

AMENDED IN SENATE JUNE 13, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL

No. 1467

Introduced by Committee on Budget (Blumenfield (Chair), Alejo, Bonilla, Brownley, Buchanan, Butler, Cedillo, Chesbro, Dickinson, Feuer, Gordon, Huffman, Mitchell, Monning, and Swanson)

January 10, 2012

An act relating to the Budget Act of 2012. An act to amend Sections 7575, 12803.3, and 15438 of, to add Section 15438.10 to, and to repeal Section 7582 of, the Government Code, to amend Sections 137, 138.4, 138.6, 152, 1324.8, 1324.24, 100950, 104150, 104160, 104162.1, 104163, 104314, 104315, 104322, 110050, 113717, 116064.2, 123865, 123870, 123875, 124300, 125130, 125205, 125215, 130060, 130316, 130317, 131051, and 131052 of, to add Sections 1324.9, 131019.5, and 131055.1 to, to repeal Sections 135, 136, 138, 150, 151, 116064.1, and 125145 of, and to repeal and add Section 113718 of, the Health and Safety Code, and to amend Sections 4362, 4362.5, 4364, 4364.5, 4366, 4367.5, 4368.5, 5820, 5821, 5822, 5830, 5840, 5845, 5846, 5847, 5848, 5878.1, 5878.3, 5890, 5891, 5892, 5897, 5898, 14046.7, 14091.3, 14105.22, 14134, 14134.1, 14154, 14165, 14166.8, 14166.12, 14166.14, 14166.17, 14166.19, 14169.7, 14169.7.5, 14169.13, 14169.31, 14169.32, 14169.33, 14169.34, 14169.36, 14169.38, 14171, 14182.4, 14182.45, 14183.6, 14204, 14301.1, 14500.5, 15911, 15916, 24000, and 24001 of, to amend and repeal Sections 14085.6, 14085.7, 14085.8, 14085.81, and 14085.9 of, to add Sections 4024.7, 5899, 14089.08, 14089.09, 14166.151, 14166.152, 14166.153, 14166.154, 14166.155, 14459.6, 14459.8, 15911.1, and 15912.1 to, to add Article 2.82 (commencing with Section 14087.98) to Chapter 7 of Part 3 of Division 9 of, and to add and repeal Section 14105.196 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 1467, as amended, Committee on Budget. ~~Budget Act of 2012.~~
Health.

(1) Under existing law, the Robert W. Crown California Children's Services Act, the State Department of Health Care Services and each county administer the California Children's Services Program (CCS program) for treatment services for persons under 21 years of age diagnosed with severe chronic disease or severe physical limitations, as specified. Existing law generally limits eligibility for CCS program services to persons in families with an annual adjusted gross income of \$40,000 or less. Under existing law, the department, or any designated local agency administering the program, is responsible for providing medically necessary occupational and physical therapy, to eligible children, as specified.

Existing law requires school districts, county offices of education, and special education local plan areas to comply with state laws that conform to the federal Individuals with Disabilities Education Act (IDEA), in order that the state may qualify for federal funds available for the education of individuals with exceptional needs. Existing law requires school districts, county offices of education, and special education local plan areas to identify, locate, and assess individuals with exceptional needs and to provide those pupils with a free appropriate public education in the least restrictive environment, and with special education and related services as reflected in an individualized education program (IEP). Existing law requires the Superintendent of Public Instruction to administer the special education provisions of the Education Code and to be responsible for assuring provision of, and supervising, education and related services to individuals with exceptional needs as required pursuant to the federal IDEA.

This bill would require, when a child has an IEP, that all occupational and physical therapy services assessed and determined to be educationally necessary by the IEP team and included in the IEP shall be provided in accordance with the federal IDEA, and not paid for by the CCS program. The bill would require the parents or estate of a child with an IEP to disclose that IEP to the CCS program at the time

of application and on revision of the child's IEP. This bill would make conforming changes to procedures applicable to the CCS program's medical therapy unit conference team, when determining a child's eligibility for those therapy services.

