

AMENDED IN SENATE JUNE 12, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

**ASSEMBLY BILL**

**No. 82**

---

---

**Introduced by Committee on Budget (Blumenfield (Chair), Bloom, Bonilla, Campos, Chesbro, Daly, Dickinson, Gordon, Jones-Sawyer, Mitchell, Mullin, Muratsuchi, Nazarian, Rendon Skinner, Stone, and Ting)**

January 10, 2013

---

---

*An act relating to the Budget Act of 2013. An act to amend Section 680 of the Business and Professions Code, to amend Sections 6254, 26605.6, 26605.7, and 26605.8 of the Government Code, to amend Sections 1180.6, 1250.2, 1254, 1254.1, 1266.1, 1275.1, 1275.5, 1324.9, 1373, 111792, 123870, 123929, 123940, and 123955 of, and to add Section 104151 to, the Health and Safety Code, to amend Sections 10125, 10127, 12693.70, 12698, 12737, and 12739.61 of the Insurance Code, and to amend Sections 359, 708, 4005.7, 4080, 5150, 5151, 5157, 5202, 5326.9, 5358, 5366.1, 5404, 5405, 5585.21, 5585.50, 5585.55, 5675, 5675.1, 5675.2, 5751.7, 5768, 5840, 5845, 5846, 5909, 6007, 6551, 7100, 14105.22, 14105.3, 14131.10, 14134, 14707.5, and 15911 of, to add Sections 14100.3, 14100.51, 14100.52, 14132.86, and 14132.89 to, to add Part 3.3 (commencing with Section 15800) to Division 9 of, to add and repeal Section 14005.281 of, and to repeal Section 14131.07 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

AB 82, as amended, Committee on Budget. ~~Budget Act of 2013.~~  
*Health.*

*(1) Existing law authorizes a sheriff to release a prisoner from a county correctional facility for transfer to a medical care facility or residential care facility upon the advice of a physician, as specified, or if the sheriff determines that the prisoner would not reasonably pose a threat to public safety and the prisoner, upon diagnosis by the examining physician, is deemed to have a life expectancy of 6 months or less, provided the sheriff gives specified notice to the superior court. Existing law also authorizes the sheriff to request the court to grant medical probation or to resentence a prisoner to medical probation in lieu of jail time if the prisoner is physically incapacitated with a medical condition that renders the prisoner permanently unable to perform activities of basic daily living, which has resulted in the prisoner requiring 24-hour care, and if that incapacitation did not exist at the time of sentencing or if the prisoner would require acute long-term inpatient rehabilitation services. Existing law requires a county that chooses to implement these provisions to pay the nonfederal share of a prisoner's or probationer's Medi-Cal costs for the period that the individual would have otherwise been incarcerated or been on medical probation. Existing law requires a county board of supervisors to adopt a process to fund the nonfederal share of Medi-Cal costs, as specified, before implementing the above-referenced provisions and to notify the State Department of Health Care Services of the process.*

*This bill would revise the conditions under which a county may implement these release or medical probation provisions by requiring the county to notify the department when a released prisoner has applied for Medi-Cal or is returned to custody and to also pay the nonfederal share of certain nonreimbursable medical costs paid by the state, and state administrative costs, as specified. The bill would specify the Legislature's intent that implementation of these provisions would not result in increased costs to the General Fund and should not jeopardize federal financial participation for the Medi-Cal program.*

*(2) Existing law establishes the Long-Term Care Quality Assurance Fund in the State Treasury and requires, beginning August 1, 2013, all revenues received by the State Department of Health Care Services categorized by the department as long-term 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, and to enhance federal financial participation in the Medi-Cal program or to provide additional reimbursement to, and to support facility quality improvement efforts in, licensed skilled nursing facilities.

*This bill would authorize the Controller to use the funds in the Long-Term Quality Assurance Fund for cashflow loans to the General Fund, as specified.*

*(3) Existing law requires the State Department of Health Care Services to provide, no later than January 10 and May 14 of each year, the fiscal committees of the Legislature with an estimate package for the Every Woman Counts Program, as specified.*

*This bill would instead require that the reporting occur each year no later than January 10 and concurrently with the May Revision of the annual budget. The bill would additionally require that the estimate package include a breakout of costs for specified clinical service activities, policy changes, and fund information.*

*(4) 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, funds a system of county mental health plans for the provision of mental health services, as specified. Among other things, the act establishes the Mental Health Services Oversight and Accountability Commission to oversee the administration of various parts of the Mental Health Services Act, and requires that the commission administer its operations separate and apart from the State Department of Health Care Services. The act provides that the Legislature may clarify procedures and terms of the act by majority vote.*

*This bill would require that the commission administer its operations separate and apart from the California Health and Human Services Agency. The bill would also make technical changes.*

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

*This bill would require the department, by January 10 and concurrently with the May Revision of the annual budget, to provide to the fiscal committees of the Legislature specified fiscal information with respect to the Medi-Cal Specialty Mental Health Services Program*

and the Drug Medi-Cal Program. The bill also would require the department to post this information on its Internet Web site.

(6) Existing federal law requires the State Department of Health Care Services to describe the Medi-Cal program in a state plan. Under existing state law, the Director of Health Care Services has those powers and duties necessary to conform to requirements for securing approval of the state plan. Existing federal law authorizes the Secretary of Health and Human Services to waive provisions of federal Medicaid law under specified circumstances, including, among others, when the secretary finds that the waiver would be cost effective and efficient. Existing state law requires the department to seek a variety of waivers of federal law, including, among others, to implement objectives that may include better care coordination for seniors, persons with disabilities, and children with special health care needs.

This bill would require the department to post on its Internet Web site all submitted state plan amendments and all federal waiver applications and requests for new waivers, waiver amendments, and waiver renewals and extensions, within 10 business days from the date the department submits these documents for approval to the federal Centers for Medicare and Medicaid Services (CMS). The bill would require the department to also post on its Internet Web site approval or denial letters, or, if applicable, withdrawal notifications, and accompanying documents for all submitted state plan amendments and federal waiver applications and requests within 10 business days from the date the department receives notification of final approval or denial from CMS, or, if applicable, within 10 business days from when the department notifies CMS of the withdrawal. The bill would require the department to post on its Internet Web site all pending submitted state plan amendments and federal waiver requests, as specified, that were submitted in 2009 and every year thereafter unless already posted pursuant to these provisions.

(7) Existing law states the intent of the Legislature that the State Department of Health Care Services develop Medi-Cal reimbursement rates for clinical laboratory or laboratory services in accordance with specified criteria. Existing law exempts from compliance with a specified regulation laboratory providers reimbursed pursuant to any payment reductions implemented pursuant to these provisions for 12 months following the date of implementation of this reduction.

This bill would extend the length of this exemption from 12 months to 21 months. The bill also would extend the date by which laboratory

*providers are required to submit certain data reports, for the purposes of establishing reimbursement rates, by an additional 5 months. The bill would also make technical changes to those provisions.*

*(8) Existing law authorizes the State Department of Health Care Services to enter into contracts with providers licensed to dispense dangerous drugs or devices, as specified, to provide specialized care in the distribution of specialized drugs for Medi-Cal beneficiaries. Existing law requires the department, when implementing those provisions, to, among other things, consult current standards of practice when executing a provider contract, contract with a nonexclusive number of providers that meet the needs of the affected population, and generate an annual report, as prescribed. Under existing law, those provisions pertaining to specialized drugs become inoperative 3 years after the date of implementation or July 1, 2013, whichever is earlier.*

*This bill would delete the provision making those provisions inoperative and would delete the reporting requirement. This bill would also make technical changes to those provisions.*

*(9) Existing law limits the total number of Medi-Cal physician office and clinic visits to 7 visits per beneficiary per fiscal year, except as specified.*

*This bill would delete these provisions.*

*(10) Existing law requires Medi-Cal beneficiaries to make copayments for specified services and, upon federal approval, existing law revises the copayment rates and makes other related changes, as specified.*

*This bill would provide that these copayment requirements shall not apply to certain preventive services or any approved adult vaccines and their administration, as specified and that these services shall be provided without any cost sharing by the beneficiary.*

*(11) Existing law requires the State Department of Health Care Services, in collaboration with specified entities, to create a plan for a performance outcomes system for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services provided to eligible Medi-Cal beneficiaries under 21 years of age.*

*This bill would require the department, by February 1, 2014, to convene a stakeholder advisory committee for purposes, among other things, of developing measures for screening and referring Medi-Cal beneficiaries to mental health services and supports, and to make recommendations regarding performance and outcome measures. The bill would require the department to incorporate into the performance*

*outcomes system these screenings and referrals, and to provide an updated performance outcomes system plan to the fiscal and appropriate policy committees of the Legislature by October 1, 2014. The bill would require the department to propose how to implement the updated performance systems outcome plan by January 10, 2015.*

*(12) Existing law requires the State Department of Health Care Services, to the extent federal participation is available pursuant to an approved state plan amendment, to extend Medi-Cal benefits to independent foster care adolescents, as defined.*

*This bill would require, until January 1, 2014, the department, using general fund moneys to the extent federal funds are not available, to maintain Medi-Cal eligibility for all former independent foster care adolescents who, on or after July 1, 2013, but no later than December 31, 2013, lose Medi-Cal coverage as a result of attaining 21 years of age.*

*(13) Existing law provides for a schedule of benefits under the Medi-Cal program, which includes all of the following: emergency and essential diagnostic and restorative dental services, subject to utilization controls, as specified, certain optional adult dental benefits, and enteral nutrition products subject to the Medi-Cal list of enteral nutrition products and utilization controls. Existing law, except as specified, requires that the purchase of enteral nutrition products be limited to those products administered through a feeding tube.*

*This bill would, on May 1, 2014, or the effective date of any necessary federal financial participation approvals, whichever is later, provide specified dental services be included as a covered medical benefit for persons 21 years of age or older, subject to utilization controls. The bill, effective May 1, 2014, would also provide that the purchase of prescribed enteral nutrition products is a covered benefit, subject to the Medi-Cal list of enteral nutrition products and utilization controls.*

*(14) Existing law requires the State Department of Health Care Services, subject to federal approval, to authorize a local Low Income Health Program (LIHP) to provide health care services to eligible low-income individuals under certain circumstances. Existing law requires the department, in consultation with participating entities, as defined, to determine actuarially sound per enrollee capitation rates for LIHPs, as specified, and to pay those rates to the participating entity. Existing law requires that, if the participating entity and the department reach an agreement regarding reimbursement rates, the rate be applied no earlier than the first day of the LIHP year in which*

*the parties agree to the rate. Existing law provides an exception to that provision with respect to the LIHP year ending June 30, 2012.*

*This bill would delete the above-described exception.*

*(15) Under existing law, the State Department of Social Services is responsible for the licensing of psychiatric health facilities, as defined, and mental health rehabilitation centers, as described, and the approval of certain 72-hour treatment and evaluation facilities. Existing law requires the State Department of Social Services to adopt regulations necessary to implement those provisions.*

*This bill would transfer, from the State Department of Social Services, those responsibilities related to licensing and approval of those facilities to the State Department of Health Care Services. The bill would authorize the State Department of Health Care Services to adopt regulations necessary to implement those responsibilities. The bill would make various related, technical, and conforming changes to reflect the transfer of those responsibilities.*

*(16) Existing law provides the Director of Health Care Services with the authority and responsibility to monitor and approve special treatment programs in skilled nursing facilities.*

*This bill would require the State Department of Health Care Services to conduct annual certification inspections of special treatment programs for the mentally disordered, as specified.*

*(17) Existing law requires the manufacturer of any cosmetic product subject to regulation by the federal Food and Drug Administration that is sold in this state to, on a schedule and in electronic or other format, determined as specified, provide a complete and accurate list of specified cosmetic products that, as of the date of submission, are sold in the state and that contain any ingredient that is a chemical identified as causing cancer or reproductive toxicity. Existing law includes, among those chemicals identified, any chemical contained in the product for purposes of fragrance or flavoring, and any chemical identified by the phrase “and other ingredients” and determined to be a trade secret, as specified.*

*This bill would require the State Department of Public Health, on or before December 31, 2013, to develop and make operational a consumer-friendly, public Internet Web site that creates a database of cosmetic product information collected pursuant to those provisions. The bill would require that the database be searchable to accommodate a wide range of users, including users with limited technical and scientific literacy. The bill would require the Internet Web site to include*

*hypertext links to other educational and informational Internet Web sites to enhance consumer understanding.*

*(18) Existing law establishes the Access for Infants and Mothers (AIM) Program, administered by the Managed Risk Medical Insurance Board. The board contracts with a variety of health plans and health care delivery systems to provide health insurance coverage to eligible persons who pay a subscriber contribution. An “AIM-linked infant” is defined as any infant born to a woman enrolled in AIM after June 30, 2004, and is eligible for health care coverage under the Healthy Families Program. Existing law establishes the Healthy Families Program administered by the board, and provides that eligible subscribers, except certain AIM-linked infants, be transitioned to the Medi-Cal program, no sooner than January 1, 2013.*

*This bill would terminate eligibility for coverage under the Healthy Families Program for AIM-linked infants, and the board would be required to cease providing health care coverage for those infants on October 1, 2013, or when the State Department of Health Care Services has implemented specified provisions, whichever occurs later. The bill would require the board to coordinate with the State Department of Health Care Services to implement the AIM-Linked Infants Program, which would be created by the bill, including transition of AIM-linked infants to the program. The bill would require the State Department of Health Care Services to administer the AIM-Linked Infants Program, as provided, to address the health care needs of children formerly covered under the Healthy Families Program. The bill would condition the implementation of these provisions on the receipt of federal approvals and the availability of federal financial participation. The bill would also make related and conforming changes.*

*This bill would also revise the eligibility criteria for the AIM Program by requiring that income be determined, counted, and valued as required under a specified provision of federal law.*

*(19) Existing law establishes the California Major Risk Medical Insurance Program, which is administered by the Managed Risk Medical Insurance Board, to provide major risk medical coverage to persons who, among other things, have been rejected for coverage by at least one private health plan. Existing law requires the board to establish program contribution amounts for each category of risk for each participating health plan and requires that these amounts be based on the average amount of subsidy funds required for the program as a whole, to be determined in a specified manner. Existing law, for the*



*period commencing January 1, 2013, to December 31, 2013, inclusive, additionally authorizes the program to further subsidize subscriber contributions based on a specified percentage of the standard average individual risk rate for comparable coverage, as specified. Existing law requires the program to pay program contribution amounts to participating health plans from the Major Risk Medical Insurance Fund, a continuously appropriated fund.*

*This bill would delete the termination date for further subsidization of subscriber contributions. By extending the duration of these subsidies made from a continuously appropriated fund, the bill would make an appropriation.*

*(20) Existing law requires the Managed Risk Medical Insurance Board to manage a temporary high risk pool to provide health coverage, until January 1, 2014, to specified individuals who have preexisting conditions, consistent with the federal Patient Protection and Affordable Care Act.*

*This bill would change the termination date to July 1, 2013, except as required by the contract between the board and the United States Department of Health and Human Services, and would no longer require the board to conduct transition activities, as prescribed.*

*(21) Existing law establishes the California Health Benefit Exchange (Exchange) within state government, specifies the powers and duties of the executive board governing the Exchange, and requires the board to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and small employers by January 1, 2014. Existing law requires the board to undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling in the Exchange, and requires the board to inform individuals of eligibility requirements for the Medi-Cal program, the Healthy Families Program, or any applicable state or local public program and, if, through screening of the application by the Exchange, the Exchange determines that an individual is eligible for of those programs, to enroll that individual in the program.*

*This bill would require the State Department of Health Care Services to accept contributions by private foundations in the amount of at least \$14,000,000 for purposes of making payments to entities and persons for Medi-Cal in-person enrollment assistance, as specified, and in the amount of at least \$12,500,000 to provide allocations for the management and funding of Medi-Cal outreach and enrollment plans, as specified. The bill would require the State Department of Health*

Care Services to immediately seek an equal amount of federal matching funds. The bill would also provide for the payment of those enrollment assistance payments, as specified.

(22) Existing law requires the State Department of Health Care Services to seek a demonstration project or federal waiver of Medicaid law to implement specified objectives, which may include better care coordination for seniors, persons with disabilities, and children with special health care needs.

This bill would require the department, commencing no later than August 1, 2013, to convene a series of stakeholder meetings to receive input from clients, family members, providers, counties, and representatives of the Legislature concerning the development of the Behavioral Health Services Plan as required by the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Medicaid Demonstration.

(23) Existing law provides specified health care coverage to individuals under the AIDS Drug Assistance Program (ADAP) and under federal Ryan White Act funded programs, which are administered by the State Department of Public Health.

This bill would require the State Department of Public Health to report to the Joint Legislative Budget Committee by October 1, 2013, on whether any of the projections or assumptions used to develop the ADAP estimated budget in the Budget Act of 2013 may result in an inability of ADAP to provide services to ADAP eligible clients. If the State Department of Public Health determines, before October 1, 2013, that ADAP is unable to provide services to ADAP eligible clients, the bill would require the department to notify the committee with 15 calendar days of making that determination.

(24) Existing law establishes the Infant Botulism Treatment and Prevention Program and requires the State Department of Public Health to administer this program.

This bill would require the State Department of Public Health, by October 1, 2013, to submit to the fiscal and appropriate policy committees of the Legislature a report describing how it plans to address the findings and recommendations described in a report relating to this program.

(25) This bill would reappropriate the balance of specified funds appropriated in the Budget Act of 2012 to the Department of Managed Health Care until June 30, 2014, to be used as specified, thereby making an appropriation.

(26) *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 2013.~~

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:*

1     *SECTION 1. Section 680 of the Business and Professions Code*  
2     *is amended to read:*

3     680. (a) Except as otherwise provided in this section, a health  
4     care practitioner shall disclose, while working, his or her name  
5     and practitioner’s license status, as granted by this state, on a name  
6     tag in at least 18-point type. A health care practitioner in a practice  
7     or an office, whose license is prominently displayed, may opt to  
8     not wear a name tag. If a health care practitioner or a licensed  
9     clinical social worker is working in a psychiatric setting or in a  
10    setting that is not licensed by the state, the employing entity or  
11    agency shall have the discretion to make an exception from the  
12    name tag requirement for individual safety or therapeutic concerns.  
13    In the interest of public safety and consumer awareness, it shall  
14    be unlawful for any person to use the title “nurse” in reference to  
15    himself or herself and in any capacity, except for an individual  
16    who is a registered nurse or a licensed vocational nurse, or as  
17    otherwise provided in Section 2800. Nothing in this section shall  
18    prohibit a certified nurse assistant from using his or her title.

19    (b) Facilities licensed by the State Department of Social Services  
20    ~~or~~, the State Department of Public Health, *or the State Department*  
21    *of Health Care Services* shall develop and implement policies to  
22    ensure that health care practitioners providing care in those  
23    facilities are in compliance with subdivision (a). The State  
24    Department of Social Services ~~and~~, the State Department of Public  
25    Health, *and the State Department of Health Care Services* shall  
26    verify through periodic inspections that the policies required  
27    pursuant to subdivision (a) have been developed and implemented  
28    by the respective licensed facilities.

29    (c) For purposes of this article, “health care practitioner” means  
30    any person who engages in acts that are the subject of licensure

1 or regulation under this division or under any initiative act referred  
2 to in this division.

3 *SEC. 2. Section 6254 of the Government Code is amended to*  
4 *read:*

5 6254. Except as provided in Sections 6254.7 and 6254.13,  
6 nothing in this chapter shall be construed to require disclosure of  
7 records that are any of the following:

8 (a) Preliminary drafts, notes, or interagency or intra-agency  
9 memoranda that are not retained by the public agency in the  
10 ordinary course of business, if the public interest in withholding  
11 those records clearly outweighs the public interest in disclosure.

12 (b) Records pertaining to pending litigation to which the public  
13 agency is a party, or to claims made pursuant to Division 3.6  
14 (commencing with Section 810), until the pending litigation or  
15 claim has been finally adjudicated or otherwise settled.

16 (c) Personnel, medical, or similar files, the disclosure of which  
17 would constitute an unwarranted invasion of personal privacy.

18 (d) Contained in or related to any of the following:

19 (1) Applications filed with any state agency responsible for the  
20 regulation or supervision of the issuance of securities or of financial  
21 institutions, including, but not limited to, banks, savings and loan  
22 associations, industrial loan companies, credit unions, and  
23 insurance companies.

24 (2) Examination, operating, or condition reports prepared by,  
25 on behalf of, or for the use of, any state agency referred to in  
26 paragraph (1).

27 (3) Preliminary drafts, notes, or interagency or intra-agency  
28 communications prepared by, on behalf of, or for the use of, any  
29 state agency referred to in paragraph (1).

30 (4) Information received in confidence by any state agency  
31 referred to in paragraph (1).

32 (e) Geological and geophysical data, plant production data, and  
33 similar information relating to utility systems development, or  
34 market or crop reports, that are obtained in confidence from any  
35 person.

36 (f) Records of complaints to, or investigations conducted by,  
37 or records of intelligence information or security procedures of,  
38 the office of the Attorney General and the Department of Justice,  
39 the California Emergency Management Agency, and any state or  
40 local police agency, or any investigatory or security files compiled

1 by any other state or local police agency, or any investigatory or  
2 security files compiled by any other state or local agency for  
3 correctional, law enforcement, or licensing purposes. However,  
4 state and local law enforcement agencies shall disclose the names  
5 and addresses of persons involved in, or witnesses other than  
6 confidential informants to, the incident, the description of any  
7 property involved, the date, time, and location of the incident, all  
8 diagrams, statements of the parties involved in the incident, the  
9 statements of all witnesses, other than confidential informants, to  
10 the victims of an incident, or an authorized representative thereof,  
11 an insurance carrier against which a claim has been or might be  
12 made, and any person suffering bodily injury or property damage  
13 or loss, as the result of the incident caused by arson, burglary, fire,  
14 explosion, larceny, robbery, carjacking, vandalism, vehicle theft,  
15 or a crime as defined by subdivision (b) of Section 13951, unless  
16 the disclosure would endanger the safety of a witness or other  
17 person involved in the investigation, or unless disclosure would  
18 endanger the successful completion of the investigation or a related  
19 investigation. However, nothing in this division shall require the  
20 disclosure of that portion of those investigative files that reflects  
21 the analysis or conclusions of the investigating officer.

22 Customer lists provided to a state or local police agency by an  
23 alarm or security company at the request of the agency shall be  
24 construed to be records subject to this subdivision.

25 Notwithstanding any other provision of this subdivision, state  
26 and local law enforcement agencies shall make public the following  
27 information, except to the extent that disclosure of a particular  
28 item of information would endanger the safety of a person involved  
29 in an investigation or would endanger the successful completion  
30 of the investigation or a related investigation:

31 (1) The full name and occupation of every individual arrested  
32 by the agency, the individual's physical description including date  
33 of birth, color of eyes and hair, sex, height and weight, the time  
34 and date of arrest, the time and date of booking, the location of  
35 the arrest, the factual circumstances surrounding the arrest, the  
36 amount of bail set, the time and manner of release or the location  
37 where the individual is currently being held, and all charges the  
38 individual is being held upon, including any outstanding warrants  
39 from other jurisdictions and parole or probation holds.

1 (2) Subject to the restrictions imposed by Section 841.5 of the  
2 Penal Code, the time, substance, and location of all complaints or  
3 requests for assistance received by the agency and the time and  
4 nature of the response thereto, including, to the extent the  
5 information regarding crimes alleged or committed or any other  
6 incident investigated is recorded, the time, date, and location of  
7 occurrence, the time and date of the report, the name and age of  
8 the victim, the factual circumstances surrounding the crime or  
9 incident, and a general description of any injuries, property, or  
10 weapons involved. The name of a victim of any crime defined by  
11 Section 220, 236.1, 261, 261.5, 262, 264, 264.1, 265, 266, 266a,  
12 266b, 266c, 266e, 266f, 266j, 267, 269, 273a, 273d, 273.5, 285,  
13 286, 288, 288a, 288.2, 288.3 (as added by Chapter 337 of the  
14 Statutes of 2006), 288.3 (as added by Section 6 of Proposition 83  
15 of the November 7, 2006, statewide general election), 288.5, 288.7,  
16 289, 422.6, 422.7, 422.75, 646.9, or 647.6 of the Penal Code may  
17 be withheld at the victim's request, or at the request of the victim's  
18 parent or guardian if the victim is a minor. When a person is the  
19 victim of more than one crime, information disclosing that the  
20 person is a victim of a crime defined in any of the sections of the  
21 Penal Code set forth in this subdivision may be deleted at the  
22 request of the victim, or the victim's parent or guardian if the  
23 victim is a minor, in making the report of the crime, or of any  
24 crime or incident accompanying the crime, available to the public  
25 in compliance with the requirements of this paragraph.

26 (3) Subject to the restrictions of Section 841.5 of the Penal Code  
27 and this subdivision, the current address of every individual  
28 arrested by the agency and the current address of the victim of a  
29 crime, where the requester declares under penalty of perjury that  
30 the request is made for a scholarly, journalistic, political, or  
31 governmental purpose, or that the request is made for investigation  
32 purposes by a licensed private investigator as described in Chapter  
33 11.3 (commencing with Section 7512) of Division 3 of the Business  
34 and Professions Code. However, the address of the victim of any  
35 crime defined by Section 220, 236.1, 261, 261.5, 262, 264, 264.1,  
36 265, 266, 266a, 266b, 266c, 266e, 266f, 266j, 267, 269, 273a,  
37 273d, 273.5, 285, 286, 288, 288a, 288.2, 288.3 (as added by  
38 Chapter 337 of the Statutes of 2006), 288.3 (as added by Section  
39 6 of Proposition 83 of the November 7, 2006, statewide general  
40 election), 288.5, 288.7, 289, 422.6, 422.7, 422.75, 646.9, or 647.6

1 of the Penal Code shall remain confidential. Address information  
2 obtained pursuant to this paragraph may not be used directly or  
3 indirectly, or furnished to another, to sell a product or service to  
4 any individual or group of individuals, and the requester shall  
5 execute a declaration to that effect under penalty of perjury.  
6 Nothing in this paragraph shall be construed to prohibit or limit a  
7 scholarly, journalistic, political, or government use of address  
8 information obtained pursuant to this paragraph.

9 (g) Test questions, scoring keys, and other examination data  
10 used to administer a licensing examination, examination for  
11 employment, or academic examination, except as provided for in  
12 Chapter 3 (commencing with Section 99150) of Part 65 of Division  
13 14 of Title 3 of the Education Code.

14 (h) The contents of real estate appraisals or engineering or  
15 feasibility estimates and evaluations made for or by the state or  
16 local agency relative to the acquisition of property, or to  
17 prospective public supply and construction contracts, until all of  
18 the property has been acquired or all of the contract agreement  
19 obtained. However, the law of eminent domain shall not be affected  
20 by this provision.

21 (i) Information required from any taxpayer in connection with  
22 the collection of local taxes that is received in confidence and the  
23 disclosure of the information to other persons would result in unfair  
24 competitive disadvantage to the person supplying the information.

25 (j) Library circulation records kept for the purpose of identifying  
26 the borrower of items available in libraries, and library and museum  
27 materials made or acquired and presented solely for reference or  
28 exhibition purposes. The exemption in this subdivision shall not  
29 apply to records of fines imposed on the borrowers.

30 (k) Records, the disclosure of which is exempted or prohibited  
31 pursuant to federal or state law, including, but not limited to,  
32 provisions of the Evidence Code relating to privilege.

33 (l) Correspondence of and to the Governor or employees of the  
34 Governor's office or in the custody of or maintained by the  
35 Governor's Legal Affairs Secretary. However, public records shall  
36 not be transferred to the custody of the Governor's Legal Affairs  
37 Secretary to evade the disclosure provisions of this chapter.

38 (m) In the custody of or maintained by the Legislative Counsel,  
39 except those records in the public database maintained by the  
40 Legislative Counsel that are described in Section 10248.

1 (n) Statements of personal worth or personal financial data  
2 required by a licensing agency and filed by an applicant with the  
3 licensing agency to establish his or her personal qualification for  
4 the license, certificate, or permit applied for.

5 (o) Financial data contained in applications for financing under  
6 Division 27 (commencing with Section 44500) of the Health and  
7 Safety Code, where an authorized officer of the California Pollution  
8 Control Financing Authority determines that disclosure of the  
9 financial data would be competitively injurious to the applicant  
10 and the data is required in order to obtain guarantees from the  
11 United States Small Business Administration. The California  
12 Pollution Control Financing Authority shall adopt rules for review  
13 of individual requests for confidentiality under this section and for  
14 making available to the public those portions of an application that  
15 are subject to disclosure under this chapter.

16 (p) Records of state agencies related to activities governed by  
17 Chapter 10.3 (commencing with Section 3512), Chapter 10.5  
18 (commencing with Section 3525), and Chapter 12 (commencing  
19 with Section 3560) of Division 4, that reveal a state agency's  
20 deliberative processes, impressions, evaluations, opinions,  
21 recommendations, meeting minutes, research, work products,  
22 theories, or strategy, or that provide instruction, advice, or training  
23 to employees who do not have full collective bargaining and  
24 representation rights under these chapters. Nothing in this  
25 subdivision shall be construed to limit the disclosure duties of a  
26 state agency with respect to any other records relating to the  
27 activities governed by the employee relations acts referred to in  
28 this subdivision.

29 (q) (1) Records of state agencies related to activities governed  
30 by Article 2.6 (commencing with Section 14081), Article 2.8  
31 (commencing with Section 14087.5), and Article 2.91  
32 (commencing with Section 14089) of Chapter 7 of Part 3 of  
33 Division 9 of the Welfare and Institutions Code, that reveal the  
34 special negotiator's deliberative processes, discussions,  
35 communications, or any other portion of the negotiations with  
36 providers of health care services, impressions, opinions,  
37 recommendations, meeting minutes, research, work product,  
38 theories, or strategy, or that provide instruction, advice, or training  
39 to employees.



1 (2) Except for the portion of a contract containing the rates of  
2 payment, contracts for inpatient services entered into pursuant to  
3 these articles, on or after April 1, 1984, shall be open to inspection  
4 one year after they are fully executed. If a contract for inpatient  
5 services that is entered into prior to April 1, 1984, is amended on  
6 or after April 1, 1984, the amendment, except for any portion  
7 containing the rates of payment, shall be open to inspection one  
8 year after it is fully executed. If the California Medical Assistance  
9 Commission enters into contracts with health care providers for  
10 other than inpatient hospital services, those contracts shall be open  
11 to inspection one year after they are fully executed.

12 (3) Three years after a contract or amendment is open to  
13 inspection under this subdivision, the portion of the contract or  
14 amendment containing the rates of payment shall be open to  
15 inspection.

16 (4) Notwithstanding any other provision of law, the entire  
17 contract or amendment shall be open to inspection by the Joint  
18 Legislative Audit Committee and the Legislative Analyst's Office.  
19 The committee and that office shall maintain the confidentiality  
20 of the contracts and amendments until the time a contract or  
21 amendment is fully open to inspection by the public.

22 (r) Records of Native American graves, cemeteries, and sacred  
23 places and records of Native American places, features, and objects  
24 described in Sections 5097.9 and 5097.993 of the Public Resources  
25 Code maintained by, or in the possession of, the Native American  
26 Heritage Commission, another state agency, or a local agency.

27 (s) A final accreditation report of the Joint Commission on  
28 Accreditation of Hospitals that has been transmitted to the State  
29 Department of Health Care Services pursuant to subdivision (b)  
30 of Section 1282 of the Health and Safety Code.

31 (t) Records of a local hospital district, formed pursuant to  
32 Division 23 (commencing with Section 32000) of the Health and  
33 Safety Code, or the records of a municipal hospital, formed  
34 pursuant to Article 7 (commencing with Section 37600) or Article  
35 8 (commencing with Section 37650) of Chapter 5 of Part 2 of  
36 Division 3 of Title 4 of this code, that relate to any contract with  
37 an insurer or nonprofit hospital service plan for inpatient or  
38 outpatient services for alternative rates pursuant to Section 10133  
39 of the Insurance Code. However, the record shall be open to  
40 inspection within one year after the contract is fully executed.

1 (u) (1) Information contained in applications for licenses to  
2 carry firearms issued pursuant to Section 26150, 26155, 26170,  
3 or 26215 of the Penal Code by the sheriff of a county or the chief  
4 or other head of a municipal police department that indicates when  
5 or where the applicant is vulnerable to attack or that concerns the  
6 applicant's medical or psychological history or that of members  
7 of his or her family.

8 (2) The home address and telephone number of prosecutors,  
9 public defenders, peace officers, judges, court commissioners, and  
10 magistrates that are set forth in applications for licenses to carry  
11 firearms issued pursuant to Section 26150, 26155, 26170, or 26215  
12 of the Penal Code by the sheriff of a county or the chief or other  
13 head of a municipal police department.

14 (3) The home address and telephone number of prosecutors,  
15 public defenders, peace officers, judges, court commissioners, and  
16 magistrates that are set forth in licenses to carry firearms issued  
17 pursuant to Section 26150, 26155, 26170, or 26215 of the Penal  
18 Code by the sheriff of a county or the chief or other head of a  
19 municipal police department.

20 (v) (1) Records of the Managed Risk Medical Insurance Board  
21 *and the State Department of Health Care Services* related to  
22 activities governed by Part 6.3 (commencing with Section 12695),  
23 Part 6.5 (commencing with Section 12700), Part 6.6 (commencing  
24 with Section 12739.5), and Part 6.7 (commencing with Section  
25 12739.70) of Division 2 of the Insurance Code, *and Chapter 2*  
26 *(commencing with Section 15850) of Part 3.3 of Division 9 of the*  
27 *Welfare and Institutions Code*, and that reveal any of the following:

28 (A) The deliberative processes, discussions, communications,  
29 or any other portion of the negotiations with entities contracting  
30 or seeking to contract with the board *or the department*, entities  
31 with which the board *or the department* is considering a contract,  
32 or entities with which the board is considering or enters into any  
33 other arrangement under which the board *or the department*  
34 provides, receives, or arranges services or reimbursement.

