to July 1, 2010.

Existing law authorizes the Director of Health Care Services to limit the rates of payment for health care services provided under the Medi-Cal program.

This bill would require the director to reduce rates applicable to radiology services so that they do not exceed 80% of the lowest maximum allowance established under the federal Medicare program for the same or similar services with dates of service on or after October 1, 2010. This bill would require the director to implement these provisions only to the extent that the director determines that the rates will comply with applicable federal Medicaid requirements and that federal financial participation is available.

This bill would require the department to develop and implement a payment methodology based on diagnosis-related groups, subject to federal approval, that reflects the costs and staffing levels associated with quality of care for patients in all general acute care hospitals, with certain exceptions, in state and out of state, as specified. The bill would provide that the diagnosis-related group-based payments apply to all claims, except as specified. The bill would require the department to submit to the Legislature annual status reports, commencing on April 1, 2011, and ending on April 1, 2014, on the implementation of the above-described provisions.

This bill would require, in order to enable the department to develop and implement the above-mentioned payment methodology, the Director of Health Care Services, subject to federal approval, to freeze rates applicable to inpatient hospital services, as specified. It would permit the department to modify this rate-freeze in order to comply with federal Medicaid requirements. The bill would require the department, within 90 days of the above-described provisions becoming effective, to develop and provide to all hospitals the methodology that will be utilized to implement the rate freeze for noncontract hospitals.

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.

Existing law, until January 1, 2011, requires the State Department of Health Care Services, subject to any necessary federal approval, to take all appropriate steps to amend the Medicaid State Plan, to implement a requirement that any hospital that does not have in effect a contract with a Medi-Cal managed care health plan that establishes payment amounts for services furnished to a beneficiary enrolled in that plan shall accept, as payment in full, prescribed payment amounts.

This bill would extend the duration of these provisions until January 1, 2012.

Under existing law, the California Medical Assistance Commission is authorized to negotiate contracts with managed health care plans and other entities in clearly defined geographic areas for the provision of Medi-Cal services, with these contracts being binding upon the department.

This bill would, instead, provide that the department, rather than the commission, has the exclusive authority to negotiate these contracts, and would make conforming changes. It would provide that contracts or contract amendments negotiated pursuant to the bill are public records for purposes of the California Public Records Act.

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

This bill would provide that, prior to October 1, 2011, the risk-adjusted countywide capitation rate shall comprise no more than 20% of the total capitation rate paid to each Medi-Cal managed care plan.

Existing law imposes various taxes, including a tax at a specified rate on the gross premiums of an insurer, as defined, and, until January 1, 2011, on the total operating revenue, as specified, of a Medi-Cal managed care plan, as defined. Existing law provides that the tax on Medi-Cal managed care plans would have no force or effect if any of specified conditions apply.

This bill would extend the imposition of the tax on the total operating revenue of Medi-Cal managed care plans until July 1, 2011, and make other conforming changes.

Existing law continuously appropriates the proceeds from the tax on Medi-Cal managed care plans (1) to the department for purposes of the Medi-Cal program in an amount equal to 38.41% of the proceeds from the tax and (2) to the Managed Risk Medical Insurance Board for purposes of the Healthy Families Program in an amount equal to 61.59% of the proceeds from the tax.

This bill, from July 1, 2010, to June 30, 2011, inclusive, would, instead, continuously appropriate (1) a percentage of the revenues from the tax on Medi-Cal managed care plans equal to the difference between 100% and the applicable federal medical assistance percentage (FMAP) to the department for purposes of the Medi-Cal program and (2) the remaining

revenues to the Managed Risk Medical Insurance Board for purposes of the Healthy Families Program. The bill would make an appropriation by extending the continuous appropriation.

Existing law requires every return required to be filed with the Insurance Commissioner pursuant to provisions governing taxes on the gross premiums of insurers and, until January 1, 2011, on the total operating revenue of Medi-Cal managed care plans, to be signed by the insurer or an executive officer of the insurer and to be made under oath or contain a written declaration that it is made under penalty of perjury.

This bill would, instead, require every return required to be filed with the Insurance Commissioner pursuant to provisions governing taxes on the total operating revenue of Medi-Cal managed care plans to be filed, as described above, until July 1, 2011. By expanding the crime of perjury, this bill would impose a state-mandated local program.

Existing law requires the department to impose a uniform quality assurance fee on each skilled nursing facility, with certain exceptions, in accordance with a prescribed formula. The formula is based on the determination of the projected net revenues of skilled nursing facilities. The fee will cease to be assessed and collected on and after July 31, 2011, and these provisions will be repealed on January 1, 2012.

This bill would provide that, beginning in the 2010–11 rate year, specified multilevel facilities will no longer be exempt from the quality assurance fee. However, the bill would provide that a multilevel facility shall not be required to pay the quality assurance fee until changes to the quality assurance fee and the rate methodology enacted in the 2010 portion of the 2009–10 Regular Session of the Legislature are approved by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services has increased the Medi-Cal rates and the increased rates are paid to facilities.

This bill would also extend the assessment and collection of the uniform quality assurance fee through July 31, 2012. The bill provides for the collection of all quality assurance fees and penalties, including interest, that have been assessed, even after the quality assurance fee ceases to be assessed and would modify the remedies for collection of these fees. The bill would extend the repeal date for these provisions until January 1, 2013.

This bill would require the State Department of Public Health, in consultation with stakeholders, to develop recommendations, as prescribed, to address the findings published in a specified report and would require the State Department of Public Health to provide the recommendations to the fiscal and policy committees of the Legislature no later than March 1, 2011.

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

implemented on July 1, 2011, with these provisions to be repealed on January 1, 2012.

This bill would extend the implementation date of the freestanding skilled nursing facility rate reimbursement provisions through July 31, 2012, would make various conforming changes in these provisions, and would extend the repeal date for all of these provisions until January 1, 2013. It would also modify, for the 2010–11 and 2011–12 rate years, the facility reimbursement formula to be used under these provisions.

This bill would also require the department, by August 1, 2011, to develop the Skilled Nursing Facility Quality and Accountability Supplemental Payment System, as specified, subject to federal approval and the availability of federal, state, or other funds. The bill would provide that the system shall be utilized for providing supplemental payments to skilled nursing facilities that improve the quality and accountability of care rendered to residents and penalizing those facilities that do not meet measurable standards, in accordance with prescribed requirements. The bill would provide specific methodologies to be used in calculating the supplemental payments to be made and the penalties to be imposed.

The bill would create in the State Treasury the Skilled Nursing Facility Quality and Accountability Special Fund and continuously appropriate the moneys in the fund, without regard to fiscal year, to the department to make the above-described supplemental payments. The bill would provide that, upon appropriation of the Legislature, the moneys in the fund may also be used to cover administrative costs incurred by the State Department of Public Health and the State Department of Health Care Services, for positions and contract funding to implement the above-described provisions, and to provide funding assistance for Long-Term Care Ombudsman program activities.

This bill would appropriate, for the 2010–11 fiscal year, $1.9 million from the Skilled Nursing Quality and Accountability Special Fund to the California Department of Aging to fund Long-Term Care Ombudsman program activities.

This bill would create in the Special Deposit Fund, the Skilled Nursing Facility Minimum Staffing Penalty Account, and would require the State Department of Public Health to deposit penalty payments collected into the account. This bill would require the State Department of Public Health to transfer, on a monthly basis, moneys in the Skilled Nursing Facility Minimum Staffing Penalty Account to the Skilled Nursing Quality and Accountability Special Fund.

The bill would make the above-described supplemental payment provisions subject to federal approval and would provide that in the event of a final judicial determination that these provisions are unlawful, they shall become inoperative.

Existing law, subject to federal approval, imposes, as a condition of participation in state-funded health insurance programs other than the Medi-Cal program, a quality assurance fee, as specified, on certain general acute care hospitals through and including December 31, 2010. Existing law creates the Hospital Quality Assurance Revenue Fund in the State

Treasury and requires that the money collected from the quality assurance fee be deposited into the fund. Existing law provides that the moneys in the fund shall, upon appropriation by the Legislature, be available only for certain purposes, including health care coverage for children.

This bill would provide that it is the intent of the Legislature that the moneys in the fund for health care coverage for children be used to expand and enhance health services for children when the health of the economy and state budget are strong enough to allow for program expansions, and strong enough to ensure that the funds supplement, rather than supplant, existing funding for children's health services during the time that the above-described provisions are in effect.

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

This bill would require the plan to delineate processes for determining county administration base costs and funding for caseload changes, cost-of-living adjustments, and program and other changes. The bill would require the department and county welfare departments to develop procedures to ensure the data clarity, consistency, and reliability of information contained in the county budget survey documents utilized under the plan that is submitted by counties to the department, including the format of the budget survey documents and use of the documents for the development of determining county administration costs. By requiring county welfare departments to develop the above-described procedures, this bill would impose a state-mandated local program. The bill would require any changes developed pursuant to the above-described provisions to be incorporated within the state's annual budget process by no later than the 2011–12 fiscal year.

Under existing law, the Legislature 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. Existing law provides that it is the intent of the Legislature to provide appropriate funding to the counties for a cost-of-doing-business adjustment, except for the 2008–09 and 2009–10 fiscal years.

This bill would additionally provide that it is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2010–11 fiscal year.

Existing law requires the State Department of Health Care Services, to the extent required by federal law, for Medi-Cal recipients who are qualified Medicare beneficiaries, to pay the Medicare premiums, deductibles, and coinsurance for elderly and disabled persons whose income does not exceed the federal poverty level or 200% of a specified Supplemental Security Income program standard. For beneficiaries with a share of cost at or below

$500 who do not qualify for assistance because their income exceeds the above-described income requirements and they are not eligible for any other federally funded assistance for the payment of their Medicare Part B premium, existing law requires the State Department of Health Care Services to pay the beneficiary's Medicare Part B premium on a monthly basis regardless of whether the beneficiary's share of cost has been met.

This bill would delete the requirement that the State Department of Health Care Services pay the beneficiary's Medicare Part B premium on a monthly basis regardless of whether the beneficiary's share of cost has been met for the above-described beneficiaries with a share of cost at or below $500.

Existing law, until July 1, 2012, requires the department, subject to the availability of federal financial participation, to exercise a federal option to expand continuous eligibility to children 19 years of age and younger for 6 months, after which date the continuous eligibility period shall be from the date of a determination of eligibility to the earlier of either the end of a 12-month period following the eligibility determination or the date the child exceeds 19 years of age.

Existing law provides that the provisions limiting continuous eligibility to 6 months shall be inoperative from March 27, 2009, until the date the Director of Health Care Services executes a declaration specifying that increased federal financial participation is no longer available pursuant to the federal American Recovery and Reinvestment Act of 2009 (ARRA). Existing law provides that during the period in which the provisions limiting continuous eligibility to 6 months are inoperative, the continuous eligibility period shall be from the date of a determination of eligibility to the earlier of either the end of a 12-month period following the eligibility determination or the date the child exceeds 19 years of age.

This bill would delete the above-described provisions in effect until July 1, 2012. This bill would delete the delayed operative date of July 1, 2012, for the above-described provisions that provide that the continuous eligibility period shall be from the date of a determination of eligibility to the earlier of either the end of a 12-month period following the eligibility determination or the date the child exceeds 19 years of age, thereby making those provisions operative on the date this bill becomes effective.

Existing law requires reimbursement to Medi-Cal pharmacy providers of legend and nonlegend drugs, as defined, to consist of the estimated acquisition cost of the drug, as defined, plus a professional fee for dispensing.

This bill, commencing January 1, 2011, and subject to federal approval, would permit the department to reimburse Medi-Cal providers for physician-administered drugs, as defined, using either the Healthcare Common Procedure Coding System code rate or the National Drug Code rate, as specified, except that the reimbursement rate shall not be less than the Medicare reimbursement rate.

This bill would provide that nonlegend acetaminophen-containing products, with the exception of children's Tylenol, selected by the department are not covered benefits.

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.

This bill would require the department to provide the appropriate fiscal and policy committees of the Legislature, the Legislative Analyst's Office, the Office of the State Chief Information Officer (OCIO), and the Bureau of State Audits (BSA) 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 and any subsequent responses from the department. The bill would provide that the reports be provided within 30 days of the close of each quarter, commencing July 1, 2010, and continuing through the life of the contract.

Upon request from the Chair of the Joint Legislative Budget Committee (JLBC), this bill would require the department to provide updates on the Implementation Advanced Planning Document provided to the federal Centers for Medicare and Medicaid Services pertaining to the CA-MMIS project. This bill would require the CA-MMIS project to be subject to reviews and recommendations of the OCIO and would require the OCIO to submit a copy of those reviews and recommendations to the JLBC. The bill would require the BSA to review the appropriate project documents and quarterly reports and make recommendations about the new system implementation project, as necessary, and would require the BSA to submit a copy of any reviews and recommendations to the JLBC. This bill would authorize the Chair of the JLBC to request an audit of the progress of the transition, development, and implementation of the CA-MMIS.

Existing law provides that a person with private health care coverage is not entitled to receive health care items or services furnished or paid for by a publicly funded health care program, as defined, if covered by that private health care coverage. Existing law entitles a publicly funded health care program that furnishes or pays for designated services to be subrogated to the rights that person has against the carrier of the coverage, to the extent of the health care items provided or services rendered. Under existing law, an entity providing private health care coverage, as defined, is required to respond to inquiries of, and agree not to deny claims submitted by, the state, in connection with the provision of a health care item or service, as specified. Existing law requires a claim for payment to be made within 3 years after provision of the relevant health care item or service.

This bill would extend the above requirements imposed upon an entity providing private health care coverage to include inquiries and claims submitted by providers, as defined.

Under existing law, the State Department of Developmental Services contracts with the regional centers to provide services and supports to persons

with developmental disabilities. The services and supports to be provided to a regional center consumer are contained in an individual program plan (IPP), developed in accordance with prescribed requirements. Under existing law, Medi-Cal benefits include intermediate care facility services for persons with developmental disabilities.

This bill, effective July 1, 2007, would require certain types of licensed intermediate care facilities for persons with developmental disabilities (ICF-DDs), as specified, to be responsible for providing day treatment and transportation services that are selected and authorized through an IPP, as specified, for each beneficiary receiving those services who resides in that licensed ICF-DD.

The bill would require the regional centers to arrange the day treatment and transportation services and would require the licensed ICF-DDs to reimburse the regional center for the full costs of making disbursements to day treatment and transportation service providers.

This bill would require the State Department of Developmental Services to be responsible for reimbursing a licensed ICF-DD for the costs of reimbursing the regional center for the full cost of making disbursements for day treatment and transportation services, plus a coordination fee which will include an administrative fee and reimbursement for increased costs associated with the quality assurance fee. This bill, effective July 1, 2007, would authorize the State Department of Developmental Services to make a supplemental payment to an enrolled Medi-Cal provider that is a licensed ICF-DD for day treatment and transportation services provided to Medi-Cal beneficiaries residing in the ICF-DDs.

This bill would require the State Department of Developmental Services to amend the regional center contracts for the 2007–08 fiscal year to extend the contract liquidation period until June 30, 2011.

This bill would require the State Department of Health Care Services to request approval from the federal Centers for Medicare and Medicaid Services for the implementation of the above-described provisions. The bill would provide that if after seeking federal approval, federal approval is not obtained or federal financial participation is no longer available, the above-described provisions shall not be implemented or shall become inoperative.

This bill would provide that due to a change in the availability of federal funding that addresses the ability of California to capture additional federal financial participation for day treatment and transportation services provided to a Medi-Cal beneficiary residing in a licensed ICF-DD, certain funds appropriated in the Budget Act of 2007 shall be available for liquidation until June 30, 2011, which would extend the term for which existing appropriation is available, thereby making an appropriation.

Existing law requires that, as a condition of participation in the Medi-Cal program, there be imposed a quality assurance fee each state fiscal year upon the entire gross receipts, as defined, of a designated intermediate care facilities, as defined. Existing law requires that the fee be placed in the General Fund and allocated to intermediate care facilities to support their

quality improvement efforts, and distributed to each facility based on the number of Medi-Cal patients at the eligible facility. Existing law requires the department to seek federal approval for the implementation of the fee.

This bill would provide that upon approval of the above-described state plan amendment authorizing reimbursement for day treatment and transportation services provided on or after July 1, 2007, the reimbursement payments made by the State Department of Developmental Services to the ICF-DDs shall be subject to the above-described quality assurance fee.

Existing law requires regional centers, in order to implement changes in the level of funding for regional center purchase of services, from February 1, 2009, to June 30, 2011, inclusive, to reduce certain payments for services delivered on or after February 1, 2009, by 3%, except as specified.

This bill would, instead, require regional centers to reduce the payments for those services by 3% from February 1, 2009, to June 30, 2010, inclusive, and by 4.25% from July 1, 2010, to June 30, 2011, inclusive.

This bill would, between July 1, 2010, and June 30, 2011, subject to certain conditions, permit a regional center, for providers who are subject to the 4.25% payment reduction, with certain exceptions, to temporarily modify personnel requirements, functions, or qualifications, or staff training requirements.

This bill would, from July 1, 2010, to June 30, 2011, inclusive, suspend prescribed annual review and reporting requirements that are imposed on providers whose payment is reduced by 4.25% pursuant to the above-described provisions.

Existing law establishes various state developmental centers, including the Agnews Developmental Center and the Lanterman Developmental Center, for the care of developmentally disabled persons. Existing law contains various provisions concerning the closure of the Agnews Developmental Center, including a provision authorizing the State Department of Developmental Services to operate any facility, provide its employees to assist in the operation of any facility, or provide other necessary services and supports if, in the discretion of the department, it determines that the activity will assist in meeting the goal of an orderly closure of Agnews Developmental Center.

This bill would extend many of the above-described provisions concerning the closure of the Agnews Developmental Center to the Lanterman Developmental Center. This bill would provide that for the Lanterman Developmental Center, the use of department employees is in effect for up to 2 years following the transfer of the last resident of the Lanterman Developmental Center, as specified. Additionally, this bill would require the State Department of Developmental Services to prepare a report on the use of the department's employees in providing services in the community to assist in the orderly closures of Agnews Developmental Center and Lanterman Developmental Center. The bill would require the report to be submitted with the Governor's proposed budget for the 2012–13 fiscal year to the fiscal committees of both houses of the Legislature and annually thereafter.

Existing law requires a service agency, which is defined as a developmental center or regional center that receives state funds to provide services to persons with developmental disabilities, to provide adequate notice, as defined, to an applicant for, or recipient of, services from the service agency, and to the applicant's or recipient's authorized representative, if any, prior to the agency making a decision without the mutual consent of the service recipient or authorized representative to reduce, terminate, or change services set forth in an IPP or prior to a recipient being determined to be no longer eligible for agency services.

This bill would require the notice to inform the recipient and authorized representative of whether or not the individual is eligible for an exemption or exception to the action the service agency proposes to take, as specified, and the specific law supporting the exemption or exception.

Existing law, until January 1, 2011, authorizes the State Department of Social Services and the State Department of Developmental Services, to jointly establish and administer a pilot project for licensing and regulating Adult Residential Facilities for Persons with Special Health Care Needs (ARFPSHN), to the extent that funds are appropriated for this purpose in the annual Budget Act. Existing law authorizes the State Department of Social Services to, subject to certain conditions, license an ARFPSHN to provide 24-hour services to up to 5 adults with developmental disabilities who have special health care and intensive support needs, as defined.

This bill would indefinitely extend the duration of the above-described program and would make conforming changes. This bill would impose a state-mandated local program by changing the definition of crimes provided for under the California Community Care Facilities Act.

Existing law provides that an ARFPSHN may be established in a facility financed pursuant to certain provisions under which the State Department of Developmental Services approves a regional center proposal to provide for housing for persons eligible for regional center services.

This bill would, instead, provide that an ARFPSHN may only be established in a facility approved by the State Department of Developmental Services to provide for housing for persons eligible for regional center services or through an approved regional center community placement plan, as specified. However, this bill would provide that the State Department of Developmental Services shall only approve the development of ARFPSHNs that are directly associated with the orderly closure of the Lanterman Developmental Center.

Existing law prohibits a regional center from paying a rate to any ARFPSHN for any consumer that exceeds the average annual cost of serving a consumer at Agnews Developmental Center, as determined by the State Department of Developmental Services.

This bill would, instead, prohibit a regional center from paying a rate to any ARFPSHN for any consumer that exceeds the rate in the State Department of Developmental Services approved community placement plan for that facility unless the regional center demonstrates that a higher

rate is necessary to protect a consumer's health and safety and the department has granted prior written authorization.

Under existing law, the State Department of Mental Health operates and maintains state institutions for the mentally disordered.

This bill would allow the State Department of Mental Health to contract with providers of health care services and health care network providers for the provision of emergency health care services, as specified. The bill would also specify maximum rates of payment for services received from health care providers either under contract, or that do not contract, with the department.

Existing law requires the State Department of Mental Health to contract with a single nonprofit agency, as specified, for the provision of mental health patients' rights and advocacy services on a multiyear basis for a contract term of up to 3 years.

This bill would, instead, require the State Department of Mental Health to contract on a multiyear basis for a contract term of up to 5 years.

Existing law, the Mental Health Services Act, was approved by the voters in November 2004 as Proposition 63, an initiative measure. Under the act, the State Department of Mental Health is required to, among other things, distribute funds for local assistance for designated mental health programs.

Existing law requires the Director of Mental Health, at the time of the release of the January 10 budget plan and the May Revision, to submit information to the Legislature regarding the expenditure of Proposition 63 funding for each state department and each major program category.

This bill would require the information submitted to the Legislature to include a complete listing of state support expenditures for the current year and for the budget year by the State Department of Mental Health, including the number of state positions and any contract funds.

Existing law, the federal Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires state child health plans to provide certain disenrollment rights and to establish sanctions against managed care organizations, as specified. The act also, among other things, requires state child health plans to convert to the Medicaid prospective payment system for services provided by federally qualified health centers and rural health clinics.

Existing law creates the Healthy Families Program, administered by the Managed Risk Medical Insurance Board (MRMIB), to arrange for the provision of health, vision, and dental benefits to children less than 19 years of age who meet certain criteria, including having a limited household income. Existing law requires MRMIB to negotiate separate contracts with participating health, dental, and vision plans for specified benefit packages.

This bill would, on and after January 1, 2011, authorize MRMIB to impose sanctions on participating health, dental, and vision plans by applying a specified Medicaid managed care provision imposed under CHIPRA. The bill would, on and after January 1, 2011, also authorize MRMIB to enter into contracts with entities other than participating health, dental, or vision plans in order to provide or pay benefits to Healthy Families Program

subscribers for certain purposes, including ensuring that Healthy Families Program subscribers have adequate access to benefits. The bill would exempt any interagency agreement entered into pursuant to these provisions, and any contract or contract amendment necessary to implement that agreement, from competitive bidding laws and review or approval of the Department of General Services. The bill would authorize MRMIB to adopt emergency regulations for purposes of implementing these requirements or any other provision of CHIPRA not addressed by those requirements.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires health care service plans to pay specified assessments each fiscal year as a reimbursement of their share of the costs and expenses reasonably incurred in the administration of the act.

This bill would authorize the Director of the Department of Managed Health Care, by notice to all licensed health care service plans on or before October 15, 2010, to require health care service plans to pay an additional assessment, which is separate and independent of the above-described assessment, to provide the department with sufficient revenues to support costs and expenses of the department, as specified, for the 2010–11 fiscal year. The bill would require the additional assessment to be paid in full by December 1, 2010. By expanding the definition of a crime, this bill would impose a state-mandated local program.

Existing law limits the amount of the assessments paid by health care service plans.

This bill would, on and after July 1, 2011, and until August 31, 2015, authorize the director to raise the assessment limit to incorporate annual expenditure levels as set forth by the above-described provisions relating to the additional assessment.

Existing law, the Confidentiality of Medical Information Act, prohibits a health care provider, a contractor, or a health care service plan from disclosing medical information, as defined, regarding a patient of the provider or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as specified.

This bill would also exempt certain medical information and records disclosed to, and their use by, MRMIB, as specified.

Existing law requires the department to submit an application to the federal Centers for Medicare and Medicaid Services for a waiver or demonstration project that would implement specified objectives.

This bill would require the State Department of Health Care Services to enter into an interagency agreement with the Department of Managed Health Care to have the Department of Managed Health Care, on behalf of the State Department of Health Care Services, conduct financial audits, medical surveys, and a review of the provider networks of the managed care health plans participating in the above-described demonstration project.

Existing law establishes the California Discount Prescription Drug Program, which is administered by the State Department of Health Care

Services. Existing law provides that the program shall become operative on or after July 1, 2010.

This bill would require the program to be implemented only if, and to the extent that, a Budget Act or other statute that is enacted on or before February 1, 2015, includes or makes an appropriation to implement the program.

Existing law requires, on August 1, 2013, the department to determine whether pharmaceutical manufacturer participation in the program has been sufficient to meet certain benchmarks. It also requires the department, on and after August 10, 2013, to reassess program outcomes, at least once every year, consistent with the benchmarks.

This bill would, if the program is implemented, extend the above-described requirement dates to August 1, 2017.

Existing law establishes the Office of Health Information Integrity within the California Health and Human Services Agency to ensure the enforcement of state law mandating confidentiality of medical information and to impose administrative fines for the unauthorized use of medical information. Existing law authorizes the California Health and Human Services Agency, or one of the departments under its jurisdiction, to apply for federal funds made available through the federal American Recovery and Reinvestment Act of 2009 (ARRA) for health information technology and exchange, and establishes the California Health Information Technology and Exchange Fund for these purposes. Existing law provides that if the agency or one of the departments under its jurisdiction elects not to submit an application for federal funds, the Governor shall designate a qualified nonprofit entity to be the state-designated entity for the purposes of establishing health information exchange.

This bill would, if the agency or one of its departments applies for federal funds, authorize the agency or department to later choose to subgrant, in whole or in part, portions of the federal grant to a qualified nonprofit entity, which would be designated as the state governance entity, for the purposes of establishing health information exchange.

This bill would specify the duties of the agency, the state-designated entity, or state governance entity in performing these functions, and would modify the membership of the initial governing board of the entity. The bill would require the agency to develop a detailed implementation plan and to submit it to the Legislature by November 1, 2010. The bill would, commencing October 1, 2010, require the agency to report, by October 1 and April 1 of each year, to the Legislature regarding expenditures and the status of health information technology and exchange activities funded through the fund.

This bill would specify that the agency, state-designated entity, or state governance entity shall establish and begin providing health information exchange services no later than January 1, 2012.

This bill would provide that all deliverables, as defined in the scope of work originated or prepared by the state-designated entity or state governance entity, as specified, shall, upon delivery and acceptance by the agency,

become the exclusive property of the state, and may be copyrighted by the state under the oversight of the agency, as prescribed.

This bill would require the agency to require the state-designated entity or state governance entity to develop specified policies and procedures to provide the public with transparency of the actions of the entity.

Existing law authorizes the State Public Health Officer, to the extent that state and federal funds are appropriated in the annual Budget Act for these purposes, to establish and administer a program to provide drug treatments to persons infected with the human immunodeficiency virus (HIV), the etiologic agent of acquired immune deficiency syndrome (AIDS). Under the program, known as the AIDS Drug Assistance Program (ADAP), the State Department of Public Health subsidizes the cost of drugs for the treatment of persons infected with HIV. Under existing law, moneys from the AIDS Drug Assistance Program Rebate Fund, a continuously appropriated fund, are used to cover costs related to the purchase of drugs and services provided through the ADAP.

