AMENDED IN ASSEMBLY JUNE 10, 2016

AMENDED IN ASSEMBLY MAY 25, 2016

SENATE BILL No. 833

Introduced by Committee on Budget and Fiscal Review

January 7, 2016

~~An act relating to the Budget Act of 2016.~~ *An act to amend Section 100504 of the Government Code, to amend Sections 1324.9, 120955, 120960, 130301, 130303, 130305, 130306, 130309, 130310, and 130313 of, to add Section 125281 to, to add Part 6.2 (commencing with Section 1179.80) to Division 1 of, to add Part 7.5 (commencing with Section 122450) to Division 105 of, and to repeal Sections 120965, 130307, and 130312 of, the Health and Safety Code, to amend and repeal Section 138.7 of the Labor Code, and to amend Sections 5848.5, 10752, 14009.5, 14046.7, 14105.436, 14105.45, 14105.456, 14105.86, 14131.10, 14132.56, 14154, 14301.1, and 14592 of, and to amend and add Section 14593 of, the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.*

LEGISLATIVE COUNSEL'S DIGEST

SB 833, as amended, Committee on Budget and Fiscal Review. ~~Budget Act of 2016.~~ *Health.*

(1) Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that took effect January 1, 2014. Among other things, PPACA requires each state, by January 1, 2014, to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. Existing state law establishes the California Health Benefit Exchange (the Exchange)

within state government for the purpose of facilitating the enrollment of qualified individuals and qualified small employers in qualified health plans, and specifies the powers and duties of the board governing the Exchange. Existing law authorizes the board of the Exchange to adopt any necessary regulations as emergency regulations until January 1, 2017. Existing law allows the emergency regulations adopted by the board to remain in effect for 3 years, as specified.

This bill would authorize the board to adopt any necessary regulations to implement the eligibility, enrollment, and appeals processes for the individual and small business exchanges, changes to the small business exchange, or any act in effect that amends the provisions governing the Exchange that is operative on or before December 31, 2016, as emergency regulations. The bill would instead allow the emergency regulations adopted by the board to remain in effect for 5 years, as specified.

(2) Existing law creates the State Department of Public Health and vests it with duties, powers, functions, jurisdiction, and responsibilities with regard to the advancement of public health.

This bill would require the department, subject to an appropriation for this purpose in the Budget Act of 2016, to award funding to local health departments, local government agencies, or on a competitive basis to community-based organizations, regional opioid prevention coalitions, or both, to support or establish programs that provide Naloxone to first responders and to at-risk opioid users through programs that serve at-risk drug users, including, but not limited to, syringe exchange and disposal programs, homeless programs, and substance use disorder treatment providers.

(3) Existing law establishes the Long-Term Care Quality Assurance Fund in the State Treasury and requires all revenues received by the State Department of Health Care Services categorized by the department as long-term care quality assurance fees, including specified fees on certain intermediate care facilities and skilled nursing facilities, as specified, to be deposited into the fund. Existing law requires the moneys in the fund to be available, upon appropriation by the Legislature, for expenditure by the department to provide supplemental Medi-Cal reimbursement for intermediate care facility services, as specified, and to enhance federal financial participation in the Medi-Cal program or to provide additional reimbursement to, and support facility quality improvement efforts in, licensed skilled nursing facilities.

This bill would continuously appropriate the moneys in the fund to the department, thereby making an appropriation.

(4) Existing law requires the State Public Health Officer, to the extent that state and federal funds are appropriated, to establish and administer a program to provide drug treatments to persons infected with human immunodeficiency virus (HIV). Existing law establishes the AIDS Drug Assistance Rebate Fund, which is continuously appropriated and contains specified rebates from drug manufacturers, and authorizes expenditures from the fund for purposes of this program.

This bill would require the State Public Health Officer, to the extent that state and federal funds are appropriated, to establish and administer a program to provide drug treatments to persons who are HIV-negative who have been prescribed preexposure prophylaxis included on the ADAP formulary for the prevention of HIV infection. The bill would authorize the State Public Health Officer, to the extent allowable under federal law and as appropriated in the annual Budget Act, to expend funding from the AIDS Drug Assistance Program Rebate Fund for this HIV infection prevention program to cover the costs of prescribed ADAP formulary medications for the prevention of HIV infection and other specified costs.

Existing law authorizes the State Department of Public Health to subsidize certain cost-sharing requirements for persons otherwise eligible for the AIDS Drug Assistance Program (ADAP) with existing non-ADAP drug coverage by paying for prescription drugs included on the ADAP formulary within the existing ADAP operational structure, as specified. Under existing law, if the State Public Health Officer determines that it would result in a cost savings to the state, the department is authorized to subsidize, using available federal funds and moneys from the AIDS Drug Assistance Program Rebate Fund, costs associated with a health care service plan or health insurance policy and premiums to purchase or maintain health insurance coverage.

The bill would delete the requirement that the State Public Health Officer determine that there would be a cost savings to the state before the department may subsidize the above-described costs with available federal funds and moneys from the AIDS Drug Assistance Program Rebate Fund.

Existing law requires the department to establish and administer a payment schedule to determine the payment obligation of a person receiving drugs under the program, as specified. Existing law limits the payment obligation to the lessor of 2 times the person's annual state

income tax liability, less health insurance premium payments, or the cost of the drugs.

This bill would delete the above-described payment obligation. The bill would also make conforming changes.

(5) Existing law establishes the State Department of Public Health for purposes of, among other things, providing or facilitating access to certain health services and programs. Existing law requires the department to administer certain programs related to hepatitis B and hepatitis C, as specified.

This bill would require the State Department of Public Health to, among other things, purchase and distribute certain hepatitis B and hepatitis C materials to local entities for purposes of testing and vaccination, as specified. The bill would further require the department to facilitate related training and other technical assistance relating to syringe exchanges. The bill would authorize the department to issue grants for these purposes. The bill would make these provisions subject to funding provided for these purposes.

(6) Existing law authorizes any postsecondary higher educational institution with a medical center to establish diagnostic and treatment centers for Alzheimer's disease, and requires the State Department of Public Health to administer grants to the postsecondary higher educational institutions that establish a center pursuant to these provisions.

This bill would require the department to allocate funds to those centers, from funds appropriated to the department in the Budget Act of 2016, to be used for specified purposes, including to conduct targeted outreach to health professionals and to provide low-cost, accessible detection and diagnosis tools, as specified.

(7) Existing law establishes the Office of Health Information Integrity, headed by the Director of the Office of Health Information Integrity, within the California Health and Human Services Agency and requires the office to assume statewide leadership, coordination, policy formulation, direction, and oversight responsibilities for implementation of the federal Health Insurance Portability and Accountability Act (HIPAA). Existing law requires the director to establish an advisory committee to obtain information on statewide HIPAA implementation activities, which is required to meet at a minimum 2 times per year. Existing law requires the Department of Finance to develop and annually publish prior to August 1 guidelines for state entities, as defined, to obtain additional HIPAA funding, and to report to the

Legislature quarterly on HIPAA allocations, redirections, and expenditures, categorized by state entity and by project.

This bill would revise those provisions to reflect the office's duties regarding ongoing compliance with HIPAA. The bill would delete the provisions pertaining to the advisory committee and the Department of Finance requirements to publish guidelines and report to the Legislature.

(8) Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Existing law prohibits a person or public or private entity who is not a party to a claim for workers' compensation benefits from obtaining individually identifiable information, as defined, that is obtained or maintained by the Division of Workers' Compensation of the Department of Industrial Relations on that claim, except as specified. Existing law authorizes, until January 1, 2017, the use by the State Department of Health Care Services of individually identifiable information to seek recovery of Medi-Cal costs.

This bill would delete that January 1, 2017, date of repeal and thereby extend the operation of this authority of the State Department of Health Care Services indefinitely.

(9) The California Health Facilities Financing Authority Act authorizes the California Health Facilities Financing Authority (authority) to make loans from the continuously appropriated California Health Facilities Financing Authority Fund to participating health institutions for financing or refinancing the acquisition, construction, or remodeling of health facilities.

Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Oversight and Accountability Commission (commission) to oversee the administration of various parts of the Mental Health Services Act. The act provides that it may be amended by the Legislature by a 2/3 vote of each house as long as the amendment is consistent with and furthers the intent of the act, and that the Legislature may also clarify procedures and terms of the act by majority vote.

Existing law establishes the Investment in Mental Health Wellness Act of 2013. Existing law provides that funds appropriated by the Legislature to the authority for the purposes of the act be made available to selected counties or counties acting jointly, except as otherwise

provided, and used to increase capacity for client assistance and services in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. Existing law requires the authority to develop and to consider specified selection criteria for awarding grants, as prescribed. Existing law provides that funds appropriated by the Legislature to the commission for the purposes of the act be allocated to selected counties, counties acting jointly, or city mental health departments, as determined by the commission through a selection process, for triage personnel to provide intensive case management and linkage to services for individuals with mental health disorders. Existing law requires the commission to consider specified selection criteria for awarding grants. Existing law prohibits funds awarded by the authority or commission from being used to supplant existing financial and resource commitments of the grantee.

This bill would extend the application of these provisions for purposes of providing mental health services to children and youth 21 years of age and under, subject to appropriation in the 2016 Budget Act. The bill would similarly provide that funds appropriated by the Legislature to the authority for these purposes be made available to selected counties or counties acting jointly, and used to increase capacity for client assistance and crisis services, as specified. The bill would require the authority to develop and consider specified selection criteria for awarding grants, as prescribed. The bill would similarly provide that funds appropriated by the Legislature to the commission for these purposes be allocated to selected counties, counties acting jointly, or city mental health departments, as determined by the commission through a selection process, for specified purposes. The bill would require the commission to consider specified selection criteria for awarding grants. The bill would require the authority and the commission to provide prescribed reports to the fiscal and policy committees of the Legislature by January 1, 2018, and annually thereafter.

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

Existing federal law requires the state to seek adjustment or recovery from an individual's estate for specified medical assistance, including

nursing facility services, home and community-based services, and related hospital and prescription drug services, if the individual was 55 years of age or older when he or she received the medical assistance. Existing federal law allows the state, at its own option, to seek recovery for any items or services covered under the state's Medicaid plan.

Existing state law, with certain exceptions, requires the State Department of Health Care Services to claim against the estate of a decedent, or against any recipient of the property of that decedent by distribution or survival, an amount equal to the payments for Medi-Cal services received or the value of the property received by any recipient from the decedent by distribution or survival, whichever is less. Existing law provides for certain exemptions that restrict the department from filing a claim against a decedent's property, including if there is a surviving spouse during his or her lifetime. Existing law requires the department, however, to make a claim upon the death of the surviving spouse, as prescribed. Existing law requires the department to waive its claim, in whole or in part, if it determines that enforcement of the claim would result in a substantial hardship, as specified. Existing law, which has been held invalid by existing case law, provides that the exemptions shall only apply to the proportionate share of the decedent's estate or property that passes to those recipients, by survival or distribution, who qualify for the exemptions.

This bill would instead require the department to make these claims only in specified circumstances for those health care services that the state is required to recover under federal law and would define health care services for these purposes. The bill would limit any claims against the estate of a decedent to only the real and personal property or other assets in the individual's probate estate that the state is required to seek recovery from under federal law. The bill would delete the proportionate share provision and would delete the requirement that the department make a claim upon the death of the surviving spouse. The bill would prohibit the department from filing a claim against a decedent's property if there is a surviving registered domestic partner. The bill would require the department, subject to federal approval, to waive its claim when the estate subject to recovery is a homestead of modest value, as defined. The bill would limit the amount of interest that is entitled to accrue on a voluntary postdeath lien, as specified. The bill would also require the department to provide a current or former member, or his or her authorized representative, upon request, with a copy of the amount of Medi-Cal expenses that would be

recoverable under these provisions, as specified. The bill would apply the changes made by these provisions only to individuals who die on or after January 1, 2017.

(11) Existing law requires the State Department of Health Care Services to establish and administer, until July 1, 2021, the Medi-Cal Electronic Health Records Incentive Program, for the purposes of providing federal incentive payments to Medi-Cal providers for the implementation and use of electronic records systems. Existing law generally prohibits General Fund moneys from being used for this purpose, except that no more than $200,000 from the General Fund may be used annually for state administrative costs associated with implementing these provisions.

This bill would increase the amount of General Fund moneys that may be used annually for state administrative costs to no more than $425,000.

(12) Existing law provides for a schedule of benefits under the Medi-Cal program, which includes Early and Periodic Screening, Diagnosis, and Treatment for any individual under 21 years of age, consistent with the requirements of federal law. Under existing law, to the extent required by the federal government and effective no sooner than required by the federal government, behavioral health treatment (BHT), as defined, is a covered service for individuals under 21 years of age, as specified.

This bill would authorize the department, commencing on the effective date of the bill to March 31, 2017, inclusive, to make available to specified individuals whom the department identifies as no longer eligible for Medi-Cal solely due to the transition of BHT coverage pursuant to the above provisions, contracted services to assist the individuals with health insurance enrollment, without regard to whether federal funds are available for the contracted services.

(13) Existing law prohibits the reimbursement to Medi-Cal pharmacy providers for legend and nonlegend drugs, as defined, from exceeding the lowest of either the estimated acquisition cost of the drug plus a professional fee for dispensing or the pharmacy's usual and customary charge, as defined. The professional fee is statutorily set at $7.25 per dispensed prescription and at $8 for legend drugs dispensed to a beneficiary residing in a skilled nursing facility or intermediate care facility, as defined. If the State Department of Health Care Services determines that a change in the dispensing fee is necessary, existing law requires the department to establish the new dispensing fee through

the state budget process and prohibits any adjustments to the dispensing fee from exceeding a specified amount. Existing law requires the estimated acquisition cost of the drug to be equal to the lowest of the average wholesale price minus 17%, the average acquisition cost, the federal upper limit, or the maximum allowable ingredient cost.

This bill, commencing April 1, 2017, would make inoperative the prescribed amounts for the professional fees and, instead, require the department to implement a new professional dispensing fee or fees, as defined, established by the department consistent with a specified provision of federal law. The bill would require the department to adjust the professional dispensing fee through the state budget process if necessary to comply with federal Medicaid requirements. The bill would revise the definition of "federal upper limit."

(14) Existing law provides for a schedule of benefits under the Medi-Cal program, which includes specified outpatient services, including acupuncture to the extent federal matching funds are provided for acupuncture, subject to utilization controls. Notwithstanding this provision, existing law excludes certain optional Medi-Cal benefits, including, among others, acupuncture services, from coverage under the Medi-Cal program.