35 (B) The impressions, opinions, recommendations, meeting  
36 minutes, research, work product, theories, or strategy of the board  
37 or its staff *or the department or its staff*, or records that provide  
38 instructions, advice, or training to *their* employees.

39 (2) (A) Except for the portion of a contract that contains the  
40 rates of payment, contracts entered into pursuant to Part 6.3

1 (commencing with Section 12695), Part 6.5 (commencing with  
2 Section 12700), Part 6.6 (commencing with Section 12739.5), or  
3 Part 6.7 (commencing with Section 12739.70) of Division 2 of the  
4 Insurance Code, or Chapter 2.2 (commencing with Section 15850)  
5 of Part 3.3 of Division 9 of the Welfare and Institutions Code, on  
6 or after July 1, 1991, shall be open to inspection one year after  
7 their effective dates.

8 (B) If a contract that is entered into prior to July 1, 1991, is  
9 amended on or after July 1, 1991, the amendment, except for any  
10 portion containing the rates of payment, shall be open to inspection  
11 one year after the effective date of the amendment.

12 (3) Three years after a contract or amendment is open to  
13 inspection pursuant to this subdivision, the portion of the contract  
14 or amendment containing the rates of payment shall be open to  
15 inspection.

16 (4) Notwithstanding any other law, the entire contract or  
17 amendments to a contract shall be open to inspection by the Joint  
18 Legislative Audit Committee. The committee shall maintain the  
19 confidentiality of the contracts and amendments thereto, until the  
20 contracts or amendments to the contracts are open to inspection  
21 pursuant to paragraph (3).

22 (w) (1) Records of the Managed Risk Medical Insurance Board  
23 related to activities governed by Chapter 8 (commencing with  
24 Section 10700) of Part 2 of Division 2 of the Insurance Code, and  
25 that reveal the deliberative processes, discussions, communications,  
26 or any other portion of the negotiations with health plans, or the  
27 impressions, opinions, recommendations, meeting minutes,  
28 research, work product, theories, or strategy of the board or its  
29 staff, or records that provide instructions, advice, or training to  
30 employees.

31 (2) Except for the portion of a contract that contains the rates  
32 of payment, contracts for health coverage entered into pursuant to  
33 Chapter 8 (commencing with Section 10700) of Part 2 of Division  
34 2 of the Insurance Code, on or after January 1, 1993, shall be open  
35 to inspection one year after they have been fully executed.

36 (3) Notwithstanding any other law, the entire contract or  
37 amendments to a contract shall be open to inspection by the Joint  
38 Legislative Audit Committee. The committee shall maintain the  
39 confidentiality of the contracts and amendments thereto, until the

1 contracts or amendments to the contracts are open to inspection  
2 pursuant to paragraph (2).

3 (x) Financial data contained in applications for registration, or  
4 registration renewal, as a service contractor filed with the Director  
5 of Consumer Affairs pursuant to Chapter 20 (commencing with  
6 Section 9800) of Division 3 of the Business and Professions Code,  
7 for the purpose of establishing the service contractor's net worth,  
8 or financial data regarding the funded accounts held in escrow for  
9 service contracts held in force in this state by a service contractor.

10 (y) (1) Records of the Managed Risk Medical Insurance Board  
11 related to activities governed by Part 6.2 (commencing with Section  
12 12693) or Part 6.4 (commencing with Section 12699.50) of  
13 Division 2 of the Insurance Code, and that reveal any of the  
14 following:

15 (A) The deliberative processes, discussions, communications,  
16 or any other portion of the negotiations with entities contracting  
17 or seeking to contract with the board, entities with which the board  
18 is considering a contract, or entities with which the board is  
19 considering or enters into any other arrangement under which the  
20 board provides, receives, or arranges services or reimbursement.

21 (B) The impressions, opinions, recommendations, meeting  
22 minutes, research, work product, theories, or strategy of the board  
23 or its staff, or records that provide instructions, advice, or training  
24 to employees.

25 (2) (A) Except for the portion of a contract that contains the  
26 rates of payment, contracts entered into pursuant to Part 6.2  
27 (commencing with Section 12693) or Part 6.4 (commencing with  
28 Section 12699.50) of Division 2 of the Insurance Code, on or after  
29 January 1, 1998, shall be open to inspection one year after their  
30 effective dates.

31 (B) If a contract entered into pursuant to Part 6.2 (commencing  
32 with Section 12693) or Part 6.4 (commencing with Section  
33 12699.50) of Division 2 of the Insurance Code is amended, the  
34 amendment shall be open to inspection one year after the effective  
35 date of the amendment.

36 (3) Three years after a contract or amendment is open to  
37 inspection pursuant to this subdivision, the portion of the contract  
38 or amendment containing the rates of payment shall be open to  
39 inspection.

1 (4) Notwithstanding any other law, the entire contract or  
2 amendments to a contract shall be open to inspection by the Joint  
3 Legislative Audit Committee. The committee shall maintain the  
4 confidentiality of the contracts and amendments thereto until the  
5 contract or amendments to a contract are open to inspection  
6 pursuant to paragraph (2) or (3).

7 (5) The exemption from disclosure provided pursuant to this  
8 subdivision for the contracts, deliberative processes, discussions,  
9 communications, negotiations, impressions, opinions,  
10 recommendations, meeting minutes, research, work product,  
11 theories, or strategy of the board or its staff shall also apply to the  
12 contracts, deliberative processes, discussions, communications,  
13 negotiations, impressions, opinions, recommendations, meeting  
14 minutes, research, work product, theories, or strategy of applicants  
15 pursuant to Part 6.4 (commencing with Section 12699.50) of  
16 Division 2 of the Insurance Code.

17 (z) Records obtained pursuant to paragraph (2) of subdivision  
18 (f) of Section 2891.1 of the Public Utilities Code.

19 (aa) A document prepared by or for a state or local agency that  
20 assesses its vulnerability to terrorist attack or other criminal acts  
21 intended to disrupt the public agency's operations and that is for  
22 distribution or consideration in a closed session.

23 (ab) Critical infrastructure information, as defined in Section  
24 131(3) of Title 6 of the United States Code, that is voluntarily  
25 submitted to the California Emergency Management Agency for  
26 use by that office, including the identity of the person who or entity  
27 that voluntarily submitted the information. As used in this  
28 subdivision, "voluntarily submitted" means submitted in the  
29 absence of the office exercising any legal authority to compel  
30 access to or submission of critical infrastructure information. This  
31 subdivision shall not affect the status of information in the  
32 possession of any other state or local governmental agency.

33 (ac) All information provided to the Secretary of State by a  
34 person for the purpose of registration in the Advance Health Care  
35 Directive Registry, except that those records shall be released at  
36 the request of a health care provider, a public guardian, or the  
37 registrant's legal representative.

38 (ad) The following records of the State Compensation Insurance  
39 Fund:

1 (1) Records related to claims pursuant to Chapter 1  
2 (commencing with Section 3200) of Division 4 of the Labor Code,  
3 to the extent that confidential medical information or other  
4 individually identifiable information would be disclosed.

5 (2) Records related to the discussions, communications, or any  
6 other portion of the negotiations with entities contracting or seeking  
7 to contract with the fund, and any related deliberations.

8 (3) Records related to the impressions, opinions,  
9 recommendations, meeting minutes of meetings or sessions that  
10 are lawfully closed to the public, research, work product, theories,  
11 or strategy of the fund or its staff, on the development of rates,  
12 contracting strategy, underwriting, or competitive strategy pursuant  
13 to the powers granted to the fund in Chapter 4 (commencing with  
14 Section 11770) of Part 3 of Division 2 of the Insurance Code.

15 (4) Records obtained to provide workers' compensation  
16 insurance under Chapter 4 (commencing with Section 11770) of  
17 Part 3 of Division 2 of the Insurance Code, including, but not  
18 limited to, any medical claims information, policyholder  
19 information provided that nothing in this paragraph shall be  
20 interpreted to prevent an insurance agent or broker from obtaining  
21 proprietary information or other information authorized by law to  
22 be obtained by the agent or broker, and information on rates,  
23 pricing, and claims handling received from brokers.

24 (5) (A) Records that are trade secrets pursuant to Section  
25 6276.44, or Article 11 (commencing with Section 1060) of Chapter  
26 4 of Division 8 of the Evidence Code, including without limitation,  
27 instructions, advice, or training provided by the State Compensation  
28 Insurance Fund to its board members, officers, and employees  
29 regarding the fund's special investigation unit, internal audit unit,  
30 and informational security, marketing, rating, pricing, underwriting,  
31 claims handling, audits, and collections.

32 (B) Notwithstanding subparagraph (A), the portions of records  
33 containing trade secrets shall be available for review by the Joint  
34 Legislative Audit Committee, the Bureau of State Audits, Division  
35 of Workers' Compensation, and the Department of Insurance to  
36 ensure compliance with applicable law.

37 (6) (A) Internal audits containing proprietary information and  
38 the following records that are related to an internal audit:

39 (i) Personal papers and correspondence of any person providing  
40 assistance to the fund when that person has requested in writing

1 that his or her papers and correspondence be kept private and  
2 confidential. Those papers and correspondence shall become public  
3 records if the written request is withdrawn, or upon order of the  
4 fund.

5 (ii) Papers, correspondence, memoranda, or any substantive  
6 information pertaining to any audit not completed or an internal  
7 audit that contains proprietary information.

8 (B) Notwithstanding subparagraph (A), the portions of records  
9 containing proprietary information, or any information specified  
10 in subparagraph (A) shall be available for review by the Joint  
11 Legislative Audit Committee, the Bureau of State Audits, Division  
12 of Workers' Compensation, and the Department of Insurance to  
13 ensure compliance with applicable law.

14 (7) (A) Except as provided in subparagraph (C), contracts  
15 entered into pursuant to Chapter 4 (commencing with Section  
16 11770) of Part 3 of Division 2 of the Insurance Code shall be open  
17 to inspection one year after the contract has been fully executed.

18 (B) If a contract entered into pursuant to Chapter 4 (commencing  
19 with Section 11770) of Part 3 of Division 2 of the Insurance Code  
20 is amended, the amendment shall be open to inspection one year  
21 after the amendment has been fully executed.

22 (C) Three years after a contract or amendment is open to  
23 inspection pursuant to this subdivision, the portion of the contract  
24 or amendment containing the rates of payment shall be open to  
25 inspection.

26 (D) Notwithstanding any other law, the entire contract or  
27 amendments to a contract shall be open to inspection by the Joint  
28 Legislative Audit Committee. The committee shall maintain the  
29 confidentiality of the contracts and amendments thereto until the  
30 contract or amendments to a contract are open to inspection  
31 pursuant to this paragraph.

32 (E) This paragraph is not intended to apply to documents related  
33 to contracts with public entities that are not otherwise expressly  
34 confidential as to that public entity.

35 (F) For purposes of this paragraph, "fully executed" means the  
36 point in time when all of the necessary parties to the contract have  
37 signed the contract.

38 This section shall not prevent any agency from opening its  
39 records concerning the administration of the agency to public  
40 inspection, unless disclosure is otherwise prohibited by law.

1 This section shall not prevent any health facility from disclosing  
2 to a certified bargaining agent relevant financing information  
3 pursuant to Section 8 of the National Labor Relations Act (29  
4 U.S.C. Sec. 158).

5 *SEC. 3. Section 26605.6 of the Government Code is amended*  
6 *to read:*

7 26605.6. (a) The sheriff, or his or her designee, has the  
8 authority, after conferring with a physician who has oversight for  
9 providing medical care at a county jail, or that physician's designee,  
10 to release from a county correctional facility, a prisoner sentenced  
11 to a county jail if the sheriff determines that the prisoner would  
12 not reasonably pose a threat to public safety and the prisoner, upon  
13 diagnosis by the examining physician, is deemed to have a life  
14 expectancy of six months or less.

15 (b) Before the release of any prisoner pursuant to this section,  
16 the sheriff shall notify the presiding judge of the superior court of  
17 his or her intention to release the prisoner. This notification shall  
18 include:

19 (1) The prisoner's name.

20 (2) The offense or offenses for which the prisoner was  
21 incarcerated, if applicable, and the pending charges, if applicable.

22 (3) The date of sentence, if applicable.

23 (4) The physician's diagnosis of the prisoner's condition.

24 (5) The physician's prognosis for the prisoner's recovery.

25 (6) The prisoner's address after release.

26 (c) (1) *This section shall be implemented only to the extent that*  
27 *a county that releases a prisoner pursuant to this section does both*  
28 *of the following:*

29 (A) *Sends a letter to the State Department of Health Care*  
30 *Services agreeing to do both of the following:*

31 (i) *Notify the State Department of Health Care Services, in*  
32 *writing, when a prisoner released pursuant to this section has*  
33 *applied for Medi-Cal.*

34 (ii) *Notify the State Department of Health Care Services, in*  
35 *writing, if a prisoner released pursuant to this section, who is*  
36 *Medi-Cal eligible, is returned to the custody of the sheriff.*

37 (B) *For the period of time that the offender would otherwise*  
38 *have been incarcerated:*

39 (i) *Reimburses the State Department of Health Care Services*  
40 *for the nonfederal share of the Medi-Cal costs and any medical*



1 *costs paid by the State Department of Health Care Services that*  
2 *are not reimbursable pursuant to Title XIX or XXI of the federal*  
3 *Social Security Act, for an offender released pursuant to this*  
4 *section.*

5 *(ii) Provides to the State Department of Health Care Services*  
6 *the nonfederal share of the state's administrative costs associated*  
7 *with this section.*

8 *(2) It is the intent of the Legislature that the implementation of*  
9 *this section shall not result in increased costs to the General Fund.*

10 *(3) Participation in the program under this section is voluntary*  
11 *for purposes of all applicable federal law. This section shall be*  
12 *implemented only to the extent that federal financial participation*  
13 *for the Medi-Cal program is not jeopardized.*

14 ~~(e)~~

15 *(d) Before a prisoner's compassionate release from a county*  
16 *jail pursuant to this section, the sheriff, or his or her designee, shall*  
17 *secure a placement option for the prisoner in the community and,*  
18 *in consultation with the county welfare department or another*  
19 *applicable county agency, examine the prisoner's eligibility for*  
20 *federal Medicaid benefits or other medical coverage that might*  
21 *assist in funding the prisoner's medical treatment while in the*  
22 *community.*

23 ~~(e)~~

24 *(e) (1) For any prisoner released pursuant to this section who*  
25 *is eligible for Medi-Cal, the county shall continue to pay the*  
26 *nonfederal share of the prisoner's Medi-Cal costs for the period*  
27 *of time that the offender would have otherwise been incarcerated.*

28 *(2) For any prisoner granted compassionate release pursuant to*  
29 *this section who is ineligible for Medi-Cal, the county shall*  
30 *consider whether the prisoner has private medical insurance or*  
31 *sufficient income or assets to provide for his or her own medical*  
32 *care. If the county determines that the prisoner can provide for his*  
33 *or her own medical care, the county shall not be required to provide*  
34 *the prisoner with medical care.*

35 ~~(e)~~

36 *(f) This section shall not be construed as authorizing the sheriff*  
37 *to refuse to receive and incarcerate a defendant or sentenced*  
38 *individual who is not in need of immediate medical care or who*  
39 *has a terminal medical condition.*

1 (g) Notwithstanding any other law, the State Department of  
2 Health Care Services may exempt individuals released pursuant  
3 to this section from mandatory enrollment in managed health care,  
4 including county-organized health plans and, as deemed necessary  
5 by the State Department of Health Care Services, may determine  
6 the proper prior authorization process for individuals who have  
7 been released pursuant to this section.

8 (h) Notwithstanding Chapter 3.5 (commencing with Section  
9 11340) of Part 1 of Division 3 of Title 2, the State Department of  
10 Health Care Services, without taking any further regulatory action,  
11 shall implement, interpret, and make specific this section by means  
12 of provider bulletins, all-county letters, manuals, or similar  
13 instructions until the time that regulations are adopted. Thereafter,  
14 the department shall adopt regulations in accordance with Chapter  
15 3.5 (commencing with Section 11340) of Part 1 of Division 3 of  
16 Title 2. Six months after the effective date of the act that added  
17 this subdivision, the department shall provide a status update to  
18 the Legislature on its efforts to adopt the regulations. Thereafter,  
19 notwithstanding Section 10231.5, the department shall report on  
20 the status of this effort to the Legislature on an annual basis, until  
21 the regulations have been adopted.

22 SEC. 4. Section 26605.7 of the Government Code is amended  
23 to read:

24 26605.7. (a) The sheriff, or his or her designee, after conferring  
25 with the physician who has oversight for providing medical care,  
26 or the physician's designee, may request the court to grant medical  
27 probation or to resentence a prisoner to medical probation in lieu  
28 of jail time for any prisoner sentenced to a county jail under either  
29 of the following circumstances:

30 (1) The prisoner is physically incapacitated with a medical  
31 condition that renders the prisoner permanently unable to perform  
32 activities of basic daily living, which has resulted in the prisoner  
33 requiring 24-hour care, if that incapacitation did not exist at the  
34 time of sentencing.

35 (2) The prisoner would require acute long-term inpatient  
36 rehabilitation services.

37 (b) Before a prisoner's release to medical probation, the sheriff,  
38 or his or her designee, shall secure a placement option for the  
39 prisoner in the community and, in consultation with the county  
40 welfare department or another applicable county agency, examine

1 the prisoner's eligibility for federal Medicaid benefits or other  
2 medical coverage that might assist in funding the prisoner's  
3 medical treatment while in the community.

4 (c) During the time on probation pursuant to this section, the  
5 probation officer or court may, at any time, request a medical  
6 reexamination of the probationer by a physician who has oversight  
7 for providing medical care to prisoners in a county jail, or the  
8 physician's designee. If the court determines, based on that medical  
9 examination, that the probationer's medical condition has improved  
10 to the extent that the probationer no longer qualifies for medical  
11 probation, the court may return the probationer to the custody of  
12 the sheriff.

13 (d) (1) For any probationer granted medical probation pursuant  
14 to this section who is eligible for Medi-Cal, the county shall  
15 continue to pay the nonfederal share of the probationer's Medi-Cal  
16 costs. After a probationer is released from medical probation, the  
17 county shall no longer be required to pay the nonfederal share of  
18 the Medi-Cal costs.

19 (2) For any probationer granted medical probation pursuant to  
20 this section who is ineligible for Medi-Cal, the county shall  
21 consider whether the probationer has private medical insurance or  
22 sufficient income or assets to provide for his or her own medical  
23 care. If the county determines that the probationer can provide for  
24 his or her own medical care, the county shall not be required to  
25 provide the probationer with medical care.

26 (e) (1) *This section shall be implemented only to the extent that*  
27 *a court sentences a person to medical probation pursuant to this*  
28 *section and the sheriff does both of the following:*

29 (A) *Sends a letter to the State Department of Health Care*  
30 *Services agreeing to do both of the following:*

31 (i) *Notify the State Department of Health Care Services, in*  
32 *writing, when a probationer released pursuant to this section has*  
33 *applied for Medi-Cal.*

34 (ii) *Notify the State Department of Health Care Services, in*  
35 *writing, if a probationer released pursuant to this section, who is*  
36 *Medi-Cal eligible, is returned to the custody of the sheriff. The*  
37 *chief probation officer shall notify the State Department of Health*  
38 *Care Services, in writing, when a Medi-Cal eligible probationer's*  
39 *term of medical probation ends.*

40 (B) *For the period of time the offender is on medical probation:*

1 (i) Reimburses the State Department of Health Care Services  
2 for the nonfederal share of the Medi-Cal costs and any medical  
3 costs paid by the State Department of Health Care Services that  
4 are not reimbursable pursuant to Title XIX or XXI of the federal  
5 Social Security Act, for an offender released pursuant to this  
6 section.

7 (ii) Provides to the State Department of Health Care Services  
8 the nonfederal share of the state's administrative costs associated  
9 with this section.

10 (2) It is the intent of the Legislature that the implementation of  
11 this section shall not result in increased costs to the General Fund.

12 (3) Participation in the program under this section is voluntary  
13 for purposes of all applicable federal law. This section shall be  
14 implemented only to the extent that federal financial participation  
15 for the Medi-Cal program is not jeopardized.

16 (f) Notwithstanding any other law, the State Department of  
17 Health Care Services may exempt individuals released pursuant  
18 to this section from mandatory enrollment in managed health care,  
19 including county-organized health plans and, as deemed necessary  
20 by the State Department of Health Care Services, may determine  
21 the proper prior authorization process for individuals who have  
22 been released pursuant to this section.

23 (g) Notwithstanding Chapter 3.5 (commencing with Section  
24 11340) of Part 1 of Division 3 of Title 2, the State Department of  
25 Health Care Services, without taking any further regulatory action,  
26 may implement, interpret, and make specific this section by means  
27 of provider bulletins, all-county letters, manuals, or similar  
28 instructions until the time that regulations are adopted. Thereafter,  
29 the department shall adopt regulations in accordance with Chapter  
30 3.5 (commencing with Section 11340) of Part 1 of Division 3 of  
31 Title 2. Six months after the effective date of the act that added  
32 this subdivision, the department shall provide a status update to  
33 the Legislature on its efforts to adopt the regulations. Thereafter,  
34 notwithstanding Section 10231.5, the department shall report on  
35 the status of this effort to the Legislature on an annual basis, until  
36 the regulations have been adopted.

37 SEC. 5. Section 26605.8 of the Government Code is amended  
38 to read:

39 26605.8. Before implementing Sections 26605.6 and 26605.7,  
40 the county board of supervisors shall adopt a process to fund the

1 nonfederal share of Medi-Cal costs for the period of time that a  
2 prisoner would have otherwise been incarcerated or for the period  
3 of time that a probationer is on medical probation. The county  
4 board of supervisors shall ~~notify~~ *provide* the State Department of  
5 Health Care Services *with written notification* of the process.

6 *SEC. 6. Section 1180.6 of the Health and Safety Code is*  
7 *amended to read:*

8 1180.6. The State Department of Public Health, the State  
9 Department of State Hospitals, the State Department of Social  
10 Services, ~~and~~ the State Department of Developmental Services,  
11 *and the State Department of Health Care Services* shall annually  
12 provide information to the Legislature, during Senate and Assembly  
13 budget committee hearings, about the progress made in  
14 implementing this division. This information shall include the  
15 progress of implementation and barriers to achieving full  
16 implementation.

17 *SEC. 7. Section 1250.2 of the Health and Safety Code is*  
18 *amended to read:*

19 1250.2. (a) (1) As defined in Section 1250, “health facility”  
20 includes a “psychiatric health facility,” defined to mean a health  
21 facility, licensed by the State Department of ~~Social Health Care~~  
22 Services, that provides 24-hour inpatient care for mentally  
23 disordered, incompetent, or other persons described in Division 5  
24 (commencing with Section 5000) or Division 6 (commencing with  
25 Section 6000) of the Welfare and Institutions Code. This care shall  
26 include, but not be limited to, the following basic services:  
27 psychiatry, clinical psychology, psychiatric nursing, social work,  
28 rehabilitation, drug administration, and appropriate food services  
29 for those persons whose physical health needs can be met in an  
30 affiliated hospital or in outpatient settings.

31 ~~It~~

32 (2) *It* is the intent of the Legislature that the psychiatric health  
33 facility shall provide a distinct type of service to psychiatric  
34 patients in a 24-hour acute inpatient setting. The State Department  
35 of ~~Social Health Care~~ Services shall require regular utilization  
36 reviews of admission and discharge criteria and lengths of stay in  
37 order to assure that these patients are moved to less restrictive  
38 levels of care as soon as appropriate.

39 (b) (1) The State Department of ~~Social Health Care~~ Services  
40 may issue a special permit to a psychiatric health facility for it to

1 provide structured outpatient services (commonly referred to as  
2 SOPS) consisting of morning, afternoon, or full daytime organized  
3 programs, not exceeding 10 hours, for acute daytime care for  
4 patients admitted to the facility. This subdivision shall not be  
5 construed as requiring a psychiatric health facility to apply for a  
6 special permit to provide these alternative levels of care.

7 ~~The~~

8 (2) *The* Legislature recognizes that, with access to structured  
9 outpatient services, as an alternative to 24-hour inpatient care,  
10 certain patients would be provided with effective intervention and  
11 less restrictive levels of care. The Legislature further recognizes  
12 that, for certain patients, the less restrictive levels of care eliminate  
13 the need for inpatient care, enable earlier discharge from inpatient  
14 care by providing a continuum of care with effective aftercare  
15 services, or reduce or prevent the need for a subsequent readmission  
16 to inpatient care.

17 (c) Any reference in any statute to Section 1250 of the Health  
18 and Safety Code shall be deemed and construed to also be a  
19 reference to this section.

20 (d) Notwithstanding any other provision of law, and to the extent  
21 consistent with federal law, a psychiatric health facility shall be  
22 eligible to participate in the medicare program under Title XVIII  
23 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.),  
24 and the medicaid program under Title XIX of the federal Social  
25 Security Act (42 U.S.C. Sec. 1396 et seq.), if all of the following  
26 conditions are met:

27 (1) The facility is a licensed facility.

28 (2) The facility is in compliance with all related statutes and  
29 regulations enforced by the State Department of ~~Social~~ *Health*  
30 *Care Services*, including regulations contained in Chapter 9  
31 (commencing with Section 77001) of Division 5 of Title 22 of the  
32 California Code of Regulations.

33 (3) The facility meets the definitions and requirements contained  
34 in subdivisions (e) and (f) of Section 1861 of the federal Social  
35 Security Act (42 U.S.C. Sec. 1395x(e) and (f)), including the  
36 approval process specified in Section 1861(e)(7)(B) of the federal  
37 Social Security Act (42 U.S.C. Sec. 1395x(e)(7)(B)), which  
38 requires that the state agency responsible for licensing hospitals  
39 has assured that the facility meets licensing requirements.

1 (4) The facility meets the conditions of participation for hospitals  
2 pursuant to Part 482 of Title 42 of the Code of Federal Regulations.

3 *SEC. 8. Section 1254 of the Health and Safety Code is amended*  
4 *to read:*

5 1254. (a) Except as provided in subdivision (e), the state  
6 department shall inspect and license health facilities. The state  
7 department shall license health facilities to provide their respective  
8 basic services specified in Section 1250. Except as provided in  
9 Section 1253, the state department shall inspect and approve a  
10 general acute care hospital to provide special services as specified  
11 in Section 1255. The state department shall develop and adopt  
12 regulations to implement the provisions contained in this section.

13 (b) Upon approval, the state department shall issue a separate  
14 license for the provision of the basic services enumerated in  
15 subdivision (c) or (d) of Section 1250 whenever these basic services  
16 are to be provided by an acute care hospital, as defined in  
17 subdivision (a), (b), or (f) of that section, where the services  
18 enumerated in subdivision (c) or (d) of Section 1250 are to be  
19 provided in any separate freestanding facility, whether or not the  
20 location of the separate freestanding facility is contiguous to the  
21 acute care hospital. The same requirement shall apply to any new  
22 freestanding facility constructed for the purpose of providing basic  
23 services, as defined in subdivision (c) or (d) of Section 1250, by  
24 any acute care hospital on or after January 1, 1984.

25 (c) (1) Those beds licensed to an acute care hospital which,  
26 prior to January 1, 1984, were separate freestanding beds and were  
27 not part of the physical structure licensed to provide acute care,  
28 and which beds were licensed to provide those services enumerated  
29 in subdivision (c) or (d) of Section 1250, are exempt from the  
30 requirements of subdivision (b).

31 (2) All beds licensed to an acute care hospital and located within  
32 the physical structure in which acute care is provided are exempt  
33 from the requirements of subdivision (b) irrespective of the date  
34 of original licensure of the beds, or the licensed category of the  
35 beds.

36 (3) All beds licensed to an acute care hospital owned and  
37 operated by the State of California or any other public agency are  
38 exempt from the requirements of subdivision (b).

39 (4) All beds licensed to an acute care hospital in a rural area as  
40 defined by Chapter 1010, of the Statutes of 1982, are exempt from

1 the requirements of subdivision (b), except where there is a  
2 freestanding skilled nursing facility or intermediate care facility  
3 which has experienced an occupancy rate of 95 percent or less  
4 during the past 12 months within a 25-mile radius or which may  
5 be reached within 30 minutes using a motor vehicle.

6 (5) All beds licensed to an acute care hospital which meet the  
7 criteria for designation within peer group six or eight, as defined  
8 in the report entitled Hospital Peer Grouping for Efficiency  
9 Comparison, dated December 20, 1982, and published by the  
10 California Health Facilities Commission, and all beds in hospitals  
11 which have fewer than 76 licensed acute care beds and which are  
12 located in a census designation place of 15,000 or less population,  
13 are exempt from the requirements of subdivision (b), except where  
14 there is a free-standing skilled nursing facility or intermediate care  
15 facility which has experienced an occupancy rate of 95 percent or  
16 less during the past 12 months within a 25-mile radius or which  
17 may be reached within 30 minutes using a motor vehicle.

18 (6) All beds licensed to an acute care hospital which has had a  
19 certificate of need approved by a health systems agency on or  
20 before July 1, 1983, are exempt from the requirements of  
21 subdivision (b).

22 (7) All beds licensed to an acute care hospital are exempt from  
23 the requirements of subdivision (b), if reimbursement from the  
24 Medi-Cal program for beds licensed for the provision of services  
25 enumerated in subdivision (c) or (d) of Section 1250 and not  
26 otherwise exempt does not exceed the reimbursement which would  
27 be received if the beds were in a separately licensed facility.

28 (d) Except as provided in Section 1253, the state department  
29 shall inspect and approve a general acute care hospital to provide  
30 special services as specified in Section 1255. The state department  
31 shall develop and adopt regulations to implement subdivisions (a)  
32 to (d), inclusive, of this section.

33 (e) The State Department of ~~Social~~ *Health Care* Services shall  
34 inspect and license psychiatric health facilities. The State  
35 Department of ~~Social~~ *Health Care* Services shall license psychiatric  
36 health facilities to provide their basic services specified in Section  
37 1250.2. The State Department of ~~Social~~ *Health Care* Services shall  
38 develop ~~and~~, adopt, *or amend* regulations to implement this  
39 subdivision.



1     *SEC. 9. Section 1254.1 of the Health and Safety Code is*  
2 *amended to read:*

3     1254.1. (a) The State Department of ~~Social Health Care~~  
4 Services shall license psychiatric health facilities to provide their  
5 basic services specified in Section 1250.

6     (b) Any reference in any statute to Section 1254 shall be deemed  
7 and construed to also be a reference to this section.

8     *SEC. 10. Section 1266.1 of the Health and Safety Code is*  
9 *amended to read:*

10     1266.1. (a) Each new or renewal application for a license for  
11 a psychiatric health facility shall be accompanied by a fee credited  
12 to the State Department of ~~Social Health Care~~ Services for its  
13 costs incurred in the review of psychiatric health facility programs,  
14 in connection with the licensing of these facilities. The amount of  
15 the fees shall be determined and collected by the State Department  
16 of ~~Social Health Care~~ Services, but the total amount of the fees  
17 collected shall not exceed the actual costs of licensure and review  
18 of psychiatric health facility programs, including, but not limited  
19 to, the costs of processing the application, inspection costs, and  
20 other related costs.

21     (b) New or renewal licensure application fees for psychiatric  
22 health facilities shall be collected by the State Department of ~~Social~~  
23 *Health Care* Services.

24     (c) The annual fees shall be waived for any psychiatric health  
25 facility conducted, maintained, or operated by this state or any  
26 state department, authority, bureau, commission, or officer, or by  
27 the Regents of the University of California, or by a local hospital  
28 district, city, county, or city and county.

29     (d) If additional private psychiatric health facilities seek new  
30 licensure on or after January 1, 1991, the State Department of  
31 ~~Social Health Care~~ Services may increase the fees for all private  
32 psychiatric health facilities with more than nine beds sufficient to  
33 accommodate the increased level of workload and costs.

34     (e) (1) Any licensee desiring to obtain a special permit to offer  
35 and provide structured outpatient services shall file an application  
36 with the State Department of ~~Social Health Care~~ Services.

37     (2) The application for a special permit, if any, shall be  
38 submitted with each new or renewal application for a license for  
39 a psychiatric health facility, and shall be accompanied by a  
40 reasonable fee, as determined by the State Department of ~~Social~~

1 *Health Care Services*, not to exceed the actual costs of  
2 administration related to the special permit. An application for a  
3 special permit submitted by a psychiatric health facility operated  
4 by a public entity shall be exempt from the fee required pursuant  
5 to this section for the issuance of the special permit.

6 (3) The State Department of ~~Social~~ *Health Care Services* shall  
7 not issue a special permit unless the applicant furnishes all of the  
8 following:

9 (A) Its annual licensing fee required pursuant to subdivision  
10 (a).

11 (B) A completed application submitted on forms furnished by  
12 the department.

13 (C) A written agreement ensuring that the facility will have  
14 additional staffing for the services to be provided under the special  
15 permit, that the additional staffing will meet the same professional  
16 standards as required by regulation for inpatient services, and that  
17 a coordinator of these services will be appointed.

18 (D) Any other information or documentation as may be required  
19 by the department for its proper and efficient administration and  
20 enforcement of special permit services.