This bill would require the State Department of Health Care Services and the State Department of Public Health, in the event state expenditures for the ADAP are identified by California to be used for a certified public expenditure for the purpose of obtaining federal financial participation under the Medi-Cal program for any purpose, to ensure the integrity of the ADAP in meeting its maintenance-of-effort requirements to receive federal funds and to obtain all ADAP drug rebates to support the ADAP.

Existing law establishes the Office of AIDS in the State Department of Public Health. Existing law authorizes HIV counselors trained by the Office of AIDS and working in an HIV counseling and testing site funded by the State Department of Public Health through a local health jurisdiction, or its agents, to perform skin punctures for purposes of withdrawing blood for HIV test purposes.

This bill would additionally authorize HIV counselors to perform skin punctures for purposes of withdrawing blood for HIV test purposes if the HIV counselor is working at an HIV counseling and testing site that utilizes HIV counseling staff who are trained by the Office of AIDS, or its agents, and has a quality assurance plan approved by the local health department, as specified, and staff who comply with certain quality assurance requirements required by regulation. The bill would authorize the Office of AIDS, or its agents, to charge a fee for training HIV counselors. The bill would authorize the local health department to charge a fee for the quality assurance plan approval.

Existing law, the California Special Supplemental Food Program for Women, Infants, and Children (WIC), authorizes establishment of a statewide program, administered by the State Department of Public Health, for providing nutritional food supplements to low-income pregnant women, low-income postpartum and lactating women, and low-income infants and children under 5 years of age, who have been determined to be at nutritional risk. The program, which implements a program authorized under existing

federal law, provides for the redemption of nutrition coupons by recipients at any authorized retail food vendor.

This bill would, by no later than January 10 and May 14 of each year, require the State Department of Public Health to provide the fiscal committees of the Legislature with an estimate package for WIC that shall include all significant assumptions underlying the estimate for the WIC program's current-year and budget-year proposals and concise information identifying applicable estimate components necessary to support the estimate.

Existing law requires the State Department of Public Health to provide breast cancer and cervical cancer screening services under a federal grant made under the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program to eligible low-income individuals. Funding for these services is provided by a combination of federal and state moneys. The above-described provisions are collectively known as the Every Woman Counts program.

This bill would, by no later than January 10 and May 14 of each year, require the State Department of Public Health to provide the fiscal committees of the Legislature with an estimate package for the Every Woman Counts program that includes all significant assumptions underlying the estimate for this program, including current-year and budget-year proposals, and that contains concise information identifying applicable estimate components necessary to support the estimate.

This bill would require the State Department of Public Health 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 Every Woman Counts program by no later than the 15th day of the month following the end of each quarter of the fiscal year.

Existing law establishes specified licensing and certification program fees for various health facilities, and contains provisions relating to methodologies for adjustment of those fees. Existing law requires the State Department of Public Health to annually prepare a report of all costs for activities of the Licensing and Certification Program. Existing law requires the report to include, among other things, recommendations for Licensing and Certification Program fees in accordance with specified criteria.

This bill would, by no later than January 10 and May 14 of each year, require the State Department of Public Health to provide the fiscal committees of the Legislature with an estimate package for the Licensing and Certification Program that includes all significant assumptions underlying the estimate for this program, including current-year and budget-year proposals, and that contains concise information identifying applicable estimate components, as specified.

This bill would, no later than January 20 of each year, require the State Department of Public Health to provide a vacancy report, effective as of December 1 of the previous calendar year, to the Joint Legislative Budget Committee and the chairs of the fiscal committees of both houses of the Legislature that identifies both filled and vacant positions within the department by center, division, branch, and classification.

This bill would require the State Department of Health Care Services to seek support from one or more foundations to support and develop a study or studies of the California Children's Services (CCS) Program, to be provided to interested stakeholders and the fiscal and appropriate policy committees of the Legislature by May 2011. It would express the intent of the Legislature concerning the purposes to which the study or studies are to be used.

This bill would require the State Department of Health Care Services to provide the fiscal and appropriate policy committees of the Legislature with semiannual updates containing certain information regarding all of California's Medicaid waivers to be provided in March and October of each year.

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

This bill would provide that 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.

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

Appropriation: yes.

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

SECTION 1. Section 56.30 of the Civil Code is amended to read:

56.30. The disclosure and use of the following medical information shall not be subject to the limitations of this part:

(a) (Mental health and developmental disabilities) Information and records obtained in the course of providing services under Division 4 (commencing with Section 4000), Division 4.1 (commencing with Section 4400), Division 4.5 (commencing with Section 4500), Division 5 (commencing with Section 5000), Division 6 (commencing with Section 6000), or Division 7 (commencing with Section 7100) of the Welfare and Institutions Code.

(b) (Public social services) Information and records that are subject to Sections 10850, 14124.1, and 14124.2 of the Welfare and Institutions Code.

(c) (State health services, communicable diseases, developmental disabilities) Information and records maintained pursuant to former Chapter 2 (commencing with Section 200) of Part 1 of Division 1 of the Health and Safety Code and pursuant to the Communicable Disease Prevention and Control Act (subdivision (a) of Section 27 of the Health and Safety Code).

(d) (Licensing and statistics) Information and records maintained pursuant to Division 2 (commencing with Section 1200) and Part 1 (commencing with Section 102100) of Division 102 of the Health and Safety Code;

pursuant to Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code; and pursuant to Section 8608, 8817, or 8909 of the Family Code.

(e) (Medical survey, workers' safety) Information and records acquired and maintained or disclosed pursuant to Sections 1380 and 1382 of the Health and Safety Code and pursuant to Division 5 (commencing with Section 6300) of the Labor Code.

(f) (Industrial accidents) Information and records acquired, maintained, or disclosed pursuant to Division 1 (commencing with Section 50), Division 4 (commencing with Section 3200), Division 4.5 (commencing with Section 6100), and Division 4.7 (commencing with Section 6200) of the Labor Code.

(g) (Law enforcement) Information and records maintained by a health facility which are sought by a law enforcement agency under Chapter 3.5 (commencing with Section 1543) of Title 12 of Part 2 of the Penal Code.

(h) (Investigations of employment accident or illness) Information and records sought as part of an investigation of an on-the-job accident or illness pursuant to Division 5 (commencing with Section 6300) of the Labor Code or pursuant to Section 105200 of the Health and Safety Code.

(i) (Alcohol or drug abuse) Information and records subject to the federal alcohol and drug abuse regulations (Part 2 (commencing with Section 2.1) of Subchapter A of Chapter 1 of Title 42 of the Code of Federal Regulations) or to Section 11977 of the Health and Safety Code dealing with narcotic and drug abuse.

(j) (Patient discharge data) Nothing in this part shall be construed to limit, expand, or otherwise affect the authority of the California Health Facilities Commission to collect patient discharge information from health facilities.

(k) Medical information and records disclosed to, and their use by, the Insurance Commissioner, the Director of the Department of Managed Health Care, the Division of Industrial Accidents, the Workers' Compensation Appeals Board, the Department of Insurance, or the Department of Managed Health Care.

(*l*) Medical information and records related to services provided on and after January 1, 2006, disclosed to, and their use by, the Managed Risk Medical Insurance Board to the same extent that those records are required to be provided to the board related to services provided on and after July 1, 2009, to comply with Section 403 of the federal Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3), applying subdivision (c) of Section 1932 of the federal Social Security Act.

SEC. 2. Section 854.1 of the Government Code is amended to read:

854.1. (a) It is the intent of the Legislature to ensure continuity of care for clients of Agnews Developmental Center and Lanterman Developmental Center.

(b) In the effort to achieve these goals, it is the intent of the Legislature to seek and implement recommendations that include all of the following services to retain Agnews and Lanterman staff as employees:

(1) Crisis management teams that provide behavioral, medical, and dental treatment, training, and technical assistance.

(2) Specialized services, including adaptive equipment design and fabrication, and medical, dental, psychological, and assessment services.

(3) Staff support in community homes to assist individuals with behavioral or psychiatric needs.

(c) As used in this chapter, the terms "mental institution" or "medical facility" also include a developmental services facility. For the purposes of this chapter "developmental services facility" means any facility or place where a public employee provides developmental services relating to the closure of Agnews Developmental Center or Lanterman Developmental Center.

SEC. 3. Section 1324.20 of the Health and Safety Code is amended to read:

1324.20. For purposes of this article, the following definitions shall apply:

(a) (1) "Continuing care retirement community" means a provider of a continuum of services, including independent living services, assisted living services as defined in paragraph (5) of subdivision (a) of Section 1771, and skilled nursing care, on a single campus, that is subject to Section 1791, or a provider of such a continuum of services on a single campus that has not received a Letter of Exemption pursuant to subdivision (d) of Section 1771.3.

(2) Notwithstanding paragraph (1), beginning with the 2010–11 rate year and for every rate year thereafter, the term "continuing care retirement community" shall have the definition contained in paragraph (11) of subdivision (c) of Section 1771.

(b) "Department," unless otherwise specified, means the State Department of Health Care Services.

(c) (1) "Exempt facility" means a skilled nursing facility that is part of a continuing care retirement community, a skilled nursing facility operated by the state or another public entity, a unit that provides pediatric subacute services in a skilled nursing facility, a skilled nursing facility that is certified by the State Department of Mental Health for a special treatment program and is an institution for mental disease as defined in Section 1396d(i) of Title 42 of the United States Code, or a skilled nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital.

(2) Notwithstanding paragraph (1), beginning with the 2010–11 rate year and for every rate year thereafter, the term "exempt facility" shall mean a skilled nursing facility that is part of a continuing care retirement community, as defined in paragraph (2) of subdivision (a), a skilled nursing facility operated by the state or another public entity, a unit that provides pediatric subacute services in a skilled nursing facility, a skilled nursing facility that is certified by the State Department of Mental Health for a special treatment program and is an institution for mental disease as defined in Section 1396d(i) of Title 42 of the United States Code, or a skilled nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital.

(3) Notwithstanding paragraph (1), beginning with the 2010–11 rate year and every rate year thereafter, a multilevel facility, as described in paragraph

(1) of subdivision (a), shall not be exempt from the quality assurance fee requirements pursuant to this article, unless it meets the definition of a continuing care retirement community in paragraph (11) of subdivision (c) of Section 1771.

(d) (1) "Net revenue" means gross resident revenue for routine nursing services and ancillary services provided to all residents by a skilled nursing facility, less Medicare revenue for routine and ancillary services, including Medicare revenue for services provided to residents covered under a Medicare managed care plan, less payer discounts and applicable contractual allowances as permitted under federal law and regulation.

(2) Notwithstanding paragraph (1), for the 2009–10 to 2011–12, inclusive, rate years, "net revenue" means gross resident revenue for routine nursing services and ancillary services provided to all residents by a skilled nursing facility, including Medicare revenue for routine and ancillary services and Medicare revenue for services provided to residents covered under a Medicare managed care plan, less payer discounts and applicable contractual allowances as permitted under federal law and regulation. To implement this paragraph, the department shall request federal approval pursuant to Section 1324.27.

(3) "Net revenue" does not mean charitable contributions and bad debt.

(e) "Payer discounts and contractual allowances" means the difference between the facility's resident charges for routine or ancillary services and the actual amount paid.

(f) "Skilled nursing facility" means a licensed facility as defined in subdivision (c) of Section 1250.

SEC. 4. Section 1324.21 of the Health and Safety Code is amended to read:

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

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

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

(B) Notwithstanding subparagraph (A), the Director of Health Care Services may increase the amount of the fee up to 3 percent of the aggregate

projected net revenue if necessary for the implementation of Article 3.8 (commencing with Section 14126) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(2) (A) For the rate year 2005–06 and subsequent rate years through and including the 2009–10 rate year, the net revenue shall be projected for all skilled nursing facilities subject to the uniform quality assurance fee. The projection of net revenue shall be based on the prior rate year's data. Once determined, the aggregate projected net revenue for all facilities shall be multiplied by 6 percent, as determined under the approved methodology, and then divided by the projected total resident days of all providers subject to the fee. The amounts so determined shall be subject to the provisions of subdivision (d).

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

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

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

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

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

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

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

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

SEC. 5. Section 1324.22 of the Health and Safety Code is amended to read:

1324.22. (a) The quality assurance fee, as calculated pursuant to Section 1324.21, shall be paid by the provider to the department for deposit in the State Treasury on a monthly basis on or before the last day of the month following the month for which the fee is imposed, except as provided in subdivision (e) of Section 1324.21.

(b) On or before the last day of each calendar quarter, each skilled nursing facility shall file a report with the department, in a prescribed form, showing the facility's total resident days for the preceding quarter and payments made. If it is determined that a lesser amount was paid to the department, the facility shall pay the amount owed in the preceding quarter to the department with the report. Any amount determined to have been paid in excess to the department during the previous quarter shall be credited to the amount owed in the following quarter.

(c) On or before August 31 of each year, each skilled nursing facility subject to an assessment pursuant to Section 1324.21 shall report to the department, in a prescribed form, the facility's total resident days and total payments made for the preceding state fiscal year. If it is determined that a lesser amount was paid to the department during the previous year, the facility shall pay the amount owed to the department with the report.

(d) (1) A newly licensed skilled nursing facility shall complete all requirements of subdivision (a) for any portion of the year in which it commences operations and of subdivision (b) for any portion of the quarter in which it commences operations.

(2) For purposes of this subdivision, "newly licensed skilled nursing facility" means a location that has not been previously licensed as a skilled nursing facility.

(e) (1) When a skilled nursing facility fails to pay all or part of the quality assurance fee within 60 days of the date that payment is due, the department may deduct the unpaid assessment and interest owed from any Medi-Cal reimbursement payments to the facility until the full amount is recovered. Any deduction shall be made only after written notice to the facility and may be taken over a period of time taking into account the financial condition of the facility.

(2) In addition to the provisions of paragraph (1), any unpaid quality assurance fee assessed by this article shall constitute a debt due to the state and may be collected pursuant to Section 12419.5 of the Government Code.

(f) Notwithstanding any other provision of law, the department shall continue to assess and collect the quality assurance fee, including any previously unpaid quality assurance fee, from each skilled nursing facility, irrespective of any changes in ownership or ownership interest or control or the transfer of any portion of the assets of the facility to another owner.

(g) During the time period in which a temporary manager is appointed to a facility pursuant to Section 1325.5 or during which a receiver is appointed by a court pursuant to Section 1327, the State Department of Public Health shall not be responsible for any unpaid quality assurance fee assessed prior to the time period of the temporary manager or receiver. Nothing in this subdivision shall affect the responsibility of the facility to

make all payments of unpaid or current quality assurance fees, as required by this section and Section 1324.21.

(h) If all or any part of the quality assurance fee remains unpaid, the department may take either or both of the following actions:

(1) Assess a penalty equal to 50 percent of the unpaid fee amount for unpaid fees assessed during the 2004–05 to 2009–10, inclusive, rate years, and up to 50 percent of the unpaid fee amount for unpaid fees assessed during the 2010–11 rate year and any subsequent rate year.

(2) (A) Delay license renewal.

(B) Beginning with the 2010–11 rate year, the department may recommend to the State Department of Public Health that license renewal be delayed until the full amount of the quality assurance fee, penalties, and interest is recovered.

(i) In accordance with the provisions of the Medicaid State Plan, the payment of the quality assurance fee shall be considered as an allowable cost for Medi-Cal reimbursement purposes.

(j) The assessment process pursuant to this section shall become operative not later than 60 days from receipt of federal approval of the quality assurance fee, unless extended by the department. The department may assess fees and collect payment in accordance with subdivision (e) of Section 1324.21 in order to provide retroactive payments for any rate increase authorized under this article.

(k) The amendments made to subdivision (d) and the addition of subdivision (f) by the act that added this subdivision shall not be construed as substantive changes, but are merely clarifying existing law.

SEC. 6. Section 1324.23 of the Health and Safety Code is amended to read:

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

(b) The director may adopt regulations as are necessary to implement this article. These regulations may be adopted as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). For purposes of this article, the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The regulations shall include, but need not be limited to, any regulations necessary for any of the following purposes:

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

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

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

(c) As an alternative to subdivision (b), and notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may

implement this article, in whole or in part, by means of a provider bulletin, or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, 2012. It is the intent of the Legislature that the regulations adopted pursuant to subdivision (b) shall be adopted on or before July 31, 2012.

SEC. 7. Section 1324.27 of the Health and Safety Code is amended to read:

1324.27. (a) (1) The department shall request approval from the federal Centers for Medicare and Medicaid Services for the implementation of this article. In making this request, the department shall seek specific approval from the federal Centers for Medicare and Medicaid Services to exempt facilities identified in subdivision (c) of Section 1324.20, including the submission of a request for waiver of broad-based requirement, waiver of uniform fee requirement, or both, pursuant to paragraphs (1) and (2) of subdivision (e) of Section 433.68 of Title 42 of the Code of Federal Regulations.

(2) The director may alter the methodology specified in this article, to the extent necessary to meet the requirements of federal law or regulations or to obtain federal approval. The Director of Health Services may also add new categories of exempt facilities or apply a nonuniform fee to the skilled nursing facilities subject to the fee in order to meet requirements of federal law or regulations. The Director of Health Services may apply a zero fee to one or more exempt categories of facilities, if necessary to obtain federal approval.

(3) If after seeking federal approval, federal approval is not obtained, this article shall not be implemented.

(b) The department shall make retrospective adjustments, as necessary, to the amounts calculated pursuant to Section 1324.21 in order to assure that the aggregate quality assurance fee for any particular state fiscal year does not exceed 6 percent of the aggregate annual net revenue of facilities subject to the fee.

SEC. 8. Section 1324.28 of the Health and Safety Code is amended to read:

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

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

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

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

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

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

(3) The state has continued its maintenance of effort for the level of state funding of nursing facility reimbursement for the 2005–06 rate year, and for every subsequent rate year continuing through the 2011–12 rate year, in an amount not less than the amount that specific facilities would have received under the rate methodology in effect on July 31, 2004, plus Medi-Cal's projected proportional costs for new state or federal mandates, not including the quality assurance fee.

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

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

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

SEC. 9. Section 1324.29 of the Health and Safety Code is amended to read:

1324.29. (a) The quality assurance fee shall cease to be assessed after July 31, 2012.

(b) Notwithstanding subdivision (a) and Section 1324.30, the department's authority and obligation to collect all quality assurance fees and penalties, including interest, shall continue in effect and shall not cease until the date that all amounts are paid or recovered in full.

(c) This section shall remain operative until the date that all fees and penalties, including interest, have been recovered pursuant to subdivision (b), and as of that date is repealed.

SEC. 10. Section 1324.30 of the Health and Safety Code is amended to read:

1324.30. This article shall become inoperative after July 31, 2012, and, as of January 1, 2013, is repealed, unless a later enacted statute, that becomes

operative on or before January 1, 2013, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 11. Section 1356.2 is added to the Health and Safety Code, to read:

1356.2. The director, by notice to all licensed health care service plans on or before October 15, 2010, may require health care service plans to pay an additional assessment to provide the department with sufficient revenues to support costs and expenses of the department as set forth in subdivision (b) of Section 1341.4 and Section 1356 for the 2010–11 fiscal year. The assessment paid pursuant to this section shall be separate and independent of the assessment imposed pursuant to subdivision (b) of Section 1356 and shall not be aggregated with the assessment imposed pursuant to subdivision (b) of Section 1356 for the purposes of limitation or otherwise. The assessment paid pursuant to this section shall not be subject to the limitations imposed on assessments pursuant to Section 1356.1. In imposing an assessment pursuant to this section, the director shall levy on each health care service plan an amount determined by the director using the categories of plans in the schedules set forth in subdivision (b) of Section 1356. The assessments imposed pursuant to this section shall be paid in full by December 1, 2010. On and after July 1, 2011, and until August 31, 2015, the director may raise the assessment limit described in subdivision (b) of Section 1356 to incorporate the annual expenditure levels set forth in this section.

SEC. 12. Section 1417.5 is added to the Health and Safety Code, to read:

1417.5. (a) The department, in consultation with stakeholders, shall develop recommendations to address the findings published in the June 2010 report entitled, "Department of Public Health: It Reported Inaccurate Financial Information and Can Likely Increase Revenues for the State and Federal Health Facilities Citation Penalties Accounts" (Report 2010-108). The recommendations shall address, but not be limited to, all of the following:

(1) Streamlining the citation appeal process, including the citation review conference process.

(2) Increasing citation penalty amounts, including late penalty fees, and annually adjusting penalty amounts to reflect an inflation indicator, such as the California Consumer Price Index.

(3) Revising state law to enable the department to recommend that the federal Centers for Medicare and Medicaid Services impose a federal civil money penalty when the department's Licensing and Certification Division determines that a facility is out of compliance with both state and federal requirements.

(4) Authorizing the department to collect citation penalty amounts upon appeal of the citation and allowing the department to place those funds into a special interest bearing account.

(b) The department shall provide the recommendations to the fiscal and policy committees of the Legislature no later than March 1, 2011.

SEC. 13. Section 1567.50 of the Health and Safety Code is amended to read:

1567.50. (a) Notwithstanding that a community care facility means a place that provides nonmedical care under subdivision (a) of Section 1502, pursuant to Article 3.5 (commencing with Section 4684.50) of Chapter 6 of Division 4.5 of the Welfare and Institutions Code, the department shall jointly implement with the State Department of Developmental Services a licensing program to provide special health care and intensive support services to adults in homelike community settings.

(b) The State Department of Social Services may license, subject to the following conditions, an Adult Residential Facility for Persons with Special Health Care Needs to provide 24-hour services to up to five adults with developmental disabilities who have special health care and intensive support needs, as defined in subdivisions (f) and (g) of Section 4684.50 of the Welfare and Institutions Code.

(1) The State Department of Developmental Services shall be responsible for granting the certificate of program approval for an Adult Residential Facility for Persons with Special Health Care Needs (ARFPSHN). The State Department of Social Services shall not issue a license unless the applicant has obtained a certification of program approval from the State Department of Developmental Services.

(2) The State Department of Social Services shall ensure that the ARFPSHN meets the administration requirements under Article 2 (commencing with Section 1520) including, but not limited to, requirements relating to fingerprinting and criminal records under Section 1522.

(3) The State Department of Social Services shall administer employee actions under Article 5.5 (commencing with Section 1558).

(4) The regional center shall monitor and enforce compliance of the program and health and safety requirements, including monitoring and evaluating the quality of care and intensive support services. The State Department of Developmental Services shall ensure that the regional center performs these functions.

(5) The State Department of Developmental Services may decertify any ARFPSHN that does not comply with program requirements. When the State Department of Developmental Services determines that urgent action is necessary to protect clients of the ARFPSHN from physical or mental abuse, abandonment, or any other substantial threat to their health and safety, the State Department of Developmental Services may request the regional center or centers to remove the clients from the ARFPSHN or direct the regional center or centers to obtain alternative services for the consumers within 24 hours.

(6) The State Department of Social Services may initiate proceedings for temporary suspension of the license pursuant to Section 1550.5.

(7) The State Department of Developmental Services, upon its decertification, shall inform the State Department of Social Services of the licensee's decertification, with its recommendation concerning revocation of the license, for which the State Department of Social Services may initiate proceedings pursuant to Section 1550.

(8) The State Department of Developmental Services and the regional centers shall provide the State Department of Social Services all available documentation and evidentiary support necessary for any enforcement proceedings to suspend the license pursuant to Section 1550.5, to revoke or deny a license pursuant to Section 1551, or to exclude an individual pursuant to Section 1558.

(9) The State Department of Social Services Community Care Licensing Division shall enter into a memorandum of understanding with the State Department of Developmental Services to outline a formal protocol to address shared responsibilities, including monitoring responsibilities, complaint investigations, administrative actions, and closures.

(10) The licensee shall provide documentation that, in addition to the administrator requirements set forth under paragraph (4) of subdivision (a) of Section 4684.63 of the Welfare and Institutions Code, the administrator, prior to employment, has completed a minimum of 35 hours of initial training in the general laws, regulations and policies and procedural standards applicable to facilities licensed by the State Department of Social Services under Article 2 (commencing with Section 1520). Thereafter, the licensee shall provide documentation every two years that the administrator has completed 40 hours of continuing education in the general laws, regulations and policies and procedural standards applicable to adult residential facilities. The training specified in this section shall be provided by a vendor approved by the State Department of Social Services and the cost of the training shall be borne by the administrator or licensee.

(c) This article shall only be implemented to the extent that funds are made available through an appropriation in the annual Budget Act.

SEC. 14. Section 120917 of the Health and Safety Code is amended to read:

120917. (a) An HIV counselor who meets the requirements of subdivision (e) may do all of the following:

(1) Perform any HIV test that is classified as waived under the federal Clinical Laboratory Improvement Act (CLIA) (42 U.S.C. Sec. 263a and following) if all of the following conditions exist:

(A) The performance of the HIV test meets the requirements of CLIA and, subject to subparagraph (B), Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code.

(B) Notwithstanding Section 1246 of the Business and Professions Code, an HIV counselor may perform skin punctures for the purpose of withdrawing blood for HIV testing, upon specific authorization from a licensed physician and surgeon, provided that the person meets both of the following requirements:

(i) He or she works under the direction of a licensed physician and surgeon.

(ii) He or she has been trained in both rapid HIV test proficiency for skin puncture blood tests and oral swab tests and in universal infection control precautions, consistent with best infection control practices established by the Division of Occupational Safety and Health in the Department of

Industrial Relations and the federal Centers for Disease Control and Prevention.

(C) The person performing the HIV test meets the requirements for the performance of waived laboratory testing pursuant to subdivision (a) of Section 1206.5 of the Business and Professions Code. For purposes of this subdivision and subdivision (a) of Section 1206.5 of the Business and Professions Code, an HIV counselor who meets the requirements of subdivision (e) shall be "other health care personnel providing direct patient care" as referred to in paragraph (12) of subdivision (a) of Section 1206.5 of the Business and Professions Code.

(D) The patient is informed that the preliminary result of the test is indicative of the likelihood of HIV infection and that the result must be confirmed by an additional more specific test, or, if approved by the federal Centers for Disease Control and Prevention for that purpose, a second different rapid HIV test. Nothing in this subdivision shall be construed to allow an HIV counselor to perform any HIV test that is not classified as waived under the CLIA.

(2) Notwithstanding Sections 1246.5 and 2053 of the Business and Professions Code, order and report HIV test results from tests performed pursuant to paragraph (1) to patients without authorization from a licensed health care professional or his or her authorized representative. Patients with indeterminate or positive test results from tests performed pursuant to paragraph (1) shall be referred to a licensed health care provider whose scope of practice includes the authority to refer patients for laboratory testing for further evaluation.

(b) An HIV counselor who has been certified pursuant to subdivision (b) of Section 120871 prior to September 1, 2009, and who will administer rapid HIV skin puncture tests shall obtain training required by clause (ii) of subparagraph (B) of paragraph (1) of subdivision (a) prior to September 1, 2011. The HIV counselor shall not, unless also certified as a limited phlebotomist technician, perform a skin puncture pursuant to this section until he or she has completed the training required by that clause.