This bill, commencing July 1, 2016, would restore acupuncture services as a covered benefit under the Medi-Cal program.

(15) Existing law requires counties to determine Medi-Cal eligibility, and requires each county to meet specified performance standards in administering Medi-Cal eligibility. 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. 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 further provides that it is the intent of the Legislature to provide appropriate funding to the counties for the effective administration of the Medi-Cal program, and that it is the intent of the Legislature to not appropriate money for a cost-of-doing-business adjustment for specified 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 2016–17 fiscal year.

(16) Under existing law, the Emergency Medical Air Transportation Act, a penalty of $4 is imposed upon every conviction for a violation of the Vehicle Code, or a local ordinance adopted pursuant to the Vehicle Code, other than a parking offense. Existing law requires the county or the court that imposed the fine to transfer the moneys collected pursuant to this act to the Emergency Medical Air Transportation Act Fund. Existing law requires the State Department of Health Care Services to administer the Emergency Medical Air Transportation Act Fund and to use the moneys in the fund, upon appropriation by the Legislature, to, among other things, offset the state portion of the Medi-Cal reimbursement rate for emergency medical air transportation services and augment emergency medical air transportation reimbursement payments made through the Medi-Cal program. Under existing law, the assessment of these penalties will terminate on January 1, 2018, and any moneys unexpended and unencumbered in the Emergency Medical Air Transportation Act Fund on June 30, 2019, will transfer to the General Fund. Existing law requires the department, by March 1, 2017, and in coordination with the Department of Finance, to develop a funding plan that ensures adequate reimbursement to emergency medical air transportation providers following the termination of the penalty assessments.

This bill would instead require the department, by March 1, 2017, and in coordination with the Department of Finance, to notify the Legislature of the fiscal impact on the Medi-Cal program resulting from, and the planned reimbursement methodology for emergency medical air transportation services after, the termination of the penalty assessments.

(17) Existing federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals so that they may continue living in the community. Federal law authorizes states to implement the PACE program as a Medicaid state option. Existing law authorizes the department to enter into contracts with up to 15 PACE organizations, defined as public or private nonprofit organizations, to implement the PACE program, as specified. Existing law, on and after April 1, 2015, requires the department to establish capitation rates paid to each PACE organization at no less than 95% of the fee-for-service equivalent cost, including the

department's cost of administration, that the department estimates would be payable for all services covered under the PACE organization contract if all those services were to be furnished to Medi-Cal beneficiaries under the fee-for-service program.

This bill would require the department to develop and pay capitation rates to contracted PACE organizations, for rates implemented no earlier than January 1, 2017, in accordance with criteria specific to those organizations, based on, among other things, standardized rate methodologies for similar populations, adjustments for geographic location, and the level of care being provided. The bill would delete the requirement that contracts for implementation of the PACE program be entered into with organizations that are nonprofit.

This bill also would authorize the department, to the extent federal financial participation is available, to seek increased federal regulatory flexibility to modernize the PACE program, as specified. Implementation of the new capitation rate methodology would be contingent on receipt of federal approval and the availability of federal financial participation. The bill would provide alternative rate capitation methodologies, depending upon whether or not the Coordinated Care Initiative is operative, as specified.

(18) This bill would also delete or make inoperative various obsolete provisions of law and make various other technical changes.

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

~~This bill would express the intent of the Legislature to enact statutory changes relating to the Budget Act of 2016.~~

Vote: majority. Appropriation: ~~no~~ *yes*. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

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

SECTION 1. Section 100504 of the Government Code is amended to read:

100504. (a) The board may do the following:

(1) With respect to individual coverage made available in the Exchange, collect premiums and assist in the administration of subsidies.

(2) Enter into contracts.

(3) Sue and be sued.

(4) Receive and accept gifts, grants, or donations of moneys from any agency of the United States, any agency of the state, and any municipality, county, or other political subdivision of the state.

(5) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, and corporations, in compliance with the conflict of interest provisions to be adopted by the board at a public meeting.

(6) Adopt rules and regulations, as necessary. Until January 1, 2017, any necessary rules and regulations may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2). *Until January 1, 2019, any necessary rules and regulations to implement the eligibility, enrollment, and appeals processes for the individual and small business exchanges, changes to the small business exchange, or any act in effect that amends this title that is operative on or before December 31, 2016, 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).* The adoption of ~~these regulations~~ *emergency regulations pursuant to this section* shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2, including subdivisions (e) and (h) of Section 11346.1, any emergency regulation adopted pursuant to this section shall be repealed by operation of law unless the adoption, amendment, or repeal of the regulation is promulgated by the board pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code within ~~three~~ *five* years of the initial adoption of the emergency regulation. Notwithstanding subdivision (h) of Section 11346.1, until January 1, 2020, the Office of Administrative Law may approve more than two readoptions of an emergency regulation adopted pursuant to this section. The amendments made to this paragraph by the act adding this sentence shall apply to any emergency regulation adopted pursuant to this section prior to the effective date of the Budget Act of 2015.

(7) Collaborate with the State Department of Health Care Services and the Managed Risk Medical Insurance Board, to the

extent possible, to allow an individual the option to remain enrolled with his or her carrier and provider network in the event the individual experiences a loss of eligibility of premium tax credits and becomes eligible for the Medi-Cal program or the Healthy Families Program, or loses eligibility for the Medi-Cal program or the Healthy Families Program and becomes eligible for premium tax credits through the Exchange.

(8) Share information with relevant state departments, consistent with the confidentiality provisions in Section 1411 of the federal act, necessary for the administration of the Exchange.

(9) Require carriers participating in the Exchange to make available to the Exchange and regularly update an electronic directory of contracting health care providers so that individuals seeking coverage through the Exchange can search by health care provider name to determine which health plans in the Exchange include that health care provider in their network. The board may also require a carrier to provide regularly updated information to the Exchange as to whether a health care provider is accepting new patients for a particular health plan. The Exchange may provide an integrated and uniform consumer directory of health care providers indicating which carriers the providers contract with and whether the providers are currently accepting new patients. The Exchange may also establish methods by which health care providers may transmit relevant information directly to the Exchange, rather than through a carrier.

(10) Make available supplemental coverage for enrollees of the Exchange to the extent permitted by the federal act, provided that no General Fund money is used to pay the cost of that coverage. Any supplemental coverage offered in the Exchange shall be subject to the charge imposed under subdivision (n) of Section 100503.

(b) The Exchange shall only collect information from individuals or designees of individuals necessary to administer the Exchange and consistent with the federal act.

(c) (1) The board shall have the authority to standardize products to be offered through the Exchange. Any products standardized by the board pursuant to this subdivision shall be discussed by the board during at least one properly noticed board meeting prior to the board meeting at which the board adopts the standardized products to be offered through the Exchange.

(2) The adoption, amendment, or repeal of a regulation by the board to implement this subdivision is exempt 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).

SEC. 2. Part 6.2 (commencing with Section 1179.80) is added to Division 1 of the Health and Safety Code, to read:

PART 6.2. NALOXONE GRANT PROGRAM

1179.80. (a) In order to reduce the rate of fatal overdose from opioid drugs including heroin and prescription opioids, the State Department of Public Health shall, subject to an appropriation for this purpose in the Budget Act of 2016, award funding to local health departments, local government agencies, or on a competitive basis to community-based organizations, regional opioid prevention coalitions, or both, to support or establish programs that provide Naloxone to first responders and to at-risk opioid users through programs that serve at-risk drug users, including, but not limited to, syringe exchange and disposal programs, homeless programs, and substance use disorder treatment providers.

(b) The department may award grants itself or enter into contracts to carry out the provisions of subdivision (a). The award of contracts and grants is exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and is exempt from approval by the Department of General Services prior to their execution.

(c) Not more than 10 percent of the funds appropriated shall be available to the department for its administrative costs in implementing this section. If deemed necessary by the department, the department may allocate funds to other state departments to assist in the implementation of subdivision (a).

SEC. 3. Section 1324.9 of the Health and Safety Code is amended to read:

1324.9. (a) The Long-Term Care Quality Assurance Fund is hereby created in the State Treasury. ~~Moneys in the fund shall be available, upon appropriation by the Legislature, for expenditure by~~ *Notwithstanding Section 13340 of the Government Code, moneys in the fund shall be continuously appropriated, without*

regard to fiscal year, to the State Department of Health Care Services for the purposes of this article and Article 7.6 (commencing with Section 1324.20). Notwithstanding Section 16305.7 of the Government Code, the fund shall contain all interest and dividends earned on moneys in the fund.

(b) Notwithstanding any other law, beginning August 1, 2013, all revenues received by the State Department of Health Care Services categorized by the State Department of Health Care Services as long-term care quality assurance fees shall be deposited into the Long-Term Care Quality Assurance Fund. Revenue that shall be deposited into this fund shall include quality assurance fees imposed pursuant to this article and quality assurance fees imposed pursuant to Article 7.6 (commencing with Section 1324.20).

(c) Notwithstanding any other law, the Controller may use the funds in the Long-Term Care Quality Assurance Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

SEC. 4. Section 120955 of the Health and Safety Code is amended to read:

120955. (a) (1) To the extent that state and federal funds are appropriated in the annual Budget Act for these purposes, the director shall establish and may administer a program to provide drug treatments to persons infected with human immunodeficiency virus (HIV), the etiologic agent of acquired immunodeficiency syndrome ~~(AIDS)~~. *(AIDS), and to persons who are HIV-negative who have been prescribed preexposure prophylaxis included on the ADAP formulary for the prevention of HIV infection. To the extent allowable under federal law, and as appropriated in the annual Budget Act, the director may expend funding from the AIDS Drug Assistance Program Rebate Fund for this HIV infection prevention program to cover the costs of prescribed ADAP formulary medications for the prevention of HIV infection and related medical copays, coinsurance, and deductibles.* If the director makes a formal determination that, in any fiscal year, funds appropriated for the program will be insufficient to provide all of those drug treatments to existing eligible persons for the fiscal year and that a suspension of the implementation of the program is necessary, the director may suspend eligibility determinations and enrollment in the program for the period of

time necessary to meet the needs of existing eligible persons in the program.

(2) The director, in consultation with the AIDS Drug Assistance Program Medical Advisory Committee, shall develop, maintain, and update as necessary a list of drugs to be provided under this program. The list shall be exempt from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law.

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

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

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

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

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

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

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

(i) The department may also subsidize certain cost-sharing requirements for persons otherwise eligible for the AIDS Drug Assistance Program (ADAP) with existing non-ADAP drug coverage by paying for prescription drugs included on the ADAP formulary within the existing ADAP operational structure up to, but not exceeding, the amount of that cost-sharing obligation. This cost sharing may only be applied in circumstances in which the other payer recognizes the ADAP payment as counting toward the individual's cost-sharing obligation. ~~If the director determines that it would result in a cost savings to the state, the~~ *The* department may subsidize, using available federal funds and moneys from the AIDS Drug Assistance Program Rebate Fund, costs associated with a health care service plan or health insurance policy, including medical copayments and deductibles for outpatient care, and premiums to purchase or maintain health insurance coverage.

SEC. 5. Section 120960 of the Health and Safety Code is amended to read:

120960. (a) The department shall establish uniform standards of financial eligibility for the drugs under the program established under this chapter.

(b) Nothing in the financial eligibility standards shall prohibit drugs to an otherwise eligible person whose modified adjusted gross income does not exceed 500 percent of the federal poverty level per year based on family size and household income.

However, the director may authorize drugs for persons with incomes higher than 500 percent of the federal poverty level per year based on family size and household income if the estimated cost of those drugs in one year is expected to exceed 20 percent of the person's modified adjusted gross income.

~~(c) The department shall establish and may administer a payment schedule to determine the payment obligation of a person receiving drugs. No person shall be obligated for payment whose modified adjusted gross income is less than four times the federal poverty level based on family size and household income. The payment obligation shall be the lesser of the following:~~

~~(1) Two times the person's annual state income tax liability, less funds expended by the person for health insurance premiums.~~

~~(2) The cost of drugs.~~

~~(d) Persons who have been determined to have a payment obligation pursuant to subdivision (c) shall be advised by the department of their right to request a reconsideration of that determination to the department. Written notice of the right to request a reconsideration shall be provided to the person at the time that notification is given that he or she is subject to a payment obligation. The payment determination shall be reconsidered if one or more of the following apply:~~

~~(1) The determination was based on an incorrect calculation made pursuant to subdivision (b).~~

~~(2) There has been a substantial change in income since the previous eligibility determination that has resulted in a current income that is inadequate to meet the calculated payment obligation.~~

~~(3) Unavoidable family or medical expenses that reduce the disposable income and that result in current income that is inadequate to meet the payment obligation.~~

~~(4) Any other situation that imposes undue financial hardship on the person and would restrict his or her ability to meet the payment obligation.~~

~~(e) The department may exempt a person, who has been determined to have a payment obligation pursuant to subdivision (c), from the obligation if both of the following criteria are satisfied:~~

~~(1) One or more of the circumstances specified in subdivision (d) exist.~~

~~(2) The department has determined that the payment obligation will impose an undue financial hardship on the person.~~

~~(f) If a person requests reconsideration of the payment obligation determination, the person shall not be obligated to make any payment until the department has completed the reconsideration request pursuant to subdivision (d). If the department denies the exemption, the person shall be obligated to make payments for drugs received while the reconsideration request is pending.~~

~~(g)~~

(c) A county public health department administering this program pursuant to an agreement with the director pursuant to subdivision (b) of Section 120955 shall use no more than 5 percent of total payments it collects pursuant to this section to cover any administrative costs related to eligibility determinations, reporting requirements, and the collection of payments.

~~(h)~~

(d) A county public health department administering this program pursuant to subdivision (b) of Section 120955 shall provide all drugs added to the program pursuant to subdivision (a) of Section 120955 within 60 days of the action of the ~~director, subject to the repayment obligations specified in subdivision (d) of Section 120965.~~ *director.*

~~(i)~~

(e) For purposes of this section, the following terms shall have the following meanings:

(1) "Family size" has the meaning given to that term in Section 36B(d)(1) of the Internal Revenue Code of 1986, and shall include same or opposite sex married couples, registered domestic partners, and any tax dependents, as defined by Section 152 of the Internal Revenue Code of 1986, of either spouse or registered domestic partner.