21 (4) The provision of structured outpatient services pursuant to  
22 a special permit may be as an alternative to admission to inpatient  
23 services, as aftercare services following discharge from inpatient  
24 care, or as both.

25 *SEC. 11. Section 1275.1 of the Health and Safety Code is*  
26 *amended to read:*

27 1275.1. (a) Notwithstanding any rules or regulations governing  
28 other health facilities, the regulations developed by the State  
29 Department of ~~Social~~ *Health Care Services, or a predecessor,* for  
30 psychiatric health facilities shall prevail. The regulations applying  
31 to psychiatric health facilities shall prescribe standards of adequacy,  
32 safety, and sanitation of the physical plant, of staffing with duly  
33 qualified licensed personnel, and of services based on the needs  
34 of the persons served thereby.

35 (b) The regulations shall include standards appropriate for two  
36 levels of disorder:

37 (1) Involuntary ambulatory psychiatric patients.

38 (2) Voluntary ambulatory psychiatric patients.

39 For purposes of this subdivision, “ambulatory patients” shall  
40 include, but not be limited to, deaf, blind, and physically

1 handicapped persons. Disoriented persons who are not bedridden  
2 or confined to a wheelchair shall also be considered as ambulatory  
3 patients.

4 (c) The regulations shall not require, but may permit building  
5 and services requirements for hospitals which are only applicable  
6 to physical health care needs of patients that can be met in an  
7 affiliated hospital or in outpatient settings including, but not limited  
8 to, such requirements as surgical, dietary, laboratory, laundry,  
9 central supply, radiologic, and pharmacy.

10 (d) The regulations shall include provisions for an “open  
11 planning” architectural concept.

12 (e) The regulations shall exempt from seismic requirements all  
13 structures of Type V and of one-story construction.

14 (f) Standards for involuntary patients shall include provisions  
15 to allow for restraint and seclusion of patients. These standards  
16 shall provide for adequate safeguards for patient safety and  
17 protection of patient rights.

18 (g) The regulations shall provide for the retention by the  
19 psychiatric health facility of a consultant pharmacist, who shall  
20 supervise and review pharmaceutical services within the facility  
21 and perform any other services, including prevention of the  
22 unlawful diversion of controlled substances subject to abuse, as  
23 ~~the state department~~ *State Department of Health Care Services*  
24 may by regulation require. Regulations adopted pursuant to this  
25 subdivision shall take into consideration the varying bed sizes of  
26 psychiatric health facilities.

27 *SEC. 12. Section 1275.5 of the Health and Safety Code is*  
28 *amended to read:*

29 1275.5. (a) The regulations relating to the licensing of  
30 hospitals, heretofore adopted by the State Department of Public  
31 Health pursuant to *former* Chapter 2 (commencing with Section  
32 1400) of Division 2, and in effect immediately prior to July 1,  
33 1973, shall remain in effect and shall be fully enforceable with  
34 respect to any hospital required to be licensed by this chapter,  
35 unless and until the regulations are readopted, amended, or repealed  
36 by the director.

37 (b) The regulations relating to private institutions receiving or  
38 caring for any mentally disordered persons, ~~mentally retarded~~  
39 *intellectually disabled* persons, and other incompetent persons,  
40 heretofore adopted by the Department of Mental Hygiene pursuant

1 to Chapter 1 (commencing with Section 7000) of Division 7 of  
2 the Welfare and Institutions Code, and in effect immediately prior  
3 to July 1, 1973, shall remain in effect and shall be fully enforceable  
4 with respect to any facility, establishment, or institution for the  
5 reception and care of mentally disordered persons, ~~mentally~~  
6 ~~retarded~~ *intellectually disabled* persons and other incompetent  
7 persons, required to be licensed by the provisions of this chapter  
8 unless and until said regulations are readopted, amended, or  
9 repealed by the director.

10 (c) (1) All regulations relating to the licensing of psychiatric  
11 health facilities heretofore adopted by the State Department of  
12 Health Services, pursuant to authority now vested in the State  
13 Department of ~~Mental Health Care Services~~ by Section ~~5652.5~~  
14 ~~4080~~ of the Welfare and Institutions Code, and in effect  
15 immediately preceding September 20, 1988, shall remain in effect  
16 and shall be fully enforceable by the State Department of ~~Mental~~  
17 ~~Health Care Services~~ with respect to any facility or program  
18 required to be licensed as a psychiatric health facility, unless and  
19 until readopted, amended, or repealed by the Director of ~~Mental~~  
20 ~~Health Care Services~~.

21 (2) The State Department of ~~Social Health Care Services~~ shall  
22 succeed to and be vested with all duties, powers, purposes,  
23 functions, responsibilities, and jurisdiction of the ~~State Department~~  
24 ~~of Mental Health, described in paragraph (1)~~, as they relate to  
25 licensing psychiatric health facilities.

26 *SEC. 13. Section 1324.9 of the Health and Safety Code is*  
27 *amended to read:*

28 1324.9. (a) The Long-Term Care Quality Assurance Fund is  
29 hereby created in the State Treasury. Moneys in the fund shall be  
30 available, upon appropriation by the Legislature, for expenditure  
31 by the State Department of Health Care Services for the purposes  
32 of this article and Article 7.6 (commencing with Section 1324.20).  
33 Notwithstanding Section 16305.7 of the Government Code, the  
34 fund shall contain all interest and dividends earned on moneys in  
35 the fund.

36 (b) Notwithstanding any other law, beginning August 1, 2013,  
37 all revenues received by the State Department of Health Care  
38 Services categorized by the State Department of Health Care  
39 Services as long-term care quality assurance fees shall be deposited  
40 into the Long-Term Care Quality Assurance Fund. Revenue that

1 shall be deposited into this fund shall include quality assurance  
2 fees imposed pursuant to this article and quality assurance fees  
3 imposed pursuant to Article 7.6 (commencing with Section  
4 1324.20).

5 *(c) Notwithstanding any other law, the Controller may use the*  
6 *funds in the Long-Term Care Quality Assurance Fund for cashflow*  
7 *loans to the General Fund as provided in Sections 16310 and*  
8 *16381 of the Government Code.*

9 *SEC. 14. Section 1373 of the Health and Safety Code is*  
10 *amended to read:*

11 1373. (a) (1) A plan contract may not provide an exception  
12 for other coverage if the other coverage is entitlement to Medi-Cal  
13 benefits under Chapter 7 (commencing with Section 14000) or  
14 Chapter 8 (commencing with Section 14200) of Part 3 of Division  
15 9 of the Welfare and Institutions Code, or Medicaid benefits under  
16 Subchapter 19 (commencing with Section 1396) of Chapter 7 of  
17 Title 42 of the United States Code.

18 ~~Each~~

19 (2) *Each* plan contract shall be interpreted not to provide an  
20 exception for the Medi-Cal or Medicaid benefits.

21 ~~A~~

22 (3) A plan contract shall not provide an exemption for enrollment  
23 because of an applicant's entitlement to Medi-Cal benefits under  
24 Chapter 7 (commencing with Section 14000) or Chapter 8  
25 (commencing with Section 14200) of Part 3 of Division 9 of the  
26 Welfare and Institutions Code, or Medicaid benefits under  
27 Subchapter 19 (commencing with Section 1396) of Chapter 7 of  
28 Title 42 of the United States Code.

29 ~~A~~

30 (4) A plan contract may not provide that the benefits payable  
31 thereunder are subject to reduction if the individual insured has  
32 entitlement to the Medi-Cal or Medicaid benefits.

33 (b) (1) A plan contract that provides coverage, whether by  
34 specific benefit or by the effect of general wording, for sterilization  
35 operations or procedures shall not impose any disclaimer,  
36 restriction on, or limitation of, coverage relative to the covered  
37 individual's reason for sterilization.

38 ~~As~~

1 (2) As used in this section, “sterilization operations or  
2 procedures” shall have the same meaning as that specified in  
3 Section 10120 of the Insurance Code.

4 (c) Every plan contract that provides coverage to the spouse or  
5 dependents of the subscriber or spouse shall grant immediate  
6 accident and sickness coverage, from and after the moment of  
7 birth, to each newborn infant of any subscriber or spouse covered  
8 and to each minor child placed for adoption from and after the date  
9 on which the adoptive child’s birth parent or other appropriate  
10 legal authority signs a written document, including, but not limited  
11 to, a health facility minor release report, a medical authorization  
12 form, or a relinquishment form, granting the subscriber or spouse  
13 the right to control health care for the adoptive child or, absent  
14 this written document, on the date there exists evidence of the  
15 subscriber’s or spouse’s right to control the health care of the child  
16 placed for adoption. No plan may be entered into or amended if it  
17 contains any disclaimer, waiver, or other limitation of coverage  
18 relative to the coverage or insurability of newborn infants of, or  
19 children placed for adoption with, a subscriber or spouse covered  
20 as required by this subdivision.

21 (d) (1) Every plan contract that provides that coverage of a  
22 dependent child of a subscriber shall terminate upon attainment  
23 of the limiting age for dependent children specified in the plan,  
24 shall also provide that attainment of the limiting age shall not  
25 operate to terminate the coverage of the child while the child is  
26 and continues to meet both of the following criteria:

27 (A) Incapable of self-sustaining employment by reason of a  
28 physically or mentally disabling injury, illness, or condition.

29 (B) Chiefly dependent upon the subscriber for support and  
30 maintenance.

31 (2) The plan shall notify the subscriber that the dependent child’s  
32 coverage will terminate upon attainment of the limiting age unless  
33 the subscriber submits proof of the criteria described in  
34 subparagraphs (A) and (B) of paragraph (1) to the plan within 60  
35 days of the date of receipt of the notification. The plan shall send  
36 this notification to the subscriber at least 90 days prior to the date  
37 the child attains the limiting age. Upon receipt of a request by the  
38 subscriber for continued coverage of the child and proof of the  
39 criteria described in subparagraphs (A) and (B) of paragraph (1),  
40 the plan shall determine whether the child meets that criteria before

1 the child attains the limiting age. If the plan fails to make the  
2 determination by that date, it shall continue coverage of the child  
3 pending its determination.

4 (3) The plan may subsequently request information about a  
5 dependent child whose coverage is continued beyond the limiting  
6 age under this subdivision but not more frequently than annually  
7 after the two-year period following the child's attainment of the  
8 limiting age.

9 (4) If the subscriber changes carriers to another plan or to a  
10 health insurer, the new plan or insurer shall continue to provide  
11 coverage for the dependent child. The new plan or insurer may  
12 request information about the dependent child initially and not  
13 more frequently than annually thereafter to determine if the child  
14 continues to satisfy the criteria in subparagraphs (A) and (B) of  
15 paragraph (1). The subscriber shall submit the information  
16 requested by the new plan or insurer within 60 days of receiving  
17 the request.

18 (5) (A) Except as set forth in subparagraph (B), under no  
19 circumstances shall the limiting age be less than 26 years of age  
20 with respect to plan years beginning on or after September 23,  
21 2010.

22 (B) For plan years beginning before January 1, 2014, a group  
23 health care service plan contract that qualifies as a grandfathered  
24 health plan under Section 1251 of the federal Patient Protection  
25 and Affordable Care Act (Public Law 111-148) and that makes  
26 available dependent coverage of children may exclude from  
27 coverage an adult child who has not attained 26 years of age only  
28 if the adult child is eligible to enroll in an eligible  
29 employer-sponsored health plan, as defined in Section 5000A(f)(2)  
30 of the Internal Revenue Code, other than a group health plan of a  
31 parent.

32 (C) (i) With respect to a child (I) whose coverage under a group  
33 or individual plan contract ended, or who was denied or not eligible  
34 for coverage under a group or individual plan contract, because  
35 under the terms of the contract the availability of dependent  
36 coverage of children ended before the attainment of 26 years of  
37 age, and (II) who becomes eligible for that coverage by reason of  
38 the application of this paragraph, the health care service plan shall  
39 give the child an opportunity to enroll that shall continue for at  
40 least 30 days. This opportunity and the notice described in clause

1 (ii) shall be provided not later than the first day of the first plan  
2 year beginning on or after September 23, 2010, consistent with  
3 the federal Patient Protection and Affordable Care Act (Public  
4 Law 111-148), as amended by the federal Health Care and  
5 Education Reconciliation Act of 2010 (Public Law 111-152), and  
6 any additional federal guidance or regulations issued by the United  
7 States Secretary of Health and Human Services.

8 (ii) The health care service plan shall provide written notice  
9 stating that a dependent described in clause (i) who has not attained  
10 26 years of age is eligible to enroll in the plan for coverage. This  
11 notice may be provided to the dependent's parent on behalf of the  
12 dependent. If the notice is included with other enrollment materials  
13 for a group plan, the notice shall be prominent.

14 (iii) In the case of an individual who enrolls under this  
15 subparagraph, coverage shall take effect no later than the first day  
16 of the first plan year beginning on or after September 23, 2010.

17 (iv) A dependent enrolling in a group health plan for coverage  
18 pursuant to this subparagraph shall be treated as a special enrollee  
19 as provided under the rules of Section 146.117(d) of Title 45 of  
20 the Code of Federal Regulations. The health care service plan shall  
21 offer the recipient of the notice all of the benefit packages available  
22 to similarly situated individuals who did not lose coverage by  
23 reason of cessation of dependent status. Any difference in benefits  
24 or cost-sharing requirements shall constitute a different benefit  
25 package. A dependent enrolling in a group health plan for coverage  
26 pursuant to this subparagraph shall not be required to pay more  
27 for coverage than similarly situated individuals who did not lose  
28 coverage by reason of cessation of dependent status.

29 (D) Nothing in this section shall require a health care service  
30 plan to make coverage available for a child of a child receiving  
31 dependent coverage. Nothing in this section shall be construed to  
32 modify the definition of "dependent" as used in the Revenue and  
33 Taxation Code with respect to the tax treatment of the cost of  
34 coverage.

35 (e) A plan contract that provides coverage, whether by specific  
36 benefit or by the effect of general wording, for both an employee  
37 and one or more covered persons dependent upon the employee  
38 and provides for an extension of the coverage for any period  
39 following a termination of employment of the employee shall also  
40 provide that this extension of coverage shall apply to dependents



1 upon the same terms and conditions precedent as applied to the  
2 covered employee, for the same period of time, subject to payment  
3 of premiums, if any, as required by the terms of the policy and  
4 subject to any applicable collective bargaining agreement.

5 (f) A group contract shall not discriminate against handicapped  
6 persons or against groups containing handicapped persons. Nothing  
7 in this subdivision shall preclude reasonable provisions in a plan  
8 contract against liability for services or reimbursement of the  
9 handicap condition or conditions relating thereto, as may be  
10 allowed by rules of the director.

11 (g) Every group contract shall set forth the terms and conditions  
12 under which subscribers and enrollees may remain in the plan in  
13 the event the group ceases to exist, the group contract is terminated,  
14 or an individual subscriber leaves the group, or the enrollees'  
15 eligibility status changes.

16 (h) (1) A health care service plan or specialized health care  
17 service plan may provide for coverage of, or for payment for,  
18 professional mental health services, or vision care services, or for  
19 the exclusion of these services. If the terms and conditions include  
20 coverage for services provided in a general acute care hospital or  
21 an acute psychiatric hospital as defined in Section 1250 and do  
22 not restrict or modify the choice of providers, the coverage shall  
23 extend to care provided by a psychiatric health facility as defined  
24 in Section 1250.2 operating pursuant to licensure by the State  
25 Department of ~~Social~~ *Health Care Services*. A health care service  
26 plan that offers outpatient mental health services but does not cover  
27 these services in all of its group contracts shall communicate to  
28 prospective group contractholders as to the availability of outpatient  
29 coverage for the treatment of mental or nervous disorders.

30 (2) No plan shall prohibit the member from selecting any  
31 psychologist who is licensed pursuant to the Psychology Licensing  
32 Law (Chapter 6.6 (commencing with Section 2900) of Division 2  
33 of the Business and Professions Code), any optometrist who is the  
34 holder of a certificate issued pursuant to Chapter 7 (commencing  
35 with Section 3000) of Division 2 of the Business and Professions  
36 Code or, upon referral by a physician and surgeon licensed pursuant  
37 to the Medical Practice Act (Chapter 5 (commencing with Section  
38 2000) of Division 2 of the Business and Professions Code), (A)  
39 any marriage and family therapist who is the holder of a license  
40 under Section 4980.50 of the Business and Professions Code, (B)

1 any licensed clinical social worker who is the holder of a license  
 2 under Section 4996 of the Business and Professions Code, (C) any  
 3 registered nurse licensed pursuant to Chapter 6 (commencing with  
 4 Section 2700) of Division 2 of the Business and Professions Code,  
 5 who possesses a master’s degree in psychiatric-mental health  
 6 nursing and is listed as a psychiatric-mental health nurse by the  
 7 Board of Registered Nursing, (D) any advanced practice registered  
 8 nurse certified as a clinical nurse specialist pursuant to Article 9  
 9 (commencing with Section 2838) of Chapter 6 of Division 2 of  
 10 the Business and Professions Code who participates in expert  
 11 clinical practice in the specialty of psychiatric-mental health  
 12 nursing, to perform the particular services covered under the terms  
 13 of the plan, and the certificate holder is expressly authorized by  
 14 law to perform these services, or (E) any professional clinical  
 15 counselor who is the holder of a license under Chapter 16  
 16 (commencing with Section 4999.10) of Division 2 of the Business  
 17 and Professions Code.

18 (3) Nothing in this section shall be construed to allow any  
 19 certificate holder or licensee enumerated in this section to perform  
 20 professional mental health services beyond his or her field or fields  
 21 of competence as established by his or her education, training, and  
 22 experience.

23 (4) For the purposes of this section:

24 (A) “Marriage and family therapist” means a licensed marriage  
 25 and family therapist who has received specific instruction in  
 26 assessment, diagnosis, prognosis, and counseling, and  
 27 psychotherapeutic treatment of premarital, marriage, family, and  
 28 child relationship dysfunctions, which is equivalent to the  
 29 instruction required for licensure on January 1, 1981.

30 (B) “Professional clinical counselor” means a licensed  
 31 professional clinical counselor who has received specific  
 32 instruction in assessment, diagnosis, prognosis, counseling, and  
 33 psychotherapeutic treatment of mental and emotional disorders,  
 34 which is equivalent to the instruction required for licensure on  
 35 January 1, 2012.

36 (5) Nothing in this section shall be construed to allow a member  
 37 to select and obtain mental health or psychological or vision care  
 38 services from a certificate holder or licensee who is not  
 39 directly affiliated with or under contract to the health care service  
 40 plan or specialized health care service plan to which the member

1 belongs. All health care service plans and individual practice  
2 associations that offer mental health benefits shall make reasonable  
3 efforts to make available to their members the services of licensed  
4 psychologists. However, a failure of a plan or association to comply  
5 with the requirements of the preceding sentence shall not constitute  
6 a misdemeanor.

7 (6) As used in this subdivision, “individual practice association”  
8 means an entity as defined in subsection (5) of Section 1307 of  
9 the federal Public Health Service Act (42 U.S.C. Sec. 300e-1(5)).

10 (7) Health care service plan coverage for professional mental  
11 health services may include community residential treatment  
12 services that are alternatives to inpatient care and that are directly  
13 affiliated with the plan or to which enrollees are referred by  
14 providers affiliated with the plan.

15 (i) If the plan utilizes arbitration to settle disputes, the plan  
16 contracts shall set forth the type of disputes subject to arbitration,  
17 the process to be utilized, and how it is to be initiated.

18 (j) A plan contract that provides benefits that accrue after a  
19 certain time of confinement in a health care facility shall specify  
20 what constitutes a day of confinement or the number of consecutive  
21 hours of confinement that are requisite to the commencement of  
22 benefits.

23 (k) If a plan provides coverage for a dependent child who is  
24 over 26 years of age and enrolled as a full-time student at a  
25 secondary or postsecondary educational institution, the following  
26 shall apply:

27 (1) Any break in the school calendar shall not disqualify the  
28 dependent child from coverage.

29 (2) If the dependent child takes a medical leave of absence, and  
30 the nature of the dependent child’s injury, illness, or condition  
31 would render the dependent child incapable of self-sustaining  
32 employment, the provisions of subdivision (d) shall apply if the  
33 dependent child is chiefly dependent on the subscriber for support  
34 and maintenance.

35 (3) (A) If the dependent child takes a medical leave of absence  
36 from school, but the nature of the dependent child’s injury, illness,  
37 or condition does not meet the requirements of paragraph (2), the  
38 dependent child’s coverage shall not terminate for a period not to  
39 exceed 12 months or until the date on which the coverage is  
40 scheduled to terminate pursuant to the terms and conditions of the

1 plan, whichever comes first. The period of coverage under this  
2 paragraph shall commence on the first day of the medical leave of  
3 absence from the school or on the date the physician and surgeon  
4 determines the illness prevented the dependent child from attending  
5 school, whichever comes first. Any break in the school calendar  
6 shall not disqualify the dependent child from coverage under this  
7 paragraph.

8 (B) Documentation or certification of the medical necessity for  
9 a leave of absence from school shall be submitted to the plan at  
10 least 30 days prior to the medical leave of absence from the school,  
11 if the medical reason for the absence and the absence are  
12 foreseeable, or 30 days after the start date of the medical leave of  
13 absence from school and shall be considered prima facie evidence  
14 of entitlement to coverage under this paragraph.

15 (4) This subdivision shall not apply to a specialized health care  
16 service plan or to a Medicare supplement plan.

17 *SEC. 15. Section 104151 is added to the Health and Safety*  
18 *Code, to read:*

19 *104151. Notwithstanding Section 10231.5 of the Government*  
20 *Code, each year, by no later than January 10 and concurrently*  
21 *with the release of the May Revision, the State Department of*  
22 *Health Care Services shall provide the fiscal committees of the*  
23 *Legislature with an estimate package for the Every Woman Counts*  
24 *Program. This estimate package shall include all significant*  
25 *assumptions underlying the estimate for the Every Woman Counts*  
26 *Program's current-year and budget-year proposals, and shall*  
27 *contain concise information identifying applicable estimate*  
28 *components, such as caseload; a breakout of costs, including, but*  
29 *not limited to, clinical service activities, including office visits and*  
30 *consults, screening mammograms, diagnostic mammograms,*  
31 *diagnostic breast procedures, case management, and other clinical*  
32 *services; policy changes; contractor information; General Fund,*  
33 *special fund, and federal fund information; and other assumptions*  
34 *necessary to support the estimate.*

35 *SEC. 16. Section 111792 of the Health and Safety Code is*  
36 *amended to read:*

37 ~~111792. (a) Commencing January 1, 2007, the~~  
38 ~~manufacturer of any cosmetic product subject to regulation by the~~  
39 ~~federal Food and Drug Administration that is sold in this state~~  
40 ~~shall, on a schedule and in electronic or other format, as determined~~

1 by the division, provide the division with a complete and accurate  
2 list of its cosmetic products that, as of the date of submission, are  
3 sold in the state and that contain any ingredient that is a chemical  
4 identified as causing cancer or reproductive toxicity, including  
5 any chemical that meets either of the following conditions:

6 (1) A chemical contained in the product for purposes of  
7 fragrance or flavoring.

8 (2) A chemical identified by the phrase “and other ingredients”  
9 and determined to be a trade secret pursuant to the procedure  
10 established in Part 20 and Section 720.8 of Part 720 of Title 21 of  
11 the Code of Federal Regulations. Any ingredient identified pursuant  
12 to this paragraph shall be considered to be a trade secret and shall  
13 be treated by the division in a manner consistent with the  
14 requirements of Part 20 and Part 720 of Title 21 of the Code of  
15 Federal Regulations. Any ingredients considered to be a trade  
16 secret shall not be subject to the California Public Records Act  
17 (Chapter 3.5 (commencing with Section 6250) of Division 7 of  
18 Title 1 of the Government Code) for the purposes of this section.

19 (b) Any information submitted pursuant to subdivision (a) shall  
20 identify each chemical both by name and Chemical Abstract  
21 Service number and shall specify the product or products in which  
22 the chemical is contained.

23 (c) If an ingredient identified pursuant to this section  
24 subsequently is removed from the product in which it was  
25 contained, is removed from the list of chemicals known to cause  
26 cancer or reproductive toxicity published under Section 25249.8,  
27 or is no longer a chemical identified as causing cancer or  
28 reproductive toxicity by an authoritative body, the manufacturer  
29 of the product containing the ingredient shall submit the new  
30 information to the division. Upon receipt of new information, the  
31 division, after verifying the accuracy of that information, shall  
32 revise the manufacturer’s information on record with the division  
33 to reflect the new information. The manufacturer shall not be under  
34 obligation to submit subsequent information on the presence of  
35 the ingredient in the product unless subsequent changes require  
36 submittal of the information.

37 (d) This section shall not apply to any manufacturer of cosmetic  
38 products with annual aggregate sales of cosmetic products, both  
39 within and outside of California, of less than one million dollars

1 (\$1,000,000), based on the manufacturer's most recent tax year  
2 filing.

3 *(e) On or before December 31, 2013, the State Department of*  
4 *Public Health shall develop and make operational a*  
5 *consumer-friendly, public Internet Web site that creates a database*  
6 *of the information collected pursuant to this section. The database*  
7 *shall be searchable to accommodate a wide range of users,*  
8 *including users with limited technical and scientific literacy. Data*  
9 *shall be presented in an educational manner with, among other*  
10 *things, hypertext links that explain the meanings of technical terms,*  
11 *including, but not limited to, "carcinogenic" and "reproductive*  
12 *toxicity." The Internet Web site shall be designed to be easily*  
13 *navigable and to enable users to compare and contrast products*  
14 *and reportable ingredients. The Internet Web site shall include*  
15 *hypertext links to other educational and informational Internet*  
16 *Web sites to enhance consumer understanding.*

17 *SEC. 17. Section 123870 of the Health and Safety Code is*  
18 *amended to read:*

19 123870. (a) The department shall establish standards of  
20 financial eligibility for treatment services under the California  
21 Children's Services Program (CCS program).

22 (1) Financial eligibility for treatment services under this program  
23 shall be limited to persons in families with an adjusted gross  
24 income of forty thousand dollars (\$40,000) or less in the most  
25 recent tax year, as calculated for California state income tax  
26 purposes. If a person is enrolled in the Healthy Families Program  
27 (Part 6.2 (commencing with Section 12693) of Division 2 of the  
28 Insurance Code), the financial documentation required for that  
29 program in Section 2699.6600 of Title 10 of the California Code  
30 of Regulations may be used instead of the person's California state  
31 income tax return. If a person is enrolled in the Medi-Cal program  
32 pursuant to Section 14005.26 of the Welfare and Institutions Code,  
33 *or enrolled in the AIM-Linked Infants Program pursuant to*  
34 *Chapter 2 (commencing with Section 15850) of Part 3.3 of Division*  
35 *9 of the Welfare and Institutions Code, the financial documentation*  
36 *required to establish eligibility for the ~~Medi-Cal program~~ respective*  
37 *programs may be used instead of the person's California state*  
38 *income tax return. However, the director may authorize treatment*  
39 *services for persons in families with higher incomes if the estimated*

1 cost of care to the family in one year is expected to exceed 20  
2 percent of the family's adjusted gross income.

3 (2) Children enrolled in the Healthy Families Program, ~~or~~  
4 ~~enrolled in~~ the Medi-Cal program pursuant to Section 14005.26  
5 of the Welfare and Institutions Code, *or the AIM-Linked Infants*  
6 *Program pursuant to Chapter 2 (commencing with Section 15850)*  
7 *of Part 3.3 of Division 9 of the Welfare and Institutions Code*, who  
8 have a CCS program eligible medical condition under Section  
9 123830, and whose families do not meet the financial eligibility  
10 requirements of paragraph (1), shall be deemed financially eligible  
11 for CCS program benefits.

12 (b) Necessary medical therapy treatment services under the  
13 California Children's Services Program rendered in the public  
14 schools shall be exempt from financial eligibility standards and  
15 enrollment fee requirements for the services when rendered to any  
16 handicapped child whose educational or physical development  
17 would be impeded without the services.

18 (c) All counties shall use the uniform standards for financial  
19 eligibility and enrollment fees established by the department. All  
20 enrollment fees shall be used in support of the California Children's  
21 Services Program.

22 (d) Annually, every family with a child eligible to receive  
23 services under this article shall pay a fee of twenty dollars (\$20),  
24 that shall be in addition to any other program fees for which the  
25 family is liable. This assessment shall not apply to any child who  
26 is eligible for full scope Medi-Cal benefits without a share of cost,  
27 for children receiving therapy through the California Children's  
28 Services Program as a related service in their individualized  
29 education plans, for children from families having incomes of less  
30 than 100 percent of the federal poverty level, or for children  
31 covered under the Healthy Families Program *or the AIM-Linked*  
32 *Infants Program*.

33 *SEC. 18. Section 123929 of the Health and Safety Code is*  
34 *amended to read:*

35 123929. (a) Except as otherwise provided in this section and  
36 Section 14133.05 of the Welfare and Institutions Code, California  
37 Children's Services Program services provided pursuant to this  
38 article require prior authorization by the department or its designee.  
39 Prior authorization is contingent on determination by the  
40 department or its designee of all of the following:

1 (1) The child receiving the services is confirmed to be medically  
 2 eligible for the CCS program.

3 (2) The provider of the services is approved in accordance with  
 4 the standards of the CCS program.

5 (3) The services authorized are medically necessary to treat the  
 6 child’s CCS-eligible medical condition.

7 (b) ~~Effective July 1, 2004, the~~ *The* department or its designee  
 8 may approve a request for a treatment authorization that is  
 9 otherwise in conformance with subdivision (a) for services for a  
 10 child participating in the Healthy Families Program *or the*  
 11 *AIM-Linked Infants Program* pursuant to clause (ii) of  
 12 subparagraph (A) of paragraph (6) of subdivision (a) of Section  
 13 12693.70 of the Insurance Code *or Chapter 2 (commencing with*  
 14 *Section 15850) of Part 3.3 of Division 9 of the Welfare and*  
 15 *Institutions Code*, received by the department or its designee after  
 16 the requested treatment has been provided to the child.

17 (c) ~~Effective July 1, 2004, if~~ *If* a provider of services who meets  
 18 the requirements of paragraph (2) of subdivision (a) incurs costs  
 19 for services described in paragraph (3) of subdivision (a) to treat  
 20 a child described in subdivision (b) who is subsequently determined  
 21 to be medically eligible for the CCS program as determined by  
 22 the department or its designee, the department may reimburse the  
 23 provider for those costs. Reimbursement under this section shall  
 24 conform to the requirements of Section 14105.18 of the Welfare  
 25 and Institutions Code.

26 *SEC. 19. Section 123940 of the Health and Safety Code is*  
 27 *amended to read:*

28 123940. (a) (1) Annually, the board of supervisors shall  
 29 appropriate a sum of money for services for handicapped children  
 30 of the county, including diagnosis, treatment, and therapy services  
 31 for physically handicapped children in public schools, equal to 25  
 32 percent of the actual expenditures for the county program under  
 33 this article for the 1990–91 fiscal year, except as specified in  
 34 paragraph (2).

35 (2) If the state certifies that a smaller amount is needed in order  
 36 for the county to pay 25 percent of costs of the county’s program  
 37 from this source. The smaller amount certified by the state shall  
 38 be the amount that the county shall appropriate.

39 (b) In addition to the amount required by subdivision (a), the  
 40 county shall allocate an amount equal to the amount determined



1 pursuant to subdivision (a) for purposes of this article from  
2 revenues allocated to the county pursuant to Chapter 6  
3 (commencing with Section 17600) of Division 9 of the Welfare  
4 and Institutions Code.

5 (c) (1) The state shall match county expenditures for this article  
6 from funding provided pursuant to subdivisions (a) and (b).

7 (2) County expenditures shall be waived for payment of services  
8 for children who are eligible pursuant to paragraph (2) of  
9 subdivision (a) of Section 123870.

10 (d) The county may appropriate and expend moneys in addition  
11 to those set forth in subdivision (a) and (b) and the state shall match  
12 the expenditures, on a dollar-for-dollar basis, to the extent that  
13 state funds are available for this article.

14 (e) County appropriations under subdivisions (a) and (b) shall  
15 include county financial participation in the nonfederal share of  
16 expenditures for services for children who are enrolled in the  
17 Medi-Cal program pursuant to Section 14005.26 of the Welfare  
18 and Institutions Code, *or the AIM-Linked Infants Program pursuant*  
19 *to Chapter 2 (commencing with Section 15850) of Part 3.3 of*  
20 *Division 9 of the Welfare and Institutions Code*, and who are  
21 eligible for services under this article pursuant to paragraph (1) of  
22 subdivision (a) of Section 123870, to the extent that federal  
23 financial participation is available at the enhanced federal  
24 reimbursement rate under Title XXI of the federal Social Security  
25 Act (42 U.S.C. Sec. 1397aa et seq.) and funds are appropriated for  
26 the California Children's Services Program in the State Budget.

27 (f) Nothing in this section shall require the county to expend  
28 more than the amount set forth in subdivision (a) plus the amount  
29 set forth in subdivision (b) nor shall it require the state to expend  
30 more than the amount of the match set forth in subdivision (c).

31 (g) Notwithstanding Chapter 3.5 (commencing with Section  
32 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
33 the department, without taking further regulatory action, shall  
34 implement this section by means of California Children's Services  
35 numbered letters.

36 *SEC. 20. Section 123955 of the Health and Safety Code is*  
37 *amended to read:*

38 123955. (a) The state and the counties shall share in the cost  
39 of administration of the California Children's Services Program  
40 at the local level.

1 (b) (1) The director shall adopt regulations establishing  
2 minimum standards for the administration, staffing, and local  
3 implementation of this article subject to reimbursement by the  
4 state.