Existing law requires that specified assessments and therapy treatment services rendered to a child referred to a local education agency for an assessment or a disabled child or youth with an IEP be exempt from financial eligibility standards and family repayment requirements.

This bill would delete these provisions.

The bill would require the State Department of Education to review regulations to ensure the appropriate implementation of educationally necessary occupational and physical therapy services required by specified provisions of federal law and specified provisions of the bill. The bill would require that specified provisions of the bill be implemented no later than October 1, 2012, and would require the State Department of Health Care Services to report, as provided, specified data relating to the implementation of the bill's provisions.

(2) Existing law transfers the Systems Integration Division of the California Health and Human Services Data Center to the California Health and Human Services Agency and provides that it shall be known as the Office of Systems Integration. Existing law prohibits the California Health and Human Services Agency from placing or transferring information technology projects in the office without further legislation authorizing these activities.

This bill would delete this prohibition.

(3) The California Health Facilities Financing Authority Act authorizes the California Health Facilities Financing Authority to make loans from the continuously appropriated California Health Facilities Financing Authority Fund to participating health institutions for financing or refinancing the acquisition, construction, or remodeling of health facilities. The act defines a health facility to include various specified facilities and facilities operated in conjunction with these facilities. It also defines a participating health institution to mean specified entities authorized by state law to provide or operate a health facility and undertake the financing or refinancing of the construction or acquisition of a project or of working capital, as defined. Existing law authorizes the authority to award grants to any eligible health facility, as defined, for purposes of financing defined projects.

This bill would authorize the authority to award one or more grants that, in the aggregate, do not exceed \$1,500,000 to one or more projects

designed to demonstrate new or enhanced cost-effective methods of delivering health care services, as specified. This bill would authorize the authority to implement a 2nd grant program to award up to \$5,000,000 to eligible recipients, if a demonstration project is successful at developing a new method of delivering certain services. This bill would create the California Health Access Model Program Account in the California Health Facilities Financing Authority Fund, and would transfer up to \$6,500,000 from the fund to the account for the purposes of the bill. The bill would require that any moneys remaining in the account as of January 1, 2020, revert to the fund. By expanding the purposes for which a continuously appropriated fund may be used, this bill would make an appropriation.

(4) Existing law establishes the Office of Women’s Health within the State Department of Health Care Services. Existing law requires the California Health and Human Services Agency to establish an interagency task force on women’s health, as specified. Existing law establishes the Office of Multicultural Health within the State Department of Public Health.

This bill would repeal these provisions and other related provisions and instead establish the Office of Health Equity within the State Department of Public Health. The bill would require the office to perform various duties relating to reducing health and mental health disparities in vulnerable communities, as defined. The bill would require that a deputy director be appointed, as specified, and that an advisory committee be established within the office no later than October 1, 2013. The bill would require that an interagency agreement be established between the State Department of Public Health and the State Department of Health Care Services to outline the process by which the departments will jointly work to advance the mission of the office, including responsibilities, scope of work, and necessary resources. This bill would make conforming and related 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. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law requires that, as a condition of participation in the Medi-Cal program, there be imposed a quality assurance fee on certain intermediate care facilities. Existing law requires that the fees be deposited into the General Fund and allocated to intermediate care facilities to support their quality improvement

efforts, and distributed to each facility based on the number of Medi-Cal patients at the eligible facility. Existing law requires the department to impose a uniform quality assurance fee on each skilled nursing facility, with certain exceptions, in accordance with a prescribed formula and requires that the fees be deposited in the State Treasury. Existing law, the Medi-Cal Long-Term Care Reimbursement Act, requires the department to implement a facility-specific reimbursement ratesetting system for certain skilled nursing facilities. Reimbursement rates for freestanding skilled nursing facilities are funded by a combination of federal funds and moneys collected pursuant to the skilled nursing uniform quality assurance fee.