(2) "Federal poverty level" refers to the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of Section 9902(2) of Title 42 of the United States Code.

(3) "Household income" means the sum of the applicant's or recipient's modified adjusted gross income, plus the modified adjusted gross income of the applicant's or recipient's spouse or registered domestic partner, and the modified adjusted gross incomes of all other individuals for whom the applicant or

recipient, or the applicant's or recipient's spouse or registered domestic partner, is allowed a federal income tax deduction for the taxable year.

(4) "Internal Revenue Code of 1986" means Title 26 of the United States Code, including all amendments enacted to that code.

(5) "Modified adjusted gross income" has the meaning given to that term in Section 36B(d)(2)(B) of the Internal Revenue Code of 1986.

SEC. 6. Section 120965 of the Health and Safety Code is repealed.

~~120965. (a) Effective March 15, 1991, a person determined eligible for benefits under this chapter shall be subject to the payment obligation specified in subdivision (c) of Section 120960.~~

~~(b) Persons who are receiving benefits under a HIV drug treatment subsidy program administered by the department prior to March 15, 1991, shall not be subject to the payment obligation specified in subdivision (c) of Section 120960.~~

~~(c) Notwithstanding subdivision (b), if any person is disenrolled from eligibility in a HIV drug treatment subsidy program administered by the department for any reason after March 15, 1991, the subsequent enrollment of that person for benefits under this chapter shall be in accordance with the payment obligation specified in subdivision (c) of Section 120960.~~

~~(d) Notwithstanding subdivision (b), if a drug is added pursuant to subdivision (a) of Section 120955, any person determined eligible for benefits under this chapter, regardless of the date of enrollment, shall be subject to the payment obligation specified in subdivision (c) of Section 120960 for the added drug. The payment obligation for any other drug shall be determined in accordance with subdivision (b).~~

SEC. 7. Part 7.5 (commencing with Section 122450) is added to Division 105 of the Health and Safety Code, to read:

PART 7.5. COMMUNICABLE DISEASE TESTING AND PREVENTION

122450. (a) Of the funds appropriated in the 2016 Budget Act for this purpose, the State Department of Public Health shall do all of the following:

(1) Purchase and distribute hepatitis B vaccine and related materials to local health jurisdictions and community-based organizations to test and vaccinate high-risk adults.

(2) Purchase hepatitis C test kits and related materials to distribute to local health jurisdictions and community-based testing programs.

(3) Train nonmedical personnel to perform HCV and HIV testing waived under the federal Clinical Laboratory Improvement Amendments of 1998 (CLIA) (42 U.S.C. Sec. 263a) in local health jurisdictions and community-based settings.

(4) Provide technical assistance to local governments and community-based organizations to increase the number of syringe exchange and disposal programs throughout California and the number of jurisdictions in which syringe exchange and disposal programs are authorized.

(b) The State Department of Public Health may issue grants for the materials and activities provided for in subdivision (a).

SEC. 8. Section 125281 is added to the Health and Safety Code, to read:

125281. From funds appropriated to the department in the Budget Act of 2016 for these purposes, the department shall allocate funds to the diagnostic and treatment centers for Alzheimer's disease established pursuant to Section 125280 to be used for all of the following purposes:

(a) To determine the standard of care in early and accurate diagnosis drawing on peer-reviewed evidence, best practices, Medicare and Medicaid policy and reimbursement, and experience working with patients seeking services at a center.

(b) To conduct targeted outreach to health professionals through medical school instruction, hospital grant rounds, continuing education, community education, and free online resources.

(c) To provide low-cost, accessible detection and diagnosis tools that the center shall make available via open source portals of the postsecondary higher educational institution that established the center. Furthermore, the department shall post these tools on its Internet Web site to serve as a resource for the state.

(d) To endorse and disseminate low-cost, accessible detection and diagnosis tools for broad use by health professionals practicing in a variety of settings.

(e) To address unique health disparities that exist within diverse populations, with special focus and attention on reaching African Americans, Latinos, and women.

(f) To evaluate the educational effectiveness and measure the impact of these efforts, including pretests and posttests for health professionals, metrics, and documented practice change.

SEC. 9. Section 130301 of the Health and Safety Code is amended to read:

130301. The Legislature finds and declares the following:

(a) The federal Health Insurance Portability and Accountability Act (Public Law 104-191), known as HIPAA, was enacted on August 21, 1996.

(b) HIPAA extends health coverage benefits to workers after they terminate or change employment by allowing the worker to participate in existing group coverage plans, thereby avoiding the additional expense associated with obtaining individual coverage as well as the potential loss of coverage because of a preexisting health condition.

(c) Administrative simplification is a key feature of HIPAA, requiring standard national identifiers for providers, employers, and health plans and the development of uniform standards for the coding and transmission of claims and health care information. Administration simplification is intended to promote the use of information technology, thereby reducing costs and increasing efficiency in the health care industry.

(d) HIPAA also contains ~~new~~ standards for safeguarding the privacy and security of health information. Therefore, the development of policies for safeguarding the privacy and security of health records is a fundamental and indispensable part of HIPAA implementation that must accompany or precede the expansion or standardization of technology for recording or transmitting health information.

(e) The federal Department of Health and Human Services has published, and continues to publish, rules pertaining to the implementation of HIPAA. Following a 60-day congressional concurrence period, health providers and insurers have 24 months in which to implement these rules.

(f) These federal rules directly apply to state and county departments that provide health coverage, health care, mental health services, and alcohol and drug treatment programs. Other

state and county departments are subject to these rules to the extent they use or exchange information with the departments to which the federal rules directly apply.

(g) In view of the substantial changes that HIPAA will require in the practices of both private and public health entities and their business associates, the ability of California government to continue the delivery of vital health services will depend upon the implementation ~~of~~ *of, and compliance with,* HIPAA in a manner that is coordinated among state departments as well as our partners in county government and the private health sector.

(h) The implementation of HIPAA shall be accomplished as required by federal law and regulations and shall be a priority for state departments.

SEC. 10. Section 130303 of the Health and Safety Code is amended to read:

130303. The office shall assume statewide leadership, coordination, policy formulation, direction, and oversight responsibilities for HIPAA ~~implementation.~~ *implementation and compliance.* The office shall exercise full authority relative to state entities to establish policy, provide direction to state entities, monitor progress, and report on implementation ~~efforts.~~ *and compliance activities.*

SEC. 11. Section 130305 of the Health and Safety Code is amended to read:

130305. The office shall be staffed, at a minimum, with the following personnel:

(a) Legal counsel to perform activities that may include, but are not limited to, determining the application of federal law pertaining to HIPAA.

(b) Staff with expertise in the rules promulgated by HIPAA.

~~(c) Staff to oversee the development of training curricula and tools and to modify the curricula and tools as required by the state's ongoing HIPAA compliance effort.~~

~~(d) Information technology staff.~~

~~(e)~~

(c) Staff, as necessary, to coordinate and monitor the progress made by all state entities in HIPAA ~~implementation.~~ *implementation and compliance.*

~~(f) Administrative staff, as necessary.~~

SEC. 12. Section 130306 of the Health and Safety Code is amended to read:

130306. ~~(a)~~ The office shall perform the following functions:

~~(1)~~

(a) Standardizing the HIPAA implementation process used in all state entities, which includes the following:

~~(A)~~

(1) Developing ~~a master plan and~~ *an* overall state strategy for HIPAA implementation *and compliance* that includes timeframes within which specified activities will be completed.

~~(B)~~

(2) Specifying tools, such as protocols for assessment and reporting, and any other tools as determined by the director for HIPAA ~~implementation.~~ *implementation and compliance.*

~~(C)~~

(3) Developing uniform policies on privacy, security, and other matters related to HIPAA that shall be adopted and implemented by all state entities. In developing these policies, the office shall consult with representatives from the private sector, state government, and other public entities affected by HIPAA.

~~(D)~~

(4) Providing an ongoing evaluation of HIPAA implementation *and compliance* in California and refining the plans, tools, and policies as required to effect implementation.

~~(E)~~

(5) Developing standards for the office to use in determining the extent of HIPAA compliance.

~~(2)~~

(b) Representing the State of California in HIPAA discussions with the federal Department of Health and Human Services and at the Workgroup for Electronic Data Interchange and other national and regional groups developing standards for HIPAA implementation, including those authorized by the federal Department of Health and Human Services to receive comments related to HIPAA. ~~In preparing comments for submission to these entities, the office shall work in coordination with private and public entities to which the comments relate.~~ The office may review and approve all comments related to HIPAA that state entities or representatives from the University of California, to the extent authorized by its Regents, propose for submission to the federal

Department of Health and Human Services or any other body or organization.

~~(3)~~

(c) Monitoring the HIPAA implementation *and compliance* activities of state entities and requiring these entities to report on their ~~implementation~~ activities at times specified by the director using a format prescribed by the director. The office shall seek the cooperation of counties in monitoring HIPAA implementation *and compliance* in programs that are administered by county government.

~~(4)~~

(d) Providing state entities with technical assistance as the director deems necessary and appropriate to advance the state's implementation *and compliance* of HIPAA as required by the schedule adopted by the federal Department of Health and Human Services. This assistance shall also include sharing information obtained by the office relating to HIPAA.

~~(5) Providing the Department of Finance with recommendations on HIPAA implementation expenditures, including proposals submitted by state entities and a recommendation on the amount to be appropriated for allocation by the Department of Finance to entities implementing HIPAA.~~

~~(6) Conducting a periodic assessment at least once every three years to determine whether staff positions established in the office and in other state entities to perform HIPAA compliance activities continue to be necessary or whether additional staff positions are required to complete these activities.~~

~~(7) Reviewing and approving contracts relating to HIPAA to which a state entity is a party prior to the contract's effective date.~~

~~(8)~~

(e) Reviewing and approving all HIPAA legislation *and regulations* proposed by state entities, other than state control agencies, prior to the proposal's review by any other entity and reviewing all analyses and positions, other than those prepared by state control agencies, on HIPAA related legislation being considered by either Congress or the Legislature.

~~(9)~~

(f) Ensuring state departments claim federal funding for those activities that qualify under federal funding criteria.

~~(10) Establishing a~~

(g) Maintaining an Internet Web site that is accessible to the public to provide information in a consistent and accessible format concerning state HIPAA implementation activities, timeframes for completing those activities, HIPAA implementation requirements that have been met, and the promulgation of federal regulations pertaining to HIPAA implementation. ~~The office shall update this Web site quarterly.~~

~~(b) In performing these functions, the office shall coordinate its activities with the State Office of Privacy Protection.~~

SEC. 13. Section 130307 of the Health and Safety Code is repealed.

~~130307. The director shall establish an advisory committee to obtain information on statewide HIPAA implementation activities, which shall meet at a minimum of two times per year. It is the intent of the Legislature that the committee's membership include representatives from county government, from consumers, and from a broad range of provider groups, such as physicians and surgeons, clinics, hospitals, pharmaceutical companies, health care service plans, disability insurers, long-term care facilities, facilities for the developmentally disabled, and mental health providers. The director shall invite key stakeholders from the federal government, the Judicial Council, health care advocates, nonprofit health care organizations, public health systems, and the private sector to provide information to the committee.~~

SEC. 14. Section 130309 of the Health and Safety Code is amended to read:

130309. (a) All state entities subject to HIPAA shall complete an assessment, in a form specified by the ~~office, prior to January 1, 2002,~~ *office* to determine the impact of HIPAA on their operations. ~~The office shall report the statewide results of the assessment to the appropriate policy and fiscal committees of the Legislature on or before May 15, 2002.~~

(b) ~~Other~~ *All* state entities shall cooperate with the office to determine whether they are subject to HIPAA, including, but not limited to, providing a completed assessment as prescribed by the office.

SEC. 15. Section 130310 of the Health and Safety Code is amended to read:

130310. All state entities shall cooperate with the efforts of the office to monitor HIPAA implementation *and compliance* activities and to obtain information on those activities.

SEC. 16. Section 130312 of the Health and Safety Code is repealed.

~~130312. (a) The Department of Finance shall provide a complete accounting of HIPAA expenditures made by all state entities.~~

~~(b) The Department of Finance, in consultation with the office, shall develop and annually publish prior to August 1, guidelines for state entities to obtain additional HIPAA funding. All funding requests from state entities for HIPAA implementation, including, but not limited to, requests for appropriations through the Budget Act or other legislation and requests for allocation of lump-sum funds from the Department of Finance, shall be reviewed and approved by the office prior to being submitted to the Department of Finance. Funding requests pertaining to information technology activities shall also be reviewed and approved by the Department of Information Technology.~~

~~(c) The Department of Finance shall notify the office and the Chairperson of the Senate Committee on Budget and Fiscal Review and the Chairperson of the Assembly Budget Committee of each allocation it approves within 10 working days of the approval. The Department of Finance shall also report to the Legislature quarterly on HIPAA allocations, redirections, and expenditures, categorized by state entity and by project.~~

SEC. 17. Section 130313 of the Health and Safety Code is amended to read:

130313. To the extent that funds are appropriated in the annual Budget Act, the office shall perform the following functions in order to comply with HIPAA requirements:

(a) ~~The establishment and ongoing~~ *Ongoing* support of departmental HIPAA project management offices.

(b) The development, revision, and issuance of HIPAA compliance policies.

(c) Modifications of programs in accordance with any revised policies.

(d) Staff training on HIPAA compliance policies and programs.

(e) Coordination and communication with other affected entities.

~~(f) Modifications to, or replacement of, information technology systems.~~

(f) Evaluate, monitor, and report on HIPAA implementation and compliance activities of state entities affected by HIPAA.

(g) Consultation with appropriate stakeholders.

SEC. 18. Section 138.7 of the Labor Code, as amended by Section 80 of Chapter 46 of the Statutes of 2012, is amended to read:

138.7. (a) Except as expressly permitted in subdivision (b), a person or public or private entity not a party to a claim for workers' compensation benefits~~ may~~ *shall* not obtain individually identifiable information obtained or maintained by the division on that claim. For purposes of this section, "individually identifiable information" means any data concerning an injury or claim that is linked to a uniquely identifiable employee, employer, claims administrator, or any other person or entity.

(b) (1) (A) The administrative director, or a statistical agent designated by the administrative director, may use individually identifiable information for purposes of creating and maintaining the workers' compensation information system as specified in Section 138.6.