5 (2) The standards shall allow necessary flexibility in the  
6 administration of county programs, taking into account the  
7 variability of county needs and resources, and shall be developed  
8 and revised jointly with state and county representatives.

9 (c) The director shall establish minimum standards for  
10 administration, staffing and local operation of the program subject  
11 to reimbursement by the state.

12 (d) Until July 1, 1992, reimbursable administrative costs, to be  
13 paid by the state to counties, shall not exceed 4.1 percent of the  
14 gross total expenditures for diagnosis, treatment and therapy by  
15 counties as specified in Section 123940.

16 (e) Beginning July 1, 1992, this subdivision shall apply with  
17 respect to all of the following:

18 (1) Counties shall be reimbursed by the state for 50 percent of  
19 the amount required to meet state administrative standards for that  
20 portion of the county caseload under this article that is ineligible  
21 for Medi-Cal to the extent funds are available in the State Budget  
22 for the California Children's Services Program.

23 (2) Counties shall be reimbursed by the state for 50 percent of  
24 the nonfederal share of the amount required to meet state  
25 administrative standards for that portion of the county caseload  
26 under this article that is enrolled in the Medi-Cal program pursuant  
27 to Section 14005.26 of the Welfare and Institutions Code *or the*  
28 *AIM-Linked Infants Program pursuant to Chapter 2 (commencing*  
29 *with Section 15850) of Part 3.3 of Division 9 of the Welfare and*  
30 *Institutions Code*, and who are eligible for services under this  
31 article pursuant to subdivision (a) of Section 123870, to the extent  
32 that federal financial participation is available at the enhanced  
33 federal reimbursement rate under Title XXI of the federal Social  
34 Security Act (42 U.S.C. Sec. 1397aa et seq.) and funds are  
35 appropriated for the California Children's Services Program in the  
36 State Budget.

37 (3) On or before September 15 of each year, each county  
38 program implementing this article shall submit an application for  
39 the subsequent fiscal year that provides information as required

1 by the state to determine if the county administrative staff and  
2 budget meet state standards.

3 (4) The state shall determine the maximum amount of state  
4 funds available for each county from state funds appropriated for  
5 CCS county administration. If the amount appropriated for any  
6 fiscal year in the Budget Act for county administration under this  
7 article differs from the amounts approved by the department, each  
8 county shall submit a revised application in a form and at the time  
9 specified by the department.

10 (f) The department and counties shall maximize the use of  
11 federal funds for administration of the programs implemented  
12 pursuant to this article, including using state and county funds to  
13 match funds claimable under Title XIX or Title XXI of the federal  
14 Social Security Act (42 U.S.C. Sec. 1396 et seq.; 42 U.S.C. Sec.  
15 1397aa et seq.).

16 *SEC. 21. Section 10125 of the Insurance Code is amended to*  
17 *read:*

18 10125. (a) On and after January 1, 1974, every insurer issuing  
19 group disability insurance which covers hospital, medical, or  
20 surgical expenses shall offer coverage for expenses incurred as a  
21 result of mental or nervous disorders, under the terms and  
22 conditions which may be agreed upon between the group  
23 policyholder and the insurer. If the terms and conditions include  
24 coverage for inpatient care for nervous or mental disorders, the  
25 coverage shall extend to treatment provided at all of the following  
26 facilities:

27 (1) A general acute care hospital as defined in subdivision (a)  
28 of Section 1250 of the Health and Safety Code.

29 (2) An acute psychiatric hospital as defined in subdivision (b)  
30 of Section 1250 of the Health and Safety Code.

31 (3) A psychiatric health facility as defined by Section 1250.2  
32 of the Health and Safety Code operating pursuant to licensure by  
33 the State Department of ~~Social~~ *Health Care Services*.

34 Nothing in this subdivision prohibits an insurer ~~which~~ *that*  
35 negotiates and enters into a contract with a professional or  
36 institutional provider for alternative rates of payment pursuant to  
37 ~~Sections Section 10133 and 11512 of this code~~ from restricting or  
38 modifying the choice of providers.

39 (b) Every insurer shall communicate to prospective group  
40 policyholders as to the availability of outpatient coverage for the

1 treatment of mental or nervous disorders. Every insurer shall  
 2 communicate the availability of that coverage to all group  
 3 policyholders and to all prospective group policyholders with  
 4 whom they are negotiating. This coverage may include community  
 5 residential treatment services, as described in *former* Section 5458  
 6 of the Welfare and Institutions Code, ~~which~~ *that* are alternatives  
 7 to institutional care.

8 *SEC. 22. Section 10127 of the Insurance Code is amended to*  
 9 *read:*

10 10127. On and after January 1, 1974, every self-insured  
 11 employee welfare benefit plan ~~which~~ *that* provides coverage for  
 12 hospital, medical, or surgical expenses shall offer coverage for  
 13 expenses incurred as a result of mental or nervous disorders, under  
 14 the terms and conditions which may be agreed upon between the  
 15 self-insured welfare benefit plan and the member. If the terms and  
 16 conditions include coverage for services provided in a general  
 17 acute care hospital, or an acute psychiatric hospital as defined in  
 18 Section 1250 of the Health and Safety Code, and do not restrict or  
 19 modify the choice of providers, the coverage shall extend to care  
 20 provided by a psychiatric health facility, as defined by Section  
 21 1250.2 of the Health and Safety Code, operating pursuant to  
 22 licensure by the State Department of ~~Social~~ *Health Care* Services.  
 23 Every plan shall communicate to prospective members as to the  
 24 availability of outpatient coverage for the treatment of mental or  
 25 nervous disorders. Every self-insured welfare benefit plan shall  
 26 communicate the availability of this coverage to all members and  
 27 prospective members. This coverage may include community  
 28 residential treatment services, as described in *former* Section 5458  
 29 of the Welfare and Institutions Code, ~~which~~ *that* are alternatives  
 30 to institutional care.

31 *SEC. 23. Section 12693.70 of the Insurance Code is amended*  
 32 *to read:*

33 12693.70. To be eligible to participate in the program, an  
 34 applicant shall meet all of the following requirements:

35 (a) Be an applicant applying on behalf of an eligible child, which  
 36 means a child who is all of the following:

37 (1) Less than 19 years of age. An application may be made on  
 38 behalf of a child not yet born up to three months prior to the  
 39 expected date of delivery. Coverage shall begin as soon as  
 40 administratively feasible, as determined by the board, after the

1 board receives notification of the birth. However, no child less  
2 than 12 months of age shall be eligible for coverage until 90 days  
3 after the enactment of the Budget Act of 1999.

4 (2) Not eligible for no-cost full-scope Medi-Cal or Medicare  
5 coverage at the time of application.

6 (3) In compliance with Sections 12693.71 and 12693.72.

7 (4) A child who meets citizenship and immigration status  
8 requirements that are applicable to persons participating in the  
9 program established by Title XXI of the Social Security Act, except  
10 as specified in Section 12693.76.

11 (5) A resident of the State of California pursuant to Section 244  
12 of the Government Code; or, if not a resident pursuant to Section  
13 244 of the Government Code, is physically present in California  
14 and entered the state with a job commitment or to seek  
15 employment, whether or not employed at the time of application  
16 to or after acceptance in, the program.

17 (6) (A) In either of the following:

18 (i) In a family with an annual or monthly household income  
19 equal to or less than 200 percent of the federal poverty level.

20 (ii) (I) When implemented by the board, subject to subdivision  
21 (b) of Section 12693.765 and pursuant to this section, a child under  
22 the age of two years who was delivered by a mother enrolled in  
23 the Access for Infants and Mothers Program as described in Part  
24 6.3 (commencing with Section 12695). Commencing July 1, 2007,  
25 eligibility under this subparagraph shall not include infants during  
26 any time they are enrolled in employer-sponsored health insurance  
27 or are subject to an exclusion pursuant to Section 12693.71 or  
28 12693.72, or are enrolled in the full scope of benefits under the  
29 Medi-Cal program at no share of cost. For purposes of this clause,  
30 any infant born to a woman whose enrollment in the Access for  
31 Infants and Mothers Program begins after June 30, 2004, shall be  
32 automatically enrolled in the Healthy Families Program, except  
33 during any time on or after July 1, 2007, that the infant is enrolled  
34 in employer-sponsored health insurance or is subject to an  
35 exclusion pursuant to Section 12693.71 or 12693.72, or is enrolled  
36 in the full scope of benefits under the Medi-Cal program at no  
37 share of cost. Except as otherwise specified in this section, this  
38 enrollment shall cover the first 12 months of the infant's life. At  
39 the end of the 12 months, as a condition of continued eligibility,  
40 the applicant shall provide income information. The infant shall

1 be disenrolled if the gross annual household income exceeds the  
2 income eligibility standard that was in effect in the Access for  
3 Infants and Mothers Program at the time the infant's mother  
4 became eligible, or following the two-month period established  
5 in Section 12693.981 if the infant is eligible for Medi-Cal with no  
6 share of cost. At the end of the second year, infants shall again be  
7 screened for program eligibility pursuant to this section, with  
8 income eligibility evaluated pursuant to clause (i), subparagraphs  
9 (B) and (C), and paragraph (2) of subdivision (a).

10 *(II) Effective on October 1, 2013, or when the State Department*  
11 *of Health Care Services has implemented Chapter 2 (commencing*  
12 *with Section 15850) of Part 3.3 of Division 9 of the Welfare and*  
13 *Institutions Code, whichever is later, eligibility for coverage in*  
14 *the program pursuant to this clause shall terminate. The board*  
15 *shall coordinate with the State Department of Health Care Services*  
16 *to implement Chapter 2 (commencing with Section 15850) of Part*  
17 *3.3 of Division 9 of the Welfare and Institutions Code, including*  
18 *transition of subscribers to the AIM-Linked Infants Program. The*  
19 *State Department of Health Care Services shall administer the*  
20 *AIM-Linked Infants Program, pursuant to Chapter 2 (commencing*  
21 *with Section 15850) of Part 3.3 of Division 9 of the Welfare and*  
22 *Institutions Code, to address the health care needs of children*  
23 *formerly covered pursuant to this clause.*

24 (B) All income over 200 percent of the federal poverty level  
25 but less than or equal to 250 percent of the federal poverty level  
26 shall be disregarded in calculating annual or monthly household  
27 income.

28 (C) In a family with an annual or monthly household income  
29 greater than 250 percent of the federal poverty level, any income  
30 deduction that is applicable to a child under Medi-Cal shall be  
31 applied in determining the annual or monthly household income.  
32 If the income deductions reduce the annual or monthly household  
33 income to 250 percent or less of the federal poverty level,  
34 subparagraph (B) shall be applied.

35 (b) The applicant shall agree to remain in the program for six  
36 months, unless other coverage is obtained and proof of the coverage  
37 is provided to the program.

38 (c) An applicant shall enroll all of the applicant's eligible  
39 children in the program.

1 (d) In filing documentation to meet program eligibility  
2 requirements, if the applicant's income documentation cannot be  
3 provided, as defined in regulations promulgated by the board, the  
4 applicant's signed statement as to the value or amount of income  
5 shall be deemed to constitute verification.

6 (e) An applicant shall pay in full any family contributions owed  
7 in arrears for any health, dental, or vision coverage provided by  
8 the program within the prior 12 months.

9 (f) By January 2008, the board, in consultation with  
10 stakeholders, shall implement processes by which applicants for  
11 subscribers may certify income at the time of annual eligibility  
12 review, including rules concerning which applicants shall be  
13 permitted to certify income and the circumstances in which  
14 supplemental information or documentation may be required. The  
15 board may terminate using these processes not sooner than 90 days  
16 after providing notification to the Chair of the Joint Legislative  
17 Budget Committee. This notification shall articulate the specific  
18 reasons for the termination and shall include all relevant data  
19 elements that are applicable to document the reasons for the  
20 termination. Upon the request of the Chair of the Joint Legislative  
21 Budget Committee, the board shall promptly provide any additional  
22 clarifying information regarding implementation of the processes  
23 required by this subdivision.

24 *SEC. 24. Section 12698 of the Insurance Code is amended to*  
25 *read:*

26 12698. To be eligible to participate in the program, a person  
27 shall meet all of the following requirements:

28 (a) Be a resident of the state. A person who is a member of a  
29 federally recognized California Indian tribe is a resident of the  
30 state for these purposes.

31 (b) (1) Until the first day of the second month following the  
32 effective date of the amendment made to this subdivision in 1994,  
33 have a household income that does not exceed 250 percent of the  
34 official federal poverty level unless the board determines that the  
35 program funds are adequate to serve households above that level.

36 (2) Upon the first day of the second month following the  
37 effective date of the amendment made to this subdivision in 1994,  
38 have a household income that is above 200 percent of the official  
39 federal poverty level but does not exceed 250 percent of the official  
40 federal poverty level unless the board determines that the program

1 funds are adequate to serve households above the 250 percent of  
2 the official federal poverty level.

3 (c) Pay an initial subscriber contribution of not more than fifty  
4 dollars (\$50), and agree to the payment of the complete subscriber  
5 contribution. A federally recognized California Indian tribal  
6 government may make the initial and complete subscriber  
7 contributions on behalf of a member of the tribe only if a  
8 contribution on behalf of members of federally recognized  
9 California Indian tribes does not limit or preclude federal financial  
10 participation under Title XXI of the Social Security Act. If a  
11 federally recognized California Indian tribal government makes a  
12 contribution on behalf of a member of the tribe, the tribal  
13 government shall ensure that the subscriber is made aware of all  
14 the health plan options available in the county where the member  
15 resides.

16 (d) *Effective January 1, 2014, when determining eligibility for*  
17 *benefits under the program, income shall be determined, counted,*  
18 *and valued in accordance with the requirements of Section*  
19 *1397bb(b)(1)(B) of Title 42 of the United States Code as added by*  
20 *the federal Patient Protection and Affordable Care Act (Public*  
21 *Law 111-148) and as amended by the federal Health Care and*  
22 *Education Reconciliation Act of 2010 (Public Law 111-152) and*  
23 *any subsequent amendments.*

24 SEC. 25. *Section 12737 of the Insurance Code is amended to*  
25 *read:*

26 12737. (a) The board shall establish program contribution  
27 amounts for each category of risk for each participating health  
28 plan. The program contribution amounts shall be based on the  
29 average amount of subsidy funds required for the program as a  
30 whole. To determine the average amount of subsidy funds required,  
31 the board shall calculate a loss ratio, including all medical costs,  
32 administration fees, and risk payments, for the program in the prior  
33 calendar year. The loss ratio shall be calculated using 125 percent  
34 of the standard average individual rates for comparable coverage  
35 as the denominator, and all medical costs, administration fees, and  
36 risk payments as the numerator. The average amount of subsidy  
37 funds required is calculated by subtracting 100 percent from the  
38 program loss ratio. For purposes of calculating the program loss  
39 ratio, no participating health plan's loss ratio shall be less than 100



1 percent and participating health plans with fewer than 1,000  
2 program members shall be excluded from the calculation.

3 Subscriber contributions shall be established to encourage  
4 members to select those health plans requiring subsidy funds at or  
5 below the program average subsidy. Subscriber contribution  
6 amounts shall be established so that no subscriber receives a  
7 subsidy greater than the program average subsidy, except that:

8 (1) In all areas of the state, at least one plan shall be available  
9 to program participants at an average subscriber contribution of  
10 125 percent of the standard average individual rates for comparable  
11 coverage.

12 (2) No subscriber contribution shall be increased by more than  
13 10 percent above 125 percent of the standard average individual  
14 rates for comparable coverage.

15 (3) Subscriber contributions for participating health plans joining  
16 the program after January 1, 1997, shall be established at 125  
17 percent of the standard average individual rates for comparable  
18 coverage for the first two benefit years the plan participates in the  
19 program.

20 (b) The program shall pay program contribution amounts to  
21 participating health plans from the Major Risk Medical Insurance  
22 Fund.

23 (c) ~~For the period commencing~~ *Commencing* January 1, 2013,  
24 ~~to December 31, 2013, inclusive,~~ in addition to the amount of  
25 subsidy funds required pursuant to subdivision (a), the program  
26 may further subsidize subscriber contributions so that the amount  
27 paid by each subscriber is below 125 percent of the standard  
28 average individual risk rate for comparable coverage but no less  
29 than 100 percent of the standard average individual risk rate for  
30 comparable coverage. For purposes of calculating premiums for  
31 the following products, any reference to, or use of, subscriber  
32 contributions, premiums, average premiums, or amounts paid by  
33 subscribers in the program shall be construed to mean subscriber  
34 contributions as described in subdivision (a) without application  
35 of the additional subsidies permitted by this subdivision:

36 (1) Standard benefit plans pursuant to Section 10127.16 and  
37 Section 1373.622 of the Health and Safety Code.

38 (2) Health benefit plans and health care service plan contracts  
39 for federally eligible defined individuals pursuant to Sections

1 10901.3 and 10901.9 and Sections 1399.805 and 1399.811 of the  
2 Health and Safety Code.

3 (3) Conversion coverage pursuant to Section 12682.1 and  
4 Section 1373.6 of the Health and Safety Code.

5 *SEC. 26. Section 12739.61 of the Insurance Code is amended*  
6 *to read:*

7 12739.61. The board shall cease to provide coverage through  
8 the program on ~~January 1, 2014,~~ *July 1, 2013, except as required*  
9 *by the contract between the board and the United States*  
10 *Department of Health and Human Services, and at that time shall*  
11 *cease to operate the program except as required to complete*  
12 *payments to, or payment reconciliations with, participating health*  
13 *plans or other contractors, process appeals, or conduct other*  
14 *necessary ~~transition~~ termination activities, ~~including, but not~~*  
15 *limited to, transition of subscribers into an exchange or exchanges*  
16 *established pursuant to the federal Patient Protection and*  
17 *Affordable Care Act (Public Law 111-148).*

18 *SEC. 27. Section 359 of the Welfare and Institutions Code is*  
19 *amended to read:*

20 359. (a) Whenever a minor who appears to be a danger to  
21 himself or others as a result of the use of narcotics ~~(as defined in~~  
22 ~~Section 11001 of the Health and Safety Code),~~ *as defined in Section*  
23 *11019 of the Health and Safety Code, or a restricted dangerous*  
24 *drug (as defined in former Section 11901 of the Health and Safety*  
25 *Code), is brought before any judge of the juvenile court, the judge*  
26 *may continue the hearing and proceed pursuant to this section.*  
27 *The court may order the minor taken to a facility designated by*  
28 *the county and approved by the State Department of ~~Social Health~~*  
29 *Care Services as a facility for 72-hour treatment and evaluation.*  
30 *Thereupon the provisions of Section 11922 of the Health and Safety*  
31 *Code shall apply, except that the professional person in charge of*  
32 *the facility shall make a written report to the court concerning the*  
33 *results of the evaluation of the minor.*

34 *¶*

35 (b) *If the professional person in charge of the facility for 72-hour*  
36 *evaluation and treatment reports to the juvenile court that the minor*  
37 *is not a danger to himself or others as a result of the use of narcotics*  
38 *or restricted dangerous drugs or that the minor does not require*  
39 *14-day intensive treatment, or if the minor has been certified for*  
40 *not more than 14 days of intensive treatment and the certification*

1 is terminated, the minor shall be released if the juvenile court  
2 proceedings have been dismissed; referred for further care and  
3 treatment on a voluntary basis, subject to the disposition of the  
4 juvenile court proceedings; or returned to the juvenile court, in  
5 which event the court shall proceed with the case pursuant to this  
6 chapter.

7 **Any**

8 (c) Any expenditure for the evaluation or intensive treatment of  
9 a minor under this section shall be considered an expenditure made  
10 under Part 2 (commencing with Section 5600) of Division 5, and  
11 shall be reimbursed by the state as are other local expenditures  
12 pursuant to that part.

13 *SEC. 28. Section 708 of the Welfare and Institutions Code is*  
14 *amended to read:*

15 708. (a) Whenever a minor who appears to be a danger to  
16 himself or herself or others as a result of the use of controlled  
17 substances (as defined in Division 10 (commencing with Section  
18 11000) of the Health and Safety Code), is brought before any judge  
19 of the juvenile court, the judge may continue the hearing and  
20 proceed pursuant to this section. The court may order the minor  
21 taken to a facility designated by the county and approved by the  
22 State Department of ~~Social Health Care~~ *Health Care* Services as a facility for  
23 72-hour treatment and evaluation. Thereupon the provisions of  
24 ~~Section 5343 of the Welfare and Institutions Code~~ shall apply,  
25 except that the professional person in charge of the facility shall  
26 make a written report to the court concerning the results of the  
27 evaluation of the minor.

28 **¶**

29 (b) *If* the professional person in charge of the facility for 72-hour  
30 evaluation and treatment reports to the juvenile court that the minor  
31 is not a danger to himself or herself or others as a result of the use  
32 of controlled substances or that the minor does not require 14-day  
33 intensive treatment, or if the minor has been certified for not more  
34 than 14 days of intensive treatment and the certification is  
35 terminated, the minor shall be released if the juvenile court  
36 proceedings have been dismissed; referred for further care and  
37 treatment on a voluntary basis, subject to the disposition of the  
38 juvenile court proceedings; or returned to the juvenile court, in  
39 which event the court shall proceed with the case pursuant to this  
40 chapter.

1 ~~Any~~

2 (c) Any expenditure for the evaluation or intensive treatment of  
3 a minor under this section shall be considered an expenditure made  
4 under Part 2 (commencing with Section 5600) of Division 5, and  
5 shall be reimbursed by the state as are other local expenditures  
6 pursuant to that part.

7 *SEC. 29. Section 4005.7 of the Welfare and Institutions Code*  
8 *is amended to read:*

9 4005.7. All regulations heretofore adopted by the State  
10 Department of Mental Health, *and its successor*, pursuant to  
11 authority vested in the State Department of ~~Social Health Care~~  
12 Services by Section 4005.1 and in effect immediately preceding  
13 the operative date of the act that ~~added~~ *amended* this section *in the*  
14 *first year of the 2013–14 Regular Session* shall remain in effect  
15 and shall be fully enforceable unless and until readopted, amended,  
16 or repealed by the Director of ~~Social Health Care~~ Services.

17 *SEC. 30. Section 4080 of the Welfare and Institutions Code is*  
18 *amended to read:*

19 4080. (a) Psychiatric health facilities, as defined in Section  
20 1250.2 of the Health and Safety Code, shall only be licensed by  
21 the State Department of ~~Social Health Care~~ Services subsequent  
22 to application by counties, county contract providers, or other  
23 organizations pursuant to this part.

24 (b) (1) For counties or county contract providers that choose  
25 to apply, the local mental health director shall first present to the  
26 local mental health advisory board for its review an explanation  
27 of the need for the facility and a description of the services to be  
28 provided. The local mental health director shall then submit to the  
29 governing body the explanation and description. The governing  
30 body, upon its approval, may submit the application to the State  
31 Department of ~~Social Health Care~~ Services.

32 (2) Other organizations that will be applying for licensure and  
33 do not intend to use any Bronzan-McCorquodale funds pursuant  
34 to Section 5707 shall submit to the local mental health director  
35 and the governing body in the county in which the facility is to be  
36 located a written and dated proposal of the services to be provided.  
37 The local mental health director and governing body shall have  
38 30 days during which to provide any advice and recommendations  
39 regarding licensure, as they deem appropriate. At any time after  
40 the 30-day period, the organizations may then submit their

1 applications, along with the mental health director's and governing  
2 body's advice and recommendations, if any, to the State  
3 Department of ~~Social~~ *Health Care Services*.

4 (c) The State Fire Marshal and other appropriate state agencies,  
5 to the extent required by law, shall cooperate fully with the State  
6 Department of ~~Social~~ *Health Care Services* to ensure that the State  
7 Department of ~~Social~~ *Health Care Services* approves or  
8 disapproves the licensure applications not later than 90 days after  
9 the application submission by a county, county contract provider,  
10 or other organization.

11 (d) Every psychiatric health facility and program for which a  
12 license has been issued shall be periodically inspected by a  
13 multidisciplinary team appointed or designated by the State  
14 Department of ~~Social~~ *Health Care Services*. The inspection shall  
15 be conducted no less than once every two years and as often as  
16 necessary to ensure the quality of care provided. During the  
17 inspections the review team shall offer such advice and assistance  
18 to the psychiatric health facility as it deems appropriate.

19 (e) (1) The program aspects of a psychiatric health facility that  
20 shall be reviewed and may be approved by the State Department  
21 of ~~Social~~ *Health Care Services* shall include, but not be limited  
22 to:

- 23 (A) Activities programs.
- 24 (B) Administrative policies and procedures.
- 25 (C) Admissions, including provisions for a mental evaluation.
- 26 (D) Discharge planning.
- 27 (E) Health records content.
- 28 (F) Health records services.
- 29 (G) Interdisciplinary treatment teams.
- 30 (H) Nursing services.
- 31 (I) Patient rights.
- 32 (J) Pharmaceutical services.
- 33 (K) Program space requirements.
- 34 (L) Psychiatrist and clinical psychological services.
- 35 (M) Rehabilitation services.
- 36 (N) Restraint and seclusion.
- 37 (O) Social work services.
- 38 (P) Space, supplies, and equipment.
- 39 (Q) Staffing standards.
- 40 (R) Unusual occurrences.

1 (S) Use of outside resources, including agreements with general  
2 acute care hospitals.

3 (T) Linguistic access and cultural competence.

4 (U) Structured outpatient services to be provided under special  
5 permit.

6 (2) The State Department of ~~Social Health Care~~ *Social Health Care* Services has  
7 the sole authority to grant program flexibility.

8 (f) Commencing July 1, ~~2012~~, 2013, the State Department of  
9 ~~Social Health Care Services~~ *Social Health Care Services* shall ~~may~~ adopt regulations *regarding*  
10 *psychiatric health facilities* that shall include, but not be limited  
11 to, all of the following:

12 (1) Procedures by which the State Department of ~~Social Health~~  
13 *Care Services* shall review and may approve the program and  
14 facility requesting licensure as a psychiatric health facility as being  
15 in compliance with program standards established by the  
16 department.

17 (2) Procedures by which the Director of ~~Social Health Care~~  
18 *Services* shall approve, or deny approval of, the program and  
19 facility licensed as a psychiatric health facility pursuant to this  
20 section.

21 (3) Provisions for site visits by the State Department of ~~Social~~  
22 *Health Care Services* for the purpose of reviewing a facility's  
23 compliance with program and facility standards.

24 (4) Provisions for the State Department of ~~Social Health Care~~  
25 *Services* for any administrative proceeding regarding denial,  
26 suspension, or revocation of a psychiatric health facility license.

27 (5) Procedures for the appeal of an administrative finding or  
28 action pursuant to paragraph (4) of this subdivision and subdivision  
29 (j).

30 (g) Regulations ~~shall may~~ be adopted by the State Department  
31 of ~~Social Health Care Services~~, ~~which shall that~~ establish standards  
32 for pharmaceutical services in psychiatric health facilities. Licensed  
33 psychiatric health facilities shall be exempt from requirements to  
34 obtain a separate pharmacy license or permit.

35 (h) (1) It is the intent of the Legislature that the State  
36 Department of ~~Social Health Care Services~~ shall license the facility  
37 in order to establish innovative and more competitive and  
38 specialized acute care services.

39 (2) The State Department of ~~Social Health Care Services~~ shall  
40 review and may approve the program aspects of public or private

1 facilities, with the exception of those facilities that are federally  
2 certified or accredited by a nationally recognized commission that  
3 accredits health care facilities, only if the average per diem charges  
4 or costs of service provided in the facility is approximately 60  
5 percent of the average per diem charges or costs of similar  
6 psychiatric services provided in a general hospital.

7 (3) (A) When a private facility is accredited by a nationally  
8 recognized commission that accredits health care facilities, the  
9 State Department of ~~Social~~ *Health Care Services* shall review and  
10 may approve the program aspects only if the average per diem  
11 charges or costs of service provided in the facility do not exceed  
12 approximately 75 percent of the average per diem charges or costs  
13 of similar psychiatric service provided in a psychiatric or general  
14 hospital.

15 (B) When a private facility serves county patients, the State  
16 Department of ~~Social~~ *Health Care Services* shall review and may  
17 approve the program aspects only if the facility is federally certified  
18 by the federal Centers for Medicare and Medicaid Services and  
19 serves a population mix that includes a proportion of Medi-Cal  
20 patients sufficient to project an overall cost savings to the county,  
21 and the average per diem charges or costs of service provided in  
22 the facility do not exceed approximately 75 percent of the average  
23 per diem charges or costs of similar psychiatric service provided  
24 in a psychiatric or general hospital.

25 (4) When a public facility is federally certified by the federal  
26 Centers for Medicare and Medicaid Services and serves a  
27 population mix that includes a proportion of Medi-Cal patients  
28 sufficient to project an overall program cost savings with  
29 certification, the State Department of ~~Social~~ *Health Care Services*  
30 shall approve the program aspects only if the average per diem  
31 charges or costs of service provided in the facility do not exceed  
32 approximately 75 percent of the average per diem charges or costs  
33 of similar psychiatric service provided in a psychiatric or general  
34 hospital.

35 (5) (A) The State Department of Health Care Services may set  
36 a lower rate for private or public facilities than that required by  
37 paragraph (3) or ~~paragraph (4)~~, respectively if so required by the  
38 federal Centers for Medicare and Medicaid Services as a condition  
39 for the receipt of federal matching funds.

1 (B) This section does not impose any obligation on any private  
2 facility to contract with a county for the provision of services to  
3 Medi-Cal beneficiaries, and any contract for that purpose is subject  
4 to the agreement of the participating facility.

5 (6) (A) In using the guidelines specified in this subdivision,  
6 the State Department of ~~Social~~ *Health Care* Services shall take  
7 into account local conditions affecting the costs or charges.

8 (B) In those psychiatric health facilities authorized by special  
9 permit to offer structured outpatient services not exceeding 10  
10 daytime hours, the following limits on per diem rates shall apply:

11 (i) The per diem charge for patients in both a morning and an  
12 afternoon program on the same day shall not exceed 60 percent of  
13 the facility's authorized per diem charge for inpatient services.

14 (ii) The per diem charge for patients in either a morning or  
15 afternoon program shall not exceed 30 percent of the facility's  
16 authorized per diem charge for inpatient services.

17 (i) The licensing fees charged for these facilities shall be credited  
18 to the State Department of ~~Social~~ *Health Care* Services for its  
19 costs incurred in the review of psychiatric health facility programs,  
20 in connection with the licensing of these facilities.

21 (j) (1) The State Department of ~~Social~~ *Health Care* Services  
22 shall establish a system for the imposition of prompt and effective  
23 civil sanctions against psychiatric health facilities in violation of  
24 the laws and regulations of this state pertaining to psychiatric health  
25 facilities. If the State Department of ~~Social~~ *Health Care* Services  
26 determines that there is or has been a failure, in a substantial  
27 manner, on the part of a psychiatric health facility to comply with  
28 the laws and regulations, the Director of ~~Social~~ *Health Care*  
29 Services may impose the following sanctions:

30 (A) Cease and desist orders.

31 (B) Monetary sanctions, which may be imposed in addition to  
32 the penalties of suspension, revocation, or cease and desist orders.  
33 The amount of monetary sanctions permitted to be imposed  
34 pursuant to this subparagraph shall not be less than fifty dollars  
35 (\$50) nor more than one hundred dollars (\$100) multiplied by the  
36 licensed bed capacity, per day, for each violation. However, the  
37 monetary sanction shall not exceed three thousand dollars (\$3,000)  
38 per day. A facility that is assessed a monetary sanction under this  
39 subparagraph, and that repeats the deficiency, may, in accordance  
40 with the regulations adopted pursuant to this subdivision, be subject



1 to immediate suspension of its license until the deficiency is  
2 corrected.

3 (2) The State Department of ~~Social Health Care Services~~ shall  
4 *may* adopt regulations necessary to implement this subdivision  
5 and paragraph (5) of subdivision (f) in accordance with the  
6 Administrative Procedure Act (Chapter 3.5 (commencing with  
7 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
8 Code).

9 (k) Proposed changes in the standards or regulations affecting  
10 health facilities that serve the mentally disordered shall be effected  
11 only with the review and coordination of the California Health and  
12 Human Services Agency.

13 (l) In psychiatric health facilities where the clinical director is  
14 not a physician, a psychiatrist, or if one is temporarily not available,  
15 a physician shall be designated who shall direct those medical  
16 treatments and services that can only be provided by, or under the  
17 direction of, a physician.

18 *SEC. 31. Section 5150 of the Welfare and Institutions Code is*  
19 *amended to read:*

20 5150. (a) When any person, as a result of mental disorder, is  
21 a danger to others, or to himself or herself, or gravely disabled, a  
22 peace officer, member of the attending staff, as defined by  
23 regulation, of an evaluation facility designated by the county,  
24 ~~designated members of a mobile crisis team provided by Section~~  
25 ~~5651.7,~~ or other professional person designated by the county may,  
26 upon probable cause, take, or cause to be taken, the person into  
27 custody and place him or her in a facility designated by the county  
28 and approved by the State Department of ~~Social Health Care~~  
29 Services as a facility for 72-hour treatment and evaluation.

30 ~~The~~

31 (b) *The* facility shall require an application in writing stating  
32 the circumstances under which the person's condition was called  
33 to the attention of the officer, member of the attending staff, or  
34 professional person, and stating that the officer, member of the  
35 attending staff, or professional person has probable cause to believe  
36 that the person is, as a result of mental disorder, a danger to others,  
37 or to himself or herself, or gravely disabled. If the probable cause  
38 is based on the statement of a person other than the officer, member  
39 of the attending staff, or professional person, the person shall be

1 liable in a civil action for intentionally giving a statement which  
2 he or she knows to be false.