This bill would instead, beginning August 1, 2013, require the quality assurance fees imposed pursuant to these provisions be deposited into the Long-Term Care Quality Assurance Fund which would be created by this bill.

(6) The State Department of Public Health is required to perform various public health functions, including providing breast and cervical cancer screening and treatment for low-income individuals, providing prostate cancer screening and treatment for low-income and uninsured men, and specified family planning services.

This bill would, commencing July 1, 2012, or the date the Budget Act of 2012 becomes effective, whichever is later, transfer the duties referenced above to the State Department of Health Care Services.

(7) Existing law, the Sherman Food, Drug, and Cosmetic Law (Sherman Law), requires the department to regulate activities related to food, drugs, devices, and cosmetics and establishes the Food Safety Fund for the deposit of money collected by the department under specified Sherman Law provisions. Money in the Food Safety Fund is available to the department, upon appropriation by the Legislature, to implement specified Sherman Law provisions. The existing California Retail Food Code regulates the health and sanitation standards for retail food facilities and establishes the Retail Food Safety and Defense Fund. Money collected by the department under specified California Retail Food Code provisions is deposited in the fund and used by the department, upon appropriation by the Legislature, to implement the California Retail Food Code.

This bill would eliminate the Retail Food Safety and Defense Fund and require all money deposited into the fund to be transferred to the Food Safety Fund. This bill would expand the purpose of the Food

Safety Fund to include carrying out the provisions of the California Retail Food Code.

(8) Existing law requires public swimming pools to be equipped with antientrapment devices or systems that meet ASME/ANSI or ASTM performance standards. Existing law permits the State Department of Public Health to assess an annual fee on public swimming pool owners, collected by the local health department, and deposited into the Recreational Health Fund along with other money collected by the department through enforcement of these provisions. Money in the fund is available to the department, upon appropriation by the Legislature, for the purpose of promoting these public swimming pool provisions.

This bill would instead require public swimming pools to be equipped with antientrapment devices or systems that comply with ANSI/APSP standard 16 and make related changes. This bill would eliminate the Recreational Health Fund and the department's authority to administer or enforce specified public swimming pool provisions.

(9) Existing law requires, after January 1, 2008, that any general acute care hospital building that is determined to be a potential risk of collapse or pose significant loss of life only be used for nonacute care hospital purposes, unless granted an extension as prescribed.

Existing law authorizes, commencing on the date when the State Department of Health Care Services receives specified federal approval for a 2011–12 fiscal year hospital quality assurance fee program that meets a specified condition, the Office of Statewide Health Planning and Development to grant a hospital an additional extension of up to 7 years for a hospital building that it owns or operates if the hospital meets specified milestones. These milestones include a March 31, 2012, deadline for submitting to the office a specified letter of intent and schedule.

This bill would extend until September 30, 2012, the deadline for the above-described milestones for submitting a letter of intent and a schedule.

(10) Existing law requires the Director of Health Care Services to appoint an Advisory Committee on Genetically Handicapped Person's Program. Existing law requires the director to seek advice from the committee when adopting regulations under the Genetically Handicapped Person's Program that would expand the list of genetically handicapping conditions covered by the program and requires approval from the committee when prioritizing funds and services.

This bill would delete the provisions that establish the Advisory Committee on Genetically Handicapped Person's Program. This bill would delete the provisions that authorize the director to expand the list of genetically handicapping conditions covered by the program and that require the director to establish priorities for the use of funds and services. This bill would make conforming changes.

(11) Existing law, the Health Insurance Portability and Accountability Implementation Act of 2001, requires the Office of HIPAA Implementation, established by the Governor's office within the agency, to perform specified activities required for compliance with the federal Health Insurance Portability and Accountability Act. Under existing law, the act will become inoperative and be repealed on January 1, 2013, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date, and all unexpended or unencumbered funds under that act will revert to the General Fund on January 1, 2013.