(c) An HIV counselor who meets the requirements of this section with respect to performing any HIV test that is classified as waived under the CLIA may not perform any other test unless that person meets the statutory and regulatory requirements for performing that other test.

(d) This section shall not be construed to certify an HIV counselor as a phlebotomy technician or a limited phlebotomy technician, or to fulfill any requirements for certification as a phlebotomy technician or a limited phlebotomy technician, unless the HIV counselor has otherwise satisfied the certification requirements imposed pursuant to Section 1246 of the Business and Professions Code.

(e) (1) An HIV counselor shall meet one of the following criteria:

(A) Is trained by the Office of AIDS and working in an HIV counseling and testing site funded by the department through a local health jurisdiction, or its agents.

(B) Is working in an HIV counseling and testing site that meets both of the following criteria:

(i) Utilizes HIV counseling staff who are trained by the Office of AIDS or its agents.

(ii) Has a quality assurance plan approved by the local health department in the jurisdiction where the site is located and has HIV counseling and testing staff who comply with the quality assurance requirements specified in Section 1230 of Article 1 of Group 9 of Subchapter 1 of Chapter 2 of Division 1 of Title 17 of the California Code of Regulations.

(2) (A) The Office of AIDS or its agents may charge a fee for training HIV counseling staff.

(B) The local health department may charge a fee for the quality assurance plan approval.

SEC. 15. Section 120971 is added to the Health and Safety Code, to read:

120971. (a) In the event state expenditures for the AIDS Drug Assistance Program (ADAP) are identified by California to be used as a certified public expenditure for the purpose of obtaining federal financial participation under the Medi-Cal program for any purposes, including federal demonstration waivers, the State Department of Health Care Services and the State Department of Public Health shall ensure the integrity of the ADAP in meeting its maintenance-of-effort requirements to receive federal funds and to obtain all ADAP drug rebates to support the ADAP.

(b) The State Department of Health Care Services and the State Department of Public Health shall keep the appropriate policy and fiscal committees of the Legislature informed of any potential concerns that may arise in the event that state expenditures for the ADAP are used as a certified public expenditure as described in subdivision (a).

SEC. 16. Section 130250.1 is added to the Health and Safety Code, to read:

130250.1. (a) This division shall be known, and may be cited, as the California Health Information Technology Act.

(b) Any duties under the act are subject to the availability of sufficient funding to carry out the duties. The provisions of this act shall only be implemented to the extent permitted by federal law.

SEC. 17. Section 130251 of the Health and Safety Code is amended to read:

130251. (a) The California Health and Human Services Agency or one of the departments under its jurisdiction may apply for federal funds made available through the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5) for health information technology and exchange. If the California Health and Human Services Agency or one of the departments under its jurisdiction submits an application pursuant to this subdivision, and later chooses to subgrant, in whole or in part, a portion of the federal grant to a qualified nonprofit entity for the purposes of establishing health information exchange, that entity shall be designated as the state governance entity.

(b) In the event that the California Health and Human Services Agency or one of the departments under its jurisdiction elects not to submit an application described in subdivision (a), the Governor shall designate a qualified nonprofit entity to be the state-designated entity for the purposes of health information exchange, pursuant to the requirements set forth in the federal American Reinvestment and Recovery Act of 2009.

(c) In addition to existing requirements applicable to nonprofit entities, the state governance entity may be held to additional requirements under federal and state law, and directives from the California Health and Human Services Agency.

(d) The agency or state-designated entity shall execute tasks related to accessing federal stimulus funds made available through ARRA, and facilitate and expand the use and disclosure of health information electronically among organizations according to nationally recognized standards and implementation specifications while protecting, to the greatest extent possible, individual privacy and the confidentiality of electronic medical records.

(e) The agency or state-designated entity shall develop strategic and operational plans to ensure that health information exchange capabilities are available, adopted, and utilized statewide so that patients do not experience disparities in access to the benefits of this technology by age, race, ethnicity, language, income, insurance status, geography, or otherwise.

(f) The agency, state-designated entity, or state governance entity shall create a plan for a self-sustaining funding mechanism that does not include use of General Fund moneys that shall cover all reasonable costs of the administration of health information exchange when federal ARRA funds expire or are exhausted. A detailed business plan and sustainability model shall be submitted to the Governor and the Legislature by April 1, 2011. The plan may include a combination of approaches to create viable revenue streams, and shall take into account the needs of safety net institutions and providers.

(g) The state-designated entity or state governance entity shall continually meet any conditions for being so designated as determined by the Secretary of California Health and Human Services. Failure to comply with this subdivision may result in the applicable entity losing its contract for state designation or subgrant agreement.

(h) As a condition of receiving the contract for state designation or subgrant agreement, the state-designated entity or state governance entity shall comply with all of the following requirements:

(1) It shall be subject to oversight by the California Health and Human Services Agency.

(2) (A) It shall be governed by an initial board with a diverse composition from multiple types of organizations from multiple regions throughout the state. The initial governing board shall include all of the following:

(i) The Secretary of California Health and Human Services or his or her designee.

(ii) The Chair of the Senate Committee on Health or his or her designee.

(iii) The Chair of the Assembly Committee on Health or his or her designee.

(iv) One administrator from a state department under the jurisdiction of the California Health and Human Services Agency responsible for a statewide health program.

(v) At least two consumer representatives, one of whom shall have expertise in privacy and security of health information.

(vi) One licensed physician and surgeon, representing a solo or small group practice.

(vii) One licensed physician and surgeon, representing a medical group or independent practice association.

(viii) One representative from a safety net clinic.

(ix) Two representatives of hospitals, one of whom shall represent a public hospital.

(x) Two representatives of health plans or health insurers, one of whom shall represent a publicly run health plan or insurer.

(xi) One local public health officer.

(xii) Two representatives of health information exchange organizations, one from northern California, and one from southern California.

(xiii) One representative of the medical informatics industry or who has experience in medical informatics.

(xiv) One representative of an employer who provides employees with health care coverage, or a group purchaser of health care coverage.

(xv) One representative from labor.

(xvi) The chief executive officer of the nonprofit entity.

(xvii) Two at-large cochairs of the nonprofit entity.

(B) The majority of the board shall be comprised of nongovernmental employees.

(3) If the governing board convenes workgroups or subcommittees, the workgroups or subcommittees shall be comprised of representatives from multiple types of organizations from multiple regions throughout the state, and meetings of any workgroup or subcommittee shall be held in an open, public, and transparent way.

(4) The state-designated entity or state governance entity shall have nondiscrimination and conflict-of-interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation by stakeholders.

(i) The California Health and Human Services Agency, in consultation with the initial governing board, may modify the composition of the initial governing board. If a modification is made to the composition of the initial governing board pursuant to this subdivision, the agency shall inform the Legislature of, and the reason for, the change implemented.

(j) Upon the completion of the initial one-year term of the two at-large cochairs of the state-designated entity or state governance entity, the board shall select a chair or two cochairs from its membership.

SEC. 18. Section 130251.15 is added to the Health and Safety Code, to read:

130251.15. (a) All deliverables, as defined in the scope of work originated or prepared by the state-designated entity or state governance entity pursuant to its applicable contract, including papers, reports, charts, and other documentation, but not including the applicable entity's administrative communications and records relating to the contract, shall, upon delivery and acceptance by the California Health and Human Services Agency, become the exclusive property of the state, and may be copyrighted by the state under the oversight of the agency.

(b) If any material funded pursuant to the contract may be copyrighted, the agency reserves the right to copyright the material, and the entity agrees not to copyright the material without prior written approval from the Secretary of California Health and Human Services. The secretary shall consent to, or give a reason for the denial to, the entity in writing within 60 days of receipt of the request.

(c) If the material is copyrighted with the consent of the agency, the agency reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, prepare derivative works, publish, distribute, and use the materials, in whole or in part, and to authorize others to do so, provided written credit is given to the author.

(d) All inventions, discoveries, or improvements of the techniques, programs, or materials developed pursuant to the contract shall be the property of the agency. The agency agrees to grant a royalty-free, nonexclusive license for any invention, discovery, or improvement to the entity and further agrees that the entity may sublicense additional persons on the same royalty-free basis subject to the approval of the agency.

(e) Nothing in this section shall be construed to limit the intellectual property and copyright authority of the federal government.

SEC. 19. Section 130252 is added to the Health and Safety Code, to read:

130252. (a) Subject to available funding, the California Health and Human Services Agency shall be responsible for ensuring that all federal grant deliverables are met. The agency shall coordinate electronic health activities in the state and work with stakeholders, state departments, and the Legislature to support policy needs for health information technology and health information exchange in California.

(b) In the event that a state governance entity is established, all of the following conditions shall be met:

(1) The agency shall be responsible for ensuring that all deliverables established in the strategic and operational plans established pursuant to subdivision (e) of Section 130251, and as required by the federal grant, are met.

(2) Any grant issued by the agency to the state governance entity for health information exchange shall be deliverables based. All deliverables shall be subject to approval and acceptance by the agency.

(c) The agency, state-designated entity, or the state governance entity shall establish and begin providing health information exchange services by January 1, 2012.

(d) The state-designated entity or state governance entity shall ensure that an effective model for health information exchange governance and accountability is in place. In order to avoid any real or apparent conflict of interest, the state-designated entity or state governance entity shall ensure organizational and functional separation exists between the governance functions of the entity and its operational functions, specifically between operating entities that are or may be involved in building and maintaining the health information exchange. The agency shall conduct periodic internal reviews at least once after an entity has received the designation, and periodically as necessary, to ensure this separation is maintained, and that the state-designated entity or state governance entity operates in a manner that ensures organizational integrity and accountability.

(e) The state-designated entity or state governance entity shall provide a process for public comment and input, which may include integrating public workgroups convened by the agency during the operational planning process into its organizational structure.

(f) The state-designated entity or state governance entity, in consultation with the Office of Health Information Integrity, shall develop detailed standards and policies to be included in all contracts with health care entities that are participants of the state-designated entity's or governance entity's health information exchange for health information exchange services provided by the applicable entity. The state-designated entity or state governance entity shall also work with the Office of Health Information Integrity to ensure standardization of privacy and security policies for health information exchange statewide. The state-designated entity or state governance entity shall develop operational policies based on privacy and security guidelines developed by the state, and create a uniform set of privacy and security rules to be used by other entities participating in health information exchanges established by the state-designated entity or state governance entity for health information exchange or a contract made by the applicable entity for health information exchange.

(g) The agency shall develop a detailed implementation plan that meets all requirements, deliverables, and goals specified in the strategic and operational plans established pursuant to subdivision (e) of Section 130251. The implementation plan shall be submitted to the Legislature by November 1, 2010. The implementation plan shall include, but need not be limited to, all of the following:

(1) A detailed work plan and communications plan.

(2) A model that defines the technical architecture for services recommended in the operational plan.

(3) A description of specific core services enabled or provided by the health information exchange and timeframes for the rollout of those services.

(4) A determination of how to most effectively engage stakeholders throughout the state.

(5) A description of specific deliverables and timeframes to ensure that statewide health information exchange is achieved pursuant to the state strategic and operational plans.

(6) Detailed information on internal infrastructure that ensures the state governance entity for health information exchange meets legal and regulatory criteria needed, including, but not limited to, a comprehensive staffing plan.

(h) Any contract for state designation or subgrant agreement pursuant to this section shall be made through an open and competitive process as required by federal law.

(i) The state designated entity or state governance entity shall comply with applicable provisions of the federal Health Information Technology for Economic and Clinical Health Act (HITECH Act; Public Law 111-5), the federal Public Health Service Act (42 U.S.C. Sec. 300x-26), and applicable federal policies, guidance, and requirements. These provisions shall include, but are not limited to, the requirement that funds be used to conduct activities to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards in effect on December 31, 2010.

SEC. 20. Section 130253 is added to the Health and Safety Code, to read:

130253. (a) To provide the public with transparency of the actions by the state-designated entity or state governance entity, the California Health and Human Services Agency shall require the state-designated entity or state governance entity to develop policies and procedures that include, but are not limited to, all of the following areas:

(1) Conflicts of interest. The policies and procedures shall be consistent with federal law and modeled on the Political Reform Act of 1974 (Title 9 (commencing with Section 81000) of the Government Code).

(2) Public access to meetings.

(A) (i) The state-designated entity or state governance entity shall hold board and workgroup meetings open to the public, including the entity's annual meeting.

(ii) The state-designated entity or state governance entity may hold additional meetings as it determines are necessary or appropriate. Subject to subparagraph (B), these meetings shall also be open to the public.

(B) The state governance entity may conduct closed sessions when it meets to consider or discuss confidential matters, including, but not limited to, those concerning the appointment, employment, performance, compensation, or dismissal of the entity's officers and employees.

(C) The state-designated entity shall award grants and contracts in public meetings consistent with federal requirements for an open and competitive process, and shall adopt all governance, technical, and policy standards in public meetings.

(3) Contracts.

(A) The Public Contract Code shall not apply to contracts issued by the state governance entity. This subparagraph shall not be construed to modify existing law regarding the application of the Public Contract Code.

(B) For contracts entered into by the state governance entity, policies shall be governed by applicable federal regulations, policies specified by the Office of the National Coordinator for Health Information Technology,

including, but not limited to, provisions required by the federal State Health Information Exchange Cooperative Agreement Program and any additional requirements as specified by the agency.

(b) The policies and procedures developed pursuant to this section are exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 21. Section 130254 is added to the Health and Safety Code, to read:

130254. Notwithstanding Section 10231.5 of the Government Code, commencing October 1, 2010, the California Health and Human Services Agency shall report, by October 1 and April 1 of each year, to the Legislature regarding the expenditures made from the California Health Information Technology and Exchange Fund, and the status of health information technology and exchange activities funded through the fund. The report shall be in compliance with Section 9795 of the Government Code. This report shall include, at a minimum, all of the following:

(a) The agency's evaluation of the extent to which the state governance entity for health information exchange has completed each deliverable outlined in grant agreements or contracts between the state and the entity, and the extent to which deliverables were completed within the timelines specified in the grant agreements or contracts.

(b) A detailed update on hiring and expenditures on staff hired through this fund, including, but not limited to, staff hired by the state governance entity for health information exchange.

(c) The status and amounts of grants and contracts awarded by the state governance entity for health information exchange, including, but not limited to, descriptions and deliverables.

SEC. 22. Section 130500 of the Health and Safety Code is amended to read:

130500. (a) This division shall be known, and may be cited, as the California Discount Prescription Drug Program.

(b) This division shall become operative on and after July 1, 2010.

(c) The California Discount Prescription Drug Program shall be implemented only if, and to the extent that, a Budget Act or other statute that is enacted on or before February 1, 2015, includes or makes an appropriation of moneys to the department to implement this program.

(d) Notwithstanding any other provision of this division, if the California Discount Prescription Drug Program is not implemented pursuant to subdivision (c), this division shall become inoperative on February 1, 2015, and as of January 1, 2016, is repealed, unless a later enacted statute, that is enacted before January 1, 2016, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 23. Section 130507 of the Health and Safety Code is amended to read:

130507. (a) On August 1, 2017, the department shall determine whether manufacturer participation in the program has been sufficient to meet both of the following benchmarks:

(1) The number and type of drugs available through the program are sufficient to give eligible Californians a formulary comparable to the Medi-Cal list of contract drugs or, if this information is available to the department, a formulary comparable to that provided to CalPERS enrollees.

(2) The volume weighted average discount of single-source prescription drugs offered pursuant to this program is equal to or below any one of the benchmark prices described in subdivision (a) of Section 130506.

(b) On and after August 1, 2017, the department shall reassess program outcomes, at least once every year, consistent with the benchmarks described in subdivision (a).

SEC. 24. Section 130509 of the Health and Safety Code is amended to read:

130509. (a) The department may require prior authorization in the Medi-Cal program for any drug of a manufacturer if the manufacturer fails to agree to a volume weighted average discount for single-source prescription drugs that is equal to or below any one of the benchmark prices described in subdivision (a) of Section 130506 and only to the extent that this requirement does not increase costs to the Medi-Cal program, as determined pursuant to subdivision (c).

(b) If prior authorization is required for a drug pursuant to this section, a Medi-Cal beneficiary shall not be denied the continued use of a drug that is part of a prescribed therapy until that drug is no longer prescribed for that beneficiary's therapy. The department shall approve or deny requests for prior authorization necessitated by this section as required by state or federal law.

(c) The department, in consultation with the Department of Finance, shall determine the fiscal impact of placing a drug on prior authorization pursuant to this section. In making this determination, the department shall consider all of the following:

(1) The net cost of the drug, including any rebates that would be lost if the drug is placed on prior authorization.

(2) The projected volume of purchases of the drug, before and after the drug is placed on prior authorization, considering the continuity of care provisions set forth in subdivision (b).

(3) The net cost of comparable drugs to which volume would be shifted if a drug is placed on prior authorization, including any additional rebates that would be received.

(4) The projected volume of purchases of comparable drugs, before and after the drug is placed on prior authorization.

(5) Any other factors determined by the department to be relevant to a determination of the fiscal impact of placing a drug on prior authorization.

(d) This section shall be implemented only to the extent permitted under federal law, and in a manner consistent with state and federal laws.

(e) This section may apply to any manufacturer that has not negotiated with the department.

(f) The department shall notify the Speaker of the Assembly and the President pro Tempore of the Senate that the department is requiring prior authorization no later than five days after making this requirement.

(g) (1) Subject to paragraph (2), this section shall be implemented on and after August 1, 2017.

(2) This section shall be implemented only if the department determines that participation by manufacturers has been insufficient to meet both of the benchmarks identified in Section 130507.

SEC. 25. Section 130543 of the Health and Safety Code is amended to read:

130543. (a) The director may adopt regulations as are necessary to implement and administer this division.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this division, in whole or in part, by means of a provider bulletin or other similar instructions, without taking regulatory action, provided that no bulletin or other similar instructions shall remain in effect after August 1, 2015. It is the intent that regulations adopted pursuant to this section shall be adopted on or before August 1, 2015.

SEC. 26. Section 12693.21 of the Insurance Code is amended to read:

12693.21. The board may do all of the following consistent with the standards in this part:

(a) Determine eligibility criteria for the program.

(b) Determine the participation requirements of applicants, subscribers, purchasing credit members, and participating health, dental, and vision plans.

(c) Determine when subscribers' coverage begins and the extent and scope of coverage.

(d) Determine family contribution amount schedules and collect the contributions.

(e) Determine who may be a family contribution sponsor and provide a mechanism for sponsorship.

(f) Provide or make available subsidized coverage through participating health, dental, and vision plans, in a purchasing pool, which may include the use of a purchasing credit mechanism, through supplemental coverage, or through coordination with other state programs.

(g) Provide for the processing of applications, the enrollment of subscribers, and the distribution of purchasing credits.

(h) Determine and approve the benefit designs and copayments required by health, dental, or vision plans participating in the purchasing pool component program.

(i) Approve those health plans eligible to receive purchasing credits.

(j) Enter into contracts.

(k) Sue and be sued.

(*l*) Employ necessary staff.

(m) Authorize expenditures from the fund to pay program expenses that exceed subscriber contributions, and to administer the program as necessary.

(n) Maintain enrollment and expenditures to ensure that expenditures do not exceed amounts available in the Healthy Families Fund and if sufficient funds are not available to cover the estimated cost of program expenditures, the board shall institute appropriate measures to limit enrollment.

(o) Issue rules and regulations, as necessary. Until January 1, 2000, any rules and regulations issued pursuant to this subdivision may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare. The regulations shall become effective immediately upon filing with the Secretary of State.

(p) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this part.

(q) Notwithstanding any other provision of law, on and after January 1, 2011, impose any sanction on, and provide notice and a hearing to, participating health, dental, and vision plans consistent with Section 403 of the federal Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3) by applying subsection (e) of Section 1932 of the federal Social Security Act.

SEC. 27. Section 12693.23 is added to the Insurance Code, to read:

12693.23. Until July 1, 2012, the adoption and readoption of regulations to implement subdivision (q) of Section 12693.21, subdivision (b) of Section 12693.26, or subdivision (*l*) of Section 56.30 of the Civil Code, or any provision of the federal Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3) not addressed by those sections, shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

SEC. 28. Section 12693.26 of the Insurance Code is amended to read:

12693.26. (a) The board shall establish a purchasing pool for coverage of program subscribers to enable applicants without access to affordable and comprehensive employer-sponsored dependent coverage to provide their eligible children with health, dental, and vision benefits. The board shall negotiate separate contracts with participating health, dental, and vision plans for each of the benefit packages described in Chapters 5 (commencing with Section 12693.60), 6 (commencing with Section 12693.63), and 7 (commencing with Section 12693.65).

(b) Notwithstanding any other provision of law, on and after January 1, 2011, the board may negotiate contracts with entities that are not participating health, dental, or vision plans, including, but not limited to, interagency agreements with the State Department of Health Care Services,

to provide or pay for benefits to subscribers under this part, if necessary for any of the following purposes:

(1) To comply with Section 403 of the federal Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3) by applying paragraph (4) of subsection (a) of Section 1932 of the federal Social Security Act.

(2) To comply with Section 503 of the federal Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3) by applying subsection (bb) of Section 1902 of the federal Social Security Act.

(3) To ensure that subscribers have adequate access to benefits under this part.

(c) Any interagency agreement entered into by a state agency with the board pursuant to subdivision (b), and any other contract or contract amendment necessary to implement that agreement, shall be exempt from any provision of law relating to competitive bidding and from the review or approval of any division of the Department of General Services in the same manner as contracts entered into by the board are exempt pursuant to Section 12693.54.

SEC. 29. Section 12009 of the Revenue and Taxation Code is amended to read:

12009. (a) "Medi-Cal managed care plan" or "plan" means any individual, organization, or entity, other than an insurer as described in Section 12003 or a dental managed care plan as described in Section 14087.46 of the Welfare and Institutions Code, that enters into a contract with the State Department of Health Care Services 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 Chapter 7 of, or pursuant to Article 1 (commencing with Section 14200) or Article 7 (commencing with Section 14490) of Chapter 8 of, Part 3 of Division 9 of the Welfare and Institutions Code.

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

SEC. 30. Section 12201 of the Revenue and Taxation Code, as amended by Section 5 of Chapter 157 of the Statutes of 2009, is amended to read:

12201. (a) Every insurer and Medi-Cal managed care plan doing business in this state shall annually pay to the state a tax on the bases, at the rates, and subject to the deductions from the tax hereinafter specified. For purposes of the tax imposed by this chapter, "insurer" shall be deemed to include a home protection company as defined in Section 12740 of the Insurance Code.

(b) Notwithstanding Section 13340 of the Government Code, the revenues derived from the imposition of the tax by this chapter on Medi-Cal managed care plans are hereby continuously appropriated as follows:

(1) To the State Department of Health Care Services for purposes of the Medi-Cal program in an amount equal to 38.41 percent of the total revenues derived from the imposition of the tax by this chapter on Medi-Cal managed care plans.

(2) To the Managed Risk Medical Insurance Board for purposes of the Healthy Families Program in an amount equal to 61.59 percent of the total revenues derived from the imposition of the tax by this chapter on Medi-Cal managed care plans.

(c) For purposes of imposing the tax on Medi-Cal managed care plans during the 2009 calendar year, the tax shall be based on total revenue for the period of January 1, 2009, to December 31, 2009, inclusive.

(d) The Insurance Commissioner shall report the amount of revenue derived from the tax imposed on Medi-Cal managed care plans pursuant to this section to the California Health and Human Services Agency, the Joint Legislative Budget Committee, and the Department of Finance.

(e) This section shall become inoperative on July 1, 2010, and, as of January 1, 2011, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2011, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 31. Section 12201 is added to the Revenue and Taxation Code, to read:

12201. (a) Every insurer and Medi-Cal managed care plan doing business in this state shall annually pay to the state a tax on the bases, at the rates, and subject to the deductions from the tax hereinafter specified. For purposes of the tax imposed by this chapter, "insurer" shall be deemed to include a home protection company as defined in Section 12740 of the Insurance Code.

(b) Notwithstanding Section 13340 of the Government Code, the revenues derived from the imposition of the tax by this chapter on Medi-Cal managed care plans are hereby continuously appropriated as follows:

(1) A percentage of the revenues derived from the imposition of the tax by this chapter on Medi-Cal managed care plans equal to the difference between 100 percent and the applicable federal medical assistance percentage (FMAP) to the department for purposes of the Medi-Cal program.

(2) After deducting the revenues appropriated pursuant to paragraph (1), any remaining revenue to the Managed Risk Medical Insurance Board for purposes of the Healthy Families Program.

(c) The Insurance Commissioner shall report the amount of revenue derived from the tax imposed on Medi-Cal managed care plans pursuant to this section to the California Health and Human Services Agency, the Joint Legislative Budget Committee, and the Department of Finance.

(d) This section shall become operative on July 1, 2010.

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

SEC. 32. Section 12201 of the Revenue and Taxation Code, as added by Section 6 of Chapter 157 of the Statutes of 2009, is amended to read:

12201. (a) Every insurer doing business in this state shall annually pay to the state a tax on the bases, at the rates, and subject to the deductions from the tax hereinafter specified. For purposes of the tax imposed by this chapter, "insurer" shall be deemed to include a home protection company as defined in Section 12740 of the Insurance Code.

(b) This section shall become operative on July 1, 2011.

SEC. 33. Section 12204 of the Revenue and Taxation Code, as amended by Section 7 of Chapter 157 of the Statutes of 2009, is amended to read:

12204. (a) The tax imposed on insurers by this chapter is in lieu of all other taxes and licenses, state, county, and municipal, upon those insurers and their property, except:

(1) Taxes upon their real estate.

(2) Any retaliatory exactions imposed by paragraph (3) of subdivision (f) of Section 28 of Article XIII of the Constitution.

(3) The tax on ocean marine insurance.

(4) Motor vehicle and other vehicle registration license fees and any other tax or license fee imposed by the state upon vehicles, motor vehicles or the operation thereof.

(5) That each corporate or other attorney-in-fact of a reciprocal or interinsurance exchange shall be subject to all taxes imposed upon corporations or others doing business in the state, other than taxes on income derived from its principal business as attorney-in-fact.

(b) This section shall not apply to any Medi-Cal managed care plan and to any tax imposed on that plan by this chapter.

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

SEC. 34. Section 12204 of the Revenue and Taxation Code, as added by Section 8 of Chapter 157 of the Statutes of 2009, is amended to read:

12204. (a) The tax imposed on insurers by this chapter is in lieu of all other taxes and licenses, state, county, and municipal, upon those insurers and their property, except:

(1) Taxes upon their real estate.

(2) Any retaliatory exactions imposed by paragraph (3) of subdivision (f) of Section 28 of Article XIII of the California Constitution.

(3) The tax on ocean marine insurance.

(4) Motor vehicle and other vehicle registration license fees and any other tax or license fee imposed by the state upon vehicles, motor vehicles or the operation thereof.

(5) That each corporate or other attorney-in-fact of a reciprocal or interinsurance exchange shall be subject to all taxes imposed upon corporations or others doing business in the state, other than taxes on income derived from its principal business as attorney-in-fact.

(b) This section shall become operative on July 1, 2011.