(B) The administrative director may publish the identity of claims administrators in the annual report disclosing the compliance rates of claims administrators pursuant to subdivision (d) of Section 138.6.

(2) (A) The State Department of Public Health may use individually identifiable information for purposes of establishing and maintaining a program on occupational health and occupational disease prevention as specified in Section 105175 of the Health and Safety Code.

(B) (i) The State Department of Health Care Services may use individually identifiable information for purposes of seeking recovery of Medi-Cal costs incurred by the state for treatment provided to injured workers that should have been incurred by employers and insurance carriers pursuant to Article 3.5 (commencing with Section 14124.70) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(ii) The Department of Industrial Relations shall furnish individually identifiable information to the State Department of Health Care Services, and the State Department of Health Care

Services may furnish the information to its designated agent, provided that the individually identifiable information shall not be disclosed for use other than the purposes described in clause (i). The administrative director may adopt regulations solely for the purpose of governing access by the State Department of Health Care Services or its designated agents to the individually identifiable information as defined in subdivision (a).

(3) (A) Individually identifiable information may be used by the Division of Workers' Compensation and the Division of Occupational Safety and Health as necessary to carry out their duties. The administrative director shall adopt regulations governing the access to the information described in this subdivision by these divisions. Any regulations adopted pursuant to this subdivision shall set forth the specific uses for which this information may be obtained.

(B) Individually identifiable information maintained in the workers' compensation information system and the Division of Workers' Compensation may be used by researchers employed by or under contract to the Commission on Health and Safety and Workers' Compensation as necessary to carry out the commission's research. The administrative director shall adopt regulations governing the access to the information described in this subdivision by commission researchers. These regulations shall set forth the specific uses for which this information may be obtained and include provisions guaranteeing the confidentiality of individually identifiable information. Individually identifiable information obtained under this subdivision shall not be disclosed to commission members. No individually identifiable information obtained by researchers under contract to the commission pursuant to this subparagraph may be disclosed to any other person or entity, public or private, for a use other than that research project for which the information was obtained. Within a reasonable period of time after the research for which the information was obtained has been completed, the data collected shall be modified in a manner so that the subjects cannot be identified, directly or through identifiers linked to the subjects.

(4) The administrative director shall adopt regulations allowing reasonable access to individually identifiable information by other persons or public or private entities for the purpose of bona fide statistical research. This research shall not divulge individually

identifiable information concerning a particular employee, employer, claims administrator, or any other person or entity. The regulations adopted pursuant to this paragraph shall include provisions guaranteeing the confidentiality of individually identifiable information. Within a reasonable period of time after the research for which the information was obtained has been completed, the data collected shall be modified in a manner so that the subjects cannot be identified, directly or through identifiers linked to the subjects.

(5) (A) This section shall not operate to exempt from disclosure any information that is considered to be a public record pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) contained in an individual's file once an application for adjudication has been filed pursuant to Section 5501.5.

(B) ~~However, individually~~ *Individually* identifiable information shall not be provided to any person or public or private entity who is not a party to the claim unless that person identifies himself or herself or that public or private entity identifies itself and states the reason for making the request. The administrative director may require the person or public or private entity making the request to produce information to verify that the name and address of the requester is valid and correct. If the purpose of the request is related to preemployment screening, the administrative director shall notify the person about whom the information is requested that the information was provided and shall include the following in 12-point type:

"IT MAY BE A VIOLATION OF FEDERAL AND STATE LAW TO DISCRIMINATE AGAINST A JOB APPLICANT BECAUSE THE APPLICANT HAS FILED A CLAIM FOR WORKERS' COMPENSATION BENEFITS."

(C) Any residence address is confidential and shall not be disclosed to any person or public or private entity except to a party to the claim, a law enforcement agency, an office of a district attorney, any person for a journalistic purpose, or other governmental agency.

(D) ~~Nothing in this~~ *This* paragraph ~~shall be construed to~~ *does not* prohibit the use of individually identifiable information for purposes of identifying bona fide lien claimants.

(c) Except as provided in subdivision (b), individually identifiable information obtained by the division is privileged and is not subject to subpoena in a civil proceeding unless, after reasonable notice to the division and a hearing, a court determines that the public interest and the intent of this section will not be jeopardized by disclosure of the information. This section shall not operate to restrict access to information by any law enforcement agency or district attorney's office or to limit admissibility of that information in a criminal proceeding.

(d) It ~~shall be~~ *is* unlawful for any person who has received individually identifiable information from the division pursuant to this section to provide that information to any person who is not entitled to it under this section.

~~(e) This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.~~

SEC. 19. Section 138.7 of the Labor Code, as amended by Section 81 of Chapter 46 of the Statutes of 2012, is repealed.

~~138.7. (a) Except as expressly permitted in subdivision (b), a person or public or private entity not a party to a claim for workers' compensation benefits may not obtain individually identifiable information obtained or maintained by the division on that claim. For purposes of this section, "individually identifiable information" means any data concerning an injury or claim that is linked to a uniquely identifiable employee, employer, claims administrator, or any other person or entity.~~

~~(b) (1) (A) The administrative director, or a statistical agent designated by the administrative director, may use individually identifiable information for purposes of creating and maintaining the workers' compensation information system as specified in Section 138.6.~~

~~(B) The administrative director may publish the identity of claims administrators in the annual report disclosing the compliance rates of claims administrators pursuant to subdivision (d) of Section 138.6.~~

~~(2) The State Department of Public Health may use individually identifiable information for purposes of establishing and~~

~~maintaining a program on occupational health and occupational disease prevention as specified in Section 105175 of the Health and Safety Code.~~

~~(3) (A) Individually identifiable information may be used by the Division of Workers' Compensation and the Division of Occupational Safety and Health as necessary to carry out their duties. The administrative director shall adopt regulations governing the access to the information described in this subdivision by these divisions. Any regulations adopted pursuant to this subdivision shall set forth the specific uses for which this information may be obtained.~~

~~(B) Individually identifiable information maintained in the workers' compensation information system and the Division of Workers' Compensation may be used by researchers employed by or under contract to the Commission on Health and Safety and Workers' Compensation as necessary to carry out the commission's research. The administrative director shall adopt regulations governing the access to the information described in this subdivision by commission researchers. These regulations shall set forth the specific uses for which this information may be obtained and include provisions guaranteeing the confidentiality of individually identifiable information. Individually identifiable information obtained under this subdivision shall not be disclosed to commission members. No individually identifiable information obtained by researchers under contract to the commission pursuant to this subparagraph may be disclosed to any other person or entity, public or private, for a use other than that research project for which the information was obtained. Within a reasonable period of time after the research for which the information was obtained has been completed, the data collected shall be modified in a manner so that the subjects cannot be identified, directly or through identifiers linked to the subjects.~~

~~(4) The administrative director shall adopt regulations allowing reasonable access to individually identifiable information by other persons or public or private entities for the purpose of bona fide statistical research. This research shall not divulge individually identifiable information concerning a particular employee, employer, claims administrator, or any other person or entity. The regulations adopted pursuant to this paragraph shall include provisions guaranteeing the confidentiality of individually~~

~~identifiable information. Within a reasonable period of time after the research for which the information was obtained has been completed, the data collected shall be modified in a manner so that the subjects cannot be identified, directly or through identifiers linked to the subjects.~~

~~(5) (A) This section shall not operate to exempt from disclosure any information that is considered to be a public record pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) contained in an individual's file once an application for adjudication has been filed pursuant to Section 5501.5.~~

~~(B) However, individually identifiable information shall not be provided to any person or public or private entity who is not a party to the claim unless that person identifies himself or herself or that public or private entity identifies itself and states the reason for making the request. The administrative director may require the person or public or private entity making the request to produce information to verify that the name and address of the requester is valid and correct. If the purpose of the request is related to preemployment screening, the administrative director shall notify the person about whom the information is requested that the information was provided and shall include the following in 12-point type:~~

~~"IT MAY BE A VIOLATION OF FEDERAL AND STATE LAW TO DISCRIMINATE AGAINST A JOB APPLICANT BECAUSE THE APPLICANT HAS FILED A CLAIM FOR WORKERS' COMPENSATION BENEFITS."~~

~~(C) Any residence address is confidential and shall not be disclosed to any person or public or private entity except to a party to the claim, a law enforcement agency, an office of a district attorney, any person for a journalistic purpose, or other governmental agency.~~

~~(D) Nothing in this paragraph shall be construed to prohibit the use of individually identifiable information for purposes of identifying bona fide lien claimants.~~

~~(c) Except as provided in subdivision (b), individually identifiable information obtained by the division is privileged and is not subject to subpoena in a civil proceeding unless, after~~

~~reasonable notice to the division and a hearing, a court determines that the public interest and the intent of this section will not be jeopardized by disclosure of the information. This section shall not operate to restrict access to information by any law enforcement agency or district attorney's office or to limit admissibility of that information in a criminal proceeding.~~

~~(d) It shall be unlawful for any person who has received individually identifiable information from the division pursuant to this section to provide that information to any person who is not entitled to it under this section.~~

~~(e) This section shall become operative on January 1, 2017.~~

SEC. 20. Section 5848.5 of the Welfare and Institutions Code is amended to read:

5848.5. (a) The Legislature finds and declares all of the following:

(1) California has realigned public community mental health services to counties and it is imperative that sufficient community-based resources be available to meet the mental health needs of eligible individuals.

(2) Increasing access to effective outpatient and crisis stabilization services provides an opportunity to reduce costs associated with expensive inpatient and emergency room care and to better meet the needs of individuals with mental health disorders in the least restrictive manner possible.

(3) Almost one-fifth of people with mental health disorders visit a hospital emergency room at least once per year. If an adequate array of crisis services is not available, it leaves an individual with little choice but to access an emergency room for assistance and, potentially, an unnecessary inpatient hospitalization.

(4) Recent reports have called attention to a continuing problem of inappropriate and unnecessary utilization of hospital emergency rooms in California due to limited community-based services for individuals in psychological distress and acute psychiatric crisis. Hospitals report that 70 percent of people taken to emergency rooms for psychiatric evaluation can be stabilized and transferred to a less intensive level of crisis care. Law enforcement personnel report that their personnel need to stay with people in the emergency room waiting area until a placement is found, and that less intensive levels of care tend not to be available.

(5) Comprehensive public and private partnerships at both local and regional levels, including across physical health services, mental health, substance use disorder, law enforcement, social services, and related supports, are necessary to develop and maintain high quality, patient-centered, and cost-effective care for individuals with mental health disorders that facilitates their recovery and leads towards wellness.

(6) The recovery of individuals with mental health disorders is important for all levels of government, business, and the local community.

(b) This section shall be known, and may be cited, as the Investment in Mental Health Wellness Act of 2013. The objectives of this section are to do all of the following:

(1) Expand access to early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.

(2) Expand the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness, resiliency, and recovery oriented.

(3) Add at least 25 mobile crisis support teams and at least 2,000 crisis stabilization and crisis residential treatment beds to bolster capacity at the local level to improve access to mental health crisis services and address unmet mental health care needs.

(4) Add at least 600 triage personnel to provide intensive case management and linkage to services for individuals with mental health care disorders at various points of access, such as at designated community-based service points, homeless shelters, and clinics.

(5) Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services and improving access to timely assistance.

(6) Reduce recidivism and mitigate unnecessary expenditures of local law enforcement.

(7) Provide local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for individuals with mental health disorders.

(8) Provide a complete continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state. The funds included in the 2016 Budget Act for the

purpose of developing the continuum of mental health crisis services for children and youth 21 years of age and under shall be for the following objectives:

(A) Provide a continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state.

(B) Provide for early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.

(C) Expand the continuum of community-based services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness-, resiliency-, and recovery-oriented.

(D) Add at least 200 mobile crisis support teams.

(E) Add at least 120 crisis stabilization services and beds and crisis residential treatment beds to increase capacity at the local level to improve access to mental health crisis services and address unmet mental health care needs.

(F) Add triage personnel to provide intensive case management and linkage to services for individuals with mental health care disorders at various points of access, such as at designated community-based service points, homeless shelters, schools, and clinics.

(G) Expand family respite care to help families and sustain caregiver health and well-being.

(H) Expand family supportive training and related services designed to help families participate in the planning process, access services, and navigate programs.

(I) Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services.

(J) Reduce recidivism and mitigate unnecessary expenditures of local law enforcement.

(K) Provide local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for children and youth 21 years of age and under with mental health disorders.

(c) Through appropriations provided in the annual Budget Act for this purpose, it is the intent of the Legislature to authorize the California Health Facilities Financing Authority, hereafter referred to as the authority, and the Mental Health Services Oversight and

Accountability Commission, hereafter referred to as the commission, to administer competitive selection processes as provided in this section for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, and specified personnel resources.

(d) Funds appropriated by the Legislature to the authority for purposes of this section shall be made available to selected counties, or counties acting jointly. The authority may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively supports this designation and collaboration in lieu of a county government directly receiving grant funds.

(1) Grant awards made by the authority shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase capacity for client assistance and services in the following areas:

(A) Crisis intervention, as authorized by Sections 14021.4, 14680, and 14684.

(B) Crisis stabilization, as authorized by Sections 14021.4, 14680, and 14684.

(C) Crisis residential treatment, as authorized by Sections 14021.4, 14680, and 14684.

(D) Rehabilitative mental health services, as authorized by Sections 14021.4, 14680, and 14684.

(E) Mobile crisis support teams, including personnel and equipment, such as the purchase of vehicles.

(2) The authority shall develop selection criteria to expand local resources, including those described in paragraph (1), and processes for awarding grants after consulting with representatives and interested stakeholders from the mental health community, including, but not limited to, the County Behavioral Health Directors Association of California, service providers, consumer organizations, and other appropriate interests, such as health care providers and law enforcement, as determined by the authority. The authority shall ensure that grants result in cost-effective expansion of the number of community-based crisis resources in regions and communities selected for funding. The authority shall also take into account at least the following criteria and factors

when selecting recipients of grants and determining the amount of grant awards:

(A) Description of need, including, at a minimum, a comprehensive description of the project, community need, population to be served, linkage with other public systems of health and mental health care, linkage with local law enforcement, social services, and related assistance, as applicable, and a description of the request for funding.

(B) Ability to serve the target population, which includes individuals eligible for Medi-Cal and individuals eligible for county health and mental health services.

(C) Geographic areas or regions of the state to be eligible for grant awards, which may include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(D) Level of community engagement and commitment to project completion.