3 *SEC. 32. Section 5151 of the Welfare and Institutions Code is*  
4 *amended to read:*

5 5151. (a) If the facility for 72-hour treatment and evaluation  
6 admits the person, it may detain him or her for evaluation and  
7 treatment for a period not to exceed 72 hours. Saturdays, Sundays,  
8 and holidays may be excluded from the 72-hour period if the State  
9 Department of ~~Social~~ *Health Care Services* certifies for each  
10 facility that evaluation and treatment services cannot reasonably  
11 be made available on those days. The certification by the  
12 department is subject to renewal every two years. The department  
13 ~~shall~~ *may* adopt regulations defining criteria for determining  
14 whether a facility can reasonably be expected to make evaluation  
15 and treatment services available on Saturdays, Sundays, and  
16 holidays.

17 ~~Prior~~

18 (b) *Prior* to admitting a person to the facility for 72-hour  
19 treatment and evaluation pursuant to Section 5150, the professional  
20 person in charge of the facility or his or her designee shall assess  
21 the individual in person to determine the appropriateness of the  
22 involuntary detention.

23 ~~If~~

24 (c) *If* in the judgment of the professional person in charge of  
25 the facility providing evaluation and treatment, or his or her  
26 designee, the person can be properly served without being detained,  
27 he or she shall be provided evaluation, crisis intervention, or other  
28 inpatient or outpatient services on a voluntary basis.

29 ~~Nothing~~

30 (d) *Nothing* in this section shall be interpreted to prevent a peace  
31 officer from delivering individuals to a designated facility for  
32 assessment under Section 5150. Furthermore, the preadmission  
33 assessment requirement of this section shall not be interpreted to  
34 require peace officers to perform any additional duties other than  
35 those specified in Sections 5150.1 and 5150.2.

36 *SEC. 33. Section 5157 of the Welfare and Institutions Code is*  
37 *amended to read:*

38 5157. (a) Each person, at the time he or she is first taken into  
39 custody under provisions of Section 5150, shall be provided, by  
40 the person who takes such other person into custody, the following

1 information orally. The information shall be in substantially the  
2 following form:

3  
4 My name is \_\_\_\_\_ .  
5 I am a \_\_\_\_\_ .  
6 (peace officer, mental health professional)  
7 with \_\_\_\_\_ .  
8 (name of agency)

9 You are not under criminal arrest, but I am taking you for examination by  
10 mental health professionals at \_\_\_\_\_ .  
11 \_\_\_\_\_  
12 (name of facility)

13 You will be told your rights by the mental health staff.  
14 If taken into custody at his or her residence, the person shall also be told the  
15 following information in substantially the following form:

16 You may bring a few personal items with you which I will have to approve.  
17 You can make a phone call and/or leave a note to tell your friends and/or family  
18 where you have been taken.

19  
20 (b) The designated facility shall keep, for each patient evaluated,  
21 a record of the advisement given pursuant to subdivision (a) which  
22 shall include:

- 23 (1) Name of person detained for evaluation.
- 24 (2) Name and position of peace officer or mental health  
25 professional taking person into custody.
- 26 (3) Date.
- 27 (4) Whether advisement was completed.
- 28 (5) If not given or completed, the mental health professional at  
29 the facility shall either provide the information specified in  
30 subdivision (a), or include a statement of good cause, as defined  
31 by regulations of the State Department of ~~Social~~ *Health Care*  
32 Services, which shall be kept with the patient's medical record.

33 (c) Each person admitted to a designated facility for 72-hour  
34 evaluation and treatment shall be given the following information  
35 by admission staff at the evaluation unit. The information shall be  
36 given orally and in writing and in a language or modality accessible  
37 to the person. The written information shall be available in the  
38 person's native language or the language which is the person's  
39 principal means of communication. The information shall be in  
40 substantially the following form:

1 My name is \_\_\_\_\_.

2 My position here is \_\_\_\_\_.

3 You are being placed into the psychiatric unit because it is our professional  
4 opinion that as a result of mental disorder, you are likely to:

5 (check applicable)

6 harm yourself \_\_\_\_\_

7 harm someone else \_\_\_\_\_

8 be unable to take care of your own

9 food, clothing, and housing needs \_\_\_\_\_

10 We feel this is true because

11 \_\_\_\_\_

12 (herewith a listing of the facts upon which the allegation of dangerous  
13 or gravely disabled due to mental disorder is based, including pertinent  
14 facts arising from the admission interview.)

15 You will be held on the ward for a period up to 72 hours.

16 This does not include weekends or holidays.

17 Your 72-hour period will begin \_\_\_\_\_

18 (day and time.)

19 During these 72 hours you will be evaluated by the hospital staff, and you  
20 may be given treatment, including medications. It is possible for you to be  
21 released before the end of the 72 hours. But if the staff decides that you need  
22 continued treatment you can be held for a longer period of time. If you are  
23 held longer than 72 hours you have the right to a lawyer and a qualified  
24 interpreter and a hearing before a judge. If you are unable to pay for the lawyer,  
25 then one will be provided free.

26  
27 (d) For each patient admitted for 72-hour evaluation and  
28 treatment, the facility shall keep with the patient’s medical record  
29 a record of the advisement given pursuant to subdivision (c) which  
30 shall include:

31 (1) Name of person performing advisement.

32 (2) Date.

33 (3) Whether advisement was completed.

34 (4) If not completed, a statement of good cause.

35 If the advisement was not completed at admission, the  
36 advisement process shall be continued on the ward until completed.

37 A record of the matters prescribed by subdivisions (a), (b), and (c)  
38 shall be kept with the patient’s medical record.

39 *SEC. 34. Section 5202 of the Welfare and Institutions Code is*  
40 *amended to read:*

1 5202. The person or agency designated by the county shall  
2 prepare the petition and all other forms required in the proceeding,  
3 and shall be responsible for filing the petition. Before filing the  
4 petition, the person or agency designated by the county shall  
5 request the person or agency designated by the county and  
6 approved by the State Department of ~~Social~~ *Health Care Services*  
7 to provide prepetition screening to determine whether there is  
8 probable cause to believe the allegations. The person or agency  
9 providing prepetition screening shall conduct a reasonable  
10 investigation of the allegations and make a reasonable effort to  
11 personally interview the subject of the petition. The screening shall  
12 also determine whether the person will agree voluntarily to receive  
13 crisis intervention services or an evaluation in his own home or in  
14 a facility designated by the county and approved by the State  
15 Department of ~~Social~~ *Health Care Services*. Following prepetition  
16 screening, the person or agency designated by the county shall file  
17 the petition if satisfied that there is probable cause to believe that  
18 the person is, as a result of mental disorder, a danger to others, or  
19 to himself or herself, or gravely disabled, and that the person will  
20 not voluntarily receive evaluation or crisis intervention.

21 If the petition is filed, it shall be accompanied by a report  
22 containing the findings of the person or agency designated by the  
23 county to provide prepetition screening. The prepetition screening  
24 report submitted to the superior court shall be confidential and  
25 shall be subject to the provisions of Section 5328.

26 *SEC. 35. Section 5326.9 of the Welfare and Institutions Code*  
27 *is amended to read:*

28 5326.9. (a) Any alleged or suspected violation of the rights  
29 described in Chapter 2 (commencing with Section 5150) shall be  
30 investigated by the local director of mental health, or his or her  
31 designee. Violations of Sections 5326.2 to 5326.8, inclusive,  
32 concerning patients involuntarily detained for evaluation or  
33 treatment under this part, or as a voluntary patient for psychiatric  
34 evaluation or treatment to a health facility, as defined in Section  
35 1250 of the Health and Safety Code, in which psychiatric  
36 evaluation or treatment is offered, shall also be investigated by the  
37 Director of Health Care Services, or his or her designee. Violations  
38 of Sections 5326.2 to 5326.8, inclusive, concerning persons  
39 committed to a state hospital shall also be investigated by the  
40 Director of State Hospitals, or his or her designee. If it is

1 determined by the local director of mental health, the Director of  
2 Health Care Services, or the Director of State Hospitals that a right  
3 has been violated, a formal notice of violation shall be issued.

4 (b) Either the local director of mental health or the Director of  
5 Health Care Services, upon issuing a notice of violation, may take  
6 any or all of the following action:

7 (1) Assign a specified time period during which the violation  
8 shall be corrected.

9 (2) Referral to the Medical Board of California or other  
10 professional licensing agency. Such board shall investigate further,  
11 if warranted, and shall subject the individual practitioner to any  
12 penalty the board finds necessary and is authorized to impose.

13 (3) ~~Make a recommendation to the State Department of Social~~  
14 ~~Services to revoke the approval of the county facility designation.~~  
15 ~~The local director of mental health may revoke~~ *Revoke* a facility's  
16 designation and authorization under Section 5404 to evaluate and  
17 treat persons detained involuntarily.

18 (4) Refer any violation of law to a local district attorney or the  
19 Attorney General for prosecution in any court with jurisdiction.

20 (c) The Director of State Hospitals, upon issuing a notice of  
21 violation, may take any or all of the following actions:

22 (1) Assign a specified time period during which the violation  
23 shall be corrected.

24 (2) Make a referral to the Medical Board of California or other  
25 professional licensing agency. The board or agency shall  
26 investigate further, if warranted, and shall subject the individual  
27 practitioner to any penalty the board finds necessary and is  
28 authorized to impose.

29 (3) Refer any violation of law to a local district attorney or the  
30 Attorney General for prosecution in any court with jurisdiction.

31 (d) Any physician who intentionally violates Sections 5326.2  
32 to 5326.8, inclusive, shall be subject to a civil penalty of not more  
33 than five thousand dollars (\$5,000) for each violation. The penalty  
34 may be assessed and collected in a civil action brought by the  
35 Attorney General in a superior court. Such intentional violation  
36 shall be grounds for revocation of license.

37 (e) Any person or facility found to have knowingly violated the  
38 provisions of the first paragraph of Section 5325.1 or to have  
39 denied without good cause any of the rights specified in Section  
40 5325 shall pay a civil penalty, as determined by the court, of fifty

1 dollars (\$50) per day during the time in which the violation is not  
2 corrected, commencing on the day on which a notice of violation  
3 was issued, not to exceed one thousand dollars (\$1,000), for each  
4 and every violation, except that any liability under this provision  
5 shall be offset by an amount equal to a fine or penalty imposed for  
6 the same violation under the provisions of Sections 1423 to 1425,  
7 inclusive, or 1428 of the Health and Safety Code. These penalties  
8 shall be deposited in the general fund of the county in which the  
9 violation occurred. The local district attorney or the Attorney  
10 General shall enforce this section in any court with jurisdiction.  
11 Where the State Department of Public Health, under the provisions  
12 of Sections 1423 to 1425, inclusive, of the Health and Safety Code,  
13 determines that no violation has occurred, the provisions of  
14 paragraph (4) of subdivision (b) shall not apply.

15 (f) The remedies provided by this subdivision shall be in addition  
16 to and not in substitution for any other remedies which an  
17 individual may have under law.

18 *SEC. 36. Section 5358 of the Welfare and Institutions Code is*  
19 *amended to read:*

20 5358. (a) (1) When ordered by the court after the hearing  
21 required by this section, a conservator appointed pursuant to this  
22 chapter shall place his or her conservatee as follows:

23 (A) For a conservatee who is gravely disabled, as defined in  
24 subparagraph (A) of paragraph (1) of subdivision (h) of Section  
25 5008, in the least restrictive alternative placement, as designated  
26 by the court.

27 (B) For a conservatee who is gravely disabled, as defined in  
28 subparagraph (B) of paragraph (1) of subdivision (h) of Section  
29 5008, in a placement that achieves the purposes of treatment of  
30 the conservatee and protection of the public.

31 (2) The placement may include a medical, psychiatric, nursing,  
32 or other state-licensed facility, or a state hospital, county hospital,  
33 hospital operated by the Regents of the University of California,  
34 a United States government hospital, or other nonmedical facility  
35 approved by the State Department of ~~Social~~ *Health Care Services*  
36 or an agency accredited by the State Department of Health Care  
37 Services, or in addition to any of the foregoing, in cases of chronic  
38 alcoholism, to a county alcoholic treatment center.

39 (b) A conservator shall also have the right, if specified in the  
40 court order, to require his or her conservatee to receive treatment

1 related specifically to remedying or preventing the recurrence of  
2 the conservatee's being gravely disabled, or to require his or her  
3 conservatee to receive routine medical treatment unrelated to  
4 remedying or preventing the recurrence of the conservatee's being  
5 gravely disabled. Except in emergency cases in which the  
6 conservatee faces loss of life or serious bodily injury, no surgery  
7 shall be performed upon the conservatee without the conservatee's  
8 prior consent or a court order obtained pursuant to Section 5358.2  
9 specifically authorizing that surgery.

10 (c) (1) For a conservatee who is gravely disabled, as defined  
11 in subparagraph (A) of paragraph (1) of subdivision (h) of Section  
12 5008, if the conservatee is not to be placed in his or her own home  
13 or the home of a relative, first priority shall be to placement in a  
14 suitable facility as close as possible to his or her home or the home  
15 of a relative. For the purposes of this section, suitable facility  
16 means the least restrictive residential placement available and  
17 necessary to achieve the purpose of treatment. At the time that the  
18 court considers the report of the officer providing conservatorship  
19 investigation specified in Section 5356, the court shall consider  
20 available placement alternatives. After considering all the evidence  
21 the court shall determine the least restrictive and most appropriate  
22 alternative placement for the conservatee. The court shall also  
23 determine those persons to be notified of a change of placement.  
24 The fact that a person for whom conservatorship is recommended  
25 is not an inpatient shall not be construed by the court as an  
26 indication that the person does not meet the criteria of grave  
27 disability.

28 (2) For a conservatee who is gravely disabled, as defined in  
29 subparagraph (B) of paragraph (1) of subdivision (h) of Section  
30 5008, first priority shall be placement in a facility that achieves  
31 the purposes of treatment of the conservatee and protection of the  
32 public. The court shall determine the most appropriate placement  
33 for the conservatee. The court shall also determine those persons  
34 to be notified of a change of placement, and additionally require  
35 the conservator to notify the district attorney or attorney  
36 representing the originating county prior to any change of  
37 placement.

38 (3) For any conservatee, if requested, the local mental health  
39 director shall assist the conservator or the court in selecting a  
40 placement facility for the conservatee. When a conservatee who



1 is receiving services from the local mental health program is  
2 placed, the conservator shall inform the local mental health director  
3 of the facility's location and any movement of the conservatee to  
4 another facility.

5 (d) (1) Except for a conservatee who is gravely disabled, as  
6 defined in subparagraph (B) of paragraph (1) of subdivision (h)  
7 of Section 5008, the conservator may transfer his or her conservatee  
8 to a less restrictive alternative placement without a further hearing  
9 and court approval. In any case in which a conservator has  
10 reasonable cause to believe that his or her conservatee is in need  
11 of immediate more restrictive placement because the condition of  
12 the conservatee has so changed that the conservatee poses an  
13 immediate and substantial danger to himself or herself or others,  
14 the conservator shall have the right to place his or her conservatee  
15 in a more restrictive facility or hospital. Notwithstanding Section  
16 5328, if the change of placement is to a placement more restrictive  
17 than the court-determined placement, the conservator shall provide  
18 written notice of the change of placement and the reason therefor  
19 to the court, the conservatee's attorney, the county patient's rights  
20 advocate and any other persons designated by the court pursuant  
21 to subdivision (c).

22 (2) For a conservatee who is gravely disabled, as defined in  
23 subparagraph (B) of paragraph (1) of subdivision (h) of Section  
24 5008, the conservator may not transfer his or her conservatee  
25 without providing written notice of the proposed change of  
26 placement and the reason therefor to the court, the conservatee's  
27 attorney, the county patient's rights advocate, the district attorney  
28 of the county that made the commitment, and any other persons  
29 designated by the court to receive notice. If any person designated  
30 to receive notice objects to the proposed transfer within 10 days  
31 after receiving notice, the matter shall be set for a further hearing  
32 and court approval. The notification and hearing is not required  
33 for the transfer of persons between state hospitals.

34 (3) At a hearing where the conservator is seeking placement to  
35 a less restrictive alternative placement pursuant to paragraph (2),  
36 the placement shall not be approved where it is determined by a  
37 preponderance of the evidence that the placement poses a threat  
38 to the safety of the public, the conservatee, or any other individual.

39 (4) A hearing as to placement to a less restrictive alternative  
40 placement, whether requested pursuant to paragraph (2) or pursuant

1 to Section 5358.3, shall be granted no more frequently than is  
2 provided for in Section 5358.3.

3 *SEC. 37. Section 5366.1 of the Welfare and Institutions Code*  
4 *is amended to read:*

5 5366.1. (a) Any person detained as of June 30, 1969, under  
6 court commitment, in a private institution, a county psychiatric  
7 hospital, facility of the Veterans Administration, or other agency  
8 of the United States government, community mental health service,  
9 or detained in a state hospital or facility of the Veterans  
10 Administration upon application of a local health officer, pursuant  
11 to former Section 5567 or Sections 6000 to 6019, inclusive, as  
12 they read immediately preceding July 1, 1969, may be detained,  
13 after January 1, 1972, for a period no longer than 180 days, except  
14 as provided in this section.

15 ~~Any~~

16 (b) Any person detained pursuant to this section on the effective  
17 date of this section shall be evaluated by the facility designated  
18 by the county and approved by the State Department of ~~Social~~  
19 *Health Care Services* pursuant to Section 5150 as a facility for  
20 72-hour treatment and evaluation. The evaluation shall be made  
21 at the request of the person in charge of the institution in which  
22 the person is detained. If in the opinion of the professional person  
23 in charge of the evaluation and treatment facility or his or her  
24 designee, the evaluation of the person can be made by the  
25 professional person or his or her designee at the institution in which  
26 the person is detained, the person shall not be required to be  
27 evaluated at the evaluation and treatment facility, but shall be  
28 evaluated at the institution where he or she is detained, or other  
29 place to determine if the person is a danger to others, himself or  
30 herself, or gravely disabled as a result of mental disorder.

31 ~~Any~~

32 (c) Any person evaluated under this section shall be released  
33 from the institution in which he or she is detained immediately  
34 upon completion of the evaluation if in the opinion of the  
35 professional person in charge of the evaluation and treatment  
36 facility, or his or her designee, the person evaluated is not a danger  
37 to others, or to himself or herself, or gravely disabled as a result  
38 of mental disorder, unless the person agrees voluntarily to remain  
39 in the institution in which he or she has been detained.

40 ~~if~~

1 (d) If in the opinion of the professional person in charge of the  
2 facility or his or her designee, the person evaluated requires  
3 intensive treatment or recommendation for conservatorship, the  
4 professional person or his or her designee shall proceed under  
5 Article 4 (commencing with Section 5250) of Chapter 2, or under  
6 Chapter 3 (commencing with Section 5350), of Part 1 of Division  
7 5.

8 If

9 (e) If it is determined from the evaluation that the person is  
10 gravely disabled and a recommendation for conservatorship is  
11 made, and if the petition for conservatorship for the person is not  
12 filed by June 30, 1972, the court commitment or detention under  
13 a local health officer application for the person shall terminate and  
14 the patient shall be released unless he or she agrees to accept  
15 treatment on a voluntary basis.

16 SEC. 38. Section 5404 of the Welfare and Institutions Code is  
17 amended to read:

18 5404. (a) Each county may designate facilities, which are not  
19 hospitals or clinics, as 72-hour evaluation and treatment facilities  
20 and as 14-day intensive treatment facilities if the facilities meet  
21 those requirements as the Director of ~~Social~~ Health Care Services  
22 shall ~~may~~ establish by regulation. The Director of ~~Social~~ Health  
23 Care Services shall encourage the use by counties of appropriate  
24 facilities, which are not hospitals or clinics, for the evaluation and  
25 treatment of patients pursuant to this part.

26 (b) All regulations relating to the approval of facilities  
27 designated by the county for 72-hour treatment and evaluation and  
28 14-day intensive treatment facilities, heretofore adopted by the  
29 State Department of Mental Health, *or a successor*, shall remain  
30 in effect and shall be fully enforceable by the State Department of  
31 ~~Social~~ Health Care Services with respect to any facility or program  
32 required to be approved as a facility for 72-hour treatment and  
33 evaluation and 14-day intensive treatment facilities, unless and  
34 until readopted, amended, or repealed by the Director of ~~Social~~  
35 Health Care Services. The State Department of ~~Social~~ Health Care  
36 Services shall succeed to and be vested with all duties, powers,  
37 purposes, functions, responsibilities, and jurisdiction of the State  
38 Department of Mental Health, *or a successor*, as they relate to  
39 approval of facilities for 72-hour treatment and evaluation and  
40 14-day intensive treatment facilities.

1     *SEC. 39. Section 5405 of the Welfare and Institutions Code is*  
2     *amended to read:*

3     5405. (a) This section shall apply to each facility licensed by  
4     the State Department of ~~Social~~ *Health Care Services*, or its  
5     delegated agent, on or after January 1, 2003. For purposes of this  
6     section, “facility” means psychiatric health facilities, as defined  
7     in Section 1250.2 of the Health and Safety Code, licensed pursuant  
8     to Chapter 9 (commencing with Section 77001) of Division 5 of  
9     Title 22 of the California Code of Regulations and mental health  
10    rehabilitation centers licensed pursuant to Chapter 3.5  
11    (commencing with Section 781.00) of Division 1 of Title 9 of the  
12    California Code of Regulations.

13    (b) (1) (A) Prior to the initial licensure or first renewal of a  
14    license on or after January 1, 2003, of any person to operate or  
15    manage a facility specified in subdivision (a), the applicant or  
16    licensee shall submit fingerprint images and related information  
17    pertaining to the applicant or licensee to the Department of Justice  
18    for purposes of a criminal record check, as specified in paragraph  
19    (2), at the expense of the applicant or licensee. The Department  
20    of Justice shall provide the results of the criminal record check to  
21    the ~~department~~ *State Department of Health Care Services*. The  
22    ~~department~~ *State Department of Health Care Services* may take  
23    into consideration information obtained from or provided by other  
24    government agencies. The ~~department~~ *State Department of Health*  
25    *Care Services* shall determine whether the applicant or licensee  
26    has ever been convicted of a crime specified in subdivision (c).  
27    The applicant or licensee shall submit fingerprint images and  
28    related information each time the position of administrator,  
29    manager, program director, or fiscal officer of a facility is filled  
30    and prior to actual employment for initial licensure or an individual  
31    who is initially hired on or after January 1, 2003. For purposes of  
32    this subdivision, “applicant” and “licensee” include the  
33    administrator, manager, program director, or fiscal officer of a  
34    facility.

35    (B) Commencing July 1, ~~2012~~, *2013*, upon the employment of,  
36    or contract with or for, any direct care staff, the direct care staff  
37    person or licensee shall submit fingerprint images and related  
38    information pertaining to the direct care staff person to the  
39    Department of Justice for purposes of a criminal record check, as  
40    specified in paragraph (2), at the expense of the direct care staff

1 person or licensee. The Department of Justice shall provide the  
2 results of the criminal record check to the ~~department~~ *State*  
3 *Department of Health Care Services*. The ~~department~~ *State*  
4 *Department of Health Care Services* shall determine whether the  
5 direct care staff person has ever been convicted of a crime specified  
6 in subdivision (c). The ~~department~~ *State Department of Health*  
7 *Care Services* shall notify the licensee of these results. No direct  
8 client contact by the trainee or newly hired staff, or by any direct  
9 care contractor shall occur prior to clearance by the ~~department~~  
10 *State Department of Health Care Services* unless the trainee, newly  
11 hired employee, contractor, or employee of the contractor is  
12 constantly supervised.

13 (C) Commencing July 1, ~~2012~~, 2013, any contract for services  
14 provided directly to patients or residents shall contain provisions  
15 to ensure that the direct services contractor submits to the  
16 Department of Justice fingerprint images and related information  
17 pertaining to the direct services contractor for submission to the  
18 State Department of ~~Social~~ *Health Care Services* for purposes of  
19 a criminal record check, as specified in paragraph (2), at the  
20 expense of the direct services contractor or licensee. The  
21 Department of Justice shall provide the results of the criminal  
22 record check to the ~~department~~ *State Department of Health Care*  
23 *Services*. The ~~department~~ *State Department of Health Care*  
24 *Services* shall determine whether the direct services contractor has ever  
25 been convicted of a crime specified in subdivision (c). The  
26 ~~department~~ *State Department of Health Care Services* shall notify  
27 the licensee of these results.

28 (2) If the applicant, licensee, direct care staff person, or direct  
29 services contractor specified in paragraph (1) has resided in  
30 California for at least the previous seven years, the applicant,  
31 licensee, direct care staff person, or direct services contractor shall  
32 only submit one set of fingerprint images and related information  
33 to the Department of Justice. The Department of Justice shall  
34 charge a fee sufficient to cover the reasonable cost of processing  
35 the fingerprint submission. Fingerprints and related information  
36 submitted pursuant to this subdivision include fingerprint images  
37 captured and transmitted electronically. When requested, the  
38 Department of Justice shall forward one set of fingerprint images  
39 to the Federal Bureau of Investigation for the purpose of obtaining  
40 any record of previous convictions or arrests pending adjudication

1 of the applicant, licensee, direct care staff person, or direct services  
2 contractor. The results of a criminal record check provided by the  
3 Department of Justice shall contain every conviction rendered  
4 against an applicant, licensee, direct care staff person, or direct  
5 services contractor, and every offense for which the applicant,  
6 licensee, direct care staff person, or direct services contractor is  
7 presently awaiting trial, whether the person is incarcerated or has  
8 been released on bail or on his or her own recognizance pending  
9 trial. ~~The department~~ *State Department of the Health Care Services*  
10 shall request subsequent arrest notification from the Department  
11 of Justice pursuant to Section 11105.2 of the Penal Code.

12 (3) An applicant and any other person specified in this  
13 subdivision, as part of the background clearance process, shall  
14 provide information as to whether or not the person has any prior  
15 criminal convictions, has had any arrests within the past 12-month  
16 period, or has any active arrests, and shall certify that, to the best  
17 of his or her knowledge, the information provided is true. This  
18 requirement is not intended to duplicate existing requirements for  
19 individuals who are required to submit fingerprint images as part  
20 of a criminal background clearance process. Every applicant shall  
21 provide information on any prior administrative action taken  
22 against him or her by any federal, state, or local government agency  
23 and shall certify that, to the best of his or her knowledge, the  
24 information provided is true. An applicant or other person required  
25 to provide information pursuant to this section that knowingly or  
26 willfully makes false statements, representations, or omissions  
27 may be subject to administrative action, including, but not limited  
28 to, denial of his or her application or exemption or revocation of  
29 any exemption previously granted.

30 (c) (1) The State Department of ~~Social~~ *Health Care Services*  
31 shall deny any application for any license, suspend or revoke any  
32 existing license, and disapprove or revoke any employment or  
33 contract for direct services, if the applicant, licensee, employee,  
34 or direct services contractor has been convicted of, or incarcerated  
35 for, a felony defined in subdivision (c) of Section 667.5 of, or  
36 subdivision (c) of Section 1192.7 of, the Penal Code, within the  
37 preceding 10 years.

38 (2) The application for licensure or renewal of any license shall  
39 be denied, and any employment or contract to provide direct  
40 services shall be disapproved or revoked, if the criminal record of

1 the person includes a conviction in another jurisdiction for an  
2 offense that, if committed or attempted in this state, would have  
3 been punishable as one or more of the offenses referred to in  
4 paragraph (1).

5 (d) (1) The State Department of ~~Social~~ *Health Care Services*  
6 may approve an application for, or renewal of, a license, or  
7 continue any employment or contract for direct services, if the  
8 person has been convicted of a misdemeanor offense that is not a  
9 crime upon the person of another, the nature of which has no  
10 bearing upon the duties for which the person will perform as a  
11 licensee, direct care staff person, or direct services contractor. In  
12 determining whether to approve the application, employment, or  
13 contract for direct services, the department shall take into  
14 consideration the factors enumerated in paragraph (2).

15 (2) Notwithstanding subdivision (c), if the criminal record of a  
16 person indicates any conviction other than a minor traffic violation,  
17 the State Department of ~~Social~~ *Health Care Services* may deny  
18 the application for license or renewal, and may disapprove or  
19 revoke any employment or contract for direct services. In  
20 determining whether or not to deny the application for licensure  
21 or renewal, or to disapprove or revoke any employment or contract  
22 for direct services, the department shall take into consideration the  
23 following factors:

24 (A) The nature and seriousness of the offense under  
25 consideration and its relationship to the person's employment,  
26 duties, and responsibilities.

27 (B) Activities since conviction, including employment or  
28 participation in therapy or education, that would indicate changed  
29 behavior.

30 (C) The time that has elapsed since the commission of the  
31 conduct or offense and the number of offenses.

32 (D) The extent to which the person has complied with any terms  
33 of parole, probation, restitution, or any other sanction lawfully  
34 imposed against the person.

35 (E) Any rehabilitation evidence, including character references,  
36 submitted by the person.

37 (F) Employment history and current employer recommendations.

38 (G) Circumstances surrounding the commission of the offense  
39 that would demonstrate the unlikelihood of repetition.

1 (H) The granting by the Governor of a full and unconditional  
2 pardon.

3 (I) A certificate of rehabilitation from a superior court.

4 (e) Denial, suspension, or revocation of a license, or disapproval  
5 or revocation of any employment or contract for direct services  
6 specified in subdivision (c) and paragraph (2) of subdivision (d)  
7 are not subject to appeal, except as provided in subdivision (f).

8 (f) After a review of the record, the director may grant an  
9 exemption from denial, suspension, or revocation of any license,  
10 or disapproval of any employment or contract for direct services,  
11 if the crime for which the person was convicted was a property  
12 crime that did not involve injury to any person and the director  
13 has substantial and convincing evidence to support a reasonable  
14 belief that the person is of such good character as to justify issuance  
15 or renewal of the license or approval of the employment or contract.

16 (g) A plea or verdict of guilty, or a conviction following a plea  
17 of nolo contendere shall be deemed a conviction within the  
18 meaning of this section. The State Department of ~~Social Health~~  
19 *Care Services* may deny any application, or deny, suspend, or  
20 revoke a license, or disapprove or revoke any employment or  
21 contract for direct services based on a conviction specified in  
22 subdivision (c) when the judgment of conviction is entered or when  
23 an order granting probation is made suspending the imposition of  
24 sentence.

25 (h) (1) For purposes of this section, “direct care staff” means  
26 any person who is an employee, contractor, or volunteer who has  
27 contact with other patients or residents in the provision of services.  
28 Administrative and licensed personnel shall be considered direct  
29 care staff when directly providing program services to participants.

30 (2) An additional background check shall not be required  
31 pursuant to this section if the direct care staff or licensee has  
32 received a prior criminal history background check while working  
33 in a mental health rehabilitation center or psychiatric health facility  
34 licensed by the State Department of ~~Social Health~~ *Care Services*,  
35 and provided the department has maintained continuous subsequent  
36 arrest notification on the individual from the Department of Justice  
37 since the prior criminal background check was initiated.

38 (3) When an application is denied on the basis of a conviction  
39 pursuant to this section, the State Department of ~~Social Health~~  
40 *Care Services* shall provide the individual whose application was



1 denied with notice, in writing, of the specific grounds for the  
2 proposed denial.

3 *SEC. 40. Section 5585.21 of the Welfare and Institutions Code*  
4 *is amended to read:*

5 5585.21. The Director of ~~Social~~ *Health Care Services* may  
6 promulgate regulations as necessary to implement and clarify the  
7 provisions of this part as they relate to minors.

8 *SEC. 41. Section 5585.50 of the Welfare and Institutions Code*  
9 *is amended to read:*

10 5585.50. (a) When any minor, as a result of mental disorder,  
11 is a danger to others, or to himself or herself, or gravely disabled  
12 and authorization for voluntary treatment is not available, a peace  
13 officer, member of the attending staff, as defined by regulation,  
14 of an evaluation facility designated by the county, ~~designated~~  
15 ~~members of a mobile crisis team provided by Section 5651.7,~~ or  
16 other professional person designated by the county may, upon  
17 probable cause, take, or cause to be taken, the minor into custody  
18 and place him or her in a facility designated by the county and  
19 approved by the State Department of ~~Social~~ *Health Care Services*  
20 as a facility for 72-hour treatment and evaluation of minors. The  
21 facility shall make every effort to notify the minor's parent or legal  
22 guardian as soon as possible after the minor is detained.

23 ~~The~~

24 (b) *The* facility shall require an application in writing stating  
25 the circumstances under which the minor's condition was called  
26 to the attention of the officer, member of the attending staff, or  
27 professional person, and stating that the officer, member of the  
28 attending staff, or professional person has probable cause to believe  
29 that the minor is, as a result of mental disorder, a danger to others,  
30 or to himself or herself, or gravely disabled and authorization for  
31 voluntary treatment is not available. If the probable cause is based  
32 on the statement of a person other than the officer, member of the  
33 attending staff, or professional person, the person shall be liable  
34 in a civil action for intentionally giving a statement which he or  
35 she knows to be false.

36 *SEC. 42. Section 5585.55 of the Welfare and Institutions Code*  
37 *is amended to read:*

38 5585.55. The minor committed for involuntary treatment under  
39 this part shall be placed in a *mental* health facility designated by  
40 the county and approved by the State Department of ~~Social~~ *Health*

1 Care Services as a facility for 72-hour evaluation and treatment.  
2 Except as provided for in Section 5751.7, each county shall ensure  
3 that minors under 16 years of age are not held with adults receiving  
4 psychiatric treatment under the provisions of the  
5 Lanterman-Petris-Short Act (Part 1 (commencing with Section  
6 5000)).