SEC. 35. Section 12207 of the Revenue and Taxation Code is amended to read:

12207. (a) Notwithstanding any other provision of this part, no credit shall be allowed under Section 12206, 12208, or 12209 against the tax imposed on Medi-Cal managed care plans pursuant to Section 12201.

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

SEC. 36. Section 12242 of the Revenue and Taxation Code is amended to read:

12242. This article shall become inoperative on July 1, 2011, and, as of January 1, 2012, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2012, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 37. Section 12251 of the Revenue and Taxation Code, as amended by Section 11 of Chapter 157 of the Statutes of 2009, is amended to read:

12251. (a) For the calendar year 1970, and each calendar year thereafter, insurers transacting insurance in this state and whose annual tax for the preceding calendar year was five thousand dollars ($5,000) or more shall make prepayments of the annual tax for the current calendar year imposed by Section 28 of Article XIII of the California Constitution and this part, provided that no prepayments shall be made with respect to the tax on ocean marine insurance underwriting profit or any retaliatory tax.

(b) Medi-Cal managed care plans shall make prepayments of the tax imposed by Section 12201 for the current calendar year, except that no prepayments shall be required prior to the effective date of the act adding this subdivision, and no penalties and interest shall be imposed pursuant to Section 12261 for not making those prepayments.

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

SEC. 38. Section 12251 of the Revenue and Taxation Code, as added by Section 12 of Chapter 157 of the Statutes of 2009, is amended to read:

12251. (a) For the calendar year 1970, and each calendar year thereafter, insurers transacting insurance in this state and whose annual tax for the preceding calendar year was five thousand dollars ($5,000) or more shall make prepayments of the annual tax for the current calendar year imposed by Section 28 of Article XIII of the California Constitution and this part, provided that no prepayments shall be made with respect to the tax on ocean marine insurance underwriting profit or any retaliatory tax.

(b) This section shall become operative on July 1, 2011.

SEC. 39. Section 12253 of the Revenue and Taxation Code, as amended by Section 13 of Chapter 157 of the Statutes of 2009, is amended to read:

12253. (a) Each insurer and Medi-Cal managed care plan required to make prepayments shall remit them on or before each of the dates of April

1st, June 1st, September 1st, and December 1st of the current calendar year. Remittances for prepayments shall be made payable to the Controller and shall be delivered to the office of the commissioner, accompanied by a prepayment form prescribed by the commissioner.

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

SEC. 40. Section 12253 of the Revenue and Taxation Code, as added by Section 14 of Chapter 157 of the Statutes of 2009, is amended to read:

12253. (a) Each insurer required to make prepayments shall remit them on or before each of the dates of April 1st, June 1st, September 1st, and December 1st of the current calendar year. Remittances for prepayments shall be made payable to the Controller and shall be delivered to the office of the commissioner, accompanied by a prepayment form prescribed by the commissioner.

(b) This section shall become operative on July 1, 2011.

SEC. 41. Section 12254 of the Revenue and Taxation Code, as amended by Section 15 of Chapter 157 of the Statutes of 2009, is amended to read:

12254. (a) (1) For each insurer, the amount of each prepayment shall be 25 percent of the amount of the annual insurance tax liability reported on the return of the insurer for the preceding calendar year.

(2) For each Medi-Cal managed care plan, the amount of each prepayment shall be 25 percent of the amount of tax the plan estimates as the amount of tax imposed by Section 12201 with respect to the plan.

(b) In establishing the prepayment amount of an insurer that has acquired the business of another insurer, the amount of tax liability of the acquiring insurer reported for the preceding calendar year shall be deemed to include the amount of tax liability of the acquired insurer reported for that year.

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

SEC. 42. Section 12254 of the Revenue and Taxation Code, as added by Section 16 of Chapter 157 of the Statutes of 2009, is amended to read:

12254. (a) The amount of each prepayment shall be 25 percent of the amount of the annual insurance tax liability reported on the return of the insurer for the preceding calendar year.

(b) In establishing the prepayment amount of an insurer that has acquired the business of another insurer, the amount of tax liability of the acquiring insurer reported for the preceding calendar year shall be deemed to include the amount of tax liability of the acquired insurer reported for that year.

(c) This section shall become operative on July 1, 2011.

SEC. 43. Section 12257 of the Revenue and Taxation Code, as amended by Section 17 of Chapter 157 of the Statutes of 2009, is amended to read:

12257. (a) If the total amount of prepayments for any calendar year exceeds the amount of annual tax for that year, the excess shall be treated

as an overpayment of annual tax and, at the election of the insurer or Medi-Cal managed care plan, may be credited against the amounts due and payable for the first prepayment of the following year. Any amount of the overpayment not so credited shall be allowed as a credit or refund under Article 2 (commencing with Section 12977) of Chapter 7 of this part.

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

SEC. 44. Section 12257 of the Revenue and Taxation Code, as added by Section 18 of Chapter 157 of the Statutes of 2009, is amended to read:

12257. (a) If the total amount of prepayments for any calendar year exceeds the amount of annual tax for that year, the excess shall be treated as an overpayment of annual tax and, at the election of the insurer, may be credited against the amounts due and payable for the first prepayment of the following year. Any amount of the overpayment not so credited shall be allowed as a credit or refund under Article 2 (commencing with Section 12977) of Chapter 7 of this part.

(b) This section shall become operative on July 1, 2011.

SEC. 45. Section 12258 of the Revenue and Taxation Code, as amended by Section 19 of Chapter 157 of the Statutes of 2009, is amended to read:

12258. (a) Any insurer or Medi-Cal managed care plan that fails to pay any prepayment within the time required shall pay a penalty of 10 percent of the amount of the required prepayment, plus interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from the due date of the prepayment until the date of payment but not for any period after the due date of the annual tax. Assessments of prepayment deficiencies may be made in the manner provided by deficiency assessments of the annual tax.

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

SEC. 46. Section 12258 of the Revenue and Taxation Code, as added by Section 20 of Chapter 157 of the Statutes of 2009, is amended to read:

12258. (a) Any insurer that fails to pay any prepayment within the time required shall pay a penalty of 10 percent of the amount of the required prepayment, plus interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from the due date of the prepayment until the date of payment but not for any period after the due date of the annual tax. Assessments of prepayment deficiencies may be made in the manner provided by deficiency assessments of the annual tax.

(b) This section shall become operative on July 1, 2011.

SEC. 47. Section 12260 of the Revenue and Taxation Code, as amended by Section 21 of Chapter 157 of the Statutes of 2009, is amended to read:

12260. (a) Notwithstanding any other provision of this article, the commissioner may relieve an insurer or Medi-Cal managed care plan of its

obligation to make prepayments where the insurer or Medi-Cal managed care plan establishes to the satisfaction of the commissioner that the insurer has ceased to transact insurance in this state or the Medi-Cal managed care plan has ceased to operate a plan in this state, or the insurer's or Medi-Cal managed care plan's annual tax for the current year will be less than five thousand dollars ($5,000).

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

SEC. 48. Section 12260 of the Revenue and Taxation Code, as added by Section 22 of Chapter 157 of the Statutes of 2009, is amended to read:

12260. Notwithstanding any other provision of this article, the commissioner may relieve an insurer of its obligation to make prepayments where the insurer establishes to the satisfaction of the commissioner that either the insurer has ceased to transact insurance in this state, or the insurer's annual tax for the current year will be less than five thousand dollars ($5,000).

(b) This section shall become operative on July 1, 2011.

SEC. 49. Section 12301 of the Revenue and Taxation Code, as amended by Section 23 of Chapter 157 of the Statutes of 2009, is amended to read:

12301. (a) The taxes imposed upon insurers by Section 28 of Article XIII of the California Constitution and this part, except with respect to taxes on ocean marine insurance and retaliatory taxes, are due and payable annually on or before April 1st of the year following the calendar year in which the insurer engaged in the business of insurance or transacted insurance in this state. The taxes imposed with respect to ocean marine insurance are due and payable on or before June 15th of that year.

(b) With respect to Medi-Cal managed care plans, the taxes imposed by Section 12201 shall be due and payable on or before April 1st of the year following the calendar year in which the plan contracted with the State Department of Health Care Services as described in Section 12009.

(c) This section shall become inoperative on July 1, 2011, and, as of January 1, 2012, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2012, deletes or extends the dates on which it becomes inoperative and is repealed. However, any tax imposed by Section 12201 shall continue to be due and payable until the tax is paid.

SEC. 50. Section 12301 of the Revenue and Taxation Code, as added by Section 24 of Chapter 157 of the Statutes of 2009, is amended to read:

12301. (a) The taxes imposed upon insurers by Section 28 of Article XIII of the California Constitution and this part, except with respect to taxes on ocean marine insurance and retaliatory taxes, are due and payable annually on or before April 1st of the year following the calendar year in which the insurer engaged in the business of insurance or transacted insurance in this state. The taxes imposed with respect to ocean marine insurance are due and payable on or before June 15th of that year.

(b) This section shall become operative on July 1, 2011.

SEC. 51. Section 12302 of the Revenue and Taxation Code, as amended by Section 25 of Chapter 157 of the Statutes of 2009, is amended to read:

12302. (a) On or before April 1st (or June 15th with respect to taxes on ocean marine insurance) every person that is subject to any tax imposed by Section 28 of Article XIII of the California Constitution or this part, in respect to the preceding calendar year shall file, in duplicate, a tax return with the commissioner in the form as the commissioner may prescribe. The return shall show that information pertaining to its insurance business, or in the case of a Medi-Cal managed care plan, pertaining to contracts for providing services as described in Section 12009, in this state as will reflect the basis of its tax as set forth in Chapter 2 (commencing with Section 12071) and Chapter 3 (commencing with Section 12201) of this part, the computation of the amount of tax for the period covered by the return, the total amount of any tax prepayments made pursuant to Article 5 (commencing with Section 12251) of Chapter 3 of this part, and any other information as the commissioner may require to carry out the purposes of this part. Separate returns shall be filed with respect to the following kinds of insurance:

(1) Life insurance (or life insurance and disability insurance).

(2) Ocean marine insurance.

(3) Title insurance.

(4) Insurance other than life insurance (or life insurance and disability insurance), ocean marine insurance or title insurance.

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

SEC. 52. Section 12302 of the Revenue and Taxation Code, as added by Section 26 of Chapter 157 of the Statutes of 2009, is amended to read:

12302. (a) On or before April 1st (or June 15th with respect to taxes on ocean marine insurance) every person that is subject to any tax imposed by Section 28 of Article XIII of the California Constitution or this part, in respect to the preceding calendar year shall file, in duplicate, an insurance tax return with the commissioner in the form as the commissioner may prescribe. The return shall show that information pertaining to its insurance business in this state as will reflect the basis of its tax as set forth in Chapter 2 (commencing with Section 12071) and Chapter 3 (commencing with Section 12201) of this part, the computation of the amount of tax for the period covered by the return, the total amount of any tax prepayments made pursuant to Article 5 (commencing with Section 12251) of Chapter 3 of this part, and any other information as the commissioner may require to carry out the purposes of this part. Separate returns shall be filed with respect to the following kinds of insurance:

(1) Life insurance (or life insurance and disability insurance).

(2) Ocean marine insurance.

(3) Title insurance.

(4) Insurance other than life insurance (or life insurance and disability insurance), ocean marine insurance or title insurance.

(b) This section shall become operative on July 1, 2011.

SEC. 53. Section 12303 of the Revenue and Taxation Code, as amended by Section 27 of Chapter 157 of the Statutes of 2009, is amended to read:

12303. (a) Every return required by this article to be filed with the commissioner shall be signed by the insurer or Medi-Cal managed care plan or an executive officer of the insurer or plan and shall be made under oath or contain a written declaration that it is made under penalty of perjury. A return of a foreign insurer may be signed and verified by its manager residing within this state. A return of an alien insurer may be signed and verified by the United States manager of the insurer.

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

SEC. 54. Section 12303 of the Revenue and Taxation Code, as added by Section 28 of Chapter 157 of the Statutes of 2009, is amended to read:

12303. (a) Every return required by this article to be filed with the commissioner shall be signed by the insurer or an executive officer of the insurer and shall be made under oath or contain a written declaration that it is made under penalty of perjury. A return of a foreign insurer may be signed and verified by its manager residing within this state. A return of an alien insurer may be signed and verified by the United States manager of the insurer.

(b) This section shall become operative on July 1, 2011.

SEC. 55. Section 12304 of the Revenue and Taxation Code, as amended by Section 29 of Chapter 157 of the Statutes of 2009, is amended to read:

12304. (a) Blank forms of returns shall be furnished by the commissioner on application, but failure to secure the form shall not relieve any insurer or Medi-Cal managed care plan from making or filing a timely return.

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

SEC. 56. Section 12304 of the Revenue and Taxation Code, as added by Section 30 of Chapter 157 of the Statutes of 2009, is amended to read:

12304. (a) Blank forms of returns shall be furnished by the commissioner on application, but failure to secure the form shall not relieve any insurer from making or filing a timely return.

(b) This section shall become operative on July 1, 2011.

SEC. 57. Section 12305 of the Revenue and Taxation Code, as amended by Section 31 of Chapter 157 of the Statutes of 2009, is amended to read:

12305. (a) The insurer or Medi-Cal managed care plan required to file a return shall deliver the return in duplicate, together with a remittance payable to the Controller, for the amount of tax computed and shown thereon,

less any prepayments made pursuant to Article 5 (commencing with Section 12251) of Chapter 3 of this part, to the office of the commissioner.

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

SEC. 58. Section 12305 of the Revenue and Taxation Code, as added by Section 32 of Chapter 157 of the Statutes of 2009, is amended to read:

12305. (a) The insurer required to file a return shall deliver the return in duplicate, together with a remittance payable to the Controller, for the amount of tax computed and shown thereon, less any prepayments made pursuant to Article 5 (commencing with Section 12251) of Chapter 3 of this part, to the office of the commissioner.

(b) This section shall become operative on July 1, 2011.

SEC. 59. Section 12307 of the Revenue and Taxation Code, as amended by Section 33 of Chapter 157 of the Statutes of 2009, is amended to read:

12307. (a) Any insurer or Medi-Cal managed care plan to which an extension is granted shall pay, in addition to the tax, interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from April 1st until the date of payment.

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

SEC. 60. Section 12307 of the Revenue and Taxation Code, as added by Section 34 of Chapter 157 of the Statutes of 2009, is amended to read:

12307. (a) Any insurer that is granted an extension shall pay, in addition to the tax, interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from April 1st until the date of payment.

(b) This section shall become operative on July 1, 2011.

SEC. 61. Section 12412 of the Revenue and Taxation Code, as amended by Section 35 of Chapter 157 of the Statutes of 2009, is amended to read:

12412. (a) Upon receipt of the duplicate copy of the return of an insurer or Medi-Cal managed care plan the board shall initially assess the tax in accordance with the data as reported by the insurer or Medi-Cal managed care plan on the return.

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

SEC. 62. Section 12412 of the Revenue and Taxation Code, as added by Section 36 of Chapter 157 of the Statutes of 2009, is amended to read:

12412. (a) Upon receipt of the duplicate copy of the return of an insurer the board shall initially assess the tax in accordance with the data as reported by the insurer on the return.

(b) This section shall become operative on July 1, 2011.

SEC. 63. Section 12413 of the Revenue and Taxation Code, as amended by Section 37 of Chapter 157 of the Statutes of 2009, is amended to read:

12413. (a) The board shall promptly transmit notice of its initial assessment to the commissioner and the Controller, and if the initial assessment differs from the amount computed by the insurer or Medi-Cal managed care plan, notice shall also be given to the insurer or Medi-Cal managed care plan.

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

SEC. 64. Section 12413 of the Revenue and Taxation Code, as added by Section 38 of Chapter 157 of the Statutes of 2009, is amended to read:

12413. (a) The board shall promptly transmit notice of its initial assessment to the commissioner and the Controller, and if the initial assessment differs from the amount computed by the insurer, notice shall also be given to the insurer.

(b) This section shall become operative on July 1, 2011.

SEC. 65. Section 12421 of the Revenue and Taxation Code, as amended by Section 39 of Chapter 157 of the Statutes of 2009, is amended to read:

12421. (a) As soon as practicable after an insurer's, surplus line broker's, or Medi-Cal managed care plan's return is filed, the commissioner shall examine it, together with any information within his or her possession or that may come into his or her possession, and he or she shall determine the correct amount of tax of the insurer, surplus line broker, or Medi-Cal managed care plan.

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

SEC. 66. Section 12421 of the Revenue and Taxation Code, as added by Section 40 of Chapter 157 of the Statutes of 2009, is amended to read:

12421. (a) As soon as practicable after an insurer's or surplus line broker's return is filed, the commissioner shall examine it, together with any information within his or her possession or that may come into his or her possession, and he or she shall determine the correct amount of tax of the insurer or surplus line broker.

(b) This section shall become operative on July 1, 2011.

SEC. 67. Section 12422 of the Revenue and Taxation Code, as amended by Section 41 of Chapter 157 of the Statutes of 2009, is amended to read:

12422. (a) If the commissioner determines that the amount of tax disclosed by the insurer's tax return and assessed by the board is less than the amount of tax disclosed by his or her examination, he or she shall propose, in writing, to the board a deficiency assessment for the difference. The proposal shall set forth the basis for the deficiency assessment and the details of its computation.

(b) If the commissioner determines that the amount of tax disclosed by the surplus line broker's tax return is less than the amount of tax disclosed by his or her examination, he or she shall propose, in writing, to the board a deficiency assessment for the difference. The proposal shall set forth the basis for the deficiency assessment and the details of its computation.

(c) If the commissioner determines that the amount of tax disclosed by the Medi-Cal managed care plan's tax return is less than the amount of tax disclosed by his or her examination, he or she shall propose, in writing, to the board a deficiency assessment for the difference. The proposal shall set forth the basis for the deficiency assessment and the details of its computation.

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

SEC. 68. Section 12422 of the Revenue and Taxation Code, as added by Section 42 of Chapter 157 of the Statutes of 2009, is amended to read:

12422. (a) If the commissioner determines that the amount of tax disclosed by the insurer's tax return and assessed by the board is less than the amount of tax disclosed by his or her examination, he or she shall propose, in writing, to the board a deficiency assessment for the difference. The proposal shall set forth the basis for the deficiency assessment and the details of its computation.

(b) If the commissioner determines that the amount of tax disclosed by the surplus line broker's tax return is less than the amount of tax disclosed by his or her examination, he or she shall propose, in writing, to the board a deficiency assessment for the difference. The proposal shall set forth the basis for the deficiency assessment and the details of its computation.

(c) This section shall become operative on July 1, 2011.

SEC. 69. Section 12423 of the Revenue and Taxation Code, as amended by Section 43 of Chapter 157 of the Statutes of 2009, is amended to read:

12423. (a) If an insurer, surplus line broker, or Medi-Cal managed care plan fails to file a return, the commissioner may require a return by mailing notice to the insurer, surplus line broker, or Medi-Cal managed care plan to file a return by a specified date or he or she may without requiring a return, or upon no return having been filed pursuant to the demand therefor, make an estimate of the amount of tax due for the calendar year or years in respect to which the insurer, surplus line broker, or Medi-Cal managed care plan failed to file the return. The estimate shall be made from any available information which is in the commissioner's possession or may come into his or her possession, and the commissioner shall propose, in writing, to the board a deficiency assessment for the amount of the estimated tax. The proposal shall set forth the basis of the estimate and the details of the computation of the tax.

(b) This section shall become inoperative on July 1, 2011, and, as of January 1, 2012, is repealed, unless a later enacted statute, that becomes

operative on or before January 1, 2012, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 70. Section 12423 of the Revenue and Taxation Code, as added by Section 44 of Chapter 157 of the Statutes of 2009, is amended to read:

12423. (a) If an insurer or surplus line broker fails to file a return, the commissioner may require a return by mailing notice to the insurer or surplus line broker to file a return by a specified date or he or she may without requiring a return, or upon no return having been filed pursuant to the demand therefor, make an estimate of the amount of tax due for the calendar year or years in respect to which the insurer or surplus line broker failed to file the return. The estimate shall be made from any available information which is in the commissioner's possession or may come into his or her possession, and the commissioner shall propose, in writing, to the board a deficiency assessment for the amount of the estimated tax. The proposal shall set forth the basis of the estimate and the details of the computation of the tax.

(b) This section shall become operative on July 1, 2011.

SEC. 71. Section 12427 of the Revenue and Taxation Code, as amended by Section 45 of Chapter 157 of the Statutes of 2009, is amended to read:

12427. (a) The board shall promptly notify the insurer, surplus line broker, or Medi-Cal managed care plan of a deficiency assessment made against the insurer, surplus line broker, or Medi-Cal managed care plan.

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

SEC. 72. Section 12427 of the Revenue and Taxation Code, as added by Section 46 of Chapter 157 of the Statutes of 2009, is amended to read:

12427. (a) The board shall promptly notify the insurer or surplus line broker of a deficiency assessment made against the insurer or surplus line broker.

(b) This section shall become operative on July 1, 2011.

SEC. 73. Section 12428 of the Revenue and Taxation Code, as amended by Section 47 of Chapter 157 of the Statutes of 2009, is amended to read:

12428. (a) An insurer, surplus line broker, or Medi-Cal managed care plan against which a deficiency assessment is made under Section 12424 or 12425 may petition for redetermination of the deficiency assessment within 30 days after service upon the insurer, surplus line broker, or Medi-Cal managed care plan of the notice thereof, by filing with the board a written petition setting forth the grounds of objection to the deficiency assessment and the correction sought. At the time the petition is filed with the board, a copy of the petition shall be filed with the commissioner.

If a petition for redetermination is not filed within the period prescribed by this section, the deficiency assessment becomes final and due and payable at the expiration of that period.

(b) This section shall become inoperative on July 1, 2011, and, as of January 1, 2012, is repealed, unless a later enacted statute, that becomes

operative on or before January 1, 2012, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 74. Section 12428 of the Revenue and Taxation Code, as added by Section 48 of Chapter 157 of the Statutes of 2009, is amended to read:

12428. (a) An insurer or surplus line broker against which a deficiency assessment is made under Section 12424 or 12425 may petition for redetermination of the deficiency assessment within 30 days after service upon the insurer or surplus line broker of the notice thereof, by filing with the board a written petition setting forth the grounds of objection to the deficiency assessment and the correction sought. At the time the petition is filed with the board, a copy of the petition shall be filed with the commissioner.

If a petition for redetermination is not filed within the period prescribed by this section, the deficiency assessment becomes final and due and payable at the expiration of that period.

(b) This section shall become operative on July 1, 2011.

SEC. 75. Section 12429 of the Revenue and Taxation Code, as amended by Section 49 of Chapter 157 of the Statutes of 2009, is amended to read:

12429. (a) If a petition for redetermination of a deficiency assessment is filed within the time allowed under Section 12428, the board shall reconsider the deficiency assessment and, if the insurer, surplus line broker, or Medi-Cal managed care plan has so requested in the petition, shall grant an oral hearing for the presentation of evidence and argument before the board or its authorized representative. The board shall give the petitioner and the commissioner at least 20 days' notice of the time and place of hearing. The hearing may be continued from time to time as may be necessary.

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

SEC. 76. Section 12429 of the Revenue and Taxation Code, as added by Section 50 of Chapter 157 of the Statutes of 2009, is amended to read:

12429. (a) If a petition for redetermination of a deficiency assessment is filed within the time allowed under Section 12428, the board shall reconsider the deficiency assessment and, if the insurer or surplus line broker has so requested in the petition, shall grant an oral hearing for the presentation of evidence and argument before the board or its authorized representative. The board shall give the petitioner and the commissioner at least 20 days' notice of the time and place of hearing. The hearing may be continued from time to time as may be necessary.

(b) This section shall become operative on July 1, 2011.

SEC. 77. Section 12431 of the Revenue and Taxation Code, as amended by Section 51 of Chapter 157 of the Statutes of 2009, is amended to read:

12431. (a) The order or decision of the board upon a petition for redetermination of a deficiency assessment becomes final 30 days after service on the insurer, surplus line broker, or Medi-Cal managed care plan

of a notice thereof, and any resulting deficiency assessment is due and payable at the time the order or decision becomes final.

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

SEC. 78. Section 12431 of the Revenue and Taxation Code, as added by Section 52 of Chapter 157 of the Statutes of 2009, is amended to read:

12431. (a) The order or decision of the board upon a petition for redetermination of a deficiency assessment becomes final 30 days after service on the insurer or surplus line broker of a notice thereof, and any resulting deficiency assessment is due and payable at the time the order or decision becomes final.

(b) This section shall become operative on July 1, 2011.

SEC. 79. Section 12433 of the Revenue and Taxation Code, as amended by Section 53 of Chapter 157 of the Statutes of 2009, is amended to read:

12433. (a) If before the expiration of the time prescribed in Section 12432 for giving of a notice of deficiency assessment the insurer, surplus line broker, or Medi-Cal managed care plan has consented in writing to the giving of the notice after that time, the notice may be given at any time prior to the expiration of the time agreed upon. The period so agreed upon may be extended by subsequent agreements in writing made before the expiration of the period previously agreed upon.

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

SEC. 80. Section 12433 of the Revenue and Taxation Code, as added by Section 54 of Chapter 157 of the Statutes of 2009, is amended to read:

12433. (a) If before the expiration of the time prescribed in Section 12432 for giving of a notice of deficiency assessment the insurer or surplus line broker has consented in writing to the giving of the notice after that time, the notice may be given at any time prior to the expiration of the time agreed upon. The period so agreed upon may be extended by subsequent agreements in writing made before the expiration of the period previously agreed upon.

(b) This section shall become operative on July 1, 2011.

SEC. 81. Section 12434 of the Revenue and Taxation Code, as amended by Section 55 of Chapter 157 of the Statutes of 2009, is amended to read:

12434. (a) Any notice required by this article shall be placed in a sealed envelope, with postage paid, addressed to the insurer, surplus line broker, or Medi-Cal managed care plan at its address as it appears in the records of the commissioner or the board. The giving of notice shall be deemed complete at the time of deposit of the notice in the United States Post Office, or a mailbox, subpost office, substation or mail chute or other facility regularly maintained or provided by the United States Postal Service, without extension of time for any reason. In lieu of mailing, a notice may be served

personally by delivering to the person to be served and service shall be deemed complete at the time of the delivery. Personal service to a corporation may be made by delivery of a notice to any person designated in the Code of Civil Procedure to be served for the corporation with summons and complaint in a civil action.

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

SEC. 82. Section 12434 of the Revenue and Taxation Code, as added by Section 56 of Chapter 157 of the Statutes of 2009, is amended to read:

12434. (a) Any notice required by this article shall be placed in a sealed envelope, with postage paid, addressed to the insurer or surplus line broker at its address as it appears in the records of the commissioner or the board. The giving of notice shall be deemed complete at the time of deposit of the notice in the United States Post Office, or a mailbox, subpost office, substation or mail chute or other facility regularly maintained or provided by the United States Postal Service, without extension of time for any reason. In lieu of mailing, a notice may be served personally by delivering to the person to be served and service shall be deemed complete at the time of the delivery. Personal service to a corporation may be made by delivery of a notice to any person designated in the Code of Civil Procedure to be served for the corporation with summons and complaint in a civil action.

(b) This section shall become operative on July 1, 2011.