(E) Financial support that, in addition to a grant that may be awarded by the authority, will be sufficient to complete and operate the project for which the grant from the authority is awarded.

(F) Ability to provide additional funding support to the project, including public or private funding, federal tax credits and grants, foundation support, and other collaborative efforts.

(G) Memorandum of understanding among project partners, if applicable.

(H) Information regarding the legal status of the collaborating partners, if applicable.

(I) Ability to measure key outcomes, including improved access to services, health and mental health outcomes, and cost benefit of the project.

(3) The authority shall determine maximum grants awards, which shall take into consideration the number of projects awarded to the grantee, as described in paragraph (1), and shall reflect reasonable costs for the project and geographic region. The authority may allocate a grant in increments contingent upon the phases of a project.

(4) Funds awarded by the authority pursuant to this section may be used to supplement, but not to supplant, existing financial and resource commitments of the grantee or any other member of a collaborative effort that has been awarded a grant.

(5) All projects that are awarded grants by the authority shall be completed within a reasonable period of time, to be determined by the authority. Funds shall not be released by the authority until the applicant demonstrates project readiness to the authority's satisfaction. If the authority determines that a grant recipient has failed to complete the project under the terms specified in awarding the grant, the authority may require remedies, including the return of all or a portion of the grant.

(6) A grantee that receives a grant from the authority under this section shall commit to using that capital capacity and program expansion project, such as the mobile crisis team, crisis stabilization unit, or crisis residential treatment program, for the duration of the expected life of the project.

(7) The authority may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, for purposes of implementing this section.

(8) The authority may adopt emergency regulations relating to the grants for the capital capacity and program expansion projects described in this section, including emergency regulations that define eligible costs and determine minimum and maximum grant amounts.

(9) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before May 1, 2014, and on or before May 1, 2015, on the progress of implementation, that include, but are not limited to, the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

(C) A description of other sources of funding for each project.

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(10) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

(e) Of the funds specified in paragraph (8) of subdivision (b), it is the intent of the Legislature to authorize the authority and the commission to administer competitive selection processes as provided in this section for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, family

respite care, family supportive training and related services, and triage personnel resources for children and youth 21 years of age and under.

(f) Funds appropriated by the Legislature to the authority to address crisis services for children and youth 21 years of age and under for the purposes of this section shall be made available to selected counties or counties acting jointly. The authority may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively support this designation and collaboration in lieu of a county government directly receiving grant funds.

(1) Grant awards made by the authority shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase capacity for client assistance and crisis services for children and youth 21 years of age and under in the following areas:

(A) Crisis intervention, as authorized by Sections 14021.4, 14680, and 14684.

(B) Crisis stabilization, as authorized by Sections 14021.4, 14680, and 14684.

(C) Crisis residential treatment, as authorized by Sections 14021.4, 14680, and 14684.

(D) Mobile crisis support teams, including the purchase of equipment and vehicles.

(E) Family respite care.

(2) The authority shall develop selection criteria to expand local resources, including those described in paragraph (1), and processes for awarding grants after consulting with representatives and interested stakeholders from the mental health community, including, but not limited to, county mental health directors, service providers, consumer organizations, and other appropriate interests, such as health care providers and law enforcement, as determined by the authority. The authority shall ensure that grants result in cost-effective expansion of the number of community-based crisis resources in regions and communities selected for funding. The authority shall also take into account at least the following criteria and factors when selecting recipients of grants and determining the amount of grant awards:

(A) Description of need, including, at a minimum, a comprehensive description of the project, community need, population to be served, linkage with other public systems of health and mental health care, linkage with local law enforcement, social services, and related assistance, as applicable, and a description of the request for funding.

(B) Ability to serve the target population, which includes individuals eligible for Medi-Cal and individuals eligible for county health and mental health services.

(C) Geographic areas or regions of the state to be eligible for grant awards, which may include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the California Behavioral Health Directors Association.

(D) Level of community engagement and commitment to project completion.

(E) Financial support that, in addition to a grant that may be awarded by the authority, will be sufficient to complete and operate the project for which the grant from the authority is awarded.

(F) Ability to provide additional funding support to the project, including public or private funding, federal tax credits and grants, foundation support, and other collaborative efforts.

(G) Memorandum of understanding among project partners, if applicable.

(H) Information regarding the legal status of the collaborating partners, if applicable.

(I) Ability to measure key outcomes, including utilization of services, health and mental health outcomes, and cost benefit of the project.

(3) The authority shall determine maximum grant awards, which shall take into consideration the number of projects awarded to the grantee, as described in paragraph (1), and shall reflect reasonable costs for the project, geographic region, and target ages. The authority may allocate a grant in increments contingent upon the phases of a project.

(4) Funds awarded by the authority pursuant to this section may be used to supplement, but not to supplant, existing financial and resource commitments of the grantee or any other member of a collaborative effort that has been awarded a grant.

(5) All projects that are awarded grants by the authority shall be completed within a reasonable period of time, to be determined

by the authority. Funds shall not be released by the authority until the applicant demonstrates project readiness to the authority's satisfaction. If the authority determines that a grant recipient has failed to complete the project under the terms specified in awarding the grant, the authority may require remedies, including the return of all, or a portion, of the grant.

(6) A grantee that receives a grant from the authority under this section shall commit to using that capital capacity and program expansion project, such as the mobile crisis team, crisis stabilization unit, family respite care, or crisis residential treatment program, for the duration of the expected life of the project.

(7) The authority may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, for the purposes of implementing this section.

(8) The authority may adopt emergency regulations relating to the grants for the capital capacity and program expansion projects described in this section, including emergency regulations that define eligible costs and determine minimum and maximum grant amounts.

(9) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before January 10, 2018, and annually thereafter, on the progress of implementation, that include, but are not limited to, the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

(C) A description of other sources of funding for each project.

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(10) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

~~(e)~~

(g) Funds appropriated by the Legislature to the commission for purposes of this section shall be allocated for triage personnel to provide intensive case management and linkage to services for individuals with mental health disorders at various points of access. These funds shall be made available to selected counties, counties acting jointly, or city mental health departments, as determined by the commission through a selection process. It is the intent of

the Legislature for these funds to be allocated in an efficient manner to encourage early intervention and receipt of needed services for individuals with mental health disorders, and to assist in navigating the local service sector to improve efficiencies and the delivery of services.

(1) Triage personnel may provide targeted case management services face to face, by telephone, or by telehealth with the individual in need of assistance or his or her significant support person, and may be provided anywhere in the community. These service activities may include, but are not limited to, the following:

(A) Communication, coordination, and referral.

(B) Monitoring service delivery to ensure the individual accesses and receives services.

(C) Monitoring the individual's progress.

(D) Providing placement service assistance and service plan development.

(2) The commission shall take into account at least the following criteria and factors when selecting recipients and determining the amount of grant awards for triage personnel as follows:

(A) Description of need, including potential gaps in local service connections.

(B) Description of funding request, including personnel and use of peer support.

(C) Description of how triage personnel will be used to facilitate linkage and access to services, including objectives and anticipated outcomes.

(D) Ability to obtain federal Medicaid reimbursement, when applicable.

(E) Ability to administer an effective service program and the degree to which local agencies and service providers will support and collaborate with the triage personnel effort.

(F) Geographic areas or regions of the state to be eligible for grant awards, which shall include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(3) The commission shall determine maximum grant awards, and shall take into consideration the level of need, population to be served, and related criteria, as described in paragraph (2), and shall reflect reasonable costs.

(4) Funds awarded by the commission for purposes of this section may be used to supplement, but not supplant, existing financial and resource commitments of the county, counties acting jointly, or city mental health department that received the grant.

(5) Notwithstanding any other law, a county, counties acting jointly, or city mental health department that receives an award of funds for the purpose of supporting triage personnel pursuant to this subdivision is not required to provide a matching contribution of local funds.

(6) Notwithstanding any other law, the commission, without taking any further regulatory action, may implement, interpret, or make specific this section by means of informational letters, bulletins, or similar instructions.

(7) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation no later than March 1, 2014.

(h) Funds appropriated by the Legislature to the commission pursuant to paragraph (8) of subdivision (b) for the purposes of addressing children's crisis services shall be allocated to support triage personnel and family supportive training and related services. These funds shall be made available to selected counties, counties acting jointly, or city mental health departments, as determined by the commission through a selection process. The commission may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively supports this designation and collaboration in lieu of a county government directly receiving grant funds.

(1) These funds may provide for a range of crisis-related services for a child in need of assistance, or his or her parent, guardian, or caregiver. These service activities may include, but are not limited to, the following:

(A) Intensive coordination of care and services.

(B) Communication, coordination, and referral.

(C) Monitoring service delivery to the child or youth.

(D) Monitoring the child's progress.

(E) Providing placement service assistance and service plan development.

(F) Crisis or safety planning.

(2) The commission shall take into account at least the following criteria and factors when selecting recipients and determining the amount of grant awards for these funds, as follows:

(A) Description of need, including potential gaps in local service connections.

(B) Description of funding request, including personnel.

(C) Description of how personnel and other services will be used to facilitate linkage and access to services, including objectives and anticipated outcomes.

(D) Ability to obtain federal Medicaid reimbursement, when applicable.

(E) Ability to provide a matching contribution of local funds.

(F) Ability to administer an effective service program and the degree to which local agencies and service providers will support and collaborate with the triage personnel effort.

(G) Geographic areas or regions of the state to be eligible for grant awards, which shall include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(3) The commission shall determine maximum grant awards, and shall take into consideration the level of need, population to be served, and related criteria, as described in paragraph (2), and shall reflect reasonable costs.

(4) Funds awarded by the commission for purposes of this section may be used to supplement, but not supplant, existing financial and resource commitments of the county, counties acting jointly, or a city mental health department that received the grant.

(5) Notwithstanding any other law, a county, counties acting jointly, or a city mental health department that receives an award of funds for the purpose of this section is not required to provide a matching contribution of local funds.

(6) Notwithstanding any other law, the commission, without taking any further regulatory action, may implement, interpret, or make specific this section by means of informational letters, bulletins, or similar instructions.

(7) The commission may waive requirements in this section for counties with a population of 100,000 or less, if the commission determines it is in the best interest of the state and meets the intent of the law.

(8) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation no later than January 10, 2018, and annually thereafter.

SEC. 21. Section 10752 of the Welfare and Institutions Code is amended to read:

10752. The department shall, by March 1, 2017, in coordination with the Department of Finance, ~~develop a funding plan that ensures adequate reimbursement to emergency medical air transportation providers following~~ *notify the Legislature of the fiscal impact on the Medi-Cal program resulting from, and the planned reimbursement methodology for emergency medical air transportation services after,* the termination of penalty assessments pursuant to subdivision (f) of Section 76000.10 of the Government Code on January 1, 2018.

SEC. 22. Section 14009.5 of the Welfare and Institutions Code is amended to read:

14009.5. (a) ~~Notwithstanding~~ *It is the intent of the Legislature, with the amendments made to this section by the act that added subdivision (g), to do all of the following:*

(1) Limit Medi-Cal estate recovery only for those services required to be collected under federal law.

(2) Limit the definition of "estate" to include only the real and personal property and other assets required to be collected under federal law.

(3) Require the State Department of Health Care Services to implement the option in the State Medicaid Manual to waive its claim, as a substantial hardship, when the estate subject to recovery is a homestead of modest value, subject to federal approval.

(4) Prohibit recovery from the estate of a deceased Medi-Cal member who is survived by a spouse or registered domestic partner.

(5) Ensure that Medi-Cal members can easily and timely receive information about how much their estate may owe Medi-Cal when they die.

(b) Notwithstanding any other provision of this chapter, the department shall claim against the estate of the decedent, or against any recipient of the property of that decedent by ~~distribution or survival~~ *distribution,* an amount equal to the payments for the

health care services received or the value of the property received by any recipient from the decedent by ~~distribution or survival, whichever is less.~~ *distribution, whichever is less, only in either of the following circumstances:*

~~(b) The department may not claim in any of the following circumstances:~~

~~(1) The decedent was under 55 when services were received, except in the case of an individual who had been an inpatient in a nursing facility.~~

~~(2) Where there is any of the following:~~

(1) Against the real property of a Medi-Cal member of any age who meets the criteria in Section 1396p(a)(1)(B) of Title 42 of the United States Code and who was or is an inpatient in a nursing facility in accordance with Section 1396p(b)(1)(A) of Title 42 of the United States Code.

(2) (A) The decedent was 55 years of age or older when the individual received health care services.

(B) The department shall not claim under this paragraph when there is any of the following:

~~(A)~~

(i) A surviving ~~spouse during his or her lifetime. However, upon the death of a surviving spouse, the department shall make a claim against the estate of the surviving spouse, or against any recipient of property from the surviving spouse obtained by distribution or survival, for either the amount paid for the medical assistance given to the decedent or the value of any of the decedent's property received by the surviving spouse through distribution or survival, whichever is less. Any statute of limitations that purports to limit the ability to recover for medical assistance granted under this chapter shall not apply to any claim made for reimbursement.~~ *spouse or surviving registered domestic partner.*

~~(B)~~

(ii) A surviving child who is under ~~age 21.~~ *21 years of age.*

~~(C)~~

(iii) A surviving child who is blind or ~~permanently and totally~~ disabled, within the meaning of Section 1614 of the federal Social Security Act (42 ~~U.S.C.A.~~ *U.S.C.* Sec. 1382c).

~~(3) Any exemption described in paragraph (2) that restricts the department from filing a claim against a decedent's property shall apply only to the proportionate share of the decedent's estate or~~

~~property that passes to those recipients, by survival or distribution, who qualify for an exemption under paragraph (2).~~

(c) (1) The department shall waive its claim, in whole or in part, if it determines that enforcement of the claim would result in substantial hardship to other dependents, heirs, or survivors of the individual against whose estate the claim exists.

(2) In determining the existence of substantial hardship, in addition to other factors considered by the department consistent with federal law and guidance, the department shall, subject to federal approval, waive its claim when the estate subject to recovery is a homestead of modest value.

~~(2)~~

(3) The department shall notify individuals of the waiver provision and the opportunity for a hearing to establish that a waiver should be granted.

(d) If the department proposes and accepts a voluntary postdeath lien, the voluntary postdeath lien shall accrue interest at the rate equal to the annual average rate earned on investments in the Surplus Money Investment Fund in the calendar year preceding the year in which the decedent died or simple interest at 7 percent per annum, whichever is lower.