7 *SEC. 43. Section 5675 of the Welfare and Institutions Code is*  
8 *amended to read:*

9 5675. (a) Mental health rehabilitation centers shall only be  
10 licensed by the State Department of ~~Social Health Care~~ *Health Care Services*  
11 subsequent to application by counties, county contract providers,  
12 or other organizations. In the application for a mental health  
13 rehabilitation center, program evaluation measures shall include,  
14 but not be limited to:

15 (1) That the clients placed in the facilities show improved global  
16 assessment scores, as measured by preadmission and postadmission  
17 tests.

18 (2) That the clients placed in the facilities demonstrate improved  
19 functional behavior as measured by preadmission and  
20 postadmission tests.

21 (3) That the clients placed in the facilities have reduced  
22 medication levels as determined by comparison of preadmission  
23 and postadmission records.

24 (b) The State Department of ~~Social Health Care~~ *Health Care Services* shall  
25 conduct annual licensing inspections of mental health rehabilitation  
26 centers.

27 (c) All regulations relating to the licensing of mental health  
28 rehabilitation centers, heretofore adopted by the State Department  
29 of Mental Health, *or its successor*, shall remain in effect and shall  
30 be fully enforceable by the State Department of ~~Social Health Care~~ *Health Care*  
31 *Services* with respect to any facility or program required to be  
32 licensed as a mental health rehabilitation center, unless and until  
33 readopted, amended, or repealed by the Director of ~~Social Health~~ *Health*  
34 *Care Services*. The State Department of ~~Social Health Care~~ *Health Care*  
35 *Services* shall succeed to and be vested with all duties, powers,  
36 purposes, functions, responsibilities, and jurisdiction of the State  
37 Department of Mental Health, *and its successor, if any*, as they  
38 relate to licensing mental health rehabilitation centers.

39 *SEC. 44. Section 5675.1 of the Welfare and Institutions Code*  
40 *is amended to read:*

1 5675.1. (a) In accordance with subdivision (b), ~~the State~~  
2 ~~Department of Social Services and the State Department of Health~~  
3 ~~Care Services~~ may establish a system for the imposition of prompt  
4 and effective civil sanctions for long-term care facilities licensed  
5 or certified by ~~those departments~~ *the department*, including  
6 facilities licensed under the provisions of Sections 5675 and 5768,  
7 and including facilities certified as providing a special treatment  
8 program under Sections 72443 to ~~72474~~, 72475, inclusive, of Title  
9 22 of the California Code of Regulations.

10 (b) If the ~~departments~~ *department* determines that  
11 there is or has been a failure, in a substantial manner, on the part  
12 of any such facility to comply with the applicable laws and  
13 regulations, the ~~directors~~ *director* may impose the following  
14 sanctions:

15 (1) A plan of corrective action that addresses all failure identified  
16 by the ~~departments~~ *department* and includes timelines for  
17 correction.

18 (2) A facility that is issued a plan of corrective action, and that  
19 fails to comply with the plan and repeats the deficiency, may be  
20 subject to immediate suspension of its license or certification, until  
21 the deficiency is corrected, when failure to comply with the plan  
22 of correction may cause a health or safety risk to residents.

23 (c) The ~~departments~~ *department* may also establish procedures  
24 for the appeal of an administrative action taken pursuant to this  
25 section, including a plan of corrective action or a suspension of  
26 license or certification.

27 *SEC. 45. Section 5675.2 of the Welfare and Institutions Code*  
28 *is amended to read:*

29 5675.2. (a) There is hereby created in the State Treasury the  
30 Mental Health Facility Licensing Fund, from which money, upon  
31 appropriation by the Legislature in the Budget Act, shall be  
32 expended by the State Department of ~~Social Health Care~~ *Health Care* Services  
33 to fund administrative and other activities in support of the mental  
34 health licensing and certification functions of the State Department  
35 of ~~Social Health Care~~ *Health Care* Services. The Mental Health Facility  
36 Licensing Fund is the successor to the Licensing and Certification  
37 Fund, Mental Health, which fund is hereby abolished. All  
38 references in any law to the Licensing and Certification Fund,  
39 Mental Health shall be deemed to refer to the Mental Health  
40 Facility Licensing Fund.

1 (b) Commencing January 1, 2005, each new and renewal  
2 application for a license to operate a mental health rehabilitation  
3 center shall be accompanied by an application or renewal fee.

4 (c) The amount of the fees shall be determined and collected  
5 by the State Department of ~~Social Health Care~~ *Health Care* Services, but the  
6 total amount of the fees collected shall not exceed the actual costs  
7 of licensure and regulation of the centers, including, but not limited  
8 to, the costs of processing the application, inspection costs, and  
9 other related costs.

10 (d) Each license or renewal issued pursuant to this chapter shall  
11 expire 12 months from the date of issuance. Application for  
12 renewal of the license shall be accompanied by the necessary fee  
13 and shall be filed with the department at least 30 days prior to the  
14 expiration date. Failure to file a timely renewal may result in  
15 expiration of the license.

16 (e) License and renewal fees collected pursuant to this section  
17 shall be deposited into the Mental Health Facility Licensing Fund.

18 (f) Fees collected by the State Department of ~~Social Health~~  
19 *Care* Services pursuant to this section shall be expended by the  
20 State Department of ~~Social Health Care~~ *Health Care* Services for the purpose  
21 of ensuring the health and safety of all individuals providing care  
22 and supervision by licensees and to support activities of the  
23 department, including, but not limited to, monitoring facilities for  
24 compliance with applicable laws and regulations.

25 (g) The State Department of ~~Social Health Care~~ *Health Care* Services may  
26 make additional charges to the facilities if additional visits are  
27 required to ensure that corrective action is taken by the licensee.

28 *SEC. 46. Section 5751.7 of the Welfare and Institutions Code*  
29 *is amended to read:*

30 5751.7. (a) For the purposes of this part and the  
31 Lanterman-Petris-Short Act (Part 1 (commencing with Section  
32 5000)), the State Department of ~~Social Health Care~~ *Health Care* Services and  
33 the State Department of State Hospitals shall ensure that, whenever  
34 feasible, minors shall not be admitted into psychiatric treatment  
35 with adults if the health facility has no specific separate housing  
36 arrangements, treatment staff, and treatment programs designed  
37 to serve children or adolescents. The Director of ~~Social Health~~  
38 *Care* Services shall provide waivers to counties, upon their request,  
39 if this policy creates undue hardship in any county due to  
40 inadequate or unavailable alternative resources. In granting the

1 waivers, the Director of ~~Social Health Care~~ *Health Care Services* shall require  
2 the county to establish specific treatment protocols and  
3 administrative procedures for identifying and providing appropriate  
4 treatment to minors admitted with adults.

5 ~~However,~~

6 *(b) However,* notwithstanding any other provision of law, no  
7 minor may be admitted for psychiatric treatment into the same  
8 treatment ward as any adult receiving treatment who is in the  
9 custody of any jailor for a violent crime, is a known registered sex  
10 offender, or has a known history of, or exhibits inappropriate,  
11 sexual, or other violent behavior which would present a threat to  
12 the physical safety of minors.

13 *SEC. 47. Section 5768 of the Welfare and Institutions Code is*  
14 *amended to read:*

15 5768. (a) Notwithstanding any other provision of law, except  
16 as to requirements relating to fire and life safety of persons with  
17 mental illness, the State Department of ~~Social Health Care~~  
18 *Services*, in its discretion, may permit new programs to be  
19 developed and implemented without complying with licensure  
20 requirements established pursuant to existing state law.

21 (b) Any program developed and implemented pursuant to  
22 subdivision (a) shall be reviewed at least once each six months,  
23 as determined by the State Department of ~~Social Health Care~~  
24 *Services*.

25 (c) The State Department of ~~Social Health Care~~ *Services* may  
26 establish appropriate licensing requirements for these new  
27 programs upon a determination that the programs should be  
28 continued.

29 (d) Within six years, any program shall require a licensure  
30 category if it is to be continued. However, in the event that any  
31 agency other than the State Department of ~~Social Health Care~~  
32 *Services* is responsible for developing a licensure category and  
33 fails to do so within the six years, the program may continue to be  
34 developed and implemented pursuant to subdivisions (a) and (b)  
35 until such time that the licensure category is established.

36 (e) (1) A nongovernmental entity proposing a program shall  
37 submit a program application and plan to the local mental health  
38 director that describes at least the following components: clinical  
39 treatment programs, activity programs, administrative policies and  
40 procedures, admissions, discharge planning, health records content,

1 health records service, interdisciplinary treatment teams, client  
2 empowerment, patient rights, pharmaceutical services, program  
3 space requirements, psychiatric and psychological services,  
4 rehabilitation services, restraint and seclusion, space, supplies,  
5 equipment, and staffing standards. If the local mental health  
6 director determines that the application and plan are consistent  
7 with local needs and satisfactorily address the above components,  
8 he or she may approve the application and plan and forward them  
9 to the department.

10 (2) Upon the State Department of ~~Social~~ *Health Care Services*'  
11 approval, the local mental health director shall implement the  
12 program and shall be responsible for regular program oversight  
13 and monitoring. The department shall be notified in writing of the  
14 outcome of each review of the program by the local mental health  
15 director, or his or her designee, for compliance with program  
16 requirements. The department shall retain ultimate responsibility  
17 for approving the method for review of each program, and the  
18 authority for determining the appropriateness of the local program's  
19 oversight and monitoring activities.

20 (f) Governmental entities proposing a program shall submit a  
21 program application and plan to the State Department of ~~Social~~  
22 *Health Care Services* that describes at least the components  
23 described in subdivision (e). Upon approval, the department shall  
24 be responsible for program oversight and monitoring.

25 (g) Implementation of a program shall be contingent upon the  
26 State Department of ~~Social~~ *Health Care Services*' approval, and  
27 the department may reject applications or require modifications  
28 as it deems necessary. The department shall respond to each  
29 proposal within 90 days of receipt.

30 (h) The State Department of ~~Social~~ *Health Care Services* shall  
31 submit an evaluation to the Legislature of all pilot projects  
32 authorized pursuant to this section within five years of the  
33 commencement of operation of the pilot project, determining the  
34 effectiveness of that program or facility, or both, based on, but not  
35 limited to, changes in clinical indicators with respect to client  
36 functions.

37 *SEC. 48. Section 5840 of the Welfare and Institutions Code is*  
38 *amended to read:*

39 5840. (a) The State Department of Health Care Services, in  
40 coordination with counties, shall establish a program designed to

1 prevent mental illnesses from becoming severe and disabling. The  
2 program shall emphasize improving timely access to services for  
3 underserved populations.

4 (b) The program shall include the following components:

5 (1) Outreach to families, employers, primary care health care  
6 providers, and others to recognize the early signs of potentially  
7 severe and disabling mental illnesses.

8 (2) Access and linkage to medically necessary care provided  
9 by county mental health programs for children with severe mental  
10 illness, as defined in Section 5600.3, and for adults and seniors  
11 with severe mental illness, as defined in Section 5600.3, as early  
12 in the onset of these conditions as practicable.

13 (3) Reduction in stigma associated with either being diagnosed  
14 with a mental illness or seeking mental health services.

15 (4) Reduction in discrimination against people with mental  
16 illness.

17 (c) The program shall include mental health services similar to  
18 those provided under other programs effective in preventing mental  
19 illnesses from becoming severe, and shall also include components  
20 similar to programs that have been successful in reducing the  
21 duration of untreated severe mental illnesses and assisting people  
22 in quickly regaining productive lives.

23 (d) The program shall emphasize strategies to reduce the  
24 following negative outcomes that may result from untreated mental  
25 illness:

26 (1) Suicide.

27 (2) Incarcerations.

28 (3) School failure or dropout.

29 (4) Unemployment.

30 (5) Prolonged suffering.

31 (6) Homelessness.

32 (7) Removal of children from their homes.

33 (e) Prevention and early intervention funds may be used to  
34 broaden the provision of community-based mental health services  
35 by adding prevention and early intervention services or activities  
36 to these services.

37 (f) In consultation with mental health stakeholders, and  
38 consistent with ~~guidelines~~ *regulations* from the Mental Health  
39 Services Oversight and Accountability Commission, pursuant to  
40 Section 5846, the department shall revise the program elements

1 in Section 5840 applicable to all county mental health programs  
2 in future years to reflect what is learned about the most effective  
3 prevention and intervention programs for children, adults, and  
4 seniors.

5 *SEC. 49. Section 5845 of the Welfare and Institutions Code is*  
6 *amended to read:*

7 5845. (a) The Mental Health Services Oversight and  
8 Accountability Commission is hereby established to oversee Part  
9 3 (commencing with Section 5800), the Adult and Older Adult  
10 Mental Health System of Care Act; Part 3.1 (commencing with  
11 Section 5820), Human Resources, Education, and Training  
12 Programs; Part 3.2 (commencing with Section 5830), Innovative  
13 Programs; Part 3.6 (commencing with Section 5840), Prevention  
14 and Early Intervention Programs; and Part 4 (commencing with  
15 Section 5850), the Children's Mental Health Services Act. The  
16 commission shall replace the advisory committee established  
17 pursuant to Section 5814. The commission shall consist of 16  
18 voting members as follows:

19 (1) The Attorney General or his or her designee.

20 (2) The Superintendent of Public Instruction or his or her  
21 designee.

22 (3) The Chairperson of the Senate Health and Human Services  
23 Committee or another member of the Senate selected by the  
24 President pro Tempore of the Senate.

25 (4) The Chairperson of the Assembly Health Committee or  
26 another member of the Assembly selected by the Speaker of the  
27 Assembly.

28 (5) Two persons with a severe mental illness, a family member  
29 of an adult or senior with a severe mental illness, a family member  
30 of a child who has or has had a severe mental illness, a physician  
31 specializing in alcohol and drug treatment, a mental health  
32 professional, a county sheriff, a superintendent of a school district,  
33 a representative of a labor organization, a representative of an  
34 employer with less than 500 employees and a representative of an  
35 employer with more than 500 employees, and a representative of  
36 a health care services plan or insurer, all appointed by the  
37 Governor. In making appointments, the Governor shall seek  
38 individuals who have had personal or family experience with  
39 mental illness.



1 (b) Members shall serve without compensation, but shall be  
2 reimbursed for all actual and necessary expenses incurred in the  
3 performance of their duties.

4 (c) The term of each member shall be three years, to be  
5 staggered so that approximately one-third of the appointments  
6 expire in each year.

7 (d) In carrying out its duties and responsibilities, the commission  
8 may do all of the following:

9 (1) Meet at least once each quarter at any time and location  
10 convenient to the public as it may deem appropriate. All meetings  
11 of the commission shall be open to the public.

12 (2) Within the limit of funds allocated for these purposes,  
13 pursuant to the laws and regulations governing state civil service,  
14 employ staff, including any clerical, legal, and technical assistance  
15 as may appear necessary. The commission shall administer its  
16 operations separate and apart from the State Department of Health  
17 Care Services *and the California Health and Human Services*  
18 *Agency*.

19 (3) Establish technical advisory committees such as a committee  
20 of consumers and family members.

21 (4) Employ all other appropriate strategies necessary or  
22 convenient to enable it to fully and adequately perform its duties  
23 and exercise the powers expressly granted, notwithstanding any  
24 authority expressly granted to any officer or employee of state  
25 government.

26 (5) Enter into contracts.

27 (6) Obtain data and information from the State Department of  
28 Health Care Services, the Office of Statewide Health Planning and  
29 Development, or other state or local entities that receive Mental  
30 Health Services Act funds, for the commission to utilize in its  
31 oversight, review, training and technical assistance, accountability,  
32 and evaluation capacity regarding projects and programs supported  
33 with Mental Health Services Act funds.

34 (7) Participate in the joint state-county decisionmaking process,  
35 as contained in Section 4061, for training, technical assistance,  
36 and regulatory resources to meet the mission and goals of the  
37 state's mental health system.

38 (8) Develop strategies to overcome stigma and discrimination,  
39 and accomplish all other objectives of Part 3.2 (commencing with

1 Section 5830), 3.6 (commencing with Section 5840), and the other  
2 provisions of the act establishing this commission.

3 (9) At any time, advise the Governor or the Legislature regarding  
4 actions the state may take to improve care and services for people  
5 with mental illness.

6 (10) If the commission identifies a critical issue related to the  
7 performance of a county mental health program, it may refer the  
8 issue to the State Department of Health Care Services pursuant to  
9 Section 5655.

10 (11) Assist in providing technical assistance to accomplish the  
11 purposes of the Mental Health Services Act, Part 3 (commencing  
12 with Section 5800), and Part 4 (commencing with Section 5850)  
13 in collaboration with the State Department of Health Care Services  
14 and in consultation with the California Mental Health Directors  
15 Association.

16 (12) Work in collaboration with the State Department of Health  
17 Care Services and the California Mental Health Planning Council,  
18 and in consultation with the California Mental Health Directors  
19 Association, in designing a comprehensive joint plan for a  
20 coordinated evaluation of client outcomes in the community-based  
21 mental health system, including, but not limited to, parts listed in  
22 subdivision (a). The California Health and Human Services Agency  
23 shall lead this comprehensive joint plan effort.

24 *SEC. 50. Section 5846 of the Welfare and Institutions Code is*  
25 *amended to read:*

26 5846. (a) The commission shall ~~issue guidelines for adopt~~  
27 *regulations for programs and expenditures pursuant to Part 3.2*  
28 *(commencing with Section 5830), for innovative programs, and*  
29 *Part 3.6 (commencing with Section 5840), for prevention and early*  
30 *intervention, no later than 180 days before the fiscal year for which*  
31 *the funds will apply.*

32 (b) *Any regulations adopted by the department pursuant to*  
33 *Section 5898 shall be consistent with the commission's regulations.*

34 (b)

35 (c) The commission may provide technical assistance to any  
36 county mental health plan as needed to address concerns or  
37 recommendations of the commission or when local programs could  
38 benefit from technical assistance for improvement of their plans.

39 (e)

1 (d) The commission shall ensure that the perspective and  
2 participation of diverse community members reflective of  
3 California populations and others suffering from severe mental  
4 illness and their family members is a significant factor in all of its  
5 decisions and recommendations.

6 *SEC. 51. Section 5909 of the Welfare and Institutions Code is*  
7 *amended to read:*

8 5909. (a) The Director of Health Care Services shall retain  
9 the authority and responsibility to monitor and approve special  
10 treatment programs in skilled nursing facilities in accordance with  
11 Sections ~~72443 to 72474~~ 72475, inclusive, of Title 22 of the  
12 California Code of Regulations.

13 (b) *The State Department of Health Care Services shall conduct*  
14 *annual certification inspections of special treatment programs for*  
15 *the mentally disordered for the purpose of approving the special*  
16 *treatment programs that are located in skilled nursing facilities*  
17 *licensed pursuant to Section 1265 of the Health and Safety Code.*

18 *SEC. 52. Section 6007 of the Welfare and Institutions Code is*  
19 *amended to read:*

20 ~~6007. Any person detained as of June 30, 1969, in a private~~  
21 ~~institution, pursuant to former Sections 6030 to 6033, inclusive,~~  
22 ~~as they read immediately preceding July 1, 1969, on the~~  
23 ~~certification of one physician, may be detained after July 1, 1969,~~  
24 ~~for a period no longer than 90 days.~~

25 ~~Any~~  
26 ~~person detained as of June 30, 1969, in a private institution,~~  
27 ~~pursuant to such sections, on the certification of two physicians,~~  
28 ~~may be detained after July 1, 1969, for a period no longer than 180~~  
29 ~~days.~~

30 ~~Any~~  
31 ~~6007. (a) Any person detained pursuant to this section after~~  
32 ~~July 1, 1969, shall be evaluated by the facility designated by the~~  
33 ~~county and approved by the State Department of Social Health~~  
34 ~~Care Services pursuant to Section 5150 as a facility for 72-hour~~  
35 ~~treatment and evaluation. The evaluation shall be made at the~~  
36 ~~request of the person in charge of the private institution in which~~  
37 ~~the person is detained or by one of the physicians who signed the~~  
38 ~~certificate. If in the opinion of the professional person in charge~~  
39 ~~of the evaluation and treatment facility or his or her designee, the~~  
40 ~~evaluation of the person can be made by the professional person~~

1 or his or her designee at the private institution in which the person  
2 is detained, the person shall not be required to be evaluated at the  
3 evaluation and treatment facility, but shall be evaluated at the  
4 private institution to determine if the person is a danger to others,  
5 himself or herself, or gravely disabled as a result of mental  
6 disorder.

7 ~~Any~~

8 (b) Any person evaluated under this section shall be released  
9 from the private institution immediately upon completion of the  
10 evaluation if in the opinion of the professional person in charge  
11 of the evaluation and treatment facility, or his or her designee, the  
12 person evaluated is not a danger to others, or to himself or herself,  
13 or gravely disabled as a result of mental disorder, unless the person  
14 agrees voluntarily to remain in the private institution.

15 ~~If~~

16 (c) If in the opinion of the professional person in charge of the  
17 facility or his or her designee, the person evaluated requires  
18 intensive treatment or recommendation for conservatorship, the  
19 professional person or his or her designee shall proceed under  
20 Article 4 (commencing with Section 5250) of Chapter 2, or under  
21 Chapter 3 (commencing with Section 5350), of Part 1 of Division  
22 5.

23 *SEC. 53. Section 6551 of the Welfare and Institutions Code is*  
24 *amended to read:*

25 6551. (a) If the court is in doubt as to whether the person is  
26 mentally disordered or ~~mentally retarded~~ *intellectually disabled*,  
27 the court shall order the person to be taken to a facility designated  
28 by the county and approved by the State Department of ~~Social~~  
29 *Health Care Services* as a facility for 72-hour treatment and  
30 evaluation. Thereupon, Article 1 (commencing with Section 5150)  
31 of Chapter 2 of Part 1 of Division 5 applies, except that the  
32 professional person in charge of the facility shall make a written  
33 report to the court concerning the results of the evaluation of the  
34 person's mental condition. If the professional person in charge of  
35 the facility finds the person is, as a result of mental disorder, in  
36 need of intensive treatment, the person may be certified for not  
37 more than 14 days of involuntary intensive treatment if the  
38 conditions set forth in subdivision (c) of Section 5250 and  
39 subdivision (b) of Section 5260 are complied with. Thereupon,  
40 Article 4 (commencing with Section 5250) of Chapter 2 of Part 1

1 of Division 5 shall apply to the person. The person may be detained  
2 pursuant to Article 4.5 (commencing with Section 5260), or Article  
3 4.7 (commencing with Section 5270.10), or Article 6 (commencing  
4 with Section 5300) of Part 1 of Division 5 if that article applies.

5 If

6 (b) If the professional person in charge of the facility finds that  
7 the person is ~~mentally retarded~~ *intellectually disabled*, the juvenile  
8 court may direct the filing in any other court of a petition for the  
9 commitment of a minor as ~~a mentally retarded~~ *an intellectually*  
10 *disabled* person to the State Department of Developmental Services  
11 for placement in a state hospital. In such case, the juvenile court  
12 shall transmit to the court in which the petition is filed a copy of  
13 the report of the professional person in charge of the facility in  
14 which the minor was placed for observation. The court in which  
15 the petition for commitment is filed may accept the report of the  
16 professional person in lieu of the appointment, or subpoenaing,  
17 and testimony of other expert witnesses appointed by the court, if  
18 the laws applicable to such commitment proceedings provide for  
19 the appointment by court of medical or other expert witnesses or  
20 may consider the report as evidence in addition to the testimony  
21 of medical or other expert witnesses.

22 If

23 (c) If the professional person in charge of the facility for 72-hour  
24 evaluation and treatment reports to the juvenile court that the minor  
25 is not affected with any mental disorder requiring intensive  
26 treatment or ~~mental retardation~~ *intellectual disability*, the  
27 professional person in charge of the facility shall return the minor  
28 to the juvenile court on or before the expiration of the 72-hour  
29 period and the court shall proceed with the case in accordance with  
30 the Juvenile Court Law.

31 Any

32 (d) Any expenditure for the evaluation or intensive treatment of  
33 a minor under this section shall be considered an expenditure made  
34 under Part 2 (commencing with Section 5600) of Division 5 and  
35 shall be reimbursed by the state as are other local expenditures  
36 pursuant to that part.

37 The

38 (e) The jurisdiction of the juvenile court over the minor shall  
39 be suspended during the time that the minor is subject to the  
40 jurisdiction of the court in which the petition for postcertification

1 treatment of an imminently dangerous person or the petition for  
2 commitment of ~~a mentally retarded~~ *an intellectually disabled*  
3 person is filed or under remand for 90 days for intensive treatment  
4 or commitment ordered by the court.

5 *SEC. 54. Section 7100 of the Welfare and Institutions Code is*  
6 *amended to read:*

7 7100. (a) The board of supervisors of each county may  
8 maintain in the county hospital or in any other hospital situated  
9 within or without the county or in any other psychiatric health  
10 facility situated within or without the county, suitable facilities  
11 and nonhospital or hospital service for the detention, supervision,  
12 care, and treatment of persons who are mentally disordered or  
13 developmentally disabled, or who are alleged to be such.

14 ~~The~~

15 (b) *The* county may contract with public or private hospitals for  
16 those facilities and hospital service when they are not suitably  
17 available in any institution, psychiatric facility, or establishment  
18 maintained or operated by the county.

19 ~~The~~

20 (c) *The* facilities and services for the mentally disordered and  
21 allegedly mentally disordered shall be subject to the approval of  
22 the State Department of ~~Social~~ *Health Care* Services, and the  
23 facilities and services for the developmentally disabled and  
24 allegedly developmentally disabled shall be subject to the approval  
25 of the State Department of Developmental Services. The  
26 professional person having charge and control of the hospital or  
27 psychiatric health facility shall allow the department whose  
28 approval is required to make investigations thereof as it deems  
29 necessary at any time.

30 ~~Nothing~~

31 (d) *Nothing* in this chapter means that mentally disordered or  
32 developmentally disabled persons may not be detained, supervised,  
33 cared for, or treated, subject to the right of inquiry or investigation  
34 by the department, in their own homes, or the homes of their  
35 relatives or friends, or in a licensed establishment.

36 *SEC. 55. Section 14005.281 is added to the Welfare and*  
37 *Institutions Code, immediately following Section 14005.28, to*  
38 *read:*

39 14005.281. (a) *The* department shall maintain eligibility for  
40 *all former independent foster care adolescents who were receiving*

1 *services pursuant to Section 14005.28 on or after July 1, 2013,*  
2 *but no later than December 31, 2013, and lost Medi-Cal coverage*  
3 *as a result of attaining 21 years of age.*

4 *(b) Subdivision (a) shall be implemented using state general*  
5 *funds to the extent federal financial participation is not available.*

6 *(c) This section shall remain in effect only until January 1, 2014,*  
7 *and as of that date is repealed, unless a later enacted statute, that*  
8 *is enacted before January 1, 2014, deletes or extends that date.*

9 *SEC. 56. Section 14100.3 is added to the Welfare and*  
10 *Institutions Code, to read:*

11 *14100.3. (a) The State Department of Health Care Services*  
12 *shall post on its Internet Web site all submitted state plan*  
13 *amendments and all federal waiver applications and requests for*  
14 *new waivers, waiver amendments, and waiver renewals and*  
15 *extensions, within 10 business days from the date the department*  
16 *submits these documents for approval to the federal Centers for*  
17 *Medicare and Medicaid Services (CMS).*

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

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

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

34 *SEC. 57. Section 14100.51 is added to the Welfare and*  
35 *Institutions Code, immediately following Section 14100.5, to read:*

36 *14100.51. (a) Each year, by no later than January 10 and*  
37 *concurrently with the release of the May Revision, the State*  
38 *Department of Health Care Services shall provide to the fiscal*  
39 *committees of the Legislature supplemental fiscal information for*  
40 *the Medi-Cal Specialty Mental Health Services Program. This*

1 *supplemental fiscal information shall include service-type*  
2 *descriptions, children's and adults' caseload and fiscal forecast*  
3 *by service type, a detailed explanation of changes to these*  
4 *forecasts, fiscal charts containing children's and adults' claim*  
5 *costs and unduplicated client counts, and summary fiscal charts*  
6 *with current-year and budget-year proposals.*

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

10 *SEC. 58. Section 14100.52 is added to the Welfare and*  
11 *Institutions Code, immediately following Section 14100.51, to*  
12 *read:*

13 *14100.52. (a) Each year, by no later than January 10 and*  
14 *concurrently with the release of the May Revision, the State*  
15 *Department of Health Care Services shall provide to the fiscal*  
16 *committees of the Legislature supplemental fiscal information for*  
17 *the Drug Medi-Cal Program. This supplemental fiscal information*  
18 *shall include adult, minor-consent, child, and perinatal unique*  
19 *client counts and summary fiscal charts with current-year and*  
20 *budget-year proposals.*

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

24 *SEC. 59. Section 14105.22 of the Welfare and Institutions Code*  
25 *is amended to read:*

26 *14105.22. (a) (1) Reimbursement for clinical laboratory or*  
27 *laboratory services, as defined in Section 51137.2 of Title 22 of*  
28 *the California Code of Regulations, ~~may~~ shall not exceed 80*  
29 *percent of the lowest maximum allowance established by the*  
30 *federal Medicare Program for the same or similar services.*

31 *(2) This subdivision shall be implemented only until the new*  
32 *rate methodology under subdivision (b) is approved by the federal*  
33 *Centers for Medicare and Medicaid Services (CMS).*

34 *(b) (1) It is the intent of the Legislature that the department*  
35 *develop reimbursement rates for clinical laboratory or laboratory*  
36 *services that are comparable to the payment amounts received*  
37 *from other payers for clinical laboratory or laboratory services.*  
38 *Development of these rates will enable the department to reimburse*  
39 *clinical laboratory or laboratory service providers in compliance*  
40 *with state and federal law.*



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

6 (B) In addition to subparagraph (A), laboratory providers  
7 reimbursed under any payment reductions implemented pursuant  
8 to this section shall not be subject to the provisions of Section  
9 51501(a) of Title 22 of the California Code of Regulations for ~~12~~  
10 21 months following the date of implementation of this reduction.

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

13 (A) The amount billed.

14 (B) The charge to the general public.

15 (C) Eighty percent of the lowest maximum allowance established  
16 by the federal Medicare Program for the same or similar services.

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

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

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

32 (5) (A) For purposes of establishing reimbursement rates for  
33 clinical laboratory or laboratory services based on the lowest  
34 amounts other payers are paying providers for similar clinical  
35 laboratory or laboratory services, laboratory service providers shall  
36 submit data reports within ~~six~~ 11 months of the date the act that  
37 added this paragraph becomes effective and annually thereafter.  
38 The data *initially* provided shall *be for the 2011 calendar year,*  
39 *and for each subsequent year, shall be based on the previous*  
40 *calendar year and shall specify the provider's lowest amounts other*

1 payers are paying, including other state Medicaid programs and  
2 private insurance, minus discounts and rebates. The specific data  
3 required for submission under this subparagraph and the format  
4 for the data submission shall be determined and specified by the  
5 department after receiving stakeholder input pursuant to paragraph  
6 (7).

7 (B) The data submitted pursuant to subparagraph (A) may be  
8 used to determine reimbursement rates by procedure code based  
9 on an average of the lowest amount other payers are paying  
10 providers for similar clinical laboratory or laboratory services,  
11 excluding significant deviations of cost or volume factors and with  
12 consideration to geographical areas. The department shall have  
13 the discretion to determine the specific methodology and factors  
14 used in the development of the lowest average amount under this  
15 subparagraph to ensure compliance with federal Medicaid law and  
16 regulations as specified in paragraph (10).

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

21 (D) The proposed rates calculated by the vendor described in  
22 subparagraph (C) may be used in determining the lowest  
23 reimbursement rate for clinical laboratories or laboratory services  
24 in accordance with paragraph (3).

25 (E) Data reports submitted to the department shall be certified  
26 by the provider's certified financial officer or an authorized  
27 individual.

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

32 (6) Data reports provided to the department pursuant to this  
33 section shall be confidential and shall be exempt from disclosure  
34 under the California Public Records Act (Chapter 3.5 (commencing  
35 with Section 6250) of Division 7 of Title 1 of the Government  
36 Code).

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

39 (8) (A) Notwithstanding Chapter 3.5 (commencing with Section  
40 11340) of Part 1 of Division 3 of Title 2 of the Government Code,

1 the department shall, without taking any further regulatory action,  
2 implement, interpret, or make specific this section by means of  
3 provider bulletins or similar instructions until regulations are  
4 adopted. It is the intent of the Legislature that the department have  
5 temporary authority as necessary to implement program changes  
6 until completion of the regulatory process.

7 (B) The department shall adopt emergency regulations no later  
8 than July 1, 2014. The department may readopt any emergency  
9 regulation authorized by this section that is the same as or  
10 substantially equivalent to an emergency regulation previously  
11 adopted pursuant to this section. The initial adoption of emergency  
12 regulations implementing the amendments to this section and the  
13 one readoption of emergency regulations authorized by this section  
14 shall be deemed an emergency and necessary for the immediate  
15 preservation of the public peace, health, safety, or general welfare.  
16 Initial emergency regulations and the one readoption of emergency  
17 regulations authorized by this section shall be exempt from review  
18 by the Office of Administrative Law.

19 (C) The initial emergency regulations and the one readoption  
20 of emergency regulations authorized by this section shall be  
21 submitted to the Office of Administrative Law for filing with the  
22 Secretary of State and each shall remain in effect for no more than  
23 180 days, by which time final regulations may be adopted.