SEC. 83. Section 12491 of the Revenue and Taxation Code, as amended by Section 57 of Chapter 157 of the Statutes of 2009, is amended to read:

12491. (a) Every tax levied upon an insurer under Article XIII of the California Constitution and this part is a lien upon all property and franchises of every kind and nature belonging to the insurer, and has the effect of a judgment against the insurer.

(b) (1) Every tax levied upon a surplus line broker under Part 7.5 (commencing with Section 13201) of Division 2 is a lien upon all property and franchises of every kind and nature belonging to the surplus line broker, and has the effect of a judgment against the surplus line broker.

(2) A lien levied pursuant to this subdivision shall not exceed the amount of unpaid tax collected by the surplus line broker.

(c) (1) Every tax levied upon a Medi-Cal managed care plan under Chapter 1 (commencing with Section 12001) is a lien upon all property and franchises of every kind and nature belonging to the Medi-Cal managed care plan, and has the effect of a judgment against the Medi-Cal managed care plan.

(2) A lien levied pursuant to this subdivision shall not exceed the amount of unpaid tax collected by the Medi-Cal managed care plan.

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

SEC. 84. Section 12491 of the Revenue and Taxation Code, as added by Section 58 of Chapter 157 of the Statutes of 2009, is amended to read:

12491. (a) Every tax levied upon an insurer under the provisions of Article XIII of the California Constitution and of this part is a lien upon all property and franchises of every kind and nature belonging to the insurer, and has the effect of a judgment against the insurer.

(b) (1) Every tax levied upon a surplus line broker under the provisions of Part 7.5 (commencing with Section 13201) of Division 2 is a lien upon all property and franchises of every kind and nature belonging to the surplus line broker, and has the effect of a judgment against the surplus line broker.

(2) A lien levied pursuant to this subdivision shall not exceed the amount of unpaid tax collected by the surplus line broker.

(c) This section shall become operative on July 1, 2011.

SEC. 85. Section 12493 of the Revenue and Taxation Code, as amended by Section 59 of Chapter 157 of the Statutes of 2009, is amended to read:

12493. (a) Every lien has the effect of an execution duly levied against all property of a delinquent insurer, surplus line broker, or Medi-Cal managed care plan.

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

SEC. 86. Section 12493 of the Revenue and Taxation Code, as added by Section 60 of Chapter 157 of the Statutes of 2009, is amended to read:

12493. (a) Every lien has the effect of an execution duly levied against all property of a delinquent insurer or surplus line broker.

(b) This section shall become operative on July 1, 2011.

SEC. 87. Section 12494 of the Revenue and Taxation Code, as amended by Section 61 of Chapter 157 of the Statutes of 2009, is amended to read:

12494. (a) No judgment is satisfied nor lien removed until either:

(1) The taxes, interest, penalties, and costs are paid.

(2) The insurer's, surplus line broker's, or Medi-Cal managed care plan's property is sold for the payment thereof.

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

SEC. 88. Section 12494 of the Revenue and Taxation Code, as added by Section 62 of Chapter 157 of the Statutes of 2009, is amended to read:

12494. (a) No judgment is satisfied nor lien removed until either:

(1) The taxes, interest, penalties, and costs are paid.

(2) The insurer's or surplus line broker's property is sold for the payment thereof.

(b) This section shall become operative on July 1, 2011.

SEC. 89. Section 12601 of the Revenue and Taxation Code, as amended by Section 63 of Chapter 157 of the Statutes of 2009, is amended to read:

12601. (a) Amounts of taxes, interest, and penalties not remitted to the commissioner with the original return of the insurer or Medi-Cal managed care plan shall be payable to the Controller.

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

SEC. 90. Section 12601 of the Revenue and Taxation Code, as added by Section 64 of Chapter 157 of the Statutes of 2009, is amended to read:

12601. (a) Amounts of taxes, interest, and penalties not remitted to the commissioner with the original return of the insurer shall be payable to the Controller.

(b) This section shall become operative on July 1, 2011.

SEC. 91. Section 12602 of the Revenue and Taxation Code, as amended by Section 65 of Chapter 157 of the Statutes of 2009, is amended to read:

12602. (a) (1) On and after January 1, 1994, and before January 1, 1995, each insurer whose annual taxes exceed fifty thousand dollars ($50,000) shall make payment by electronic funds transfer, as defined by Section 45 of the Insurance Code. On and after January 1, 1995, each insurer whose annual taxes exceed twenty thousand dollars ($20,000) shall make payment by electronic funds transfer. The insurer shall choose one of the acceptable methods described in Section 45 of the Insurance Code for completing the electronic funds transfer.

(2) Each Medi-Cal managed care plan shall make payment by electronic funds transfer, as defined by Section 45 of the Insurance Code. The plan shall choose one of the acceptable methods described in Section 45 of the Insurance Code for completing the electronic funds transfer.

(b) Payment shall be deemed complete on the date the electronic funds transfer is initiated, if settlement to the state's demand account occurs on or before the banking day following the date the transfer is initiated. If settlement to the state's demand account does not occur on or before the banking day following the date the transfer is initiated, payment shall be deemed to occur on the date settlement occurs.

(c) (1) Any insurer or Medi-Cal managed care plan required to remit taxes by electronic funds transfer pursuant to this section that remits those taxes by means other than an appropriate electronic funds transfer, shall be assessed a penalty in an amount equal to 10 percent of the taxes due at the time of the payment.

(2) If the Department of Insurance finds that an insurer's or Medi-Cal managed care plan's failure to make payment by an appropriate electronic funds transfer in accordance with subdivision (a) is due to reasonable cause or circumstances beyond the insurer's or Medi-Cal managed care plan's control, and occurred notwithstanding the exercise of ordinary care and in the absence of willful neglect, that insurer or Medi-Cal managed care plan shall be relieved of the penalty provided in paragraph (1).

(3) Any insurer or Medi-Cal managed care plan seeking to be relieved of the penalty provided in paragraph (1) shall file with the Department of

Insurance a statement under penalty of perjury setting forth the facts upon which the claim for relief is based.

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

SEC. 92. Section 12602 of the Revenue and Taxation Code, as added by Section 66 of Chapter 157 of the Statutes of 2009, is amended to read:

12602. (a) On and after January 1, 1994, and before January 1, 1995, each insurer whose annual taxes exceed fifty thousand dollars ($50,000) shall make payment by electronic funds transfer, as defined by Section 45 of the Insurance Code. On and after January 1, 1995, each insurer whose annual taxes exceed twenty thousand dollars ($20,000) shall make payment by electronic funds transfer. The insurer shall choose one of the acceptable methods described in Section 45 of the Insurance Code for completing the electronic funds transfer.

(b) Payment shall be deemed complete on the date the electronic funds transfer is initiated, if settlement to the state's demand account occurs on or before the banking day following the date the transfer is initiated. If settlement to the state's demand account does not occur on or before the banking day following the date the transfer is initiated, payment shall be deemed to occur on the date settlement occurs.

(c) (1) Any insurer required to remit taxes by electronic funds transfer pursuant to this section that remits those taxes by means other than an appropriate electronic funds transfer, shall be assessed a penalty in an amount equal to 10 percent of the taxes due at the time of the payment.

(2) If the Department of Insurance finds that an insurer's failure to make payment by an appropriate electronic funds transfer in accordance with subdivision (a) is due to reasonable cause or circumstances beyond the insurer's control, and occurred notwithstanding the exercise of ordinary care and in the absence of willful neglect, that insurer shall be relieved of the penalty provided in paragraph (1).

(3) Any insurer seeking to be relieved of the penalty provided in paragraph (1) shall file with the Department of Insurance a statement under penalty of perjury setting forth the facts upon which the claim for relief is based.

(d) This section shall become operative on July 1, 2011.

SEC. 93. Section 12631 of the Revenue and Taxation Code, as amended by Section 67 of Chapter 157 of the Statutes of 2009, is amended to read:

12631. (a) Any insurer or Medi-Cal managed care plan that fails to pay any tax, except a tax determined as a deficiency assessment by the board under Article 3 (commencing with Section 12421) of Chapter 4, within the time required, shall pay a penalty of 10 percent of the amount of the tax in addition to the tax, plus interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from the due date of the tax until the date of payment.

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

SEC. 94. Section 12631 of the Revenue and Taxation Code, as added by Section 68 of Chapter 157 of the Statutes of 2009, is amended to read:

12631. (a) Any insurer that fails to pay any tax, except a tax determined as a deficiency assessment by the board under Article 3 (commencing with Section 12421) of Chapter 4, within the time required, shall pay a penalty of 10 percent of the amount of the tax in addition to the tax, plus interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from the due date of the tax until the date of payment.

(b) This section shall become operative on July 1, 2011.

SEC. 95. Section 12632 of the Revenue and Taxation Code, as amended by Section 69 of Chapter 157 of the Statutes of 2009, is amended to read:

12632. (a) An insurer or Medi-Cal managed care plan that fails to pay any deficiency assessment when it becomes due and payable shall, in addition to the deficiency assessment, pay a penalty of 10 percent of the amount of the deficiency assessment, exclusive of interest and penalties. The amount of any deficiency assessment, exclusive of penalties, shall bear interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from the date on which the amount, or any portion thereof, would have been payable if properly reported and assessed until the date of payment.

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

SEC. 96. Section 12632 of the Revenue and Taxation Code, as added by Section 70 of Chapter 157 of the Statutes of 2009, is amended to read:

12632. (a) An insurer that fails to pay any deficiency assessment when it becomes due and payable shall, in addition to the deficiency assessment, pay a penalty of 10 percent of the amount of the deficiency assessment, exclusive of interest and penalties. The amount of any deficiency assessment, exclusive of penalties, shall bear interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from the date on which the amount, or any portion thereof, would have been payable if properly reported and assessed until the date of payment.

(b) This section shall become operative on July 1, 2011.

SEC. 97. Section 12636 of the Revenue and Taxation Code, as amended by Section 71 of Chapter 157 of the Statutes of 2009, is amended to read:

12636. (a) If the board finds that an insurer's or Medi-Cal managed care plan's failure to make a timely return or payment is due to reasonable cause and to circumstances beyond the insurer's or Medi-Cal managed care plan's control, and which occurred despite the exercise of ordinary care and in the absence of willful neglect, the insurer or Medi-Cal managed care plan

may be relieved of the penalty provided by Section 12258, 12282, 12287, 12631, 12632, or 12633.

Any insurer or Medi-Cal managed care plan seeking to be relieved of the penalty shall file with the board a statement under penalty of perjury setting forth the facts upon which the claim for relief is based.

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

SEC. 98. Section 12636 of the Revenue and Taxation Code, as added by Section 72 of Chapter 157 of the Statutes of 2009, is amended to read:

12636. (a) If the board finds that an insurer's failure to make a timely return or payment is due to reasonable cause and to circumstances beyond the insurer's control, and which occurred despite the exercise of ordinary care and in the absence of willful neglect, the insurer may be relieved of the penalty provided by Section 12258, 12282, 12287, 12631, 12632, or 12633.

Any insurer seeking to be relieved of the penalty shall file with the board a statement under penalty of perjury setting forth the facts upon which the claim for relief is based.

(b) This section shall become operative on July 1, 2011.

SEC. 99. Section 12636.5 of the Revenue and Taxation Code, as amended by Section 73 of Chapter 157 of the Statutes of 2009, is amended to read:

12636.5. (a) Every payment on an insurer's, surplus line broker's, or Medi-Cal managed care plan's delinquent annual tax shall be applied as follows:

(1) First, to any interest due on the tax.

(2) Second, to any penalty imposed by this part.

(3) The balance, if any, to the tax itself.

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

SEC. 100. Section 12636.5 of the Revenue and Taxation Code, as added by Section 74 of Chapter 157 of the Statutes of 2009, is amended to read:

12636.5. (a) Every payment on an insurer's or surplus line broker's delinquent annual tax shall be applied as follows:

(1) First, to any interest due on the tax.

(2) Second, to any penalty imposed by this part.

(3) The balance, if any, to the tax itself.

(b) This section shall become operative on July 1, 2011.

SEC. 101. Section 12679 of the Revenue and Taxation Code, as amended by Section 75 of Chapter 157 of the Statutes of 2009, is amended to read:

12679. (a) If an insurer's or Medi-Cal managed care plan's right to do business has been forfeited or its corporate powers suspended, service of summons may be made upon the persons designated by law to be served as agents or officers of the insurer or Medi-Cal managed care plan, and these

persons are the agents of the insurer or Medi-Cal managed care plan for all purposes necessary in order to prosecute the action. In the case of corporations whose powers have been suspended, the persons constituting the board of directors may defend the action.

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

SEC. 102. Section 12679 of the Revenue and Taxation Code, as added by Section 76 of Chapter 157 of the Statutes of 2009, is amended to read:

12679. (a) If an insurer's right to do business has been forfeited or its corporate powers suspended, service of summons may be made upon the persons designated by law to be served as agents or officers of the insurer, and these persons are the agents of the insurer for all purposes necessary in order to prosecute the action. In the case of corporations whose powers have been suspended, the persons constituting the board of directors may defend the action.

(b) This section shall become operative on July 1, 2011.

SEC. 103. Section 12681 of the Revenue and Taxation Code, as amended by Section 77 of Chapter 157 of the Statutes of 2009, is amended to read:

12681. (a) In the action, a certificate of the Controller or of the secretary of the board, showing unpaid taxes against an insurer or Medi-Cal managed care plan is prima facie evidence of:

(1) The assessment of the taxes.

(2) The delinquency.

(3) The amount of the taxes, interest, and penalties due and unpaid to the state.

(4) That the insurer or Medi-Cal managed care plan is indebted to the state in the amount of taxes, interest, and penalties appearing unpaid.

(5) That there has been compliance with all the requirements of law in relation to the assessment of the taxes.

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

SEC. 104. Section 12681 of the Revenue and Taxation Code, as added by Section 78 of Chapter 157 of the Statutes of 2009, is amended to read:

12681. (a) In the action, a certificate of the Controller or of the secretary of the board, showing unpaid taxes against an insurer is prima facie evidence of:

(1) The assessment of the taxes.

(2) The delinquency.

(3) The amount of the taxes, interest, and penalties due and unpaid to the state.

(4) That the insurer is indebted to the state in the amount of taxes, interest, and penalties appearing unpaid.

(5) That there has been compliance with all the requirements of law in relation to the assessment of the taxes.

(b) This section shall become operative on July 1, 2011.

SEC. 105. Section 12801 of the Revenue and Taxation Code, as amended by Section 79 of Chapter 157 of the Statutes of 2009, is amended to read:

12801. (a) Annually, between December 10th and 15th, the Controller shall transmit to the commissioner a statement showing the names of all insurers and Medi-Cal managed care plans that failed to pay on or before December 10th the whole or any portion of the tax that became delinquent in the preceding June or which has been unpaid for more than 30 days from the date it became due and payable as a deficiency assessment under this part or the whole or any part of the interest or penalties due with respect to the tax. The statement shall show the amount of the tax, interest, and penalties due from each insurer or Medi-Cal managed care plan.

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

SEC. 106. Section 12801 of the Revenue and Taxation Code, as added by Section 80 of Chapter 157 of the Statutes of 2009, is amended to read:

12801. (a) Annually, between December 10th and 15th, the Controller shall transmit to the commissioner a statement showing the names of all insurers that failed to pay on or before December 10th the whole or any portion of the tax that became delinquent in the preceding June or which has been unpaid for more than 30 days from the date it became due and payable as a deficiency assessment under this part or the whole or any part of the interest or penalties due with respect to the tax. The statement shall show the amount of the tax, interest, and penalties due from each insurer.

(b) This section shall become operative on July 1, 2011.

SEC. 107. Section 12951 of the Revenue and Taxation Code, as amended by Section 81 of Chapter 157 of the Statutes of 2009, is amended to read:

12951. (a) If any amount has been illegally assessed, the board shall set forth that fact in its records, certify the amount determined to be assessed in excess of the amount legally assessed and the insurer, surplus line broker, or Medi-Cal managed care plan against which the assessment was made, and authorize the cancellation of the amount upon the records of the Controller and the board. The board shall mail a notice to the insurer, surplus line broker, or Medi-Cal managed care plan of any cancellation authorized. Any proposed determination by the board pursuant to this section with respect to an amount in excess of fifty thousand dollars ($50,000) shall be available as a public record for at least 10 days prior to the effective date of that determination.

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

SEC. 108. Section 12951 of the Revenue and Taxation Code, as added by Section 82 of Chapter 157 of the Statutes of 2009, is amended to read:

12951. (a) If any amount has been illegally assessed, the board shall set forth that fact in its records, certify the amount determined to be assessed in excess of the amount legally assessed and the insurer or surplus line broker against which the assessment was made, and authorize the cancellation of the amount upon the records of the Controller and the board. The board shall mail a notice to the insurer or surplus line broker of any cancellation authorized. Any proposed determination by the board pursuant to this section with respect to an amount in excess of fifty thousand dollars ($50,000) shall be available as a public record for at least 10 days prior to the effective date of that determination.

(b) This section shall become operative on July 1, 2011.

SEC. 109. Section 12977 of the Revenue and Taxation Code, as amended by Section 83 of Chapter 157 of the Statutes of 2009, is amended to read:

12977. (a) If the board determines that any tax, interest, or penalty has been paid more than once or has been erroneously or illegally collected or computed, the board shall set forth that fact in its records of the board, certify the amount of the taxes, interest, or penalties collected in excess of what was legally due, and from whom they were collected or by whom paid, and certify the excess to the Controller for credit or refund.

(b) The Controller upon receipt of a certification for credit or refund shall credit the excess on any amounts then due and payable from the insurer, surplus line broker, or Medi-Cal managed care plan under this part and refund the balance.

(c) Any proposed determination by the board pursuant to this section with respect to an amount in excess of fifty thousand dollars ($50,000) shall be available as a public record for at least 10 days prior to the effective date of that determination.

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

SEC. 110. Section 12977 of the Revenue and Taxation Code, as added by Section 84 of Chapter 157 of the Statutes of 2009, is amended to read:

12977. (a) If the board determines that any tax, interest, or penalty has been paid more than once or has been erroneously or illegally collected or computed, the board shall set forth that fact in its records of the board, certify the amount of the taxes, interest, or penalties collected in excess of what was legally due, and from whom they were collected or by whom paid, and certify the excess to the Controller for credit or refund.

(b) The Controller upon receipt of a certification for credit or refund shall credit the excess on any amounts then due and payable from the insurer or surplus line broker under this part and refund the balance.

(c) Any proposed determination by the board pursuant to this section with respect to an amount in excess of fifty thousand dollars ($50,000) shall

be available as a public record for at least 10 days prior to the effective date of that determination.

(d) This section shall become operative on July 1, 2011.

SEC. 111. Section 12983 of the Revenue and Taxation Code, as amended by Section 85 of Chapter 157 of the Statutes of 2009, is amended to read:

12983. (a) Interest shall be allowed upon the amount of any overpayment of tax by an insurer or Medi-Cal managed care plan pursuant to this part at the modified adjusted rate per month established pursuant to Section 6591.5, from the first day of the monthly period following the period during which the overpayment was made. For purposes of this section, "monthly period" means the month commencing on the day after the due date of the payment through the same date as the due date in each successive month. In addition, a refund or credit shall be made of any interest imposed upon the claimant with respect to the amount being refunded or credited.

The interest shall be paid as follows:

(1) In the case of a refund, to the last day of the calendar month following the date upon which the claimant is notified in writing that a claim may be filed or the date upon which the claim is approved by the board, whichever date is the earlier.

(2) In the case of a credit, to the same date as that to which interest is computed on the tax or amount against which the credit is applied.

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

SEC. 112. Section 12983 of the Revenue and Taxation Code, as added by Section 86 of Chapter 157 of the Statutes of 2009, is amended to read:

12983. (a) Interest shall be allowed upon the amount of any overpayment of tax by an insurer pursuant to this part at the modified adjusted rate per month established pursuant to Section 6591.5, from the first day of the monthly period following the period during which the overpayment was made. For purposes of this section, "monthly period" means the month commencing on the day after the due date of the payment through the same date as the due date in each successive month. In addition, a refund or credit shall be made of any interest imposed upon the claimant with respect to the amount being refunded or credited.

The interest shall be paid as follows:

(1) In the case of a refund, to the last day of the calendar month following the date upon which the claimant is notified in writing that a claim may be filed or the date upon which the claim is approved by the board, whichever date is the earlier.

(2) In the case of a credit, to the same date as that to which interest is computed on the tax or amount against which the credit is applied.

(b) This section shall become operative on July 1, 2011.

SEC. 113. Section 12984 of the Revenue and Taxation Code, as amended by Section 87 of Chapter 157 of the Statutes of 2009, is amended to read:

12984. (a) If the board determines that any overpayment has been made intentionally or made not incident to a bona fide and orderly discharge of a liability reasonably assumed by the insurer, surplus line broker, or Medi-Cal managed care plan to be imposed by law, no interest shall be allowed on the overpayment.

(b) If any insurer, surplus line broker, or Medi-Cal managed care plan which has filed a claim for refund requests the board to defer action on its claim, the board, as a condition to deferring action, may require the claimant to waive interest for the period during which the insurer, surplus line broker, or Medi-Cal managed care plan requests the board to defer action on the claim.

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

SEC. 114. Section 12984 of the Revenue and Taxation Code, as added by Section 88 of Chapter 157 of the Statutes of 2009, is amended to read:

12984. (a) If the board determines that any overpayment has been made intentionally or made not incident to a bona fide and orderly discharge of a liability reasonably assumed by the insurer or surplus line broker to be imposed by law, no interest shall be allowed on the overpayment.

(b) If any insurer or surplus line broker which has filed a claim for refund requests the board to defer action on its claim, the board, as a condition to deferring action, may require the claimant to waive interest for the period during which the insurer or surplus line broker requests the board to defer action on the claim.

(c) This section shall become operative on July 1, 2011.

SEC. 115. Section 13108 of the Revenue and Taxation Code, as amended by Section 89 of Chapter 157 of the Statutes of 2009, is amended to read:

13108. (a) A judgment shall not be rendered in favor of the plaintiff when the action is brought by or in the name of an assignee of the insurer paying the tax, interest, or penalties, or by any person other than the insurer or Medi-Cal managed care plan that has paid the tax, interest, or penalties.

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

SEC. 116. Section 13108 of the Revenue and Taxation Code, as added by Section 90 of Chapter 157 of the Statutes of 2009, is amended to read:

13108. (a) A judgment shall not be rendered in favor of the plaintiff when the action is brought by or in the name of an assignee of the insurer paying the tax, interest, or penalties, or by any person other than the insurer that has paid the tax, interest, or penalties.

(b) This section shall become operative on July 1, 2011.

SEC. 117. Section 4101.5 is added to the Welfare and Institutions Code, to read:

4101.5. (a) Notwithstanding any other law, the State Department of Mental Health may contract with providers of health care services and health care network providers, including, but not limited to, health plans, preferred provider organizations, and other health care network managers. Hospitals that do not contract with the department for emergency health care services shall provide these services to the department on the same basis as they are required to provide these services pursuant to Section 489.24 of Title 42 of the Code of Federal Regulations.

(b) The department may only reimburse a noncontract provider of hospital or physician services at a rate equal to or less than the amount payable under the Medicare Fee Schedule, regardless of whether the hospital is located within or outside of California. An entity that provides ambulance or any other emergency or nonemergency response service to the department, and that does not contract with the department for that service, shall be reimbursed for the service at the rate payable under the Medicare Fee Schedule, regardless of whether the provider is located within or outside of California.

(c) Until regulations or emergency regulations are adopted in accordance with subdivision (g), the department shall not reimburse a contract provider of hospital services at a rate that exceeds 130 percent of the amount payable under the Medicare Fee Schedule, a contract provider of physician services at a rate that exceeds 110 percent of the amount payable under the Medicare Fee Schedule, or a contract provider of ambulance services at a rate that exceeds 120 percent of the amount payable under the Medicare Fee Schedule. The maximum rates established by this subdivision shall not apply to reimbursement for administrative days, transplant services, services provided pursuant to competitively bid contracts, or services provided pursuant to a contract executed prior to September 1, 2009.

(d) The maximum rates set forth in this section shall not apply to contracts entered into through the department's designated health care network provider, if any. The rates for those contracts shall be negotiated at the lowest rate possible under the circumstances.

(e) The department and its designated health care network provider may enter into exclusive or nonexclusive contracts on a bid or negotiated basis for hospital, physician, and ambulance services contracts.

(f) The Director of Mental Health may adopt regulations to implement this section. The adoption, amendment, or repeal of a regulation authorized by this section is hereby exempted from 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).

(g) The Director of Mental Health may change the maximum rates set forth in this section by regulation or emergency regulation, adopted in accordance with the Administrative Procedure Act, but no sooner than 30 days after notification to the Joint Legislative Budget Committee. Those changes may include, but are not limited to, increasing or decreasing rates, or adding location-based differentials such as those provided to small and rural hospitals as defined in Section 124840 of the Health and Safety Code.

The adoption, amendment, repeal, or readoption of a regulation authorized by this subdivision is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the director is hereby exempted for this purpose from the requirements of subdivision (b) of Section 11346.1 of the Government Code.

(h) For persons who are transferred from the Department of Corrections and Rehabilitation to, or are housed in, a state hospital or psychiatric program under the jurisdiction of the State Department of Mental Health, and while these persons remain under the jurisdiction of the Department of Corrections and Rehabilitation as inmates or parolees, health care or emergency services provided for these persons outside of a State Department of Mental Health state hospital or psychiatric program shall continue to be paid for or reimbursed by the Department of Corrections and Rehabilitation in accordance with Section 5023.5 of the Penal Code.

SEC. 118. Section 4474.2 of the Welfare and Institutions Code is amended to read:

4474.2. (a) Notwithstanding any provision of law to the contrary, the department may operate any facility, provide its employees to assist in the operation of any facility, or provide other necessary services and supports if, in the discretion of the department, it determines that the activity will assist in meeting the goal of the orderly closures of Agnews Developmental Center and Lanterman Developmental Center. The department may contract with any entity for the use of the department's employees to provide services in furtherance of the orderly closures of Agnews Developmental Center and Lanterman Developmental Center. For the Lanterman Developmental Center, the use of department employees is in effect for up to two years following the transfer of the last resident of the Lanterman Developmental Center, unless a later enacted statute deletes or extends this provision.

(b) The department shall prepare a report on the use of the department's employees in providing services in the community to assist in the orderly closures of Agnews Developmental Center and Lanterman Developmental Center. The report shall include data on the number and classification of state employees working in the community program. The report shall be submitted with the Governor's proposed budget for the 2012–13 fiscal year to the fiscal committees of both houses of the Legislature and annually thereafter.

SEC. 119. Section 4474.3 of the Welfare and Institutions Code is amended to read:

4474.3. The provisions of Section 10411 of the Public Contract Code shall not apply to any person who, in connection with the closures of Agnews Developmental Center or Lanterman Developmental Center, provides developmental services.

SEC. 120. Section 4474.4 of the Welfare and Institutions Code is amended to read:

4474.4. Notwithstanding any other provision of law to the contrary, the Secretary of California Health and Human Services shall verify that the State Department of Developmental Services and the State Department of

Health Care Services have established protocols in place between the departments, as well as with the regional centers and health care plans participating in the Medi-Cal program who will be providing services, including health, dental, and vision care, to people with developmental disabilities transitioning from Agnews Developmental Center and Lanterman Developmental Center.