(e) (1) The department shall provide a current or former member, or his or her authorized representative designated under Section 14014.5, upon request, a copy of the amount of Medi-Cal expenses that may be recoverable under this section through the date of the request. The information may be requested once per calendar year for a fee to cover the department's reasonable administrative costs, not to exceed five dollars ($5) if the current or former member meets either of the following descriptions:

(A) An individual who is 55 years of age or older when the individual received health care services.

(B) A permanently institutionalized individual who is an inpatient in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institution.

(2) The department shall permit a member to request the information described in paragraph (1) through the Internet, by telephone, by mail, or through other commonly available electronic means. Upon receipt of the request for information described in paragraph (1), the department shall work with the member to

ensure that the member submits documentation necessary to identify the individual and process the member's request.

(3) The department shall conspicuously post on its Internet Web site a description of the methods by which a request under this subdivision may be made, including, but not limited to, the department's telephone number and any addresses that may be used for this purpose. The department shall also include this information in its pamphlet for the Medi-Cal Estate Recovery Program and any other notices the department distributes to members specifically regarding estate recovery.

(4) Upon receiving a request for the information described in paragraph (1) and all necessary supporting documentation, the department shall provide the information requested within 90 days after receipt of the request.

~~(d)~~

(f) The following definitions shall govern the construction of this section:

(1) "Decedent" means a ~~beneficiary~~ *member* who has received health care under this chapter or Chapter 8 (commencing with Section 14200) and who has died leaving property to others ~~either through distribution or survival.~~ *through distribution.*

(2) "Dependents" includes, but is not limited to, immediate family or blood relatives of the decedent.

(3) "Estate" means all real and personal property and other assets in the individual's probate estate that are required to be subject to a claim for recovery pursuant to Section 1396p(b)(4)(A) of Title 42 of the United States Code.

(4) "Health care services" means only those services required to be recovered under Section 1396p(b)(1)(B)(i) of Title 42 of the United States Code.

(5) "Homestead of modest value" means a home whose fair market value is 50 percent or less of the average price of homes in the county where the homestead is located, as of the date of the decedent's death.

(g) The amendments made to this section by the act that added this subdivision shall apply only to individuals who die on or after January 1, 2017.

SEC. 23. Section 14046.7 of the Welfare and Institutions Code is amended to read:

14046.7. (a) General Fund moneys shall not be used for the purposes of this article.

(b) Notwithstanding subdivision (a), no more than ~~two hundred thousand dollars ($200,000)~~ *four hundred twenty-five thousand dollars ($425,000)* from the General Fund may be used annually for state administrative costs associated with implementing this article.

SEC. 24. Section 14105.436 of the Welfare and Institutions Code is amended to read:

14105.436. (a) Effective July 1, 2002, all pharmaceutical manufacturers shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 and reimbursed through the Medi-Cal outpatient fee-for-service drug program. The state rebate shall be negotiated as necessary between the department and the pharmaceutical manufacturer. The negotiations shall take into account offers such as rebates, discounts, disease management programs, and other cost savings offerings and shall be retroactive to July 1, 2002.

(b) The department may use existing administrative mechanisms for any drug for which the department does not obtain a rebate pursuant to subdivision (a). The department may only use those mechanisms in the event that, by February 1, 2003, the manufacturer refuses to provide the additional rebate. This subdivision shall become inoperative on January 1, 2010.

(c) For purposes of this section, "Medi-Cal utilization data" means the data used by the department to reimburse providers under all programs that qualify for federal drug rebates pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8) or that otherwise qualify for federal funds under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) pursuant to the Medicaid state plan or waivers. Medi-Cal utilization data excludes data from covered entities identified in Section 256b(a)(4) of Title 42 of the United States Code in accordance with Sections 256b(a)(5)(A) and 1396r-8(a)(5)(C) of Title 42 of the United States Code, and those capitated plans that include a prescription drug benefit in the capitated rate and that have negotiated contracts for rebates or discounts with manufacturers.

(d) ~~Subdivision~~ *Upon implementation of paragraphs (4) and (5) of subdivision (b) of Section 14105.33 for drugs pursuant to this section, subdivisions (a) and* (c) shall become inoperative ~~when the department implements paragraphs (4) and (5) of~~ *and "utilization data" shall be described pursuant to* subdivision (b) of Section 14105.33. The department shall post on its Internet Web site a notice that it has implemented paragraphs (4) and (5) of subdivision (b) of Section ~~14105.33.~~ *14105.33 for drugs pursuant to this section.*

(e) Effective July 1, 2009, all pharmaceutical manufacturers shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, equal to an amount not less than 10 percent of the average manufacturer price based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2.

(f) Pharmaceutical manufacturers shall, by January 1, 2010, enter into a supplemental rebate agreement for the rebate required in subdivision ~~(d)~~ *(e)* for drug products added to the Medi-Cal list of contract drugs on or before December 31, 2009.

(g) Effective January 1, 2010, all pharmaceutical manufacturers who have not entered into a supplemental rebate agreement pursuant to subdivisions ~~(d)~~ *(e)* and ~~(e),~~ *(f)* shall provide to the department a state rebate, in addition to rebates pursuant to other provisions of state or federal law, equal to an amount not less than 20 percent of the average manufacturer price based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 prior to January 1, 2010. If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement by March 1, 2010, the manufacturer's drug product shall be made available only through an approved treatment authorization request pursuant to subdivision ~~(h).~~ *(i).*

(h) For a drug product added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 on or after January 1, 2010, a pharmaceutical manufacturer shall provide to the department a state rebate pursuant to subdivision ~~(d).~~ *(e).* If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement within 60 days after the addition of the drug to the Medi-Cal list of contract drugs, the manufacturer shall provide

to the department a state rebate equal to not less than 20 percent of the average manufacturers price based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2. If the pharmaceutical manufacturer does not enter into a supplemental rebate agreement within 120 days after the addition of the drug to the Medi-Cal list of contract drugs, the pharmaceutical manufacturer's drug product shall be made available only through an approved treatment authorization request pursuant to subdivision ~~(h).~~ *(i)*. For supplemental rebate agreements executed more than 120 days after the addition of the drug product to the Medi-Cal list of contract drugs, the state rebate shall equal an amount not less than 20 percent of the average manufacturers price based on Medi-Cal utilization data for any drug products that have been added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2.

(i) Notwithstanding any other ~~provision of~~ law, drug products added to the Medi-Cal list of contract drugs pursuant to Section 14105.43 or 14133.2 of manufacturers who do not execute an agreement to pay additional rebates pursuant to this ~~section,~~ *section* shall be available only through an approved treatment authorization request.

(j) For drug products added on or before December 31, 2009, a beneficiary may obtain a drug product that requires a treatment authorization request pursuant to subdivision ~~(h)~~ *(i)* if the beneficiary qualifies for continuing care status. To be eligible for continuing care status, a beneficiary must be taking the drug product and the department must have record of a reimbursed claim for the drug product with a date of service that is within 100 days prior to the date the drug product was placed on treatment authorization request status. A beneficiary may remain eligible for continuing care status, provided that a claim is submitted for the drug product in question at least every 100 days and the date of service of the claim is within 100 days of the date of service of the last claim submitted for the same drug product.

(k) Changes made to the Medi-Cal list of contract drugs under this section shall be exempt from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Part 1 of Division

3 of Title 2 of the Government Code), and shall not be subject to the review and approval of the Office of Administrative Law.

SEC. 25. Section 14105.45 of the Welfare and Institutions Code is amended to read:

14105.45. (a) For purposes of this section, the following definitions shall apply:

(1) "Average acquisition cost" means the average weighted cost determined by the department to represent the actual acquisition cost paid for drugs by Medi-Cal pharmacy providers, including those that provide specialty drugs. The average acquisition cost shall not be considered confidential and shall be subject to disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

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

(3) "Average wholesale price" means the price for a drug product listed as the average wholesale price in the department's primary price reference source.

(4) "Estimated acquisition cost" means the department's best estimate of the price generally and currently paid by providers for a drug product sold by a particular manufacturer or principal labeler in a standard package.

(5) "Federal upper limit" means the maximum per unit reimbursement when established by the federal Centers for Medicare and Medicaid ~~Services and published by the department in Medi-Cal pharmacy provider bulletins and manuals.~~ *Services.*

(6) "Generically equivalent drugs" means drug products with the same active chemical ingredients of the same strength and dosage form, and of the same generic drug name, as determined by the United States Adopted Names (USAN) and accepted by the federal Food and Drug Administration (FDA), as those drug products having the same chemical ingredients.

(7) "Legend drug" means any drug whose labeling states "Caution: Federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(8) "Maximum allowable ingredient cost" (MAIC) means the maximum amount the department will reimburse Medi-Cal pharmacy providers for generically equivalent drugs.

(9) "Innovator multiple source drug," "noninnovator multiple source drug," and "single source drug" have the same meaning as those terms are defined in Section 1396r-8(k)(7) of Title 42 of the United States Code.

(10) "Nonlegend drug" means any drug whose labeling does not contain the statement referenced in paragraph (7).

(11) "Pharmacy warehouse," as defined in Section 4163 of the Business and Professions Code, means a physical location licensed as a wholesaler for prescription drugs that acts as a central warehouse and performs intracompany sales or transfers of those drugs to a group of pharmacies under common ownership and control.

(12) "Professional dispensing fee" has the same meaning as that term is defined in Section 447.502 of Title 42 of the Code of Federal Regulations.

~~(12)~~

(13) "Specialty drugs" means drugs determined by the department pursuant to subdivision (f) of Section 14105.3 to generally require special handling, complex dosing regimens, specialized self-administration at home by a beneficiary or caregiver, or specialized nursing facility services, or may include extended patient education, counseling, monitoring, or clinical support.

~~(13)~~

(14) "Volume weighted average" means the aggregated average volume for a group of legend or nonlegend drugs, weighted by each drug's percentage of the group's total volume in the Medi-Cal fee-for-service program during the previous six months. For purposes of this paragraph, volume is based on the standard billing unit used for the legend or nonlegend drugs.

~~(14)~~

(15) "Wholesaler" means a drug wholesaler that is engaged in wholesale distribution of prescription drugs to retail pharmacies in California.

~~(15)~~

(16) "Wholesaler acquisition cost" means the price for a drug product listed as the wholesaler acquisition cost in the department's primary price reference source.

(b) (1) Reimbursement to Medi-Cal pharmacy providers for legend and nonlegend drugs shall not exceed the lowest of either of the following:

(A) The estimated acquisition cost of the drug plus a professional ~~fee for dispensing.~~ *dispensing fee.*

(B) The pharmacy's usual and customary charge as defined in Section 14105.455.

(2) ~~The professional~~ *(A) Until April 1, 2017, the professional dispensing* fee shall be seven dollars and twenty-five cents ($7.25) per dispensed ~~prescription. The professional~~ *prescription, and the professional dispensing* fee for legend drugs dispensed to a beneficiary residing in a skilled nursing facility or intermediate care facility shall be eight dollars ($8) per dispensed prescription. For purposes of this ~~paragraph~~ *paragraph,* "skilled nursing facility" and "intermediate care facility" ~~shall~~ have the same meaning as *those terms are* defined in Division 5 (commencing with Section 70001) of Title 22 of the California Code of Regulations. ~~If the department determines that a change in dispensing fee is necessary pursuant to this section, the department shall establish the new dispensing fee through the budget process and implement the new dispensing fee pursuant to subdivision (d).~~

(B) Commencing April 1, 2017, the department shall implement a new professional dispensing fee or fees.

(i) When establishing the new professional dispensing fee or fees, the department shall establish the professional dispensing fee or fees consistent with subsection (d) of Section 447.518 of Title 42 of the Code of Federal Regulations.

(ii) The department shall consult with interested parties and appropriate stakeholders in implementing this subparagraph.

(C) If the department determines that a change in the amount of a professional dispensing fee is necessary pursuant to this section in order to meet federal Medicaid requirements, the department shall establish the new professional dispensing fee through the state budget process.

(3) The department shall establish the estimated acquisition cost of legend and nonlegend drugs as follows:

(A) For single source and innovator multiple source drugs, the estimated acquisition cost shall be equal to the lowest of the average wholesale price minus 17 percent, the average acquisition cost, the federal upper limit, or the MAIC.

(B) For noninnovator multiple source drugs, the estimated acquisition cost shall be equal to the lowest of the average wholesale price minus 17 percent, the average acquisition cost, the federal upper limit, or the MAIC.

(C) Average wholesale price shall not be used to establish the estimated acquisition cost once the department has determined that the average acquisition cost methodology has been fully implemented.

(4) For purposes of paragraph (3), the department shall establish a list of MAICs for generically equivalent drugs, which shall be published in pharmacy provider bulletins and manuals. The department shall establish a MAIC only when three or more generically equivalent drugs are available for purchase and dispensing by retail pharmacies in California. The department shall update the list of MAICs and establish additional MAICs in accordance with all of the following:

(A) The department shall base the MAIC on the mean of the average manufacturer's price of drugs generically equivalent to the particular innovator drug plus a percent markup determined by the department to be necessary for the MAIC to represent the average purchase price paid by retail pharmacies in California.

(B) If average manufacturer prices are unavailable, the department shall establish the MAIC in one of the following ways:

(i) Based on the volume weighted average of wholesaler acquisition costs of drugs generically equivalent to the particular innovator drug plus a percent markup determined by the department to be necessary for the MAIC to represent the average purchase price paid by retail pharmacies in California.

(ii) Pursuant to a contract with a vendor for the purpose of surveying drug price information, collecting data, and calculating a proposed MAIC.

(iii) Based on the volume weighted average acquisition cost of drugs generically equivalent to the particular innovator drug adjusted by the department to represent the average purchase price paid by Medi-Cal pharmacy providers.

(C) The department shall update MAICs at least every three months and notify Medi-Cal providers at least 30 days prior to the effective date of a MAIC.

(D) The department shall establish a process for providers to seek a change to a specific MAIC when the providers believe the MAIC does not reflect current available market prices. If the department determines a MAIC change is warranted, the department may update a specific MAIC prior to notifying providers.

(E) In determining the average purchase price, the department shall consider the provider-related costs of the products that include, but are not limited to, shipping, handling, storage, and delivery. Costs of the provider that are included in the costs of the dispensing shall not be used to determine the average purchase price.