24 (9) To the extent that the director determines that the new  
25 methodology or payment reductions are not consistent with the  
26 requirements of Section 1396a(a)(30)(A) of Title 42 of the United  
27 States Code, the department may revert to the methodology under  
28 subdivision (a) to ensure access to care is not compromised.

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

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

39 (C) To the extent that the director determines that the rates and  
40 payments do not comply with applicable federal Medicaid

1 requirements or that federal financial participation is not available  
2 with respect to any reimbursement rate, the director retains the  
3 discretion not to implement that rate or payment and may revise  
4 the rate or payment as necessary to comply with federal Medicaid  
5 requirements. The department shall notify the Joint Legislative  
6 Budget Committee 10 days prior to revising the rate or payment  
7 to comply with federal Medicaid requirements.

8 *SEC. 60. Section 14105.3 of the Welfare and Institutions Code*  
9 *is amended to read:*

10 14105.3. (a) The department is considered to be the purchaser,  
11 but not the dispenser or distributor, of prescribed drugs under the  
12 Medi-Cal program for the purpose of enabling the department to  
13 obtain from manufacturers of prescribed drugs the most favorable  
14 price for those drugs furnished by one or more manufacturers,  
15 based upon the large quantity of the drugs purchased under the  
16 Medi-Cal program, and to enable the department, notwithstanding  
17 any other provision of state law, to obtain from the manufacturers  
18 discounts, rebates, or refunds based on the quantities purchased  
19 under the program, insofar as may be permissible under federal  
20 law. Nothing in this section shall interfere with usual and  
21 customary distribution practices in the drug industry.

22 (b) The department may enter into exclusive or nonexclusive  
23 contracts on a bid or negotiated basis with manufacturers,  
24 distributors, dispensers, or suppliers of appliances, durable medical  
25 equipment, medical supplies, and other product-type health care  
26 services and with laboratories for clinical laboratory services for  
27 the purpose of obtaining the most favorable prices to the state and  
28 to assure adequate quality of the product or service. Except as  
29 provided in subdivision (f), this subdivision shall not apply to  
30 prescribed drugs dispensed by pharmacies licensed pursuant to  
31 Article 7 (commencing with Section 4110) of Chapter 9 of Division  
32 2 of the Business and Professions Code.

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

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

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

10 (f) In order to provide specialized care in the distribution of  
11 specialized drugs, as identified by the department and that include,  
12 but are not limited to, blood factors and immunizations, the  
13 department may enter into contracts with providers licensed to  
14 dispense dangerous drugs or devices pursuant to Chapter 9  
15 (commencing with Section 4000) of Division 2 of the Business  
16 and Professions Code, for programs that qualify for federal funding  
17 pursuant to the ~~medicaid~~ *Medicaid* state plan, or waivers, and the  
18 programs authorized by Article 5 (commencing with Section  
19 123800) of Chapter 3 of Part 2 of, and Article 1 (commencing with  
20 Section 125125) of Chapter 2 of Part 5 of, Division 106 of the  
21 Health and Safety Code, in accordance with this subdivision.

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

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

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

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

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

4 (D) Obtaining a recommendation from the Medi-Cal Drug  
5 Utilization Review Advisory Committee, established pursuant to  
6 Section 1927 of the federal Social Security Act (42 U.S.C. Sec.  
7 1396r-8), on the inclusion or exclusion of drugs into the specialty  
8 pharmacy program distribution based on clinical best practices  
9 related to each drug considered.

10 (3) For purposes of this subdivision, the definition of “blood  
11 factors” has the same meaning as that term is defined in Section  
12 14105.86.

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

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

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

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

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

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

28 ~~(E) Results of patient satisfaction surveys.~~

29 ~~(F) The cost-effectiveness of the program.~~

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

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

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

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

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

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

25 (2) Consult with the statewide association of clinical laboratories  
26 and other appropriate stakeholders on the implementation of the  
27 contracting provisions specified in this section to ensure maximum  
28 access for Medi-Cal patients consistent with the savings targets  
29 projected by the 2002-03 budget conference committee for clinical  
30 laboratory services provided under the Medi-Cal program.

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

36 *SEC. 61. Section 14131.07 of the Welfare and Institutions Code*  
37 *is repealed.*

38 ~~14131.07.—(a) Notwithstanding any other provision of this~~  
39 ~~chapter or Chapter 8 (commencing with Section 14200), the total~~  
40 ~~number of physician office and clinic visits for physician services~~

1 provided by a physician, or under the direction of a physician, that  
2 are a covered benefit under the Medi-Cal program shall be limited  
3 to seven visits per beneficiary per fiscal year, excepting visits that  
4 meet the conditions set forth in subdivision (b). For purposes of  
5 this limit, a visit shall include physician services provided at any  
6 federally qualified health center, rural health clinic, community  
7 clinic, outpatient clinic, and hospital outpatient department. The  
8 department may seek input from consumer organizations and the  
9 provider community, as applicable, prior to implementation.

10 (b) (1) Visits exceeding seven per beneficiary per fiscal year  
11 shall be required to be certified by the physician, or other medical  
12 professional under the supervision of a physician, attesting that  
13 one or more of the following circumstances is applicable:

14 (A) The services will prevent deterioration in a beneficiary's  
15 condition that would otherwise foreseeably result in admission to  
16 the emergency department.

17 (B) The services will prevent deterioration in the beneficiary's  
18 condition that would otherwise result in inpatient admission.

19 (C) The services will prevent disruption in ongoing medical  
20 therapy or surgical therapy, or both, including, but not limited to,  
21 medications, radiation, or wound management.

22 (D) The services constitute diagnostic workup in progress that  
23 would otherwise foreseeably result in inpatient or emergency  
24 department admission.

25 (E) The services are for the purpose of assessment and form  
26 completion for Medi-Cal recipients seeking or receiving in-home  
27 supportive services.

28 (2) The certification shall consist of a written declaration by the  
29 physician, or other medical professional under the supervision of  
30 the physician, that the visit meets the requirements of any one or  
31 more of the circumstances set forth in paragraph (1), and shall  
32 include a description of the services provided.

33 (3) The certification shall be maintained onsite at the physician's  
34 office or clinic location at which the medical records for the  
35 beneficiary are maintained and shall be subject to audit and  
36 inspection by the department.

37 (4) This subdivision does not authorize or direct a beneficiary  
38 to obtain services at a physician office or clinic visit for an  
39 emergency medical condition or that should properly be provided  
40 in the emergency department or as hospital inpatient services.



1 ~~(e) Specialty mental health services furnished or arranged for~~  
2 ~~the provision of mental health services to Medi-Cal beneficiaries~~  
3 ~~pursuant to Chapter 8.9 (commencing with Section 14700), shall~~  
4 ~~not be subject to the limit provided in subdivision (a).~~

5 ~~(d) Any pregnancy-related visit, or any visit for the treatment~~  
6 ~~of any other condition that might complicate a pregnancy, shall~~  
7 ~~not be subject to the limit provided in subdivision (a).~~

8 ~~(e) The limit on physician office and clinic visits provided in~~  
9 ~~subdivision (a) shall not apply to any of the following:~~

10 ~~(1) A beneficiary under the Early and Periodic Screening,~~  
11 ~~Diagnosis, and Treatment (EPSDT) Program.~~

12 ~~(2) A beneficiary receiving long-term care in a nursing facility~~  
13 ~~that is both of the following:~~

14 ~~(A) A skilled nursing facility or intermediate care facility as~~  
15 ~~defined in subdivisions (c), (d), (e), (g), and (h), respectively, of~~  
16 ~~Section 1250 of the Health and Safety Code, and facilities~~  
17 ~~providing continuous skilled nursing care to persons with~~  
18 ~~developmental disabilities under the pilot project established~~  
19 ~~pursuant to Section 14132.20.~~

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

22 ~~(f) For managed health care plans that contract with the~~  
23 ~~department pursuant to this chapter or Chapter 8 (commencing~~  
24 ~~with Section 14200), except for the Senior Care Action Network~~  
25 ~~or AIDS Healthcare Foundation, payments shall be reduced by the~~  
26 ~~actuarial equivalent amount of the benefit reductions resulting~~  
27 ~~from the implementation of the benefit cap amounts specified in~~  
28 ~~this section pursuant to contract amendments or change orders~~  
29 ~~effective on July 1, 2011, or thereafter.~~

30 ~~(g) This section shall be implemented only to the extent~~  
31 ~~permitted by federal law.~~

32 ~~(h) Notwithstanding Chapter 3.5 (commencing with Section~~  
33 ~~11340) of Part 1 of Division 3 of Title 2 of the Government Code,~~  
34 ~~the department may implement this section by means of all-county~~  
35 ~~letters, provider bulletins, or similar instructions, without taking~~  
36 ~~regulatory action.~~

37 ~~(i) This section shall be implemented on the first day of the first~~  
38 ~~calendar month following 180 days after the effective date of the~~  
39 ~~act that added this section, or on the first day of the calendar month~~  
40 ~~following 60 days after the date the department secures all~~

1 necessary federal approvals to implement this section, whichever  
 2 is later. If the implementation date occurs after July 1, 2011, then  
 3 the benefit caps described in subdivision (a) for the first year of  
 4 implementation shall be applied from the implementation date to  
 5 June 30 of the state fiscal year in which implementation begins.  
 6 Thereafter, the benefit caps shall apply on a state fiscal year basis.

7 *SEC. 62. Section 14131.10 of the Welfare and Institutions Code*  
 8 *is amended to read:*

9 14131.10. (a) Notwithstanding any other provision of this  
 10 chapter, Chapter 8 (commencing with Section 14200), or Chapter  
 11 8.75 (commencing with Section 14591), in order to implement  
 12 changes in the level of funding for health care services, specific  
 13 optional benefits are excluded from coverage under the Medi-Cal  
 14 program.

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

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

18 (B) Acupuncture services.

19 (C) Audiology services and speech therapy services.

20 (D) Chiropractic services.

21 (E) Optometric and optician services, including services  
 22 provided by a fabricating optical laboratory.

23 (F) Podiatric services.

24 (G) Psychology services.

25 (H) Incontinence creams and washes.

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

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

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

39 (i) *Amalgam and composite restorations.*

40 (ii) *Stainless steel, resin, and resin window crowns.*

- 1 (iii) Complete dentures, including immediate dentures.  
2 (iv) Complete denture adjustments, repairs, and relines.  
3 (D) Services specified in this paragraph shall be included as a  
4 covered medical benefit under the Medi-Cal program pursuant to  
5 Section 14132.89.  
6 (3) Pregnancy-related services and services for the treatment of  
7 other conditions that might complicate the pregnancy are not  
8 excluded from coverage under this section.  
9 (c) The optional benefit exclusions do not apply to either of the  
10 following:  
11 (1) Beneficiaries under the Early and Periodic Screening  
12 Diagnosis and Treatment Program.  
13 (2) Beneficiaries receiving long-term care in a nursing facility  
14 that is both:  
15 (A) A skilled nursing facility or intermediate care facility as  
16 defined in subdivisions (c) and (d) of Section 1250 of the Health  
17 and Safety Code.  
18 (B) Licensed pursuant to subdivision (k) of Section 1250 of the  
19 Health and Safety Code.  
20 (d) This section shall only be implemented to the extent  
21 permitted by federal law.  
22 (e) Notwithstanding Chapter 3.5 (commencing with Section  
23 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
24 the department may implement the provisions of this section by  
25 means of all-county letters, provider bulletins, or similar  
26 instructions, without taking further regulatory action.  
27 (f) The department shall seek approval for federal financial  
28 participation and coverage of services specified in paragraph (2)  
29 of subdivision (b) under the Medi-Cal program.  
30 ~~(f)~~  
31 (g) This section, except as specified in subparagraph (C) of  
32 paragraph (2) of subdivision (b), shall be implemented on the first  
33 day of the month following 90 days after the operative date of this  
34 section.  
35 SEC. 63. Section 14132.86 is added to the Welfare and  
36 Institutions Code, to read:  
37 14132.86. (a) Notwithstanding subdivision (ab) of Section  
38 14132, effective May 1, 2014, purchase of prescribed enteral  
39 nutrition products is covered, subject to the Medi-Cal list of enteral

1 nutrition products pursuant to Section 14105.8 and utilization  
2 controls pursuant to Section 14105.395.

3 (b) Notwithstanding Chapter 3.5 (commencing with Section  
4 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
5 the department shall implement this section by means of a provider  
6 bulletin or similar instruction, without taking regulatory action.

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

9 (d) The department shall seek approval for federal financial  
10 participation and coverage of the service specified in subdivision  
11 (a) under the Medi-Cal program.

12 SEC. 64. Section 14132.89 is added to the Welfare and  
13 Institutions Code, to read:

14 14132.89. (a) Notwithstanding subdivision (h) of Section  
15 14132, effective May 1, 2014, or the effective date of any necessary  
16 federal approvals as required by subdivision (d), all of the  
17 following are covered benefits for persons 21 years of age or older,  
18 subject to utilization controls and medically necessary services:

19 (1) Amalgam and composite restorations.

20 (2) Stainless steel, resin, and resin window crowns.

21 (3) Complete dentures, including immediate dentures.

22 (4) Complete denture adjustments, repairs, and relines.

23 (5) Emergency procedures are also covered in the above  
24 categories of service.

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

27 (c) Notwithstanding Chapter 3.5 (commencing with Section  
28 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
29 the department shall implement this section by means of a provider  
30 bulletin or similar instruction, without taking regulatory action.

31 (d) The department shall seek approval for federal financial  
32 participation and coverage of services specified in subdivision (a)  
33 under the Medi-Cal program.

34 SEC. 65. Section 14134 of the Welfare and Institutions Code,  
35 as amended by Section 84 of Chapter 23 of the Statutes of 2012,  
36 is amended to read:

37 14134. (a) Except for any prescription, refill, visit, service,  
38 device, or item for which the program's payment is ten dollars  
39 (\$10) or less, in which case no copayment shall be required, a  
40 recipient of services under this chapter shall be required to make

1 copayments not to exceed the maximum permitted under federal  
2 regulations or federal waivers as follows:

3 (1) Copayment of five dollars (\$5) shall be made for  
4 nonemergency services received in an emergency department or  
5 emergency room when the services do not result in the treatment  
6 of an emergency medical condition or inpatient admittance. For  
7 the purposes of this section, “nonemergency services” means  
8 services not required to, as appropriate, medically screen, examine,  
9 evaluate, or stabilize an emergency medical condition that  
10 manifests itself by acute symptoms of sufficient severity, including  
11 severe pain, such that the absence of immediate medical attention  
12 could reasonably be expected to result in any of the following:

13 (A) Placing the individual’s health, or, with respect to a pregnant  
14 woman, the health of the woman or her unborn child, in serious  
15 jeopardy.

16 (B) Serious impairment to bodily functions.

17 (C) Serious dysfunction of any bodily organ or part.

18 (2) Copayment of one dollar (\$1) shall be made for each drug  
19 prescription or refill.

20 (3) Copayment of one dollar (\$1) shall be made for each visit  
21 for services under subdivisions (a) and (h) of Section 14132.

22 (4) The copayment amounts set forth in paragraphs (1), (2), and  
23 (3) may be collected and retained or waived by the provider.

24 (5) The department shall not reduce the reimbursement otherwise  
25 due to providers as a result of the copayment. The copayment  
26 amounts shall be in addition to any reimbursement otherwise due  
27 the provider for services rendered under this program.

28 (6) This section does not apply to emergency services, family  
29 planning services, or to any services received by:

30 (A) Any child in AFDC-Foster Care, as defined in Section  
31 11400.

32 (B) Any person who is an inpatient in a health facility, as defined  
33 in Section 1250 of the Health and Safety Code.

34 (C) Any person 18 years of age or under.

35 (D) Any woman receiving perinatal care.

36 (7) Paragraph (2) does not apply to any person 65 years of age  
37 or over.

38 (8) A provider of service shall not deny care or services to an  
39 individual solely because of that person’s inability to copay under

1 this section. An individual shall, however, remain liable to the  
2 provider for any copayment amount owed.

3 *(9) This section shall not apply to any preventive services that*  
4 *are assigned a grade of A or B by the United States Preventive*  
5 *Services Task Force provided by a physician or other licensed*  
6 *practitioner of the healing arts, or any approved adult vaccines*  
7 *and their administration recommended by the Advisory Committee*  
8 *on Immunization Practices. Pursuant to Section 1905(b) of the*  
9 *federal Social Security Act (42 U.S.C. Sec. 1396d(b)), these*  
10 *services shall be provided without any cost sharing by the*  
11 *beneficiary in order for the state to receive an increased federal*  
12 *medical assistance percentage for these services.*

13 ~~(9)~~

14 *(10) The department shall seek any federal waivers necessary*  
15 *to implement this section. The provisions for which appropriate*  
16 *federal waivers cannot be obtained shall not be implemented, but*  
17 *provisions for which waivers are either obtained or found to be*  
18 *unnecessary shall be unaffected by the inability to obtain federal*  
19 *waivers for the other provisions.*

20 ~~(10)~~

21 *(11) The director shall adopt any regulations necessary to*  
22 *implement this section as emergency regulations in accordance*  
23 *with Chapter 3.5 (commencing with Section 11340) of Part 1 of*  
24 *Division 3 of Title 2 of the Government Code. The adoption of*  
25 *the regulations shall be deemed to be an emergency and necessary*  
26 *for the immediate preservation of the public peace, health and*  
27 *safety, or general welfare. The director shall transmit these*  
28 *emergency regulations directly to the Secretary of State for filing*  
29 *and the regulations shall become effective immediately upon filing.*  
30 *Upon completion of the formal regulation adoption process and*  
31 *prior to the expiration of the 120 day duration period of emergency*  
32 *regulations, the director shall transmit directly to the Secretary of*  
33 *State for filing the adopted regulations, the rulemaking file, and*  
34 *the certification of compliance as required by subdivision (e) of*  
35 *Section 11346.1 of the Government Code.*

36 *(b) This section, or subdivisions thereof, if applicable, shall*  
37 *become inoperative on the implementation date for copayments*  
38 *stated in the declaration executed by the director pursuant to*  
39 *Section 14134 as added by Section 101.5 of the act that added this*  
40 *subdivision of Chapter 3 of the Statutes of 2011.*

1     *SEC. 66. Section 14134 of the Welfare and Institutions Code,*  
2 *as amended by Section 85 of Chapter 23 of the Statutes of 2012,*  
3 *is amended to read:*

4     14134. (a) The Legislature finds and declares all of the  
5 following:

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

10    (2) In order to minimize the need for drastically cutting  
11 enrollment standards or benefits or imposing further reductions  
12 on Medi-Cal providers during times of economic crisis, it is crucial  
13 to find areas within the program where beneficiaries can share  
14 responsibility for utilization of health care, whether they are  
15 participating in the fee-for-service or the managed care model of  
16 service delivery.

17    (3) The establishment of cost-sharing obligations within the  
18 Medi-Cal program is complex and is subject to close supervision  
19 by the United States Department of Health and Human Services.

20    (4) As the single state agency for Medicaid in California, the  
21 State Department of Health Care Services has unique expertise  
22 that can inform decisions that set or adjust cost-sharing  
23 responsibilities for Medi-Cal beneficiaries receiving health care  
24 services.

25    (b) Therefore, it is the intent of the Legislature for the  
26 department to obtain federal approval to implement cost-sharing  
27 for Medi-Cal beneficiaries and permit providers to require that  
28 individuals meet their cost-sharing obligation prior to receiving  
29 care or services.

30    (c) A Medi-Cal beneficiary shall be required to make  
31 copayments as described in this section. These copayments  
32 represent a contribution toward the rate of payment made to  
33 providers of Medi-Cal services and shall be as follows:

34    (1) Copayment of up to fifty dollars (\$50) shall be made for  
35 nonemergency services received in an emergency department or  
36 emergency room when the services do not result in the treatment  
37 of an emergency condition or inpatient admittance. For the  
38 purposes of this section, “nonemergency services” means services  
39 not required to, as appropriate, medically screen, examine, evaluate,  
40 or stabilize an emergency medical condition that manifests itself

1 by acute symptoms of sufficient severity, including severe pain,  
2 such that the absence of immediate medical attention could  
3 reasonably be expected to result in any of the following:

4 (A) Placing the individual's health, or, with respect to a pregnant  
5 woman, the health of the woman or her unborn child, in serious  
6 jeopardy.

7 (B) Serious impairment to bodily functions.

8 (C) Serious dysfunction of any bodily organ or part.

9 (2) Copayment of up to fifty dollars (\$50) shall be made for  
10 emergency services received in an emergency department or  
11 emergency room when the services result in the treatment of an  
12 emergency medical condition or inpatient admittance. For purposes  
13 of this section, "emergency services" means services required to,  
14 as appropriate, medically screen, examine, evaluate, or stabilize  
15 an emergency medical condition that manifests itself by acute  
16 symptoms of sufficient severity, including severe pain, such that  
17 the absence of immediate medical attention could reasonably be  
18 expected to result in any of the following:

19 (A) Placing the individual's health, or, with respect to a pregnant  
20 woman, the health of the woman or her unborn child, in serious  
21 jeopardy.

22 (B) Serious impairment to bodily functions.

23 (C) Serious dysfunction of any bodily organ or part.

24 (3) Copayment of up to one hundred dollars (\$100) shall be  
25 made for each hospital inpatient day, up to a maximum of two  
26 hundred dollars (\$200) per admission.

27 (4) Copayment of up to three dollars (\$3) shall be made for each  
28 preferred drug prescription or refill. A copayment of up to five  
29 dollars (\$5) shall be made for each nonpreferred drug prescription  
30 or refill. Except as provided in subdivision (g), "preferred drug"  
31 shall have the same meaning as in Section 1916A of the Social  
32 Security Act (42 U.S.C. Sec. 1396o-1).

33 (5) Copayment of up to five dollars (\$5) shall be made for each  
34 visit for services under subdivision (a) of Section 14132 and for  
35 dental services received on an outpatient basis provided as a  
36 Medi-Cal benefit pursuant to this chapter or Chapter 8  
37 (commencing with Section 14200), as applicable.

38 (6) This section does not apply to services provided pursuant  
39 to subdivision (aa) of Section 14132.



1 (d) The copayments established pursuant to subdivision (c) shall  
2 be set by the department, at the maximum amount provided for in  
3 the applicable paragraph, except that each copayment amount shall  
4 not exceed the maximum amount allowable pursuant to the state  
5 plan amendments or other federal approvals.

6 (e) The copayment amounts set forth in subdivision (c) may be  
7 collected and retained or waived by the provider. The department  
8 shall deduct the amount of the copayment from the payment the  
9 department makes to the provider whether retained, waived, or not  
10 collected by the provider.

11 (f) Notwithstanding any other provision of law, and only to the  
12 extent allowed pursuant to federal law, a provider of service has  
13 no obligation to provide services to a Medi-Cal beneficiary who  
14 does not, at the point of service, pay the copayment assessed  
15 pursuant to this section. If the provider provides services without  
16 collecting the copayment, and has not waived the copayment, the  
17 provider may hold the beneficiary liable for the copayment amount  
18 owed.

19 (g) (1) Notwithstanding any other provision of law, except as  
20 described in paragraph (2), this section shall apply to Medi-Cal  
21 beneficiaries enrolled in a health plan contracting with the  
22 department pursuant to this chapter or Chapter 8 (commencing  
23 with Section 14200), except for the Senior Care Action Network  
24 or AIDS Healthcare Foundation. To the extent permitted by federal  
25 law and pursuant to any federal waivers or state plan adjustments  
26 obtained, a managed care health plan may establish a lower  
27 copayment or no copayment.

28 (2) For the purpose of paragraph (4) of subdivision (c),  
29 copayments assessed against a beneficiary who receives Medi-Cal  
30 services through a health plan described in paragraph (1) shall be  
31 based on the plan's designation of a drug as preferred or  
32 nonpreferred.

33 (3) To the extent provided by federal law, capitation payments  
34 shall be calculated on an actuarial basis as if copayments described  
35 in this section were collected.

36 (h) *This section shall not apply to any preventive services that*  
37 *are assigned a grade of A or B by the United States Preventive*  
38 *Services Task Force provided by a physician or other licensed*  
39 *practitioner of the healing arts, or any approved adult vaccines*  
40 *and their administration recommended by the Advisory Committee*

1 *on Immunization Practices. Pursuant to Section 1905(b) of the*  
 2 *federal Social Security Act (42 U.S.C. Sec. 1396d(b)), these*  
 3 *services shall be provided without any cost sharing by the*  
 4 *beneficiary in order for the state to receive an increased federal*  
 5 *medical assistance percentage for these services.*

6 ~~(h)~~

7 (i) This section shall be implemented only to the extent that  
 8 federal financial participation is available. The department shall  
 9 seek and obtain any federal waivers or state plan amendments  
 10 necessary to implement this section. The provisions for which  
 11 appropriate federal waivers or state plan amendments cannot be  
 12 obtained shall not be implemented, but provisions for which  
 13 waivers or state plan amendments are either obtained or found to  
 14 be unnecessary shall be unaffected by the inability to obtain federal  
 15 waivers or state plan amendments for the other provisions.

16 ~~(i)~~

17 (j) Notwithstanding Chapter 3.5 (commencing with Section  
 18 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
 19 the department may implement, interpret, or make specific this  
 20 section by means of all-county letters, all-plan letters, provider  
 21 bulletins, or similar instructions, without taking further regulatory  
 22 actions.

23 ~~(j)~~

24 (k) (1) This section shall become operative on the date that the  
 25 act adding this section is effective, but shall not be implemented  
 26 until the date in the declaration executed by the director pursuant  
 27 to paragraph (2). In no event shall the director set an  
 28 implementation date prior to the date federal approval is received.

29 (2) The director shall execute a declaration that states the date  
 30 that implementation of the copayments described in this section  
 31 or subdivisions thereof, if applicable, will commence and shall  
 32 post the declaration on the department's Internet Web site and  
 33 provide a copy of the declaration to the Chair of the Joint  
 34 Legislative Budget Committee, the Chief Clerk of the Assembly,  
 35 the Secretary of the Senate, the Office of the Legislative Counsel,  
 36 and the Secretary of State.

37 *SEC. 67. Section 14707.5 of the Welfare and Institutions Code*  
 38 *is amended to read:*

39 14707.5. (a) It is the intent of the Legislature to develop a  
 40 performance outcome system for Early and Periodic Screening,

1 Diagnosis, and Treatment (EPSDT) mental health services that  
2 will improve outcomes at the individual and system levels and will  
3 inform fiscal decision making related to the purchase of services.

4 (b) The State Department of Health Care Services, in  
5 collaboration with the California Health and Human Services  
6 Agency, and in consultation with the Mental Health Services  
7 Oversight and Accountability Commission, shall create a plan for  
8 a performance outcome system for EPSDT mental health services  
9 provided to eligible Medi-Cal beneficiaries under the age of 21  
10 pursuant to 42 U.S.C. Section 1396d(a)(4)(B).

11 (1) Commencing no later than September 1, 2012, the  
12 department shall convene a stakeholder advisory committee  
13 comprised of representatives of child and youth clients, family  
14 members, providers, counties, and the Legislature. This  
15 consultation shall inform the creation of a plan for a performance  
16 outcome system for EPSDT mental health services.

17 (2) In developing a plan for a performance outcomes system  
18 for EPSDT mental health services, the department shall consider  
19 the following objectives, among others:

20 (A) High quality and accessible EPSDT mental health services  
21 for eligible children and youth, consistent with federal law.

22 (B) Information that improves practice at the individual,  
23 program, and system levels.

24 (C) Minimization of costs by building upon existing resources  
25 to the fullest extent possible.

26 (D) Reliable data that are collected and analyzed in a timely  
27 fashion.

28 (3) At a minimum, the plan for a performance outcome system  
29 for EPSDT mental health services shall consider evidence-based  
30 models for performance outcome systems, such as the Child and  
31 Adolescent Needs and Strengths (CANS), federal requirements,  
32 including the review by the External Quality Review Organization  
33 (EQRO), and, timelines for implementation at the provider, county,  
34 and state levels.

35 (c) The State Department of Health Care Services shall provide  
36 the performance outcomes system plan, including milestones and  
37 timelines, for EPSDT mental health services described in  
38 subdivision (a) to all fiscal committees and appropriate policy  
39 committees of the Legislature no later than October 1, 2013.

1 (d) The State Department of Health Care Services shall propose  
 2 how to implement the performance outcomes system plan for  
 3 EPSDT mental health services described in subdivision (a) no later  
 4 than January 10, 2014.

5 (e) *Commencing no later than February 1, 2014, the department*  
 6 *shall convene a stakeholder advisory committee comprised of*  
 7 *advocates for and representatives of, child and youth clients, family*  
 8 *members, managed care health plans, providers, counties, and the*  
 9 *Legislature. The committee shall develop methods to routinely*  
 10 *measure, assess, and communicate program information regarding*  
 11 *informing, identifying, screening, assessing, referring, and linking*  
 12 *Medi-Cal eligible beneficiaries to mental health services and*  
 13 *supports. The committee shall also review health plan screenings*  
 14 *for mental health illness, health plan referrals to Medi-Cal*  
 15 *fee-for-service providers, and health plan referrals to county*  
 16 *mental health plans, among others. The committee shall make*  
 17 *recommendations to the department regarding performance and*  
 18 *outcome measures that will contribute to improving timely access*  
 19 *to appropriate care for Medi-Cal eligible beneficiaries.*

20 (1) *The department shall incorporate into the performance*  
 21 *outcomes system established pursuant to this section the screenings*  
 22 *and referrals described in this subdivision, including milestones*  
 23 *and timelines, and shall provide an updated performance outcomes*  
 24 *system plan to all fiscal committees and the appropriate policy*  
 25 *committees of the Legislature no later than October 1, 2014.*

26 (2) *The department shall propose how to implement the updated*  
 27 *performance systems outcome plan described in paragraph (1) no*  
 28 *later than January 10, 2015.*

29 SEC. 68. *Part 3.3 (commencing with Section 15800) is added*  
 30 *to Division 9 of the Welfare and Institutions Code, to read:*

31  
 32 **PART 3.3. HEALTH CARE COVERAGE ASSISTANCE**

33  
 34 **CHAPTER 1. GENERAL PROVISIONS**

35  
 36 15800. (a) (1) *Commencing October 1, 2013, the State*  
 37 *Department of Health Care Services shall administer the*  
 38 *AIM-Linked Infants Program to address the health care needs of*  
 39 *children formerly covered pursuant to clause (ii) of subparagraph*  
 40 *(A) of paragraph (6) of subdivision (a) of Section 12693.70 of the*

1 *Insurance Code. The department is vested with the same powers,*  
2 *purposes, responsibilities, and jurisdiction exercised by the*  
3 *Managed Risk Medical Insurance Board as they relate to those*  
4 *children. Nothing in this paragraph shall be construed to alter,*  
5 *diminish, or supersede the authority of the Managed Risk Medical*  
6 *Insurance Board to exercise the same powers, purposes,*  
7 *responsibilities, and jurisdiction within the Healthy Families*  
8 *Program established under Part 6.2 (commencing with Section*  
9 *12693) of Division 2 of the Insurance Code.*

10 (2) *The department may, before October 1, 2013, conduct*  
11 *transition activities necessary to ensure the efficient transfer of*  
12 *the program identified in subdivision (a) and populations served*  
13 *by that program.*

14 (b) *The department shall seek any federal waivers, approvals,*  
15 *and state plan amendments necessary to implement this part. This*  
16 *part shall only be implemented to the extent that necessary federal*  
17 *approvals are obtained and federal financial participation is*  
18 *available for eligible programs and services.*

19 15801. *The terms of all regulations and orders adopted by the*  
20 *Managed Risk Medical Insurance Board in effect immediately*  
21 *preceding October 1, 2013, that relate to the operation of the*  
22 *program and to the children transferred by the act that added this*  
23 *section and are not rendered legally unenforceable by the act that*  
24 *added this section shall be fully enforceable by the State*  
25 *Department of Health Care Services within the AIM-Linked Infants*  
26 *Program unless and until the department adopts regulations for*  
27 *the AIM-Linked Infants Program. Nothing in this section shall be*  
28 *construed to alter, diminish, or supersede the authority of the*  
29 *Managed Risk Medical Insurance Board to interpret, enforce,*  
30 *maintain, or amend the same regulations for purposes of the*  
31 *Healthy Families Program established under Part 6.2 (commencing*  
32 *with Section 12693) of Division 2 of the Insurance Code.*

33 15802. (a) *The State Department of Health Care Services may*  
34 *issue rules and regulations to carry out the purposes of this part.*

35 (b) *Notwithstanding subdivision (a) or Chapter 3.5 (commencing*  
36 *with Section 11340) of Part 1 of Division 3 of Title 2 of the*  
37 *Government Code, the department, without taking any further*  
38 *regulatory actions, may implement, interpret, or make specific this*  
39 *part and amend or repeal regulations and orders adopted by the*  
40 *Managed Risk Medical Insurance Board as provided in Section*

1 15801 by means of all-county letters, plan letters, plan or provider  
2 bulletins, or similar instructions, without taking regulatory action  
3 during the transition of the programs to the department. Thereafter,  
4 the adoption and re-adoption of regulations to implement, interpret,  
5 or make specific this part shall be deemed to be an emergency that  
6 calls for immediate action to avoid serious harm to the public  
7 peace, health, safety, or general welfare for purposes of Sections  
8 11346.1 and 11349.6 of the Government Code, and the department  
9 is exempted from the requirement that it describe facts showing  
10 the need for immediate action. The regulations shall become  
11 effective immediately upon filing with the Secretary of State.