The Secretary of California Health and Human Services shall provide written verification of the establishment of these protocols to the Joint Legislative Budget Committee, as well as to the fiscal and policy committees of the Legislature that oversee health and human services programs.

The purpose of the protocols is to ensure that a mutual goal of providing appropriate, high-quality care and services to children and adults who have developmental disabilities in order to optimize the health and welfare of each individual. Further, the purpose of the protocols is to ensure that all involved parties, including consumers and families, the state, regional centers, and providers, are clear as to their roles and responsibilities, and are appropriately accountable for optimizing the health and welfare of each individual.

The protocols, at a minimum, shall address enrollment for services, all referral practices, including those to specialty care, authorization practices for services of all involved parties, coordination of case management services, education and training services to be provided, the management of medical records, and provider reimbursement methods. These protocols shall be provided to the consumers and their families, and be made available to the public upon request.

SEC. 121. Section 4474.5 of the Welfare and Institutions Code is amended to read:

4474.5. (a) In order to meet the unique medical health needs of consumers transitioning from Agnews Developmental Center into Alameda, San Mateo, and Santa Clara Counties pursuant to the Plan for the Closure of Agnews Developmental Center, and consumers transitioning from Lanterman Developmental Center into various health plans, whose individual program plans document the need for coordinated medical and specialty care that cannot be met using the traditional Medi-Cal fee-for-service system, services provided under the contract shall be provided by Medi-Cal managed care health plans that are currently operational in these counties as a county organized health system or a local initiative if consumers, where applicable, choose to enroll. Reimbursement shall be by the State Department of Health Care Services for all Medi-Cal services provided under the contract that are not reimbursed by the Medicare Program.

(b) Medi-Cal managed care health plans enrolling members referred to in subdivision (a) shall be further reimbursed for the reasonable cost of administrative services. Administrative services pursuant to this subdivision include, but are not limited to, coordination of care and case management not provided by a regional center, provider credentialing and contracting, quality oversight, assuring member access to covered services, consultation with Agnews Developmental Center staff, Lanterman Developmental Center

staff, regional center staff, Department of Developmental Services staff, contractors, and family members, and financial management of the program, including claims processing. Reasonable cost is defined as the actual cost incurred by the Medi-Cal managed care health plan, including both direct and indirect costs incurred by the Medi-Cal managed care health plan, in the performance of administrative services, but shall not include any incurred costs found by the State Department of Health Care Services to be unnecessary for the efficient delivery of necessary health services. Payment for administrative services shall continue on a reasonable cost basis until sufficient cost experience exists to allow these costs to be part of an all-inclusive capitation rate covering both administrative services and direct patient care services.

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

(d) The State Department of Health Care Services shall seek any approval necessary for implementation of this section from the federal government, for purposes of federal financial participation under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.). Notwithstanding any other provision of law, this section shall be implemented only to the extent that federal financial participation is available pursuant to necessary federal approvals.

SEC. 122. Section 4474.8 of the Welfare and Institutions Code is amended to read:

4474.8. Notwithstanding any other provision of law to the contrary, the State Department of Developmental Services shall continue the operation of the Agnews Outpatient Clinic and the Lanterman Outpatient Clinic until such time as the State Department of Developmental Services is no longer responsible for the property at the respective developmental center, as applicable.

SEC. 123. Section 4646.55 is added to the Welfare and Institutions Code, to read:

4646.55. (a) Notwithstanding any other provision of law or regulation to the contrary, and to the extent federal financial participation is available, effective July 1, 2007, the State Department of Developmental Services is hereby authorized to make supplemental payment to an enrolled Medi-Cal provider that is a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled, for day treatment and transportation services provided pursuant to Sections 4646 and 4646.5, applicable regulations, and Section 14132.925, to Medi-Cal beneficiaries residing in a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled. These payments shall be considered supplemental payments to the enrolled Medi-Cal provider and shall be comprised of the full costs of reimbursing regional centers for making disbursements to day treatment and transportation service providers, plus a coordination fee which will include an administrative fee and reimbursement for the increased costs associated with the quality assurance fee paid accordingly and without a separate State Department of Developmental Services contract.

(b) Notwithstanding any other provision of law and to the extent federal financial participation is available, and in furtherance of this section and Section 14132.925, the State Department of Developmental Services shall amend the regional center contracts for the 2007–08 fiscal year to extend the contract liquidation period until June 30, 2011. The contract amendments and budget adjustments shall be exempt from the provisions of Article 1 (commencing with Section 4620).

SEC. 124. The heading of Article 3.5 (commencing with Section 4684.50) of Chapter 6 of Division 4.5 of the Welfare and Institutions Code is amended to read:

Article 3.5. Adult Residential Facilities for Persons with Special Health Care Needs

SEC. 125. Section 4684.50 of the Welfare and Institutions Code is amended to read:

4684.50. (a) (1) “Adult Residential Facility for Persons with Special Health Care Needs (ARFPSHN)” means any adult residential facility that provides 24-hour health care and intensive support services in a homelike setting that is licensed to serve up to five adults with developmental disabilities as defined in Section 4512.

(2) For purposes of this article, an ARFPSHN may only be established in a facility approved pursuant to Section 4688.5 or through an approved regional center community placement plan pursuant to Section 4418.25.

(b) “Consultant” means a person professionally qualified by training and experience to give expert advice, information, training, or to provide

health-related assessments and interventions specified in a consumer's individual health care plan.

(c) "Direct care personnel" means all personnel who directly provide program or nursing services to consumers. Administrative and licensed personnel shall be considered direct care personnel when directly providing program or nursing services to clients. Consultants shall not be considered direct care personnel.

(d) "Individual health care plan" means the plan that identifies and documents the health care and intensive support service needs of a consumer.

(e) "Individual health care plan team" means those individuals who develop, monitor, and revise the individual health care plan for consumers residing in an Adult Residential Facility for Persons with Special Health Care Needs. The team shall, at a minimum, be composed of all of the following individuals:

(1) Regional center service coordinator and other regional center representative, as necessary.

(2) Consumer, and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative.

(3) Consumer's primary care physician, or other physician as designated by the regional center.

(4) ARFPSHN administrator.

(5) ARFPSHN registered nurse.

(6) Others deemed necessary for developing a comprehensive and effective plan.

(f) "Intensive support needs" means the consumer requires physical assistance in performing four or more of the following activities of daily living:

(1) Eating.

(2) Dressing.

(3) Bathing.

(4) Transferring.

(5) Toileting.

(6) Continence.

(g) "Special health care needs" means the consumer has health conditions that are predictable and stable, as determined by the individual health care plan team, and for which the individual requires nursing supports for any of the following types of care:

(1) Nutrition support, including total parenteral feeding and gastrostomy feeding, and hydration.

(2) Cardiorespiratory monitoring.

(3) Oxygen support, including continuous positive airway pressure and bilevel positive airway pressure, and use of other inhalation-assistive devices.

(4) Nursing interventions for tracheostomy care and suctioning.

(5) Nursing interventions for colostomy, ileostomy, or other medical or surgical procedures.

(6) Special medication regimes including injection and intravenous medications.

(7) Management of insulin-dependent diabetes.
(8) Manual fecal impaction, removal, enemas, or suppositories.
(9) Indwelling urinary catheter/catheter procedure.
(10) Treatment for staphylococcus infection.
(11) Treatment for wounds or pressure ulcers (stages 1 and 2).
(12) Postoperative care and rehabilitation.
(13) Pain management and palliative care.
(14) Renal dialysis.

SEC. 126. Section 4684.53 of the Welfare and Institutions Code is amended to read:

4684.53. (a) The State Department of Developmental Services and the State Department of Social Services shall jointly implement a licensing program to provide special health care and intensive support services to adults in homelike community settings.

(b) The pilot project shall be implemented through the following regional centers only:

(1) The San Andreas Regional Center.
(2) The Regional Center of the East Bay.
(3) The Golden Gate Regional Center.
(4) All regional centers involved in the closure of the Lanterman Developmental Center, as determined by the State Department of Developmental Services.

(c) Each ARFPSHN shall possess a community care facility license issued pursuant to Article 9 (commencing with Section 1567.50) of Chapter 3 of Division 2 of the Health and Safety Code, and shall be subject to the requirements of Chapter 1 (commencing with Section 80000) of Division 6 of Title 22 of the California Code of Regulations, except for Article 8 (commencing with Section 80090).

(d) For purposes of this article, a health facility licensed pursuant to subdivision (e) or (h) of Section 1250 may place its licensed bed capacity in voluntary suspension for the purpose of licensing the facility to operate an ARFPSHN if the facility is selected to participate pursuant to Section 4684.58. Consistent with subdivision (a) of Section 4684.50, any facility licensed pursuant to this section shall serve up to five adults. A facility's bed capacity shall not be placed in voluntary suspension until all consumers residing in the facility under the license to be suspended have been relocated. No consumer may be relocated unless it is reflected in the consumer's individual program plan developed pursuant to Sections 4646 and 4646.5.

(e) Each ARFPSHN shall be subject to the requirements of Subchapters 5 through 9 of Chapter 1 of, and Subchapters 2 and 4 of Chapter 3 of, Division 2 of Title 17 of the California Code of Regulations.

(f) Each ARFPSHN shall ensure that an operable automatic fire sprinkler system is installed and maintained.

(g) Each ARFPSHN shall have an operable automatic fire sprinkler system that is approved by the State Fire Marshal and that meets the National Fire Protection Association (NFPA) 13D standard for the installation of sprinkler systems in single- and two-family dwellings and manufactured

homes. A local jurisdiction shall not require a sprinkler system exceeding this standard by amending the standard or by applying standards other than NFPA 13D. A public water agency shall not interpret this section as changing the status of a facility from a residence entitled to residential water rates, nor shall a new meter or larger connection pipe be required of the facility.

(h) Each ARFPSHN shall provide an alternative power source to operate all functions of the facility for a minimum of six hours in the event the primary power source is interrupted. The alternative power source shall comply with the manufacturer's recommendations for installation and operation. The alternative power source shall be maintained in safe operating condition, and shall be tested every 14 days under the full load condition for a minimum of 10 minutes. Written records of inspection, performance, exercising period, and repair of the alternative power source shall be regularly maintained on the premises and available for inspection by the State Department of Developmental Services.

SEC. 127. Section 4684.55 of the Welfare and Institutions Code is amended to read:

4684.55. (a) No regional center may pay a rate to any ARFPSHN for any consumer that exceeds the rate in the State Department of Developmental Services' approved community placement plan for that facility unless the regional center demonstrates that a higher rate is necessary to protect a consumer's health and safety, and the department has granted prior written authorization.

(b) The payment rate for ARFPSHN services shall be negotiated between the regional center and the ARFPSHN, and shall be paid by the regional center under the service code "Specialized Residential Facility (Habilitation)."

(c) The established rate for a full month of service shall be made by the regional center when a consumer is temporarily absent from the ARFPSHN 14 days or less per month. When the consumer's temporary absence is due to the need for inpatient care in a health facility, as defined in subdivision (a), (b), or (c) of Section 1250 of the Health and Safety Code, the regional center shall continue to pay the established rate as long as no other consumer occupies the vacancy created by the consumer's temporary absence, or until the individual health care plan team has determined that the consumer will not return to the facility. In all other cases, the established rate shall be prorated for a partial month of service by dividing the established rate by 30.44 then by multiplying the quotient by the number of days the consumer resided in the facility.

SEC. 128. Section 4684.58 of the Welfare and Institutions Code is amended to read:

4684.58. (a) The regional center may recommend for participation, to the State Department of Developmental Services, an applicant to provide services as part of an approved community placement plan when the applicant meets all of the following requirements:

(1) The applicant employs or contracts with a program administrator who has a successful record of administering residential services for at least

two years, as evidenced by substantial compliance with the applicable state licensing requirements.

(2) The applicant prepares and submits, to the regional center, a complete facility program plan that includes, but is not limited to, all of the following:

(A) The total number of the consumers to be served.

(B) A profile of the consumer population to be served, including their health care and intensive support needs.

(C) A description of the program components, including a description of the health care and intensive support services to be provided.

(D) A week's program schedule, including proposed consumer day and community integration activities.

(E) A week's proposed program staffing pattern, including licensed, unlicensed, and support personnel and the number and distribution of hours for such personnel.

(F) An organizational chart, including identification of lead and supervisory personnel.

(G) The consultants to be utilized, including their professional disciplines and hours to be worked per week or month, as appropriate.

(H) The plan for accessing and retaining consultant and health care services, including assessments, in the areas of physical therapy, occupational therapy, respiratory therapy, speech pathology, audiology, pharmacy, dietary/nutrition, dental, and other areas required for meeting the needs identified in consumers' individual health care plans.

(I) A description, including the size, layout, location, and condition of the proposed home.

(J) A description of the equipment and supplies available, or to be obtained, for programming and care.

(K) The type, location, and response time of emergency medical service personnel.

(L) The in-service training program plan for at least the next 12 months, which shall include the plan for ensuring that the direct care personnel understands their roles and responsibilities related to implementing individual health care plans, prior to, or within, the first seven days of providing direct care in the home and for ensuring the administrator understands the unique roles, responsibilities, and expectations for administrators of community-based facilities.

(M) The plan for ensuring that outside services are coordinated, integrated, and consistent with those provided by the ARFPSHN.

(N) Written certification that an alternative power system required by subdivision (g) of Section 4684.53 meets the manufacturer's recommendations for installation and operation.

(3) Submits a proposed budget itemizing direct and indirect costs, total costs, and the rate for services.

(4) The applicant submits written certification that they have the ability to comply with all of the requirements of Section 1520 of the Health and Safety Code.

(b) The regional center shall provide all documentation specified in paragraphs (2) to (4), inclusive, of subdivision (a) and a letter recommending program certification to the State Department of Developmental Services.

(c) The State Department of Developmental Services shall either approve or deny the recommendation and transmit its written decision to the regional center and to the State Department of Social Services within 30 days of its decision. The decision of the State Department of Developmental Services not to approve an application for program certification shall be the final administrative decision.

(d) Any change in the ARFPSHN operation that alters the contents of the approved program plan shall be reported to the State Department of Developmental Services and the contracting regional center, and approved by both agencies, prior to implementation.

SEC. 129. Section 4684.60 of the Welfare and Institutions Code is amended to read:

4684.60. The vendoring regional center shall, before placing any consumer into an ARFPSHN, ensure that the ARFPSHN has a license issued by the State Department of Social Services for not more than five adults and a contract with the regional center that includes, at a minimum, all of the following:

(a) The names of the regional center and the licensee.

(b) A requirement that the contractor shall comply with all applicable statutes and regulations, including Section 4681.1.

(c) The effective date and termination date of the contract.

(d) The definition of terms.

(e) A requirement that the execution of any amendment or modification to the contract be in accordance with all applicable federal and state statutes and regulations and be by mutual agreement of both parties.

(f) A requirement that the licensee and the agents and employees of the licensee, in the performance of the contract, shall act in an independent capacity, and not as officers or employees or agents of the regional center.

(g) A requirement that the assignment of the contract for consumer services shall not be allowed.

(h) The rate of payment per consumer.

(i) Incorporation, by reference, of the ARFPSHN's approved program plan.

(j) A requirement that the contractor verify, and maintain for the duration of the project, possession of commercial general liability insurance in the amount of at least one million dollars ($1,000,000) per occurrence.

(k) Contractor performance criteria.

SEC. 130. Section 4684.63 of the Welfare and Institutions Code is amended to read:

4684.63. (a) Each ARFPSHN shall do all of the following:

(1) Meet the minimum requirements for a Residential Facility Service Level 4-i pursuant to Sections 56004 and 56013 of Title 17 of the California Code of Regulations, and ensure that all of the following conditions are met:

(A) That a licensed registered nurse, licensed vocational nurse, or licensed psychiatric technician, is awake and on duty 24-hours per day, seven days per week.

(B) That a licensed registered nurse is awake and on duty at least eight hours per person, per week.

(C) That at least two staff on the premises are awake and on duty when providing care to four or more consumers.

(2) Ensure the consumer remains under the care of a physician at all times and is examined by the primary care physician at least once every 60 days, or more often if required by the consumer's individual health care plan.

(3) Ensure that an administrator is on duty at least 20 hours per week to ensure the effective operation of the ARFPSHN.

(4) Ensure that the administrator completes the 35-hour administrator certification program pursuant to paragraph (1) of subdivision (c) of Section 1562.3 of the Health and Safety Code without exception, has at least one year of administrative and supervisory experience in a licensed residential program for persons with developmental disabilities, and is one or more of the following:

(A) A licensed registered nurse.

(B) A licensed nursing home administrator.

(C) A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities.

(D) An individual with a bachelors degree or more advanced degree in the health or human services field and two years experience working in a licensed residential program for persons with developmental disabilities and special health care needs.

(b) The regional center shall require an ARFPSHN to provide additional professional, administrative, or supportive personnel whenever the regional center determines, in consultation with the individual health care plan team, that additional personnel are needed to provide for the health and safety of consumers.

(c) An ARFPSHN shall ensure that all direct care personnel complete the training requirements specified in Section 4695.2.

SEC. 131. Section 4684.65 of the Welfare and Institutions Code is amended to read:

4684.65. (a) A regional center shall not place, or fund the placement for, any consumer in an ARFPSHN until the individual health care plan team has prepared a written individual health care plan that can be fully and immediately implemented upon the consumer's placement.

(b) (1) An ARFPSHN shall only accept, for initial admission, consumers who meet the following requirements:

(A) Reside at Lanterman Developmental Center at the time of the proposed placement.

(B) Have an individual program plan that specifies placement in an ARFPSHN.

(C) Have special health care and intensive support needs.

(2) Except as provided in paragraph (3), when a vacancy in an ARFPSHN occurs due to the permanent relocation or death of a resident, the vacancy may only be filled by a consumer who meets the requirements of paragraph (1).

(3) If there is no resident residing in a developmental center who meets the requirements of subparagraphs (B) and (C) of paragraph (1), a vacancy may be filled by a consumer who is at risk of placement into a developmental center, as determined by the regional center, and who meets the requirements of subparagraphs (B) and (C) of paragraph (1).

(c) The ARFPSHN shall not admit a consumer if the individual health care plan team determines that the consumer is likely to exhibit behaviors posing a threat of substantial harm to others, or has a serious health condition that is unpredictable or unstable. A determination that the individual is a threat to others may only be based on objective evidence or recent behavior and a determination that the threat cannot be mitigated by reasonable interventions.

SEC. 132. Section 4684.70 of the Welfare and Institutions Code is amended to read:

4684.70. (a) The State Department of Social Services, in administering the licensing program, shall not have any responsibility for evaluating consumers' level of care or health care provided by ARFPSHN. Any suspected deficiencies in a consumer's level of care or health care identified by the State Department of Social Services' personnel shall be reported immediately to the appropriate regional center and the State Department of Developmental Services for investigation.

(b) The regional center shall have responsibility for monitoring and evaluating the implementation of the consumer's individual plan objectives, including, but not limited to, the health care and intensive support service needs identified in the consumer's individual health care plan and the consumer's integration and participation in community life.

(c) For each consumer placed in an ARFPSHN, the regional center shall assign a service coordinator pursuant to subdivision (b) of Section 4647.

(d) A regional center licensed registered nurse shall visit, with or without prior notice, the consumer, in person, at least monthly in the ARFPSHN, or more frequently if specified in the consumer's individual health care plan. At least four of these visits, annually, shall be unannounced.

(e) The State Department of Developmental Services shall monitor and ensure the regional centers' compliance with the requirements of this article. The monitoring shall include onsite visits to all the ARFPSHNs at least every six months.

SEC. 133. Section 4684.74 of the Welfare and Institutions Code is repealed.

SEC. 134. Section 4684.74 is added to the Welfare and Institutions Code, to read:

4684.74. The State Department of Developmental Services shall only approve the development of Adult Residential Facilities for Persons with Special Health Care Needs (ARFPSHNs) that are directly associated with

the orderly closure of the Lanterman Developmental Center, unless a later enacted statute deletes or extends this provision.

SEC. 135. Section 4684.75 of the Welfare and Institutions Code is amended to read:

4684.75. (a) The State Department of Developmental Services may adopt emergency regulations to implement this article. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the State Department of Developmental Services is hereby exempted from the requirement that it describe specific facts showing the need for immediate action. A certificate of compliance for these implementing regulations shall be filed within 24 months following the adoption of the first emergency regulations filed pursuant to this section.

(b) This article shall only be implemented to the extent that funds are made available through an appropriation in the annual Budget Act.

SEC. 136. Section 4701.1 is added to the Welfare and Institutions Code, to read:

4701.1. Adequate notice, as defined by Section 4701, shall inform the recipient and authorized representative of both of the following:

(a) Whether or not the individual is eligible for an exemption or exception to the action the service agency proposes to take as specified in subparagraph (D) of paragraph (6) of subdivision (a) of Section 4648, subdivision (d) of Section 4648.35, subdivision (c) of Section 4648.5, subdivision (d) of Section 4659, subparagraph (A) of paragraph (3) of subdivision (a) of Section 4686.5, subdivision (i) of Section 4689, and subdivisions (a) and (d) of Section 4689.05, subdivision (b) of Section 95004 of the Government Code, and paragraph (3) of subdivision (e) of Section 95020 of the Government Code.

(b) The specific law supporting any of the above-specified exemptions or exceptions.

SEC. 137. Section 4791 is added to the Welfare and Institutions Code, to read:

4791. (a) Notwithstanding any other provision of law or regulation, between July 1, 2010, and June 30, 2011, inclusive, regional centers may temporarily modify personnel requirements, functions, or qualifications, or staff training requirements for providers, except for licensed or certified residential providers, whose payments are reduced by 4.25 percent pursuant to the amendments to Section 10 of Chapter 13 of the Third Extraordinary Session of the Statutes of 2009, as contained in Section 164 of the act that adds this section.

(b) A temporary modification pursuant to subdivision (a), effective during any agreed upon period of time between July 1, 2010, and June 30, 2011, inclusive, may only be approved when the regional center determines that the change will not do any of the following:

(1) Adversely affect the health and safety of a consumer receiving services or supports from the provider.

(2) Result in a consumer receiving services in a more restrictive environment.

(3) Negatively impact the availability of federal financial participation.

(4) Violate any state licensing or labor laws or other provisions of Title 17 of the California Code of Regulations not eligible for modification pursuant to this section.

(c) A temporary modification pursuant to subdivision (a) shall be described in a written services contract between the regional center purchasing the services and the provider, and a copy of the written services contract and any related documentation shall be retained by the provider and the regional center purchasing the services from the provider.

(d) Notwithstanding any other provision of law or regulation, the department shall suspend, from July 1, 2010, to June 30, 2011, inclusive, the requirements described in Sections 56732 and 56800 of Title 17 of the California Code of Regulations requiring community-based day programs and in-home respite agencies to conduct annual reviews and to submit written reports to vendoring regional centers, user regional centers, and the department.

(e) Notwithstanding any other provision of law or regulation, from July 1, 2010, to June 30, 2011, inclusive, a residential service provider, vendored by a regional center and whose payment is reduced by 4.25 percent pursuant to the amendments to Section 10 of Chapter 13 of the Third Extraordinary Session of the Statutes of 2009, as contained in Section 163 of the act that adds this section, shall not be required to complete quarterly and semiannual progress reports required in subdivisions (b) and (c) of Section 56026 of Title 17 of the California Code of Regulations. During program review, the provider shall inform the regional center case manager of the consumer's progress and any barrier to the implementation of the individual program plan for each consumer residing in the residence.

SEC. 138. Section 5370.2 of the Welfare and Institutions Code is amended to read:

5370.2. (a) Beginning January 1, 1996, the State Department of Mental Health shall contract with a single nonprofit agency that meets the criteria specified in subdivision (b) of Section 5510 to conduct the following activities:

(1) Provide patients' rights advocacy services for, and conduct investigations of alleged or suspected abuse and neglect of, including deaths of, persons with mental disabilities residing in state hospitals.

(2) Investigate and take action as appropriate and necessary to resolve complaints from or concerning recipients of mental health services residing in licensed health or community care facilities regarding abuse, and unreasonable denial, or punitive withholding of rights guaranteed under this division that cannot be resolved by county patients' rights advocates.

(3) Provide consultation, technical assistance, and support to county patients' rights advocates in accordance with their duties under Section 5520.

(4) Conduct program review of patients' rights programs.

(b) The services shall be provided in coordination with the appropriate mental health patients' rights advocates.

(c) (1) The contractor shall develop a plan to provide patients' rights advocacy services for, and conduct investigations of alleged or suspected abuse and neglect of, including the deaths of, persons with mental disabilities residing in state hospitals.

(2) The contractor shall develop the plan in consultation with the statewide organization of mental health patients' rights advocates, the statewide organization of mental health clients, and the statewide organization of family members of persons with mental disabilities, and the statewide organization of county mental health directors.

(3) In order to ensure that persons with mental disabilities have access to high quality advocacy services, the contractor shall establish a grievance procedure and shall advise persons receiving services under the contract of the availability of other advocacy services, including services provided by the protection and advocacy agency specified in Section 4901 and the county patients' rights advocates specified in Section 5520.

(d) Nothing contained in this section shall be construed to restrict or limit the authority of the department to conduct the reviews and investigations it deems necessary for personnel, criminal, and litigation purposes.

(e) The State Department of Mental Health shall contract on a multiyear basis for a contract term of up to five years.

SEC. 139. Section 5813.6 is added to the Welfare and Institutions Code, to read:

5813.6. (a) At the time of the release of the January 10 budget plan and the May Revision, the Director of Mental Health shall submit to the Legislature information regarding the projected expenditure of Proposition 63 funding for each state department, and for each major program category specified in the measure, for local assistance. This shall include actual past-year expenditures, estimated current-year expenditures, and projected budget-year expenditures of local assistance funding. In addition, it shall include a complete listing of state support expenditures for the current year and for the budget year by the State Department of Mental Health, including the number of state positions and any contract funds. A description of these state expenditures shall accompany the fiscal information the director is required to submit to the Legislature pursuant to this section.

(b) During each fiscal year, the Director of Mental Health shall submit to the fiscal committees of the Legislature, 30 days in advance, written notice of the intention to expend Proposition 63 local assistance funding in excess of the amounts presented in its May Revision projection for that fiscal year. The written notice shall include information regarding the amount of the additional spending and its purpose.

SEC. 140. Section 10022 of the Welfare and Institutions Code is amended to read:

10022. (a) Each publicly funded health care program, as defined in paragraph (1) of subdivision (b) of Section 10020, that furnishes or pays for health care items or services under this division to a person having private

health care coverage shall be entitled to be subrogated to the rights that person has against the carrier of the coverage to the extent of the health care items provided or services rendered.

(b) An entity providing private health care coverage, as defined in paragraph (2) of subdivision (b) of Section 10020, shall do all of the following:

(1) Accept the state's right of recovery and the assignment to the state of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the state plan.

(2) Respond to any inquiry by the state or a provider, as defined in subdivision (o) of Section 14043.1, including a billing agent or a billing agent of the provider, as defined in subdivision (a) of Section 14040.1, regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of that health care item or service.