(5) (A) The department may establish the average acquisition cost in one of the following ways:

(i) Based on the volume weighted average acquisition cost adjusted by the department to ensure that the average acquisition cost represents the average purchase price paid by retail pharmacies in California.

(ii) Based on the proposed average acquisition cost as calculated by the vendor pursuant to subparagraph (B).

(iii) Based on a national pricing benchmark obtained from the federal Centers for Medicare and Medicaid Services or on a similar benchmark listed in the department's primary price reference source adjusted by the department to ensure that the average acquisition cost represents the average purchase price paid by retail pharmacies in California.

(B) For the purposes of paragraph (3), the department may contract with a vendor for the purposes of surveying drug price information, collecting data from providers, wholesalers, or drug manufacturers, and calculating a proposed average acquisition cost.

(C) (i) Medi-Cal pharmacy providers shall submit drug price information to the department or a vendor designated by the department for the purposes of establishing the average acquisition cost. The information submitted by pharmacy providers shall include, but not be limited to, invoice prices and all discounts, rebates, and refunds known to the provider that would apply to the

acquisition cost of the drug products purchased during the calendar quarter. Pharmacy warehouses shall be exempt from the survey process, but shall provide drug cost information upon audit by the department for the purposes of validating individual pharmacy provider acquisition costs.

(ii) Pharmacy providers that fail to submit drug price information to the department or the vendor as required by this subparagraph shall receive notice that if they do not provide the required information within five working days, they shall be subject to suspension under subdivisions (a) and (c) of Section 14123.

(D) (i) For new drugs or new formulations of existing drugs, ~~where~~ *if* drug price information is unavailable pursuant to clause (i) of subparagraph (C), drug manufacturers and wholesalers shall submit drug price information to the department or a vendor designated by the department for the purposes of establishing the average acquisition cost. Drug price information shall include, but not be limited to, net unit sales of a drug product sold to retail pharmacies in California divided by the total number of units of the drug sold by the manufacturer or wholesaler in a specified period of time determined by the department.

(ii) Drug products from manufacturers and wholesalers that fail to submit drug price information to the department or the vendor as required by this subparagraph ~~may~~ *shall* not be a reimbursable benefit of the Medi-Cal program for those manufacturers and wholesalers until the department has established the average acquisition cost for those drug products.

(E) Drug pricing information provided to the department or a vendor designated by the department for the purposes of establishing the average acquisition cost pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(F) Prior to the implementation of an average acquisition cost methodology, the department shall collect data through a survey of pharmacy providers for purposes of establishing a professional ~~fee for dispensing~~ *dispensing fee or fees* in compliance with federal Medicaid requirements.

(i) The department shall seek stakeholder input on the retail pharmacy factors and elements used for the pharmacy survey relative to both average acquisition costs and ~~dispensing costs.~~

~~Any adjustment to the dispensing fee shall not exceed the aggregate savings associated with the implementation of the average acquisition cost methodology.~~ *professional dispensing costs.*

(ii) For drug products provided by pharmacy providers pursuant to subdivision (f) of Section 14105.3, a differential professional fee or payment for services to provide specialized care may be considered as part of the contracts established pursuant to that section.

(G) When the department implements the average acquisition cost methodology, the department shall update the Medi-Cal claims processing system to reflect the average acquisition cost of drugs not later than 30 days after the department has established average acquisition cost pursuant to subparagraph (A).

(H) Notwithstanding any other ~~provision of~~ law, if the department implements average acquisition cost pursuant to clause (i) or (ii) of subparagraph (A), the department shall update actual acquisition costs at least every three months and notify Medi-Cal providers at least 30 days prior to the effective date of any change in an actual acquisition cost.

(I) The department shall establish a process for providers to seek a change to a specific average acquisition cost when the providers believe the average acquisition cost does not reflect current available market prices. If the department determines an average acquisition cost change is warranted, the department may update a specific average acquisition cost prior to notifying providers.

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

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of a provider bulletin or notice, policy letter, or other similar instructions, without taking regulatory action.

(e) The department may enter into contracts with a vendor for the purposes of implementing this section on a bid or nonbid basis. In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this section is

necessary. Therefore, contracts entered into to implement this section, and all contract amendments and change orders, shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

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

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

(3) To the extent that the director determines that the rates do not comply with applicable federal Medicaid requirements or that federal financial participation is not available with respect to any rate of reimbursement described in this section, the director retains the discretion not to implement that rate and may revise the rate as necessary to comply with federal Medicaid requirements.

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

(h) This section shall not be construed to require the department to collect cost data, to conduct cost studies, or to set or adjust a rate of reimbursement based on cost data that has been collected.

(i) Adjustments to pharmacy drug product payment pursuant to Section 14105.192 shall no longer apply when the department determines that the average acquisition cost methodology has been fully implemented and the department's pharmacy budget reduction targets, consistent with payment reduction levels pursuant to Section 14105.192, have been met.

(j) Prior to implementation of this section, the department shall provide the appropriate fiscal and policy committees of the Legislature with information on the department's plan for implementation of the average acquisition cost methodology pursuant to this section.

SEC. 26. Section 14105.456 of the Welfare and Institutions Code is amended to read:

14105.456. (a) For purposes of this section, the following definitions shall apply:

(1) "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)~~ *(3)* 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. 27. Section 14105.86 of the Welfare and Institutions Code is amended to read:

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

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

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

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

(A) Coagulation factors, including:

(i) Factor VIII, nonrecombinant.

(ii) Factor VIII, porcine.

(iii) Factor VIII, recombinant.

(iv) Factor IX, nonrecombinant.

(v) Factor IX, complex.

(vi) Factor IX, recombinant.

(vii) Antithrombin III.

(viii) Anti-inhibitor factor.

(ix) Von Willebrand factor.

(x) Factor VIIa, recombinant.

(B) Immune Globulin Intravenous.

(C) Alpha-1 Proteinase Inhibitor.

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

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

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

(e) (1) Effective July 1, 2008, the department shall collect a state rebate, in addition to rebates pursuant to other provisions of state or federal law, for blood factors reimbursed pursuant to this section by programs that qualify for federal drug rebates pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8) or otherwise qualify for federal funds under Title XIX

of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) pursuant to the Medicaid state plan or waivers and the programs authorized by Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of, and Article 1 (commencing with Section 125125) of Chapter 2 of Part 5 of, Division 106 of the Health and Safety Code.

(2) ~~Paragraph (1) shall become inoperative when the department implements~~ *Upon implementation of* paragraphs (4) and (5) of subdivision (b) of Section ~~14105.33.~~ *14105.33 for blood factors pursuant to this section, "utilization data" used to determine the state rebate shall be described pursuant to subdivision (b) of Section 14105.33.* The department shall post on its Internet Web site a notice that it has implemented paragraphs (4) and (5) of subdivision (b) of Section ~~14105.33.~~ *14105.33 for blood factors pursuant to this section.*

(3) The state rebate shall be negotiated as necessary between the department and the manufacturer. Manufacturers who do not execute an agreement to pay additional rebates pursuant to this section shall have their blood factors available only through an approved treatment or service authorization request. All blood factors that meet the definition of a covered outpatient drug pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8) shall remain a benefit subject to the utilization controls provided for in this section.

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

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

claim is within 100 days of the date of service of the last claim submitted for the same blood factor.

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

SEC. 28. Section 14131.10 of the Welfare and Institutions Code is amended to read:

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

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

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

~~(B) Acupuncture services.~~

~~(C)~~

(B) Audiology services and speech therapy services.

~~(D)~~

(C) Chiropractic services.

~~(E)~~

(D) Optometric and optician services, including services provided by a fabricating optical laboratory.

~~(F)~~

(E) Podiatric services.

~~(G)~~

(F) Psychology services.

~~(H)~~

(G) Incontinence creams and washes.

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

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

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

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

(ii) Amalgam and composite restorations.

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

(iv) Anterior root canal therapy.

(v) Complete dentures, including immediate dentures.

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

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

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

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

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

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

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

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

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

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

~~(f) The department shall seek approval for federal financial participation and coverage of services specified in subparagraph (C) of paragraph (2) of subdivision (b) under the Medi-Cal program.~~

~~(g) This section, except as specified in subparagraph (C) of paragraph (2) of subdivision (b), shall be implemented on the first day of the month following 90 days after the operative date of this section.~~

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

SEC. 29. Section 14132.56 of the Welfare and Institutions Code is amended to read:

14132.56. (a) (1) Only to the extent required by the federal government and effective no sooner than required by the federal government, behavioral health treatment (BHT), as defined by Section 1374.73 of the Health and Safety Code, shall be a covered Medi-Cal service for individuals under 21 years of age.

(2) It is the intent of the Legislature that, to the extent the federal government requires BHT to be a covered Medi-Cal service, the department shall seek statutory authority to implement this new benefit in Medi-Cal.

(b) The department shall implement, or continue to implement, this section only after all of the following occurs or has occurred:

(1) The department receives all necessary federal approvals to obtain federal funds for the service.

(2) The department seeks an appropriation that would provide the necessary state funding estimated to be required for the applicable fiscal year.

(3) The department consults with stakeholders.

(c) The department shall develop and define eligibility criteria, provider participation criteria, utilization controls, and delivery system structure for services under this section, subject to limitations allowable under federal law, in consultation with stakeholders.

(d) (1) The department, commencing on the effective date of the act that added this subdivision until March 31, 2017, inclusive, may make available to individuals described in paragraph (2) contracted services to assist those individuals with health insurance

enrollment, without regard to whether federal funds are available for the contracted services.

(2) The contracted services described in paragraph (1) may be provided only to an individual under 21 years of age whom the department identifies as no longer eligible for Medi-Cal solely due to the transition of BHT coverage from the waiver program under Section 1915(c) of the federal Social Security Act to the Medi-Cal state plan in accordance with this section and who meets all of the following criteria:

(A) He or she was enrolled in the home and community-based services waiver for persons with developmental disabilities under Section 1915(c) of the Social Security Act as of January 31, 2016.

(B) He or she was deemed to be institutionalized in order to establish eligibility under the terms of the waiver.

(C) He or she has not been found eligible under any other federally funded Medi-Cal criteria without a share of cost.

(D) He or she had received a BHT service from a regional center for persons with developmental disabilities as provided in Chapter 5 (commencing with Section 4620) of Division 4.5.

~~(d)~~

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

~~(e)~~

(f) For the purposes of implementing this section, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including contracts for the purpose of obtaining subject matter expertise or other technical assistance. Contracts may be statewide or on a more limited geographic basis. Contracts

entered into or amended under this subdivision shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract ~~Code~~ *Code, Section 19130 of the Government Code,* and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code, and shall be exempt from the review or approval of any division of the Department of General Services.

~~(f)~~

(g) The department may seek approval of any necessary state plan amendments or waivers to implement this section. The department shall make any state plan amendments or waiver requests public at least 30 days prior to submitting to the federal Centers for Medicare and Medicaid Services, and the department shall work with stakeholders to address the public comments in the state plan amendment or waiver request.

~~(g)~~

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

SEC. 30. Section 14154 of the Welfare and Institutions Code is amended to read:

14154. (a) (1) The department shall establish and maintain a plan whereby costs for county administration of the determination of eligibility for benefits under this chapter will be effectively controlled within the amounts annually appropriated for that administration. The plan, to be known as the County Administrative Cost Control Plan, shall establish standards and performance criteria, including workload, productivity, and support services standards, to which counties shall adhere. The plan shall include standards for controlling eligibility determination costs that are incurred by performing eligibility determinations at county hospitals, or that are incurred due to the outstationing of any other eligibility function. Except as provided in Section 14154.15, reimbursement to a county for outstationed eligibility functions shall be based solely on productivity standards applied to that county's welfare department office.

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

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

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

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

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

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

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

the county budget survey documents was utilized and, if applicable, modified and the rationale for the changes.

(6) Notwithstanding any other law, the department shall develop and implement, in consultation with county program and fiscal representatives, a new budgeting methodology for Medi-Cal county administrative costs that reflects the impact of PPACA implementation on county administrative work. The new budgeting methodology shall be used to reimburse counties for eligibility processing and case maintenance for applicants and beneficiaries.

(A) The budgeting methodology may include, but is not limited to, identification of the costs of eligibility determinations for applicants, and the costs of eligibility redeterminations and case maintenance activities for recipients, for different groupings of cases, based on variations in time and resources needed to conduct eligibility determinations. The calculation of time and resources shall be based on the following factors: complexity of eligibility rules, ongoing eligibility requirements, and other factors as determined appropriate by the department. The development of the new budgeting methodology may include, but is not limited to, county survey of costs, time and motion studies, in-person observations by department staff, data reporting, and other factors deemed appropriate by the department.

(B) The new budgeting methodology shall be clearly described, state the necessary data elements to be collected from the counties, and establish the timeframes for counties to provide the data to the state.

(C) The new budgeting methodology developed pursuant to this paragraph shall be implemented no sooner than the 2015–16 fiscal year. The department may develop a process for counties to phase in the requirements of the new budgeting methodology.

(D) The department shall provide the new budgeting methodology to the legislative fiscal committees by March 1 of the fiscal year immediately preceding the first fiscal year of implementation of the new budgeting methodology.

(E) To the extent that the funding for the county budgets developed pursuant to the new budget methodology is not fully appropriated in any given fiscal year, the department, with input from the counties, shall identify and consider options to align funding and workload responsibilities.

(F) For purposes of this paragraph, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(G) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this paragraph by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the implementation of the new budgeting methodology pursuant to this paragraph, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

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

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

(2) It is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2008–09, 2009–10, 2010–11, 2011–12, 2012–13, 2014–15, ~~and 2015–16~~ *2015–16, and 2016–17* 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.

(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) If 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.~~

~~(l)~~

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and except as provided in subparagraph (G) of paragraph (6) of subdivision (a), the department shall, without taking any further regulatory action, implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters or similar instructions.

SEC. 31. Section 14301.1 of the Welfare and Institutions Code, as amended by Section 28 of Chapter 37 of the Statutes of 2013, is amended to read:

14301.1. (a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health-plan- and county-specific rates. Notwithstanding any other law, this section shall apply to any managed care organization, licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), that has contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS for rates established on or after July 1, 2012. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

(1) Health-plan-specific encounter and claims data.

(2) Supplemental utilization and cost data submitted by the health plans.

(3) Fee-for-service data for the underlying county of operation or other appropriate counties as deemed necessary by the department.

(4) Department of Managed Health Care financial statement data specific to Medi-Cal operations.