12 15803. (a) To implement this part and clause (ii) of  
13 subparagraph (A) of paragraph (6) of subdivision (a) of Section  
14 12693.70 of the Insurance Code, the State Department of Health  
15 Care Services may contract with public or private entities,  
16 including the Managed Risk Medical Insurance Board, which  
17 administers the Access for Infants and Mothers Program pursuant  
18 to Part 6.3 (commencing with Section 12695) of Division 2 of the  
19 Insurance Code. Contracts entered into under this part may be on  
20 a noncompetitive bid basis and shall be exempt from the following:

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

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

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

28 (b) During the transition of the programs to the department,  
29 the department shall also be exempt from the review or approval  
30 of feasibility study reports and the requirements of Sections  
31 4819.35 to 4819.37, inclusive, and 4920 to 4928, inclusive, of the  
32 State Administrative Manual.

33 15804. On October 1, 2013, or when the State Department of  
34 Health Care Services has implemented Chapter 2 (commencing  
35 with Section 15850), whichever occurs later, the Managed Risk  
36 Medical Insurance Board shall cease to provide coverage to the  
37 children transferred to the AIM-Linked Infants Program, pursuant  
38 to Section 15800.

39 15805. (a) The Managed Risk Medical Insurance Board shall  
40 provide the State Department of Health Care Services any data,

1 *information, or record concerning the Healthy Families Program*  
2 *or the Access for Infants and Mothers Program as are necessary*  
3 *to implement this part and clause (ii) of subparagraph (A) of*  
4 *paragraph (6) of subdivision (a) of Section 12693.70 of the*  
5 *Insurance Code.*

6 *(b) Notwithstanding any other law, all of the following shall*  
7 *apply:*

8 *(1) The term “data, information, or record” shall include, but*  
9 *is not limited to, personal information as defined in Section 1798.3*  
10 *of the Civil Code.*

11 *(2) Any data, information, or record shall be exempt from*  
12 *disclosure under the California Public Records Act (Chapter 3.5*  
13 *(commencing with Section 6250) of Division 7 of the Government*  
14 *Code) and any other law, to the same extent that it was exempt*  
15 *from disclosure or privileged prior to the provision of the data,*  
16 *information, or record to the department.*

17 *(3) The provision of any data, information, or record to the*  
18 *department shall not constitute a waiver of any evidentiary*  
19 *privilege or exemption from disclosure.*

20 *(4) The department shall keep all data, information, or records*  
21 *provided by the Managed Risk Medical Insurance Board*  
22 *confidential to the full extent permitted by law, including, but not*  
23 *limited to, the California Public Records Act (Chapter 3.5*  
24 *(commencing with Section 6250) of Division 7 of the Government*  
25 *Code), and consistent with the Managed Risk Medical Insurance*  
26 *Board’s contractual obligations to keep data, information, or*  
27 *records confidential.*

28

29 *CHAPTER 2. AIM-LINKED INFANTS PROGRAM*

30

31 *15810. This chapter shall be known, and may be cited, as the*  
32 *AIM-Linked Infants Program.*

33 *15811. The definitions contained in this section govern the*  
34 *construction of this chapter, unless the context requires otherwise.*

35 *(a) “AIM-linked infant” means any infant born to a woman*  
36 *whose enrollment in the Access for Infants and Mothers Program*  
37 *under Part 6.3 (commencing with Section 12695) of Division 2 of*  
38 *the Insurance Code begins after June 30, 2004.*

39 *(b) “Department” means the State Department of Health Care*  
40 *Services.*

1 (c) “Program” means the AIM-Linked Infants Program.

2 (d) “Subscriber” means an individual who is eligible for and  
3 enrolled in the program.

4 (e) “Subscriber contribution” means the cost to the subscriber  
5 to participate in the program.

6 15822. Health care services under the program shall include,  
7 but are not limited to, all of the following:

8 (a) Preventive, screening, diagnostic, and treatment services  
9 furnished directly by a licensed clinic, either onsite or by formal  
10 written contract, on a case-managed basis, to patients who remain  
11 less than 24 hours at the clinic for an illness or injury, advice,  
12 counseling, outreach, and translation as needed.

13 (b) Physician services.

14 (c) Emergency first aid, perinatal, obstetric, radiology,  
15 laboratory, and nutrition services.

16 (d) Services of advanced practice nurses or mid-level  
17 practitioners who are authorized to perform any of the services  
18 listed in this section within the scope of their licensure.

19 (e) All services and benefits set forth in Chapter 7 (commencing  
20 with Section 14000) of Part 3.

21 15824. To the extent permitted by federal law, services for  
22 individuals eligible under this chapter shall be provided, at the  
23 department’s discretion and to the extent the department  
24 determines the selected delivery system is cost effective, through  
25 the Medi-Cal fee-for-service or managed care delivery system, or  
26 both.

27 15826. The department shall administer the program and may  
28 do all of the following:

29 (a) Determine eligibility criteria for the program. These criteria  
30 shall include the requirements set forth in Section 15832.

31 (b) Determine the eligibility of AIM-linked infants.

32 (c) Determine when subscribers are covered and the extent and  
33 scope of coverage.

34 (d) Determine subscriber contribution amounts schedules.  
35 Subscriber contributions shall not be greater than those applicable  
36 on March 23, 2010, for infants enrolled pursuant to clause (ii) of  
37 subparagraph (A) of paragraph (6) of subdivision (a) of Section  
38 12693.70 of the Insurance Code.

39 (e) Provide coverage through Medi-Cal delivery systems and  
40 contract for the administration of the program and the enrollment



1 of subscribers. Any contract entered into pursuant to this chapter  
2 shall be exempt from any provision of law relating to competitive  
3 bidding, and shall be exempt from the review or approval of any  
4 division of the Department of General Services. The department  
5 shall not be required to specify the amounts encumbered for each  
6 contract, but may allocate funds to each contract based on  
7 projected and actual subscriber enrollments in a total amount not  
8 to exceed the amount appropriated for the program.

9 (f) Authorize expenditures to pay program expenses that exceed  
10 subscriber contributions, and to administer the program as  
11 necessary.

12 (g) Develop a promotional component of the program to make  
13 Californians aware of the program and the opportunity that it  
14 presents.

15 (h) (1) Issue rules and regulations as necessary to administer  
16 the program.

17 (2) During the 2011–12 to 2014–15 fiscal years, inclusive, the  
18 adoption and readoption of regulations pursuant to this chapter  
19 shall be deemed to be an emergency that calls for immediate action  
20 to avoid serious harm to the public peace, health, safety, or general  
21 welfare for purposes of Sections 11346.1 and 11349.6 of the  
22 Government Code, and the department is hereby exempted from  
23 the requirement that the department describe facts showing the  
24 need for immediate action.

25 (i) Exercise all powers reasonably necessary to carry out the  
26 powers and responsibilities expressly granted or imposed by this  
27 chapter.

28 15828. The department shall coordinate with other state  
29 agencies, as appropriate, to help ensure continuity of health care  
30 services.

31 15830. (a) The department may contract with a variety of  
32 health plans and types of health care service delivery systems in  
33 order to offer subscribers a choice of plans, providers, and types  
34 of service delivery.

35 (b) Participating health plans contracting with the department  
36 pursuant to this chapter shall provide benefits or coverage to  
37 subscribers only as determined by the department pursuant to  
38 subdivision (b) of Section 15826.

39 15832. To be eligible to participate in the program, a person  
40 shall meet all of the following requirements:

1 (a) (1) *Be a child under two years of age who is delivered by*  
2 *a mother enrolled in the program under Part 6.3 (commencing*  
3 *with Section 12695) of Division 2 of the Insurance Code. Except*  
4 *as stated in this section, these infants shall be automatically*  
5 *enrolled in the program.*

6 (2) *For the applicable month, not be enrolled in*  
7 *employer-sponsored health care coverage, or have been enrolled*  
8 *in that health care coverage in the prior three months or enrolled*  
9 *in full-scope Medi-Cal without a share of cost. Exceptions may be*  
10 *identified in regulations or other guidance and shall, at minimum,*  
11 *include all exceptions applicable to the Healthy Families Program*  
12 *on and after March 23, 2010.*

13 (3) *Be subject to subscriber contributions as determined by the*  
14 *department. The subscriber contributions shall not be greater than*  
15 *those applicable on March 23, 2010, for infants enrolled in the*  
16 *Healthy Families Program pursuant to clause (ii) of subparagraph*  
17 *(A) of paragraph (6) of subdivision (a) of Section 12693.70 of the*  
18 *Insurance Code.*

19 (b) *For AIM-linked infants identified in subdivision (a), all of*  
20 *the following shall apply:*

21 (1) *Enrollment shall cover the first 12 months of the infant's*  
22 *life unless he or she is eligible for Medi-Cal benefits under Section*  
23 *14005.26. If the infant is eligible under Section 14005.26, he or*  
24 *she shall be automatically enrolled in the Medi-Cal program on*  
25 *that basis.*

26 (2) (A) *At the end of the 12 months, as a condition of continued*  
27 *eligibility, the subscriber shall provide income information. The*  
28 *infant shall be disenrolled from the program if the annual*  
29 *household income exceeds 300 percent of the federal poverty level,*  
30 *or if the infant is eligible for full-scope Medi-Cal with no share of*  
31 *cost.*

32 (B) *Effective January 1, 2014, when determining eligibility for*  
33 *benefits under the program, income shall be determined, counted,*  
34 *and valued in accordance with the requirements of Section*  
35 *1397bb(b)(1)(B) of Title 42 of the United States Code as added by*  
36 *the federal Patient Protection and Affordable Care Act (Public*  
37 *Law 111-148) and as amended by the federal Health Care and*  
38 *Education Reconciliation Act of 2010 (Public Law 111-152) and*  
39 *any subsequent amendments.*

1 (3) At the end of their first and second year in the program,  
2 infants shall be screened for eligibility for the Medi-Cal program.

3 (c) If at any time the director determines that the eligibility  
4 criteria established under this chapter for the program may  
5 jeopardize the state's ability to receive federal financial  
6 participation under the federal Patient Protection and Affordable  
7 Care Act (Public Law 111-148), or any amendment or extension  
8 of that act, the director may alter the eligibility criteria to the  
9 extent necessary for the state to receive that federal financial  
10 participation.

11 15834. A person shall not be eligible for covered services under  
12 the program if those services are covered through private health  
13 care coverage arrangements at the time of eligibility.

14 15836. (a) If a subscriber is dissatisfied with any action, or  
15 failure to act, that has occurred in connection with eligibility or  
16 covered services under this chapter, the subscriber may appeal to  
17 the department and shall be accorded an opportunity for a fair  
18 hearing. Hearings may be conducted pursuant to the provisions  
19 of Chapter 5 (commencing with Section 11500) of Part 1 of  
20 Division 3 of Title 2 of the Government Code.

21 (b) The department may place a lien on compensation or benefits  
22 that are recovered or recoverable by a subscriber for whom  
23 benefits have been provided under a policy or plan issued under  
24 this chapter from any party or parties responsible for the  
25 compensation or benefits.

26 15838. (a) A provider who is furnished documentation of a  
27 subscriber's enrollment in the program shall not seek  
28 reimbursement or attempt to obtain payment for any covered  
29 services provided to that subscriber other than from the  
30 participating health plan or insurer covering the subscriber or  
31 from the department.

32 (b) Subdivision (a) shall not apply to any copayment required  
33 by the department under this chapter for the covered services  
34 provided to the subscriber.

35 (c) For purposes of this chapter, "provider" means any  
36 professional person, organization, health facility, or other person  
37 or institution licensed by the state to deliver or furnish health care  
38 services and includes as that term is defined in subdivision (o) of  
39 Section 14043.1.

1 15840. (a) At a minimum, coverage provided pursuant to this  
2 chapter shall be provided to eligible AIM-linked infants less than  
3 two years of age.

4 (b) Coverage provided pursuant to this chapter shall include,  
5 at a minimum, those services required to be provided by health  
6 care service plans approved by the Secretary of Health and Human  
7 Services as a federally qualified health care service plan pursuant  
8 to Section 417.101 of Title 42 of the Code of Federal Regulations.

9 (c) Medically necessary prescription drugs shall be a required  
10 benefit in the coverage provided pursuant to this chapter.

11 15842. Notwithstanding any other law, for a subscriber who  
12 is determined by the California Children's Services Program to  
13 be eligible for benefits under the program pursuant to Article 5  
14 (commencing with Section 123800) of Chapter 3 of Part 2 of  
15 Division 106 of the Health and Safety Code, a provider shall not  
16 be responsible for the provision of, or payment for, the particular  
17 services authorized by the California Children's Services Program  
18 for the particular subscriber for the treatment of a California  
19 Children's Services Program eligible medical condition. Providers  
20 shall refer a child whom they reasonably suspect of having a  
21 medical condition that is eligible for services under the California  
22 Children's Services Program to the California Children's Services  
23 Program. The California Children's Services Program shall  
24 provide case management and authorization of services if the child  
25 is found to be medically eligible for the California Children's  
26 Services Program. Diagnosis and treatment services that are  
27 authorized by the California Children's Services Program shall  
28 be performed by paneled providers for that program and approved  
29 special care centers of that program in accordance with treatment  
30 plans approved by the California Children's Services Program.  
31 All other services provided under this chapter shall be available  
32 to the subscriber.

33 15844. A child enrolled in the program under this chapter who  
34 has a medical condition that is eligible for services pursuant to  
35 the California Children's Services Program, and whose family is  
36 not financially eligible for the California Children's Services  
37 Program, shall have the medically necessary treatment services  
38 for his or her California Children's Services Program eligible  
39 medical condition authorized and paid for by the California  
40 Children's Services Program. County expenditures for the payment

1 of services for the child shall be waived and these expenditures  
2 shall be paid for by the state from Title XXI of the federal Social  
3 Security Act (42 U.S.C. Sec. 1397aa et seq.) funds and state general  
4 funds.

5 15846. The department shall encourage all providers who  
6 provide services under the program to have viable protocols for  
7 screening and referring children needing supplemental services  
8 outside of the scope of the screening, preventive, and medically  
9 necessary and therapeutic services covered by the contract to  
10 public programs providing such supplemental services for which  
11 they may be eligible, as well as for coordination of care between  
12 the provider and the public programs. The public programs for  
13 which providers may be required to develop screening, referral,  
14 and care coordination protocols may include the California  
15 Children's Services Program, the regional centers, county mental  
16 health programs, programs administered by the Department of  
17 Alcohol and Drug Programs or its successor agency or agencies,  
18 and programs administered by local education agencies.

19 SEC. 69. Section 15911 of the Welfare and Institutions Code  
20 is amended to read:

21 15911. (a) Funding for each LIHP shall be based on all of the  
22 following:

23 (1) The amount of funding that the participating entity  
24 voluntarily provides for the nonfederal share of LIHP expenditures.

25 (2) For a LIHP that had in operation a Health Care Coverage  
26 Initiative program under Part 3.5 (commencing with Section 15900)  
27 as of November 1, 2010, and elects to continue funding the  
28 program, the amount of funds requested to ensure that eligible  
29 enrollees continue to receive health care services for persons  
30 enrolled in the Health Care Coverage Initiative program as of  
31 November 1, 2010.

32 (3) Any limitations imposed by the Special Terms and  
33 Conditions of the demonstration project.

34 (4) The total allocations requested by participating entities for  
35 Health Care Coverage Initiative eligible individuals.

36 (5) Whether funding under this part would result in the reduction  
37 of other payments under the demonstration project.

38 (b) Nothing in this part shall be construed to require a political  
39 subdivision of the state to participate in a LIHP as set forth in this  
40 part, and those local funds expended or transferred for the

1 nonfederal share of LIHP expenditures under this part shall be  
2 considered voluntary contributions for purposes of the federal  
3 Patient Protection and Affordable Care Act (Public Law 111-148),  
4 as amended by the federal Health Care and Education  
5 Reconciliation Act of 2010 (Public Law 111-152), and the federal  
6 American Recovery and Reinvestment Act of 2009 (Public Law  
7 111-5), as amended by the federal Patient Protection and  
8 Affordable Care Act.

9 (c) No state General Fund moneys shall be used to fund LIHP  
10 services, nor to fund any related administrative costs incurred by  
11 counties or any other political subdivision of the state.

12 (d) Subject to the Special Terms and Conditions of the  
13 demonstration project, if a participating entity elects to fund the  
14 nonfederal share of a LIHP, the nonfederal funding and payments  
15 to the LIHP shall be provided through one of the following  
16 mechanisms, at the options of the participating entity:

17 (1) On a quarterly basis, the participating entity shall transfer  
18 to the department for deposit in the LIHP Fund established for the  
19 participating counties and pursuant to subparagraph (A), the  
20 amount necessary to meet the nonfederal share of estimated  
21 payments to the LIHP for the next quarter under subdivision (g)  
22 Section 15910.3.

23 (A) The LIHP Fund is hereby created in the State Treasury.  
24 Notwithstanding Section 13340 of the Government Code, all  
25 moneys in the fund shall be continuously appropriated to the  
26 department for the purposes specified in this part. The fund shall  
27 contain all moneys deposited into the fund in accordance with this  
28 paragraph.

29 (B) The department shall obtain the related federal financial  
30 participation and pay the rates established under Section 15910.3,  
31 provided that the intergovernmental transfer is transferred in  
32 accordance with the deadlines imposed under the Medi-Cal  
33 Checkwrite Schedule, no later than the next available warrant  
34 release date. This payment shall be a nondiscretionary obligation  
35 of the department, enforceable under a writ of mandate pursuant  
36 to Section 1085 of the Code of Civil Procedure. Participating  
37 entities may request expedited processing within seven business  
38 days of the transfer as made available by the Controller's office,  
39 provided that the participating entity prepay the department for

1 the additional administrative costs associated with the expedited  
2 processing.

3 (C) Total quarterly payment amounts shall be determined in  
4 accordance with estimates of the number of enrollees in each rate  
5 category, subject to annual reconciliation to final enrollment data.

6 (2) If a participating entity operates its LIHP through a contract  
7 with another entity, the participating entity may pay the operating  
8 entity based on the per enrollee rates established under Section  
9 15910.3 on a quarterly basis in accordance with estimates of the  
10 number of enrollees in each rate category, subject to annual  
11 reconciliation to final enrollment data.

12 (A) (i) On a quarterly basis, the participating entity shall certify  
13 the expenditures made under this paragraph and submit the report  
14 of certified public expenditures to the department.

15 (ii) The department shall report the certified public expenditures  
16 of a participating entity under this paragraph on the next available  
17 quarterly report as necessary to obtain federal financial  
18 participation for the expenditures. The total amount of federal  
19 financial participation associated with the participating entity's  
20 expenditures under this paragraph shall be reimbursed to the  
21 participating entity.

22 (B) At the option of the participating entity, the LIHP may be  
23 reimbursed on a cost basis in accordance with the methodology  
24 applied to Health Care Coverage Initiative programs established  
25 under Part 3.5 (commencing with Section 15900) including interim  
26 quarterly payments.

27 (e) ~~(f)~~ Notwithstanding Section 15910.3 and subdivision (d)  
28 of this section, if the participating entity cannot reach an agreement  
29 with the department as to the appropriate rate to be paid under  
30 Section 15910.3, at the option of the participating entity, the LIHP  
31 shall be reimbursed on a cost basis in accordance with the  
32 methodology applied to Health Care Coverage Initiative programs  
33 established under Part 3.5 (commencing with Section 15900),  
34 including interim quarterly payments. If the participating entity  
35 and the department reach an agreement as to the appropriate rate,  
36 the rate shall be applied no earlier than the first day of the LIHP  
37 year in which the parties agree to the rate, ~~except that for the LIHP~~  
38 ~~year ending June 30, 2012, the rate may apply as early as July 1,~~  
39 ~~2011, without regard to the date of the agreement between the~~  
40 ~~participating entity and the department~~ *rate*.

- 1     ~~(2) (A) The department finds and declares all of the following:~~  
2     ~~(i) The department, in consultation with a number of the LIHPs,~~  
3     ~~has proposed LIHP capitation rates for federal approval.~~  
4     ~~(ii) There is some concern that federal approval of the proposed~~  
5     ~~rates will not be received, and implementing contracts may not be~~  
6     ~~signed, before June 30, 2012.~~  
7     ~~(iii) The amendments made to this subdivision by the act that~~  
8     ~~added this clause would allow the federally approved capitation~~  
9     ~~rates to apply to the LIHP year, which is July 1, 2011, to June 30,~~  
10    ~~2012, inclusive, even if federal approval and the necessary contract~~  
11    ~~amendments are not finalized until after June 30, 2012.~~  
12    ~~(B) Therefore, it is the intent of the Legislature in amending~~  
13    ~~this subdivision to allow the LIHP capitation rates to apply for the~~  
14    ~~2011-12 fiscal year even if final agreements on the capitation rates~~  
15    ~~are delayed while awaiting federal approval and are not finalized~~  
16    ~~until after June 30, 2012.~~  
17    (f) If authorized under the Special Terms and Conditions of the  
18    demonstration project, pending the department's development of  
19    rates in accordance with Section 15910.3, the department shall  
20    make interim quarterly payments to approved LIHPs for  
21    expenditures based on estimated costs submitted for rate setting.  
22    (g) Participating entities that operate a LIHP directly or through  
23    contract with another entity shall be entitled to any federal financial  
24    participation available for administrative expenditures incurred in  
25    the operation of the Medi-Cal program or the demonstration  
26    project, including, but not limited to, outreach, screening and  
27    enrollment, program development, data collection, reporting and  
28    quality monitoring, and contract administration, but only to the  
29    extent that the expenditures are allowable under federal law and  
30    only to the extent the expenditures are not taken into account in  
31    the determination of the per enrollee rates under Section 15910.3.  
32    (h) On and after January 1, 2014, the state shall implement  
33    comprehensive health care reform for the populations targeted by  
34    the LIHP in compliance with federal health care reform law,  
35    regulation, and policy, including the federal Patient Protection and  
36    Affordable Care Act (Public Law 111-148), as amended by the  
37    federal Health Care and Education Reconciliation Act of 2010  
38    (Public Law 111-152), and subsequent amendments.  
39    (i) Subject to the Special Terms and Conditions of the  
40    demonstration project, a participating entity may elect to include,



1 in collaboration with the department, as the nonfederal share of  
2 LIHP expenditures, voluntary intergovernmental transfers or  
3 certified public expenditures of another governmental entity, as  
4 long as the intergovernmental transfer or certified public  
5 expenditure is consistent with federal law.

6 (j) Participation in the LIHP under this part is voluntary on the  
7 part of the eligible entity for purposes of all applicable federal  
8 laws. As part of its voluntary participation under this article, the  
9 participating entity shall agree to reimburse the state for the  
10 nonfederal share of state staffing and administrative costs directly  
11 attributable to the cost of administering that LIHP, including, but  
12 not limited to, the state administrative costs related to certified  
13 public expenditures and intergovernmental transfers. This section  
14 shall be implemented only to the extent federal financial  
15 participation is not jeopardized.

16 *SEC. 70. (a) The State Department of Health Care Services*  
17 *shall accept contributions by private foundations in the amount*  
18 *of at least fourteen million dollars (\$14,000,000) for the purpose*  
19 *of this section and shall immediately seek an equal amount of*  
20 *federal matching funds.*

21 *(b) Entities and persons that are eligible for Medi-Cal in-person*  
22 *enrollment assistance payments of fifty-eight dollars (\$58) per*  
23 *approved Medi-Cal application and payment processing costs*  
24 *shall be those trained and eligible for in-person enrollment*  
25 *assistance payments by the California Health Benefit Exchange.*  
26 *The payments may be made by the State Department of Health*  
27 *Care Services or through the California Health Benefit Exchange*  
28 *in-person assistance payment system.*

29 *(c) Enrollment assistance payments shall be made only for*  
30 *Medi-Cal applicants newly eligible for coverage pursuant to the*  
31 *federal Patient Protection and Affordable Care Act (Public Law*  
32 *111-148), as amended by the Health Care and Education*  
33 *Reconciliation Act of 2010 (Public Law 111-152), or those who*  
34 *have not been enrolled in the Medi-Cal program during the*  
35 *previous 12 months prior to making the application.*

36 *(d) The commencement of enrollment assistance payments shall*  
37 *be consistent with those of the California Health Benefit Exchange.*

38 *(e) The State Department of Health Care Services or the*  
39 *California Health Benefit Exchange shall provide monthly and*

1 cumulative payment updates and number of persons enrolled  
2 through in-person assistance payments on its Internet Web site.

3 SEC. 71. (a) (1) The State Department of Health Care Services  
4 shall accept funding from private foundations in the amount of at  
5 least \$12.5 million to provide allocations for the management and  
6 funding of Medi-Cal outreach and enrollment plans specific to the  
7 provisions contained in this section.

8 (2) The department shall seek necessary federal approval for  
9 purposes of obtaining federal funding for activities conducted  
10 under this section.

11 (3) Notwithstanding any other law, and in a manner that the  
12 Director of Health Care Services shall provide, the department  
13 may make allocations to fund Medi-Cal outreach and enrollment  
14 activities as described in this section.

15 (b) (1) Funds appropriated by the Legislature to the department  
16 for the purposes of this section shall be made available to selected  
17 counties, counties acting jointly, and the County Medical Services  
18 Program Governing Board pursuant to Section 16809 of the  
19 Welfare and Institutions Code.

20 (2) Selected counties, counties acting jointly, and the County  
21 Medical Services Program Governing Board may partner with  
22 community-based organizations as applicable to conduct outreach  
23 and enrollment to the target population as contained in subdivision  
24 (d).

25 (3) The director may, at his or her discretion, also give  
26 consideration to community-based organizations in an area or  
27 region of the state if a county, or counties acting jointly do not  
28 seek an allocation or funds are made available.

29 (4) For purposes of this section only, "county" shall be defined  
30 as county, city and county, a consortium of counties serving a  
31 region consisting of more than one county, the County Medical  
32 Services Program Governing Board, or a health authority.

33 (c) (1) The allocations shall be apportioned geographically, by  
34 the entities identified in subdivision (b), according to the estimated  
35 number of persons who are eligible but not enrolled in Medi-Cal  
36 and who will be newly Medi-Cal eligible as of January 1, 2014.

37 (2) The department may determine the number of allocations  
38 and the application process. The director may consult or obtain  
39 technical assistance from private foundations in implementation  
40 of the application and allocation process.

1 (3) *The department shall coordinate and partner with the*  
2 *California Health Benefit Exchange on certified application*  
3 *assister and outreach, enrollment, and marketing activities related*  
4 *to the federal Patient Protection and Affordable Care Act.*

5 (d) *Notwithstanding any other law, the department shall develop*  
6 *selection criteria to allocate funds for the Medi-Cal outreach and*  
7 *enrollment activities with special emphasis targeting all of the*  
8 *following populations:*

9 (1) *Persons with mental health disorder needs.*

10 (2) *Persons with substance use disorder needs.*

11 (3) *Persons who are homeless.*

12 (4) *Young men of color.*

13 (5) *Persons who are in county jail, in state prison, on state*  
14 *parole, on county probation, or under postrelease community*  
15 *supervision.*

16 (6) *Families of mixed-immigration status.*

17 (7) *Persons with limited English proficiency.*

18 (e) (1) *The funds allocated under this section shall be used only*  
19 *for the Medi-Cal outreach and enrollment activities and may*  
20 *supplement, but shall not supplant, existing local, state, and*  
21 *foundation funding of county outreach and enrollment activities.*

22 (2) *Notwithstanding Section 10744 of the Welfare and*  
23 *Institutions Code, the department may recoup or withhold all or*  
24 *part of an allocation for failure to comply with any requirements*  
25 *or standards set forth by the department for the purposes of this*  
26 *section.*

27 (f) *The department shall begin the payment for the outreach*  
28 *and enrollment allocation program no later than February 1, 2014.*

29 (g) *Under the terms of the approved allocation for the outreach*  
30 *and enrollment program, funded entities under this section shall*  
31 *not receive payment for in-person assister payments for assisting*  
32 *potential Medi-Cal enrollees.*

33 (h) *The department shall require progress reports, in a manner*  
34 *as determined by the department, from those receiving allocations*  
35 *under this section.*

36 (i) *To the extent federal funding is received for the services*  
37 *specified in this section, reimbursements for costs incurred under*  
38 *the approved allocations shall be made in compliance with federal*  
39 *law.*

1 (j) Notwithstanding Chapter 3.5 (commencing with Section  
2 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
3 the department may implement, interpret, or make specific this  
4 section by means of all-county letters, provider bulletins, or similar  
5 instructions.

6 (k) The department may use a portion of the private foundation  
7 funding pursuant to paragraph (a) to carry out the activities under  
8 this section.

9 SEC. 72. Commencing no later than August 1, 2013, the State  
10 Department of Health Care Services shall convene a series of  
11 stakeholder meetings to receive input from clients, family members,  
12 providers, counties, and representatives of the Legislature  
13 concerning the development of the Behavioral Health Services  
14 Plan, as required by paragraph 25.d of the Special Terms and  
15 Conditions of California's Bridge to Reform Section 1115(a)  
16 Medicaid Demonstration.

17 SEC. 73. Given the uncertainty within which persons diagnosed  
18 with HIV/AIDS from federal Ryan White HIV/AIDS Treatment  
19 Extension Act of 2009 funded programs may transition to Medi-Cal  
20 or other health insurance coverage, the State Department of Public  
21 Health shall report to the Joint Legislative Budget Committee by  
22 October 1, 2013, on whether any of the projections or assumptions  
23 used to develop the AIDS Drug Assistance Program (ADAP)  
24 estimated budget for the Budget Act of 2013 may result in an  
25 inability of ADAP to provide services to ADAP eligible clients. If  
26 the State Department of Public Health determines, before October  
27 1, 2013, that ADAP is unable to provide services to ADAP eligible  
28 clients, the State Department of Public Health shall provide  
29 notification to the Joint Legislative Budget Committee within 15  
30 calendar days of making this determination.

31 SEC. 74. By October 1, 2013, the State Department of Public  
32 Health shall submit to the fiscal and appropriate policy committees  
33 of the Legislature a report describing how it plans to address the  
34 findings and recommendations described in its "Zero-Based  
35 Budgeting Review" report dated May 14, 2013, regarding the  
36 Infant Botulism Treatment and Prevention Program (BabyBIG  
37 program).

38 SEC. 75. As part of the Governor's annual budget release to  
39 the Legislature in January and May, the State Department of  
40 Health Care Services shall identify as a separate policy change

1 *within the Medi-Cal Local Assistance Estimate, the projected*  
2 *General Fund savings attributable to the receipt of enhanced*  
3 *federal funding for Medi-Cal eligibles, subject to the use of*  
4 *Modified Adjusted Gross Income as the basis for their income*  
5 *eligibility, who were previously calculated as being currently*  
6 *eligible and for whom the state received only a 50 percent federal*  
7 *matching assistant payment. The identified savings shall be*  
8 *attributed to the receipt of enhanced federal funding under Title*  
9 *XIX of the federal Social Security Act. The State Department of*  
10 *Health Care Services shall confer with applicable fiscal and policy*  
11 *staff of the Legislature by no later than October 1, 2013, regarding*  
12 *the potential content and attributes of the information provided in*  
13 *this policy change. This separate policy change format shall be*  
14 *provided through 2019–20.*

15 *SEC. 76. Notwithstanding any other law, the balance of Item*  
16 *4150-001-0890 of the Budget Act of 2012 is reappropriated to the*  
17 *Department of Managed Health Care for the purposes of*  
18 *continuing operation of consumer assistance programs to help*  
19 *uninsured individuals obtain health care coverage pursuant to the*  
20 *terms of the federal Consumer Assistance Program Grant. These*  
21 *funds shall be available for encumbrance and expenditure until*  
22 *June 30, 2014.*

23 *SEC. 77. The adoption and readoption of regulations*  
24 *implementing portions of this act by the Managed Risk Medical*  
25 *Insurance Board shall be deemed an emergency and necessary to*  
26 *avoid serious harm to the public peace, health, safety, or general*  
27 *welfare for purposes of Sections 11346.1 and 11349.6 of the*  
28 *Government Code, and the board is hereby exempted from the*  
29 *requirement that it describe facts showing the need for immediate*  
30 *action and from review by the Office of Administrative Law.*

31 *SEC. 78. The Legislature finds and declares that Section 2 of*  
32 *this act, which amends Section 6254 to the Government Code, and*  
33 *Section 68 of this act, which adds Part 3.3 (commencing with*  
34 *Section 15800) to Division 9 of the Welfare and Institution Code,*  
35 *impose a limitation on the public's right of access to the meetings*  
36 *of public bodies or the writings of public officials and agencies*  
37 *within the meaning of Section 3 of Article I of the California*  
38 *Constitution. Pursuant to that constitutional provision, the*  
39 *Legislature makes the following findings to demonstrate the interest*

1 *protected by this limitation and the need for protecting that*  
2 *interest:*

3 *(a) In order to ensure that the State Department of Health Care*  
4 *Services is not constrained in exercising its fiduciary powers and*  
5 *obligations to negotiate on behalf of the public as it implements*  
6 *the provisions of Part 3.3 (commencing with Section 15800) of*  
7 *Division 9 of the Welfare and Institutions Code, the limitations on*  
8 *the public’s right of access imposed by Section 2 of this act are*  
9 *necessary.*

10 *(b) To ensure the continued confidentiality of otherwise*  
11 *privileged or confidential information, the limitations on the*  
12 *public’s right of access imposed by Section 68 of this act are*  
13 *necessary.*

14 *SEC. 79. This act is a bill providing for appropriations related*  
15 *to the Budget Bill within the meaning of subdivision (e) of Section*  
16 *12 of Article IV of the California Constitution, has been identified*  
17 *as related to the budget in the Budget Bill, and shall take effect*  
18 *immediately.*

19 ~~SECTION 1. It is the intent of the Legislature to enact statutory~~  
20 ~~changes relating to the Budget Act of 2013.~~