(3) Agree not to deny a claim submitted by the state or a provider, as defined in paragraph (2), solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim if both of the following occur:

(A) The claim is submitted by the state or a provider, as defined in paragraph (2), within the three-year period beginning on the date on which the item or service was furnished.

(B) Any action by the state or a provider, as defined in paragraph (2), to enforce its rights with respect to that claim is commenced within six years of the state's or provider's submission of the claim.

SEC. 141. Section 14005.11 of the Welfare and Institutions Code is amended to read:

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

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

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

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

(e) For a Medi-Cal beneficiary who has a share of cost but who is ineligible for the assistance provided pursuant to subdivision (a), or who is ineligible for any other federally funded assistance for the payment of the

beneficiary's Medicare Part B premium, the department shall pay for the beneficiary's Medicare Part B premium in the month following each month that the beneficiary's share of cost has been met.

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

SEC. 142. Section 14005.25 of the Welfare and Institutions Code, as amended by Section 1 of Chapter 24 of the Third Extraordinary Session of the Statutes of 2009, is repealed.

SEC. 143. Section 14005.25 of the Welfare and Institutions Code, as amended by Section 2 of Chapter 24 of the Third Extraordinary Session of the Statutes of 2009, is amended to read:

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

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

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

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

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

SEC. 144. Section 14089 of the Welfare and Institutions Code is amended to read:

14089. (a) The purpose of this article is to provide a comprehensive program of managed health care plan services to Medi-Cal recipients residing in clearly defined geographical areas. It is, further, the purpose of this article to create maximum accessibility to health care services by permitting Medi-Cal recipients the option of choosing from among two or more managed health care plans or fee-for-service managed case arrangements, including, but not limited to, health maintenance organizations, prepaid health plans, and primary care case management plans. Independent practice associations, health insurance carriers, private foundations, and university medical centers systems, not-for-profit clinics, and other primary care providers, may be offered as choices to Medi-Cal recipients under this article if they are organized and operated as managed care plans, for the provision of preventive managed health care plan services.

(b) The department may seek proposals and then shall enter into contracts based on relative costs, extent of coverage offered, quality of health services to be provided, financial stability of the health care plan or carrier, recipient access to services, cost-containment strategies, peer and community participation in quality control, emphasis on preventive and managed health care services and the ability of the health plan to meet all requirements for both of the following:

(1) Certification, where legally required, by the Director of the Department of Managed Health Care and the Insurance Commissioner.

(2) Compliance with all of the following:

(A) The health plan shall satisfy all applicable state and federal legal requirements for participation as a Medi-Cal managed care contractor.

(B) The health plan shall meet any standards established by the department for the implementation of this article.

(C) The health plan receives the approval of the department to participate in the pilot project under this article.

(c) (1) (A) The proposals shall be for the provision of preventive and managed health care services to specified eligible populations on a capitated, prepaid, or postpayment basis.

(B) Enrollment in a Medi-Cal managed health care plan under this article shall be voluntary for beneficiaries eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).

(2) The cost of each program established under this section shall not exceed the total amount that the department estimates it would pay for all services and requirements within the same geographic area under the fee-for-service Medi-Cal program.

(d) (1) An eligible beneficiary shall be entitled to enroll in any health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides. The department shall make available to recipients information summarizing the benefits and limitations of each health care plan available pursuant to this section in the geographic area in which the recipient resides. A Medi-Cal or CalWORKs applicant or beneficiary shall be informed of the health care options available regarding methods of receiving Medi-Cal benefits. The county shall ensure that each beneficiary is informed of these options and informed that a health care options presentation is available.

(2) No later than 30 days following the date a Medi-Cal or CalWORKs recipient is informed of the health care options described in paragraph (1), the recipient shall indicate his or her choice, in writing, of one of the available health care plans and his or her choice of primary care provider or clinic contracting with the selected health care plan. Notwithstanding the 30-day deadline set forth in this paragraph, if a beneficiary requests a directory for the entire service area within 30 days of the date of receiving an enrollment form, the deadline for choosing a plan shall be extended an additional 30 days from the date of that request.

(3) The health care options information described in this subdivision shall include the following elements:

(A) Each beneficiary or eligible applicant shall be provided, at a minimum, with the name, address, telephone number, and specialty, if any, of each primary care provider, by specialty or clinic participating in each managed health care plan option through a personalized provider directory for that beneficiary or applicant. This information shall be presented under the geographic area designations by the name of the primary care provider and clinic, and shall be updated based on information electronically provided monthly by the health care plans to the department, setting forth changes in the health care plan provider network. The geographic areas shall be based on the applicant's residence address, the minor applicant's school address, the applicant's work address, or any other factor deemed appropriate by the department, in consultation with health plan representatives, legislative staff, and consumer stakeholders. In addition, directories of the entire service area, including, but not limited to, the name, address, and telephone number of each primary care provider and hospital, of all Geographic Managed Care health plan provider networks shall be made available to beneficiaries or applicants who request them from the health care options contractor. Each personalized provider directory shall include information regarding the availability of a directory of the entire service area, provide telephone numbers for the beneficiary to request a directory of the entire service area, and include a postage-paid mail card to send for a directory of the entire service area. The personalized provider directory shall be implemented as a pilot project in Sacramento County pursuant to this article, and in Los Angeles County (Two-Plan Model) pursuant to Article 2.7 (commencing with Section 14087.305). The content, form, and geographic areas used shall be determined by the department in consultation with a workgroup to include health plan representatives, legislative staff, and consumer stakeholders, with an emphasis on the inclusion of stakeholders from Los Angeles and Sacramento Counties. The personalized provider directories may include a section for each health plan. Prior to implementation of the pilot project, the department, in consultation with consumer stakeholders, legislative staff, and health plans, shall determine the parameters, methodology, and evaluation process of the pilot project. The pilot project shall thereafter be in effect for a minimum of two years. Three months prior to the end of the first two years of the pilot project, the department shall promptly provide the fiscal and policy committees of the Legislature with an evaluation of the personalized provider directory pilot project and its impact on the Medi-Cal managed care program, including whether the pilot project resulted in a reduction of default assignments and a more informed choice process for beneficiaries, and its overall cost-benefit to the state. Following two years of operation as a pilot project in two counties and submission of the evaluation to the Legislature, the department, in consultation with consumer stakeholders, legislative staff, and health plans, shall determine whether to implement personalized provider directories as a permanent program statewide. This determination shall be based on the

outcomes set forth in the evaluation provided to the Legislature. If necessary, the pilot project shall continue beyond the initial two-year period until this determination is made. This pilot project shall only be implemented to the extent that it is budget neutral to the department.

(B) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider or clinic contracting with any of the health plans available and has the available capacity and agrees to continue to treat that beneficiary or eligible applicant.

(C) Each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, he or she shall be assigned to, and enrolled in, a health care plan.

(4) At the time the beneficiary or eligible applicant selects a health care plan, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider or clinic contracting with the selected health care plan.

(5) Commencing with the implementation of a geographic managed care project in a designated county, a Medi-Cal or CalWORKs beneficiary who does not make a choice of health care plans in accordance with paragraph (2), shall be assigned to and enrolled in an appropriate health care plan providing service within the area in which the beneficiary resides.

(6) If a beneficiary or eligible applicant does not choose a primary care provider or clinic, or does not select a primary care provider who is available, the health care plan selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.

(7) A Medi-Cal or CalWORKs beneficiary dissatisfied with the primary care provider or health care plan shall be allowed to select or be assigned to another primary care provider within the same health care plan. In addition, the beneficiary shall be allowed to select or be assigned to another health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides in accordance with Section 1903(m)(2)(F)(ii) of the Social Security Act.

(8) The department or its contractor shall notify a health care plan when it has been selected by or assigned to a beneficiary. The health care plan that has been selected or assigned by a beneficiary shall notify the primary care provider that has been selected or assigned. The health care plan shall also notify the beneficiary of the health care plan and primary care provider selected or assigned.

(9) This section shall be implemented in a manner consistent with any federal waiver that is required to be obtained by the department to implement this section.

(e) A participating county may include within the plan or plans providing coverage pursuant to this section, employees of county government, and

others who reside in the geographic area and who depend upon county funds for all or part of their health care costs.

(f) Funds may be provided to prospective contractors to assist in the design, development, and installation of appropriate programs. The award of these funds shall be based on criteria established by the department.

(g) In implementing this article, the department may enter into contracts for the provision of essential administrative and other services. Contracts entered into under this subdivision may be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(h) Notwithstanding any other provision of law, on and after the effective date of the act adding this subdivision, the department shall have exclusive authority to set the rates, terms, and conditions of geographic managed care contracts and contract amendments under this article. As of that date, all references to this article to the negotiator or to the California Medical Assistance Commission shall be deemed to mean the department.

(i) Notwithstanding subdivision (q) of Section 6254 of the Government Code, a contract or contract amendments executed by both parties after the effective date of the act adding this subdivision shall be considered a public record for purposes of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and shall be disclosed upon request. This subdivision includes contracts that reveal the department's rates of payment for health care services, the rates themselves, and rate manuals.

SEC. 145. Section 14089.05 of the Welfare and Institutions Code is amended to read:

14089.05. (a) (1) The department may implement a multiplan project in the County of San Diego, upon approval of the Board of Supervisors of the County of San Diego, for the provision of benefits under this chapter to eligible Medi-Cal recipients. The multiplan project implemented in San Diego County pursuant to this section shall provide diagnostic, therapeutic, and preventive services provided under the Medi-Cal program, and additional benefits including, but not limited to, medical-related transportation, comprehensive patient management, and referral to other support services.

(2) The County of San Diego shall be eligible to receive funds transferred pursuant to paragraph (1) of subdivision (p) of Section 14163 for the development and implementation of this section. These funds in the amount allocated by the department for the County of San Diego shall be paid by the department upon the enactment of this section to the County of San Diego to reimburse a portion of the costs of the development of the project. To the full extent permitted by state and federal law, these funds shall be distributed by the department for expenditure by the County of San Diego in a manner that qualifies for federal financial participation under the Medicaid Program and the department shall expedite the payment of the federal funds to the County of San Diego. The department shall seek additional state, federal, and other funds to pay for costs that are incurred by the County of San Diego to develop the multiplan project in excess of

the payment required by this section, and the department shall assist the county in obtaining the additional funds.

(b) (1) The County of San Diego may establish two advisory boards, one of which shall be composed of consumer representatives and the other of which shall be composed of health care professional's representatives. Each board shall advise the Department of Health Services of the County of San Diego and review and comment on all aspects of the implementation of the multiplan project. At least one of the members of each advisory board shall be appointed by the board of supervisors. The board of supervisors shall establish a number of members to serve on each advisory board, with each supervisor to appoint an equal number of members from his or her district. Each advisory board shall vote on all pilot project policies and issues that are submitted to the board of supervisors.

(2) Notwithstanding any other provision of law, a member of an advisory board established pursuant to this section shall not be deemed to be interested in a contract entered into by the department within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code if the member is a Medi-Cal recipient or if all of the following apply:

(A) The member was appointed to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations.

(B) The contract authorizes the member or the organization the member represents to provide Medi-Cal services under the multiplan project.

(C) The contract contains substantially the same terms and conditions as contracts entered into with other individuals or organizations the member was appointed to represent.

(D) The member does not influence or attempt to influence the joint advisory board or another member of the joint advisory board to recommend that the department enter into the contract in which the member is interested.

(E) The member discloses the interest to the joint advisory board and abstains from voting on any recommendation on the contract.

(F) The advisory board notes the member's disclosure and abstention in its official records.

(3) Members of the advisory boards shall not be paid compensation for activities relating to their duties as members, but members who are Medi-Cal recipients shall be reimbursed an appropriate amount by the County of San Diego for travel and child care expenses incurred in performing their duties under this section.

(c) At the discretion of the department, the County of San Diego, the department, or other appropriate entities may perform any of the following in a manner that accomplishes the integration of the intake of eligible beneficiaries to the project, the assessment of beneficiary individual and family needs and circumstances, and the timely referral of beneficiaries to health care and other services to respond to their individual and family needs:

(1) Determine the eligibility of Medi-Cal applicants and recipients in a manner and environment that is accessible to the recipients and applicants.

(2) Perform enrollment activities in a manner that ensures that recipients be given the opportunity to select the provider of their choice in a manner and environment that is accessible to the recipients.

(3) The department may negotiate and amend its contract with the county to provide for specified quality improvement activities, and may require each of the health plans to participate in those activities. The department shall also participate in the county's quality improvement activities.

(d) Notwithstanding Section 14089 or any other provision of law, the County of San Diego, when contracting with the department pursuant to this section or subdivision (d), (i), or (j) of Section 14089, shall not be liable for damages for injury to persons or property arising out of the actions or inactions of the department, the department's other contractors, or providers of health care or other services, or Medi-Cal recipients. This section shall not relieve the County of San Diego from liability arising out of its actions or inactions.

(e) The County of San Diego, when contracting with the department pursuant to Section 14089 or this section, shall have no legal duty to provide health care or other services to Medi-Cal recipients, and shall have no financial responsibility for the department's other contractors or providers of health care or other services, except to the extent specifically set forth in contracts between the department and the county.

(f) Notwithstanding Section 14089.6, the department may terminate any existing managed care contract with either a prepaid health plan or a primary care case management plan for services in the County of San Diego in accordance with the terms and conditions set forth in the existing contract, at any time that the department determines that termination is in the best interest of the state. The department shall notify an existing prepaid health plan at least 90 days prior to termination. The department shall notify a primary care case management plan at least 30 days prior to termination.

(g) All contracts entered into by the department and the County of San Diego pursuant to Section 14089 or this section shall not be for the benefit of any third party, and no third-party beneficiary relationship shall be established between the county and any other party, except as may be specifically set forth in contracts between the department and the County of San Diego.

(h) The department shall report to the appropriate committees of the Legislature on the project implemented pursuant to this section.

(i) (1) For purposes of this section, "multiplan project" means a program authorized by this section in which a number of Knox-Keene licensed health plans designated by the county and approved by the department shall be the only Medi-Cal managed care health plans authorized to operate within San Diego County, with the exception of special projects approved by the department.

(2) Designated health plans shall include, but not be limited to, health plans sponsored by traditional Medi-Cal physicians, neighborhood health

centers, community clinics, health systems, including hospitals and other providers, or a combination thereof.

(3) Participating health plans shall first be designated by the county for approval by the department. Health plans approved by the department shall be eligible to contract with the department. Designation by the county and approval by the department provides the health plan only with the opportunity to compete for a contract and does not guarantee a contract with the state.

(4) Designation requirements imposed by the county shall not conflict with the requirements imposed by the department, the federal Medicaid Program, and the Medi-Cal program, and may not impose stricter requirements, without the department's approval, than those imposed by the department, the federal Medicaid Program, and the Medi-Cal program.

(5) Designation of health plans by the county will continue for the term of the Medi-Cal contract.

(j) Nothing in this section relieves the county of duties or liabilities imposed by Part 5 (commencing with Section 17000) or which it has assumed through contract with entities other than the department.

(k) Indian health facilities in San Diego County may contract directly with the department as Medi-Cal fee-for-service case management providers apart from the geographic managed care program or may participate in the network of one or more of the geographic managed care plans. Indian health service facilities that contract with the department as fee-for-service case management providers may enroll Medi-Cal recipients, including, but not limited to, recipients who are in any of the geographic managed care mandatory enrollment aid codes.

SEC. 146. Section 14089.4 of the Welfare and Institutions Code is amended to read:

14089.4. The department may consult with the Department of Insurance or the Department of Managed Health Care and shall consult with the Department of Justice Medi-Cal Fraud Unit, the appropriate licensing boards, and the laboratory field services unit of the department for the purposes of determining the qualifications, performance capability, and financial stability of prospective contractors.

SEC. 147. Section 14091.3 of the Welfare and Institutions Code is amended to read:

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

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

(2) "Medi-Cal managed care health plan" means an individual, organization, or entity operating under a Medi-Cal managed care plan

contract with the department under this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14590).

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

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

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

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

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

(d) Medi-Cal managed care health plans that, pursuant to the department's encouragement in All Plan Letter 07003, have been paying out-of-network hospitals the most recent California Medical Assistance Commission regional average per diem rate as a temporary rate for purposes of Section 1932(b)(2)(D) of the Social Security Act (SSA), which became effective January 1, 2007, shall make reconciliations and adjustments for all hospital payments made since January 1, 2007, based upon rates published by the department pursuant to Section 1932(b)(2)(D) of the SSA and effective January 1, 2007, to June 30, 2008, inclusive, and, if applicable, provide

supplemental payments to hospitals as necessary to make payments that conform with Section 1932(b)(2)(D) of the SSA. In order to provide managed care health plans with 60 working days to make any necessary supplemental payments to hospitals prior to these payments becoming subject to the payment of interest, Section 1300.71 of Title 28 of the California Code of Regulations shall not apply to these supplemental payments until 30 working days following the publication by the department of the rates.

(e) (1) The department shall provide a written report to the policy and fiscal committees of the Legislature on October 1, 2009, and May 1, 2010, on the implementation and impact made by this section, including the impact of these changes on access to hospitals by managed care enrollees and on contracting between hospitals and managed care health plans, including the increase or decrease in the number of these contracts.

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

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

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

SEC. 148. Section 14105.08 is added to the Welfare and Institutions Code, to read:

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

(b) Except as otherwise provided in this section, reimbursement rates applicable to radiology services shall not exceed 80 percent of the lowest

maximum allowance established under the federal Medicare Program for the same or similar services with dates of service on or after October 1, 2010.

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

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

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

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

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

SEC. 149. Section 14105.28 is added to the Welfare and Institutions Code, to read:

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

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

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

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

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

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

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

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

(8) Facilitation of improvement of quality and outcomes.

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

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

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

(ii) This section shall be implemented on the date that the replacement Medicaid Management Information System, described in subparagraph (C), becomes fully operational, but no later than June 30, 2014. The director shall execute a declaration stating the date on which the replacement system has become fully operational.

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

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

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

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

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

(C) Hospital case mix factors.

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

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

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

(G) The extent to which the particular grouping algorithm for the diagnosis-related groups accommodates ICD-10 diagnosis and procedure

codes, and applicable requirements of the federal Health Insurance Portability and Accountability Act of 1996.

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

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

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

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

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

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

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

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

(2) As an alternative to paragraph (1), and notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of

Division 3 of Title 2 of the Government Code, or any other provision of law, the department may implement and administer this section by means of provider bulletins, all-county letters, manuals, or other similar instructions, without taking regulatory action. The department shall notify the fiscal and appropriate policy committees of the Legislature of its intent to issue a provider bulletin, all-county letter, manual, or other similar instruction, at least five days prior to issuance. In addition, the department shall provide a copy of any provider bulletin, all-county letter, manual, or other similar instruction issued under this paragraph to the fiscal and appropriate policy committees of the Legislature.

SEC. 150. Section 14105.281 is added to the Welfare and Institutions Code, to read:

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

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

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

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

(3) The freeze shall remain in effect during the period of time supplemental payments are made under Article 5.21 (commencing with

Section 14167.1), and thereafter, to the extent that the rates, alone or in combination with any available supplemental payments, are consistent with federal law as provided in this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 151. Section 14105.456 is added to the Welfare and Institutions Code, to read:

14105.456. (a) For purposes of this section, the following definitions shall apply:

(1) “Generically equivalent drugs” means drug products with the same active chemical ingredients of the same strength, quantity, and dosage form, and of the same generic drug name, as determined by the United States

Adopted Names Council (USANC) and accepted by the federal Food and Drug Administration (FDA), as those drug products having the same chemical ingredients.

(2) "Legend drug" means any drug with a label that states "Caution: Federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(3) "Medicare rate" means the rate of reimbursement established by the Centers for Medicare and Medicaid Services for the Medicare Program.

(4) "Nonlegend drug" means any drug with a label that does not contain a statement referenced in paragraph (2).

(5) "Pharmacy rate of reimbursement" means the reimbursement to a Medi-Cal pharmacy provider pursuant to the provisions of paragraph (2) of subdivision (b) of Section 14105.45.

(6) "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.

(7) "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 at a rate not less than the Medicare rate.

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

(g) (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.

(h) 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. 152. Section 14126.022 is added to the Welfare and Institutions Code, 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) 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.

(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.

(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 (*l*), 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 (m), 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 for program activities pursuant to Chapter 11 (commencing with Section 9700) of Division 8.5.

(c) No appropriation associated with this bill 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 per patient per day requirements pursuant to Section 1276.5 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 per patient per day requirements pursuant to Section 1276.5 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 Section 100171 and 131071 of the Health and Safety Code shall 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) Nothing in this section shall 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 rate year:

(i) Immunization rates.

(ii) Facility acquired pressure ulcer incidence.

(iii) The use of physical restraints.

(iv) Compliance with the nursing hours per patient per day requirements pursuant to Section 1276.5 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 2012–13 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 2011–12 rate year.

(iii) The use of chemical restraints.

(j) 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.

(k) Beginning with the 2011–12 rate year, the department shall set aside 1 percent of the weighted average Medi-Cal reimbursement rate, from which the department shall transfer the General Fund portion into the Skilled Nursing Facility Quality and Accountability Special Fund.

(*l*) If this act is extended beyond the dates on which it becomes inoperative and is repealed, in accordance with Section 14126.033, beginning with the 2012–13 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) (1) Beginning with the 2011–12 rate year, the department shall pay a supplemental payment, by April 30, 2012, 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.

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

(3) Notwithstanding paragraph (1), if a facility appeals the performance measure of compliance with the nursing hours per patient per day requirements, pursuant to Section 1276.5 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, 2012, then on May 1, 2012, 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, 2011, to increase provider rates retroactively to August 1, 2011.

(n) 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.

(o) 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 shall be exempt from the requirements of the Public Contract Code, through December 31, 2012.

(p) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the following shall 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.

(q) Notwithstanding paragraph (1) of subdivision (m), 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 by the administrator of the federal Centers for Medicare and Medicaid Services, that any payments pursuant to subdivisions (a) and (m), 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 (a) of Section 14126.033 shall be reduced by the amounts described in subdivisions (j) and (k). For the 2012–13 rate year and for each subsequent rate year, any rate increase shall be reduced by the amounts described in subdivisions (j) and (*l*).

SEC. 153. Section 14126.023 of the Welfare and Institutions Code is amended to read:

14126.023. (a) The methodology developed pursuant to this article shall be facility specific and reflect the sum of the projected cost of each cost category and passthrough costs, as follows:

(1) Labor costs limited as specified in subdivisions (d) and (e).

(2) Indirect care nonlabor costs limited to the 75th percentile.

(3) (A) Administrative costs limited to the 50th percentile.

(B) Notwithstanding subparagraph (A), beginning with the 2010–11 rate year and in each subsequent rate year, the administrative cost category shall not include any legal and consultant fees in connection with a fair hearing or other litigation against or involving any governmental agency or department until all issues related to the fair hearing or litigation issues are ultimately decided or resolved.

(C) Notwithstanding subparagraph (A), beginning with the 2010–11 rate year and in each subsequent rate year, the department shall not allow any

cost associated with legal or consultant fees in connection with a fair hearing or other litigation against any governmental agency or department where any of the following apply:

(i) A decision has been rendered in favor of the governmental agency or department.

(ii) The determination of the governmental agency or department otherwise stands.

(iii) A settlement or similar resolution has been reached regarding any citation issued under subdivision (c), (d), or (e) of Section 1424 of the Health and Safety Code or regarding any remedy imposed under Subpart F of Part 489 of Title 42 of the Code of Federal Regulations.

(iv) A settlement or similar resolution has been reached under the provisions of Section 14123 or 14171.

(D) Facilities shall report supplemental data required to disallow costs described in subparagraph (C) in a format and by the deadline determined by the department.

(4) Capital costs based on a fair rental value system (FRVS) limited as specified in subdivision (f).

(5) (A) Direct passthrough of proportional Medi-Cal costs for property taxes, facility license fees, new state and federal mandates, caregiver training costs, and liability insurance projected on the prior year's costs.

(B) (i) Notwithstanding subparagraph (A), for the 2010–11 rate year and each rate year thereafter, professional liability insurance costs, including any insurance deductible costs paid by the facility, shall be limited to the 75th percentile computed on a specific geographic peer group basis.

(ii) Facilities shall report supplemental data described in this subparagraph in a format and by the deadline determined by the department, or the insurance deductible costs shall continue to be reimbursed in the administrative cost category.

(b) (1) The percentiles in paragraphs (1) through (3) of subdivision (a) shall be based on annualized costs divided by total resident days and computed on a specific geographic peer group basis. Costs within a specific cost category shall not be shifted to any other cost category.

(2) Notwithstanding paragraph (1), for the 2010–11 and 2011–12 rate years, the percentiles in paragraphs (1) to (5), inclusive, of subdivision (a) shall be based on annualized audited costs divided by total resident days and computed on a specific geographic peer group basis. Costs within a specific category shall not be shifted to any other cost category.

(c) (1) Facilities newly certified to participate in the Medi-Cal program shall receive a reimbursement rate based on the peer group weighted average Medi-Cal reimbursement rate. Facilities shall continue to receive the peer group weighted average Medi-Cal reimbursement rate until either of the following conditions is met:

(A) The department shall calculate the Freestanding Skilled Nursing Facility-B facility specific rate when a minimum of six months of Medi-Cal cost data has been audited. The facility specific rate shall be calculated

prospectively and shall be effective on August 1 of each rate year, pursuant to Section 14126.021.

(B) The department shall calculate the Freestanding Subacute Skilled Nursing Facility-B facility specific rate when a cost report with a minimum of 12 months of Medi-Cal cost data has been audited. The facility specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Section 14126.021.

(2) Facilities that have been decertified for less than six months and upon recertification shall continue to receive the facility per diem reimbursement rate in effect prior to decertification. Facilities shall continue to receive the facility per diem reimbursement rate until either of the following conditions is met:

(A) The department shall calculate the Freestanding Skilled Nursing Facility-B facility specific rate when a minimum of six months of Medi-Cal cost data has been audited. The facility specific rate based on the audited six months of Medi-Cal cost data shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Section 14126.021.

(B) The department shall calculate the Freestanding Subacute Skilled Nursing Facility-B facility specific rate when a cost report with a minimum of 12 months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Section 14126.021.

(3) Facilities that have been decertified for six months or longer and upon recertification shall receive a reimbursement rate based on the peer group weighted average Medi-Cal reimbursement rate. Facilities shall continue to receive the peer group weighted average Medi-Cal reimbursement rate until either of the following conditions is met:

(A) The department shall calculate the Freestanding Skilled Nursing Facility-B facility specific rate when a minimum of six months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Section 14126.021.

(B) The department shall calculate the Freestanding Subacute Skilled Nursing Facility-B facility specific rate when a cost report with a minimum of 12 months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Section 14126.021.

(4) Facilities that have a change of ownership or change of the licensed operator shall continue to receive the facility per diem reimbursement rate in effect with the previous owner. Facilities shall continue to receive the facility per diem reimbursement rate until either of the following conditions is met:

(A) The department shall calculate the Freestanding Skilled Nursing Facility-B facility specific rate when a minimum of six months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Section 14126.021.