(5) Other demographic factors, such as age, gender, or diagnostic-based risk adjustments, as the department deems appropriate.

(b) To the extent that the department is unable to obtain sufficient actual plan data, it may substitute plan model, similar plan, or county-specific fee-for-service data.

(c) The department shall develop rates that include administrative costs, and may apply different administrative costs with respect to separate aid code groups.

(d) The department shall develop rates that shall include, but are not limited to, assumptions for underwriting, return on investment, risk, contingencies, changes in policy, and a detailed review of health plan financial statements to validate and reconcile costs for use in developing rates.

(e) The department may develop rates that pay plans based on performance incentives, including quality indicators, access to care, and data submission.

(f) The department may develop and adopt condition-specific payment rates for health conditions, including, but not limited to, childbirth delivery.

(g) (1) Prior to finalizing Medi-Cal managed care capitation rates, the department shall provide health plans with information on how the rates were developed, including rate sheets for that specific health plan, and provide the plans with the opportunity to provide additional supplemental information.

(2) For contracts entered into between the department and any entity pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7, the department, by June 30 of each year, or, if the budget has not passed by that date, no later than five working days after the budget is signed, shall provide preliminary rates for the upcoming fiscal year.

(h) For the purposes of developing capitation rates through implementation of this ratesetting methodology, Medi-Cal managed care health plans shall provide the department with financial and utilization data in a form and substance as deemed necessary by the department to establish rates. This data shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the

Government Code as contained in the California Public Records Act (Division 7 (commencing with Section 6250) of Title 1 of the Government Code).

(i) Notwithstanding any other ~~provision of~~ law, on and after the effective date of the act adding this subdivision, the department may apply this section to the capitation rates it pays under any managed care health plan contract.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may set and implement managed care capitation rates, and interpret or make specific this section and any applicable federal waivers and state plan amendments by means of plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

(k) The department shall report, upon request, to the fiscal and policy committees of the respective houses of the Legislature regarding implementation of this section.

(*l*) Prior to October 1, 2011, the risk-adjusted countywide capitation rate shall comprise no more than 20 percent of the total capitation rate paid to each Medi-Cal managed care plan.

(m) (1) It is the intent of the Legislature to preserve the policy goal to support and strengthen traditional safety net providers who treat high volumes of uninsured and Medi-Cal patients when Medi-Cal enrollees are defaulted into Medi-Cal managed care plans.

(2) As the department adds additional factors, such as managed care plan costs, to the Medi-Cal managed care plan default assignment algorithm, it shall consult with the Auto Assignment Performance Incentive Program stakeholder workgroup to develop cost factor disregards related to intergovernmental transfers and required wraparound payments that support safety net providers.

(n) (1) The department shall develop and pay capitation rates to entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), using actuarial methods and in a manner consistent with this section, except as provided in this subdivision.

(2) The department may develop capitation rates using a standardized rate methodology across managed care plan models for comparable populations. The specific rate methodology applied to PACE organizations shall address features of PACE that distinguishes it from other managed care plan models.

(3) The department may develop statewide rates and apply geographic adjustments, using available data sources deemed appropriate by the department. Consistent with actuarial methods, the primary source of data used to develop rates for each PACE organization shall be its Medi-Cal cost and utilization data or other data sources as deemed necessary by the department.

(4) Rates developed pursuant to this subdivision shall reflect the level of care associated with the specific populations served under the contract.

(5) The rate methodology developed pursuant to this subdivision shall contain a mechanism to account for the costs of high-cost drugs and treatments.

(6) Rates developed pursuant to this subdivision shall be actuarially certified prior to implementation.

(7) The department shall consult with those entities contracted pursuant to Chapter 8.75 (commencing with Section 14591) in developing a rate methodology according to this subdivision.

(8) Consistent with the requirements of federal law, the department shall calculate an upper payment limit for payments to PACE organizations. In calculating the upper payment limit, the department shall correct the applicable data as necessary and shall consider the risk of nursing home placement for the comparable population when estimating the level of care and risk of PACE participants.

(9) During the first three rate years in which the methodology developed pursuant to this subdivision is used by the department to set rates for entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), the department shall pay the entity at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11), as necessary to mitigate the impact to the entity during the transition to the methodology developed pursuant to this subdivision.

(10) During the first two years in which a new PACE organization or existing PACE organization enters a previously unserved area, the department shall pay at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11).

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

(12) This subdivision shall apply for rates implemented no earlier than January 1, 2017.

~~(n)~~

(o) This section shall be inoperative if the Coordinated Care Initiative becomes inoperative pursuant to Section 34 of ~~the act that added this subdivision.~~ *Chapter 37 of the Statutes of 2013.*

SEC. 32. Section 14301.1 of the Welfare and Institutions Code, as added by Section 29 of Chapter 37 of the Statutes of 2013, 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.

(k) (1) It is the intent of the Legislature to preserve the policy goal to support and strengthen traditional safety net providers who

treat high volumes of uninsured and Medi-Cal patients when Medi-Cal enrollees are defaulted into Medi-Cal managed care plans.

(2) As the department adds additional factors, such as managed care plan costs, to the Medi-Cal managed care plan default assignment algorithm, it shall consult with the Auto Assignment Performance Incentive Program stakeholder workgroup to develop cost factor disregards related to intergovernmental transfers and required wraparound payments that support safety net providers.

(l) (1) The department shall develop and pay capitation rates to entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), using actuarial methods and in a manner consistent with this section, except as provided in this subdivision.

(2) The department may develop capitation rates using a standardized rate methodology across managed care plan models for comparable populations. The specific rate methodology applied to PACE organizations shall address features of PACE that distinguish it from other managed care plan models.

(3) The department may develop statewide rates and apply geographic adjustments, using available data sources deemed appropriate by the department. Consistent with actuarial methods, the primary source of data used to develop rates for each PACE organization shall be its Medi-Cal cost and utilization data or other data sources as deemed necessary by the department.

(4) Rates developed pursuant to this subdivision shall reflect the level of care associated with the specific populations served under the contract.

(5) The rate methodology developed pursuant to this subdivision shall contain a mechanism to account for the costs of high-cost drugs and treatments.

(6) Rates developed pursuant to this subdivision shall be actuarially certified prior to implementation.

(7) The department shall consult with those entities contracted pursuant to Chapter 8.75 (commencing with Section 14591) in developing a rate methodology according to this subdivision.

(8) Consistent with the requirements of federal law, the department shall calculate an upper payment limit for payments to PACE organizations. In calculating the upper payment limit, the department shall correct the applicable data as necessary and shall consider the risk of nursing home placement for the

comparable population when estimating the level of care and risk of PACE participants.

(9) During the first three rate years in which the methodology developed pursuant to this subdivision is used by the department to set rates for entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), the department shall pay the entity at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11), as necessary to mitigate the impact to the entity during the transition to the methodology developed pursuant to this subdivision.

(10) During the first two years in which a new PACE organization or existing PACE organization enters a previously unserved area, the department shall pay at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11).

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

(12) This subdivision shall apply for rates implemented no earlier than January 1, 2017.

~~(l)~~

(m) This section shall be operative only if Section 28 of ~~the act that added this section~~ *Chapter 37 of the Statutes of 2013* becomes inoperative pursuant to subdivision (n) of that Section 28.

SEC. 33. Section 14592 of the Welfare and Institutions Code is amended to read:

14592. (a) For purposes of this chapter, "PACE organization" means an entity as defined in Section 460.6 of Title 42 of the Code of Federal Regulations.

(b) The Director of Health Care Services shall establish the California Program of All-Inclusive Care for the Elderly, to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medi-Cal State Plan and under contracts entered into between the federal Centers for Medicare and Medicaid Services, the department, and PACE organizations, meeting the requirements of the Balanced Budget Act of 1997 (Public Law 105-33) and ~~Part 460 (commencing with~~

~~Section 460.2) of Title 42 of the Code of Federal Regulations.~~ *any other applicable law or regulation.*

SEC. 34. Section 14593 of the Welfare and Institutions Code is amended to read:

14593. (a) (1) The department may enter into contracts with public or private ~~nonprofit~~ organizations for implementation of the PACE program, and also may enter into separate contracts with PACE organizations, to fully implement the single state agency responsibilities assumed by the department in those contracts, Section 14132.94, and any other state requirement found necessary by the department to provide comprehensive community-based, risk-based, and capitated long-term care services to California's frail elderly.

(2) The department may enter into separate contracts as specified in ~~subdivision (a)~~ *paragraph (1)* with up to 15 PACE organizations. *This paragraph shall become inoperative upon federal approval of a capitation rate methodology, pursuant to subdivision (n) of Section 14301.1.*

(b) The requirements of the PACE model, as provided for pursuant to Section 1894 (42 U.S.C. Sec. 1395eee) and Section 1934 (42 U.S.C. Sec. 1396u-4) of the federal Social Security Act, shall not be waived or modified. The requirements that shall not be waived or modified include all of the following:

(1) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

(2) The delivery of comprehensive, integrated acute and long-term care services.

(3) The interdisciplinary team approach to care management and service delivery.

(4) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

(5) The assumption by the provider of full financial risk.

(6) The provision of a PACE benefit package for all participants, regardless of source of payment, that shall include all of the following:

(A) All Medicare-covered items and services.

(B) All Medicaid-covered items and services, as specified in the state's Medicaid plan.

(C) Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

(c) Sections 14002, 14005.12, 14005.17, and 14006 shall apply when determining the eligibility for Medi-Cal of a person receiving the services from an organization providing services under this chapter.

(d) Provisions governing the treatment of income and resources of a married couple, for the purposes of determining the eligibility of a nursing-facility certifiable or institutionalized spouse, shall be established so as to qualify for federal financial participation.

(e) (1) The department shall establish capitation rates paid to each PACE organization at no less than 95 percent of the fee-for-service equivalent cost, including the department's cost of administration, that the department estimates would be payable for all services covered under the PACE organization contract if all those services were to be furnished to Medi-Cal beneficiaries under the fee-for-service Medi-Cal program provided for pursuant to Chapter 7 (commencing with Section 14000).

(2) This subdivision shall be implemented only to the extent that federal financial participation is available.

(3) This subdivision shall become inoperative upon federal approval of a capitation rate methodology, pursuant to subdivision (n) of Section 14301.1.

(f) Contracts under this chapter may be on a nonbid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

~~(g) This section shall become operative on April 1, 2015.~~

(g) (1) Notwithstanding subdivision (b), and only to the extent federal financial participation is available, the department, in consultation with PACE organizations, shall seek increased federal regulatory flexibility from the federal Centers for Medicare and Medicaid Services to modernize the PACE program, which may include, but is not limited to, addressing all of the following:

(A) Composition of PACE interdisciplinary teams (IDT).

(B) Use of community-based physicians.

(C) Marketing practices.

(D) Development of a streamlined PACE waiver process.

(2) This subdivision shall be operative upon federal approval of a capitation rate methodology pursuant to subdivision (n) of Section 14301.1.

(h) This section shall become inoperative if the Coordinated Care Initiative becomes inoperative pursuant to Section 34 of Chapter 37 of the Statutes of 2013 and shall be repealed on January 1 next following the date upon which it becomes inoperative.

SEC. 35. Section 14593 is added to the Welfare and Institutions Code, to read:

14593. (a) (1) The department may enter into contracts with public or private organizations for implementation of the PACE program, and also may enter into separate contracts with PACE organizations, to fully implement the single state agency responsibilities assumed by the department in those contracts, Section 14132.94, and any other state requirement found necessary by the department to provide comprehensive community-based, risk-based, and capitated long-term care services to California's frail elderly.

(2) The department may enter into separate contracts as specified in paragraph (1) with up to 15 PACE organizations. This paragraph shall become inoperative upon federal approval of a capitation rate methodology pursuant to subdivision (l) of Section 14301.1.

(b) The requirements of the PACE model, as provided for pursuant to Section 1894 (42 U.S.C. Sec. 1395eee) and Section 1934 (42 U.S.C. Sec. 1396u-4) of the federal Social Security Act, shall not be waived or modified. The requirements that shall not be waived or modified include all of the following:

(1) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

(2) The delivery of comprehensive, integrated acute and long-term care services.

(3) The interdisciplinary team approach to care management and service delivery.

(4) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

(5) The assumption by the provider of full financial risk.

(6) The provision of a PACE benefit package for all participants, regardless of source of payment, that shall include all of the following:

(A) All Medicare-covered items and services.

(B) All Medicaid-covered items and services, as specified in the state's Medicaid plan.

(C) Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

(c) Sections 14002, 14005.12, 14005.17, and 14006 shall apply when determining the eligibility for Medi-Cal of a person receiving the services from an organization providing services under this chapter.

(d) Provisions governing the treatment of income and resources of a married couple, for the purposes of determining the eligibility of a nursing-facility certifiable or institutionalized spouse, shall be established so as to qualify for federal financial participation.

(e) (1) The department shall establish capitation rates paid to each PACE organization at no less than 95 percent of the fee-for-service equivalent cost, including the department's cost of administration, that the department estimates would be payable for all services covered under the PACE organization contract if all those services were to be furnished to Medi-Cal beneficiaries under the fee-for-service Medi-Cal program provided for pursuant to Chapter 7 (commencing with Section 14000).

(2) This subdivision shall be implemented only to the extent that federal financial participation is available.

(3) This subdivision shall become inoperative upon federal approval of a capitation rate methodology pursuant to subdivision (l) of Section 14301.1.

(f) Contracts under this chapter may be on a nonbid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(g) (1) Notwithstanding subdivision (b), and only to the extent federal financial participation is available, the department, in consultation with PACE organizations, shall seek increased federal regulatory flexibility from the federal Centers for Medicare and Medicaid Services to modernize the PACE program, which may include, but is not limited to, addressing:

(A) Composition of PACE interdisciplinary teams (IDT).

(B) Use of community-based physicians.

(C) Marketing practices.

(D) Development of a streamlined PACE waiver process.

(2) This subdivision shall be operative upon federal approval of a capitation rate methodology pursuant to subdivision (l) of Section 14301.1.

(h) This section shall become operative only if Section 28 of Chapter 37 of the Statutes of 2013 becomes inoperative.

SEC. 36. The amendments made to Section 14131.10 of the Welfare and Institutions Code by this act shall become operative on July 1, 2016.

SEC. 37. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

~~SECTION 1. It is the intent of the Legislature to enact statutory changes, relating to the Budget Act of 2016.~~

O