(B) The department shall calculate the Freestanding Subacute Skilled Nursing Facility B facility-specific rate when a cost report with a minimum of 12 months of Medi-Cal cost data has been audited. The facility-specific rate shall be calculated prospectively and shall be effective on August 1 of each rate year, pursuant to Section 14126.021.

(5) This subdivision represents codification of existing rules promulgated by the department under the authority of Section 14126.027.

(d) The labor costs category shall be comprised of a direct resident care labor cost category, an indirect care labor cost category, and a labor-driven operating allocation cost category, as follows:

(1) Direct resident care labor cost category which shall include all labor costs related to routine nursing services including all nursing, social services, activities, and other direct care personnel. These costs shall be limited to the 90th percentile.

(2) Indirect care labor cost category which shall include all labor costs related to staff supporting the delivery of patient care including, but not limited to, housekeeping, laundry and linen, dietary, medical records, inservice education, and plant operations and maintenance. These costs shall be limited to the 90th percentile.

(3) Labor-driven operating allocation shall include an amount equal to 8 percent of labor costs, minus expenditures for temporary staffing, which may be used to cover allowable Medi-Cal expenditures. In no instance shall the operating allocation exceed 5 percent of the facility's total Medi-Cal reimbursement rate.

(e) Notwithstanding subdivision (d), beginning with the 2010–11 rate year and each rate year thereafter, the labor cost category shall not include the labor-driven operating allocation and shall be comprised only of a direct resident care labor cost category and an indirect care labor cost category.

(f) The capital cost category shall be based on a FRVS that recognizes the value of the capital related assets necessary to care for Medi-Cal residents. The capital cost category includes mortgage principal and interest, leases, leasehold improvements, depreciation of real property, equipment, and other capital related expenses. The FRVS methodology shall be based on the formula developed by the department that assesses facility value based on age and condition and uses a recognized market interest factor. Capital investment and improvement expenditures included in the FRVS formula shall be documented in cost reports or supplemental reports required by the department. The capital costs based on FRVS shall be limited as follows:

(1) For the 2005–06 rate year, the capital cost category for all facilities in the aggregate shall not exceed the department's estimated value for this cost category for the 2004–05 rate year.

(2) For the 2006–07 rate year and subsequent rate years, the maximum annual increase for the capital cost category for all facilities in the aggregate shall not exceed 8 percent of the prior rate year's FRVS cost component.

(3) If the total capital costs for all facilities in the aggregate for the 2005–06 rate year exceeds the value of the capital costs for all facilities in

the aggregate for the 2004–05 rate year, or if that capital cost category for all facilities in the aggregate for the 2006–07 rate year or any rate year thereafter exceeds 8 percent of the prior rate year's value, the department shall reduce the capital cost category for all facilities in equal proportion in order to comply with paragraphs (1) and (2).

(g) For the 2005–06 and 2006–07 rate years, the facility specific Medi-Cal reimbursement rate calculated under this article shall not be less than the Medi-Cal rate that the specific facility would have received under the rate methodology in effect as of July 31, 2005, plus Medi-Cal's projected proportional costs for new state or federal mandates for rate years 2005–06 and 2006–07, respectively.

(h) The department shall update each facility specific rate calculated under this methodology annually. The update process shall be prescribed in the Medicaid State Plan, regulations, and the provider bulletins or similar instructions described in Section 14126.027, and shall be adjusted in accordance with the results of facility specific audit and review findings in accordance with subdivisions (i), (j), and (k).

(i) (1) The department shall establish rates pursuant to this article on the basis of facility cost data reported in the integrated long-term care disclosure and Medi-Cal cost report required by Section 128730 of the Health and Safety Code for the most recent reporting period available, and cost data reported in other facility financial disclosure reports or supplemental information required by the department in order to implement this article.

(2) Notwithstanding paragraph (1), or any other provision of law, beginning with the 2010–11 and 2011–12 rate years, the department shall establish rates pursuant to this article on the basis of facility audited cost data reported in the integrated long-term care disclosure and Medi-Cal cost report described in Section 128730 of the Health and Safety Code and audited cost data reported in other facility financial disclosure reports or audited supplemental information required by the department in order to implement this article.

(3) Notwithstanding paragraph (1), or any other provision of law, beginning with the 2010–11 rate year and each rate year thereafter, the department may determine a facility ineligible to receive supplemental payments pursuant to Section 14126.022 if a facility fails to provide supplemental data as requested by the department.

(4) This subdivision represents codification of existing rules promulgated by the department under the authority of Section 14126.027.

(j) The department shall conduct financial audits of facility and home office cost data as follows:

(1) The department shall audit facilities a minimum of once every three years to ensure accuracy of reported costs.

(2) It is the intent of the Legislature that the department develop and implement limited scope audits of key cost centers or categories to assure that the rate paid in the years between each full scope audit required in paragraph (1) accurately reflects actual costs.

(3) For purposes of updating facility specific rates, the department shall adjust or reclassify costs reported consistent with applicable requirements of the Medicaid state plan as required by Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations.

(4) Overpayments to any facility shall be recovered in a manner consistent with applicable recovery procedures and requirements of state and federal laws and regulations.

(k) (1) On an annual basis, the department shall use the results of audits performed pursuant to subdivisions (i) and (j), the results of any federal audits, and facility cost reports, including supplemental reports of actual costs incurred in specific cost centers or categories as required by the department, to determine any difference between reported costs used to calculate a facility's rate and audited facility expenditures in the rate year.

(2) If the department determines that there is a difference between reported costs and audited facility expenditures pursuant to paragraph (1), the department shall adjust a facility's reimbursement prospectively over the intervening years between audits by an amount that reflects the difference, consistent with the methodology specified in this article.

(*l*) For nursing facilities that obtain an audit appeal decision that results in revision of the facility's allowable costs, the facility shall be entitled to seek a retroactive adjustment in its facility specific reimbursement rate.

(m) Except as provided in Section 14126.022, compliance by each facility with state laws and regulations regarding staffing levels shall be documented annually either through facility cost reports, including supplemental reports, or through the annual licensing inspection process specified in Section 1422 of the Health and Safety Code.

SEC. 154. Section 14126.027 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

(c) As an alternative to the adoption of regulations pursuant to subdivision (b), and notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this article, in whole or in part, by means of a provider bulletin or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, 2012. It is the intent that regulations adopted pursuant to subdivision (b) shall be in place on or before July 31, 2012.

SEC. 155. Section 14126.033 of the Welfare and Institutions Code is amended to read:

14126.033. (a) This article, including Section 14126.031, shall be funded as follows:

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

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

(B) Beginning with the 2006–07 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not exceed 5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

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

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

(3) (A) For the 2010–11 rate year, if the increase in the federal medical assistance percentage (FMAP) pursuant to the federal American Recovery

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) This article shall become inoperative after July 31, 2012, and as of January 1, 2013, is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 156. Section 14132 of the Welfare and Institutions Code is amended to read:

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

(a) Outpatient services are covered as follows:

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

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

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

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

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

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

department shall notify and consult with appropriate stakeholders in implementing, interpreting, or making specific this paragraph.

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

(4) (A) Nonlegend acetaminophen-containing products, with the exception of children's Tylenol, selected by the department are not covered benefits. For the purposes of this paragraph, nonlegend has the same meaning as defined in subdivision (a) of Section 14105.45.

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

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

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

(g) Blood and blood derivatives are covered.

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

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

(A) Periodontal treatment is not a benefit.

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

(C) Laboratory processed crowns are not a benefit.

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

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

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

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

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

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

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

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

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

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

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

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

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are

covered, subject to utilization controls, when either of the following criteria are met:

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

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

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

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

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

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

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

(2) All dental hygiene services provided by a registered dental hygienist in alternative practice pursuant to Sections 1768 and 1770 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist in alternative practice.

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

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

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

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

directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

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

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

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

(3) Physician fees for home visits.

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

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

(6) Medically related personal services.

(7) Home nursing education.

(8) Emergency maintenance repair.

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

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

(11) Emergency and nonemergency medical transportation.

(12) Medical supplies.

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

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

(15) Special drugs and medications.

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

(17) Therapy services.

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

(19) Modification of medical equipment for home use.

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

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

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

(t) Home- and community-based services approved by the United States Department of Health and Human Services may be covered to the extent

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

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

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

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

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

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

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

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

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

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

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

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United States Code, which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United States Code. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and Medicaid Services and only to the extent that federal financial participation is available for the services. Nothing in this section shall prohibit the department from seeking the Family PACT successor state plan amendment during the operation of the waiver.

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

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

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

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

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

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

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

of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

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

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

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

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

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

(xi) Possible contraceptive consequences and followup.

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

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

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

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

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

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

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

SEC. 157. Section 14132.925 is added to the Welfare and Institutions Code, to read:

14132.925. (a) (1) Notwithstanding any other provision of law or regulation to the contrary, to the extent federal financial participation is available, in furtherance of Section 14105.06 and subdivisions (a) and (c) of Section 14132.92, effective July 1, 2007, a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled shall be responsible for providing day treatment and transportation services consistent with Section 14105.06 and subdivision (a) of Section 14132.92, that are selected and authorized through the individual program plan process pursuant to Sections 4646 and 4646.5 and applicable regulations, for each beneficiary receiving those services who resides in that licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled.

(2) (A) The services described in paragraph (1) shall be arranged by the regional center pursuant to Sections 4646 and 4646.5 and applicable regulations.

(B) The licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled shall reimburse the regional center for the full costs of making the disbursements to day treatment and transportation service providers.

(3) Nothing in this section shall authorize the licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled to substitute day treatment or transportation services not selected and authorized through the individual program plan process pursuant to Sections 4646 and 4646.5 and applicable regulations.

(b) (1) The State Department of Developmental Services shall be responsible for reimbursing a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled for the costs of reimbursing the regional center for the full cost of making disbursements for day treatment and transportation services, plus a coordination fee which will include an administrative fee and reimbursement for increased costs associated with the quality assurance fee. This payment shall be a supplement to the Medi-Cal payment from the State Department of Health Care Services described in Sections 14105.06 and 14132.92.

(2) A licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally

disabled may authorize the regional center to invoice the State Department of Developmental Services on its behalf for the services described in subdivision (a).

(3) (A) The licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled shall reimburse the regional center for the full costs of making disbursements for day treatment and transportation services within 30 days of receipt of payment from the State Department of Developmental Services pursuant to instructions from the State Department of Developmental Services.

(B) If there is a failure to reimburse the regional center within 30 days of receipt of payment from the State Department of Developmental Services, for all or part of the costs associated with disbursement for day treatment and transportation services, the outstanding amount shall be recovered by any of the following methods:

(i) Lump sum payment by the provider.

(ii) Offset against current payments due to the provider from the State of California.

(iii) A repayment agreement between the provider and the State of California.

(c) (1) A licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled shall report the costs incurred pursuant to subdivision (a) according to instructions from the State Department of Health Care Services.

(2) 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 subdivision by means of a provider bulletin or similar instruction.

(d) (1) If the services meeting the conditions of subdivision (a) have been provided to a Medi-Cal beneficiary on or after July 1, 2007, and, notwithstanding Section 14115, a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled may authorize the regional center to invoice the State Department of Developmental Services on its behalf for arranging for the services described in subdivision (a). The licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled shall reimburse the regional center the full cost of making disbursements for day treatment and transportation services within 30 days of receipt of payment from the State Department of Developmental Services pursuant to instruction from the State Department of Developmental Services. If a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate

care facility/developmentally disabled fails to reimburse the regional center within 30 days of receipt of payment from the State Department of Developmental Services, for all or part of the costs associated with the day treatment and transportation services, the outstanding amount shall be recovered by any of the following methods:

(A) Lump sum payment by the provider.

(B) Offset against current payments due to the provider from the State of California.

(C) A repayment agreement between the provider and the State of California.

(2) The department shall seek federal financial participation, including any moneys available pursuant to the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), pursuant to a federally approved state plan amendment authorizing reimbursement for costs incurred pursuant to subdivision (a) for day treatment and transportation services provided on or after July 1, 2007.

(3) Upon approval of the state plan amendment, the reimbursement payments made pursuant to this section by the State Department of Developmental Services to a licensed intermediate care facility/developmentally disabled-habilitative, licensed intermediate care facility/developmentally disabled-nursing, or licensed intermediate care facility/developmentally disabled shall be subject to the quality assurance fee imposed upon designated intermediate care facilities pursuant to Article 7.5 (commencing with Section 1324) of Chapter 2 of Division 2 of the Health and Safety Code.

(4) If federal financial participation is not made available for day treatment and transportation services provided on or after July 1, 2007, the services nonetheless shall be reimbursed from the General Fund by the State Department of Developmental Services.

(e) The State Department of Health Care Services shall request approval from the federal Centers for Medicare and Medicaid Services for the implementation of this section. The Director of Health Care Services, with the concurrence of the Director of Developmental Services, may alter the methodology specified in this section to the extent necessary to meet the requirements of federal law or regulations or to obtain federal approval. If after seeking federal approval, federal approval is not obtained or federal financial participation is no longer available, this section and Section 4646.55 shall not be implemented or shall become inoperative.

SEC. 158. 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), Food Stamp, and Medical Assistance (Medi-Cal) programs. Allocations shall be made to each county and shall be limited by and determined based upon the County Administrative Cost Control Plan. In administering the plan to control county administrative costs, the department shall not allocate state funds to cover county cost overruns that result from county failure to meet requirements of the plan. The department and the State Department of Social Services shall budget, administer, and allocate state funds for county administration in a uniform and consistent manner.

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

(5) The department shall provide a clear narrative description along with fiscal detail in the Medi-Cal estimate package, submitted to the Legislature in January and May of each year, of each component of the county administrative funding for the Medi-Cal program. This shall describe how the information obtained from the county budget survey documents was utilized and, where applicable, modified and the rationale for the changes.

(b) Nothing in this section, Section 15204.5, or Section 18906 shall be construed so as to limit the administrative or budgetary responsibilities of

the department in a manner that would violate Section 14100.1, and thereby jeopardize federal financial participation under the Medi-Cal program.

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

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

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

(1) Complete eligibility determinations as follows:

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

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

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

(B) Upon the development and implementation of the best-practice guidelines and expedited processes, the department and the counties may develop an expedited enrollment timeframe for newborns that is separate from the standards for all other applications, to the extent that the timeframe is consistent with these guidelines and processes.

(C) Notwithstanding the rulemaking procedures of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the

Government Code, the department may implement this section by means of all-county letters or similar instructions, without further regulatory action.

(3) Perform timely annual redeterminations, as follows:

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

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

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

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

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

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

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

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

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

(f) On January 1 of each year, each applicable county, as determined by the department, shall report to the department on the county's results in meeting the performance standards specified in this section. The report shall be subject to verification by the department. County reports shall be provided to the public upon written request.

(g) If the department finds that a county is not in compliance with one or more of the standards set forth in this section, the county shall, within

60 days, submit a corrective action plan to the department for approval. The corrective action plan shall, at a minimum, include steps that the county shall take to improve its performance on the standard or standards with which the county is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the county in order to avoid a sanction.

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

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

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

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

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

SEC. 159. Section 14165.4 of the Welfare and Institutions Code is amended to read:

14165.4. It is the intent of the Legislature that beginning July 1, 1983, the functions, powers, and duties contained in Article 2.6 (commencing with Section 14081) become subject to the provisions contained herein.

SEC. 160. Section 14167.351 is added to the Welfare and Institutions Code, to read:

14167.351. It is the intent of the Legislature that the funds in the Hospital Quality Assurance Revenue Fund identified pursuant to paragraph (2) of subdivision (c) of Section 14167.35 are to be used to expand and enhance health services for children when the health of the economy and state budget are strong enough to allow for the expansion of children’s health services programs, and strong enough to ensure that these funds supplement, rather

than supplant, existing funding for children's health services during the time that this article is in effect.

SEC. 161. Section 14183.6 is added to the Welfare and Institutions Code, to read:

14183.6. 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. 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 to the Department of Managed Health Care.

SEC. 162. Section 14301.1 of the Welfare and Institutions Code is amended to read:

14301.1. (a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health-plan- and county-specific rates. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

(1) Health-plan-specific encounter and claims data.

(2) Supplemental utilization and cost data submitted by the health plans.

(3) Fee-for-service data for the underlying county of operation or other appropriate counties as deemed necessary by the department.

(4) Department of Managed Health Care financial statement data specific to Medi-Cal operations.

(5) Other demographic factors, such as age, gender, or diagnostic-based risk adjustments, as the department deems appropriate.

(b) To the extent that the department is unable to obtain sufficient actual plan data, it may substitute plan model, similar plan, or county-specific fee-for-service data.

(c) The department shall develop rates that include administrative costs, and may apply different administrative costs with respect to separate aid code groups.

(d) The department shall develop rates that shall include, but are not limited to, assumptions for underwriting, return on investment, risk, contingencies, changes in policy, and a detailed review of health plan financial statements to validate and reconcile costs for use in developing rates.

(e) The department may develop rates that pay plans based on performance incentives, including quality indicators, access to care, and data submission.

(f) The department may develop and adopt condition-specific payment rates for health conditions, including, but not limited to, childbirth delivery.

(g) (1) Prior to finalizing Medi-Cal managed care capitation rates, the department shall provide health plans with information on how the rates were developed, including rate sheets for that specific health plan, and provide the plans with the opportunity to provide additional supplemental information.

(2) For contracts entered into between the department and any entity pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7, the department, by June 30 of each year, or, if the budget has not passed by that date, no later than five working days after the budget is signed, shall provide preliminary rates for the upcoming fiscal year.

(h) For the purposes of developing capitation rates through implementation of this ratesetting methodology, Medi-Cal managed care health plans shall provide the department with financial and utilization data in a form and substance as deemed necessary by the department to establish rates. This data shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act (Division 7 (commencing with Section 6250) of Title 1 of the Government Code).

(i) The department shall report, upon request, to the fiscal and policy committees of the respective houses of the Legislature regarding implementation of this section.

(j) 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.

SEC. 163. Section 14301.11 of the Welfare and Institutions Code is amended to read:

14301.11. (a) The department shall use funds attributable to the tax on Medi-Cal managed care plans imposed by Section 12201 of the Revenue and Taxation Code for the purpose specified in paragraph (1) of subdivision (b) of Section 12201 of the Revenue and Taxation Code.

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

SEC. 164. Section 10 of Chapter 13 of the Third Extraordinary Session of the Statutes of 2009, as amended by Section 3 of Chapter 4 of the Eighth Extraordinary Session of the Statutes of 2010, is amended to read:

Sec. 10. (a) Notwithstanding any other provision of law, in order to implement changes in the level of funding for regional center purchase of services, regional centers shall reduce payments for services and supports provided pursuant to Title 14 (commencing with Section 95000) of the Government Code and Division 4.1 (commencing with Section 4400) and Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code. From February 1, 2009, to June 30, 2010, inclusive, regional centers

shall reduce all payments for these services and supports paid from purchase of services funds for services delivered on or after February 1, 2009, by 3 percent, and from July 1, 2010, to June 30, 2011, inclusive, by 4.25 percent, unless the regional center demonstrates that a nonreduced payment is necessary to protect the health and safety of the individual for whom the services and supports are proposed to be purchased, and the State Department of Developmental Services has granted prior written approval.

(b) Regional centers shall not reduce payments pursuant to subdivision (a) for the following:

(1) Supported employment services with rates set by Section 4860 of the Welfare and Institutions Code.

(2) Services with "usual and customary" rates established pursuant to Section 57210 of Title 17 of the California Code of Regulations.

(3) Payments to offset reductions in Supplemental Security Income/State Supplementary Payment (SSI/SSP) benefits for consumers receiving supported and independent living services.

(c) Notwithstanding any other provision of law, in order to implement changes in the level of funding appropriated for regional centers, the department shall amend regional center contracts to adjust regional center budgets accordingly for the 2008–09 fiscal year through the 2010–11 fiscal year. The contract amendments and budget adjustments shall be exempt from the provisions of Article 1 (commencing with Section 4620) of Chapter 5 of Division 4.5 of the Welfare and Institutions Code.

SEC. 165. Due to a change in the availability of federal funding that addresses the ability of California to capture additional federal financial participation for day treatment and transportation services provided to a Medi-Cal beneficiary residing in a licensed intermediate care facility/developmentally disabled-habilitative, a licensed intermediate care facility/developmentally disabled-nursing, or a licensed intermediate care facility/developmental disability, as specified in Sections 4646.55 and 14132.925 of the Welfare and Institutions Code, funds appropriated in Item 4300-101-0001 of the Budget Act of 2007 (Chapters 171 and 172, Statutes of 2007) shall be available for liquidation until June 30, 2011.

SEC. 166. (a) The State Department of Health Care Services shall provide the appropriate fiscal and policy committees of the Legislature, the Legislative Analyst's Office, the Office of the State Chief Information Officer (OCIO), and the Bureau of State Audits (BSA) with quarterly reports on the transition and takeover progress efforts of the Medi-Cal Fiscal Intermediary Contract. These quarterly reports shall be provided within 30 days of the close of each quarter, commencing July 1, 2010, and continuing throughout the life of the new system implementation project. These quarterly reports shall contain the following information:

(1) A project status summary that identifies the progress or key milestones and objectives for the quarter on transition and takeover efforts by the prime contractor and the legacy contractor.

(2) A description of whether the project is on budget.

(3) Copies of any oversight reports developed by contractors of the department for the California Medicaid Management Information System (CA-MMIS) project and any subsequent responses from the department.

(b) Upon request from the Chair of the Joint Legislative Budget Committee (JLBC), the department shall provide updates on the Implementation Advanced Planning Document provided to the federal Centers for Medicare and Medicaid Services pertaining to the CA-MMIS project.

(c) The CA-MMIS project shall be subject to the reviews and recommendations of the OCIO. The OCIO shall submit a copy of its reviews and recommendations to the JLBC. In conducting its review, the OCIO shall consult with the department to review the project governance and management framework to ensure that it is best designed for success and will serve as a resource throughout the project implementation.

(d) The BSA shall review the appropriate project documents and quarterly reports and make recommendations about the new system implementation project, as necessary. The BSA shall submit a copy of any reviews and recommendations to the JLBC.

(e) The Chair of the JLBC may request an audit of the progress of the transition, development, and implementation of the CA-MMIS.

SEC. 167. By no later than January 10 and May 14 of each year, the State Department of Public Health shall provide the fiscal committees of the Legislature with an estimate package for the California Special Supplemental Food Program for Women, Infants, and Children (the WIC program). This estimate package shall include all significant assumptions underlying the estimate for the WIC program's current-year and budget-year proposals, and shall contain concise information identifying applicable estimate components, such as caseload, policy changes, federal fund information, manufacturer rebate information, state positions and organization charts, and other assumptions necessary to support the estimate.

SEC. 168. By no later than January 10 and May 14 of each year, the State Department of Public Health shall provide the fiscal committees of the Legislature with an estimate package for the 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, policy changes, contractor information, special fund and federal fund information, and other assumptions necessary to support the estimate.

SEC. 169. The State Department of Public Health shall provide the fiscal and appropriate policy committees of the Legislature with quarterly updates on caseload, estimated expenditures, and related program monitoring data for the Every Woman Counts Program. These updates shall be provided by no later than the 15th day of the month following the end of each quarter of the fiscal year, which would be October 15, January 15, April 15, and August 15. The purpose of these updates is to provide the Legislature with the most recent information on the program, and is in response to previously

failed efforts by the State Department of Public Health to adequately track, monitor, and report information regarding the Every Woman Counts Program as articulated in two recent audits conducted by the Department of Finance and the Bureau of State Audits in Spring 2010.

SEC. 170. By no later than January 10 and May 14 of each year, the State Department of Public Health shall provide the fiscal committees of the Legislature with an estimate package for the Licensing and Certification Program. This estimate package shall include all significant assumptions underlying the estimate for the Licensing and Certification Program, including current-year and budget-year proposals, and shall contain concise information identifying applicable estimate components, such as licensing visits, personnel needs, policy changes, all fund sources, and any other applicable information, including organization charts and other assumptions necessary to support the estimate. This estimate package shall not serve as a replacement for any other reporting requirements regarding Licensing and Certification Program fees.

SEC. 171. No later than January 20 of each year, the State Department of Public Health shall provide a vacancy report, effective as of December 1 of the previous calendar year, to the Joint Legislative Budget Committee and the chairs of the fiscal committees of both houses of the Legislature. This report shall identify both filled and vacant positions within the department by center, division, branch, and classification.

SEC. 172. (a) The State Department of Health Care Services shall seek support from one or more foundations to support and develop a study or studies of the California Children's Services (CCS) Program to be provided to interested stakeholders and the fiscal and appropriate policy committees of the Legislature by no later than May 2011. Issues to be addressed by these analyses may include the following:

(1) Systems analysis of core business processes and practices of the program, including service authorization requests (SARs), requests for durable medical equipment, and reimbursement processing.

(2) Review of CCS provider certification and enrollment process.

(3) Review of medical eligibility processing.

(4) Oversight and monitoring of quality of care.

(5) Identification of best practices for case management and care coordination functions, including discharge planning.

(6) Opportunities for the use of Web-based tools, telemedicine, e-prescribing, and other technologies to reduce costs and to streamline.

(b) It is the intent of the Legislature for the study or studies to be used to do all of the following:

(1) Administratively streamline the CCS Program.

(2) Serve as a tool to facilitate the development of statewide policies and procedures to improve the program.

(3) Serve as a baseline for development of CCS Program pilots implemented through the state's Section 1115 Medicaid Waiver.

SEC. 173. The State Department of Health Care Services shall provide the fiscal and appropriate policy committees of the Legislature with

semiannual updates regarding all of California's Medicaid waivers to be provided in March and October of each year. At a minimum, the semiannual updates shall include a listing of all Medicaid waivers with all of the following information for each waived:

(a) Description of what federal laws or regulations are being waived.

(b) Description of the purpose of the wavier.

(c) Description of whom the waiver serves and the number of enrollees.

(d) Status of the waiver, including its expiration date and pending renewal dates where applicable.

(e) State plan amendment number listing and date that is applicable to the waiver.

(f) Department that administers the program.

(g) Any other information deemed useful by the department, including any separate attachments or reports on a particular waiver.

SEC. 174. (a) It is the intent of the Legislature, consistent with current law contained in subdivision (e) of Section 1324.21 of the Health and Safety Code, that beginning in the 2010–11 rate year or in any other rate year thereafter, a multilevel facility, as defined in paragraph (1) of subdivision (a) of Section 1324.20 of the Health and Safety Code, may be assessed the amount the facility would be required to pay the department, but shall not be required to pay the quality assurance fee until both of the following occur:

(1) Changes to both the quality assurance fee and the rate methodology enacted in the 2010 portion of the 2009–10 Regular Session of the Legislature are approved by the federal Centers for Medicare and Medicaid Services.

(2) The State Department of Health Care Services has increased Medi-Cal rates and the increased rates are paid to facilities.

(b) A multilevel facility, as defined in paragraph (1) of subdivision (a) of Section 1324.20 of the Health and Safety Code, that has been assessed a fee by the department shall pay the fee assessed within 60 days of the date rates are increased in accordance with Section 1324.28 and paid to the facilities.

SEC. 175. 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. 176. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of

Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the necessary statutory changes to implement the Budget Act of 2010, it is necessary that this act take effect immediately.

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