The bill would extend the act's duration to June 30, 2016, when it would be inoperative and repealed, and all funds under the act that are unexpended or unencumbered as of that date would revert to the General Fund.

(12) Under existing law, the State Department of Mental Health is authorized and required to perform various functions relating to the care and treatment of persons with mental disorders. Existing law requires the Director of Mental Health, with the advice of the Statewide Resources Consultant, as described, to contract with nonprofit community resource agencies to establish regionally based resource centers to provide services for brain-impaired adults.

This bill would transfer the Director of Mental Health's responsibilities with respect to these resource centers to the Director of Health Care Services.

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

This bill would authorize the commission to assist in providing technical assistance, as specified, and would authorize the commission to work in collaboration with, and in consultation with, various entities in designing a comprehensive joint plan for coordinated evaluation of client outcomes. This bill would require the California Health and Human Services Agency to lead the comprehensive joint plan effort. This bill would transfer various functions of the State Department of Mental Health under the Mental Health Services Act to the State Department of Health Care Services and the Office of Statewide Health Planning and Development. This bill would make various technical and conforming changes to reflect the transfer of those mental health responsibilities. This bill would require all projects included in the innovative programs portion of the county plan to meet specified requirements.

Existing law requires each county mental health program to prepare and submit a 3-year plan that includes specified components.

This bill, in this regard, would require the plan to be a 3-year program and expenditure plan adopted by the county board of supervisors and submitted to the commission, would require annual updates, and would require plans to be certified by the county mental health director and the county auditor-controller, as specified. This bill would require the State Department of Health Care Services to inform the California Mental Health Directors Association and the commission of the methodology used for revenue allocation to the counties. This bill would require the State Department of Health Care Services, in consultation with the commission and the California Mental Health Directors Association, to develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report, as prescribed.

This bill would declare that it clarifies procedures and terms of the Mental Health Services Act.

This bill would require the Governor or the Director of Health Care Services to appoint, subject to confirmation by the Senate, a Deputy Director of Mental Health and Substance Use Disorder Services of the State Department of Health Care Services.

(14) Existing law requires the State Department of Health Care Services to establish and administer, until July 1, 2021, the Medi-Cal Electronic Health Records Incentive Program, for the purposes of providing federal incentive payments to Medi-Cal providers for the

implementation and use of electronic records systems. Existing law prohibits General Fund moneys from being used for this purpose.

This bill would instead provide that no more than \$200,000 from the General Fund may be used annually for state administrative costs associated with implementing these provisions.

(15) Existing law establishes the Emergency Services and Supplemental Payments Fund, the Medi-Cal Education Supplemental Payment Fund, the Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund, and the Small and Rural Hospital Supplemental Payments Fund administered by the department from which the department is required to make supplemental payments to certain hospitals based on specified criteria.

This bill would provide that these provisions shall become inoperative on June 30, 2013, and shall be repealed on January 1, 2014.

(16) Existing law authorizes the department to provide health care services to Medi-Cal beneficiaries through various models of managed care, including though a comprehensive program of managed health care plan services for Medi-Cal recipients residing in clearly defined geographical areas. Existing law provides for a schedule of benefits under the Medi-Cal program, which, with some exceptions, includes certain dental services.

This bill would authorize the Director of Health Care Services to enter into contracts with one or more managed health care plans to provide a comprehensive program of managed health care services to Medi-Cal beneficiaries residing in specified counties. This bill would also make enrollment in Medi-Cal managed health care plans mandatory for beneficiaries residing in these counties.

This bill would require the department to establish a list of performance measures to ensure dental health plans meet quality criteria required by the department to be included in dental health contracts entered into between the department and a dental health plan. This bill would require the department to designate an external quality review organization to conduct quality reviews for any dental health plan contracting with the department, as specified. This bill would require the Director of Health Care Services to establish a beneficiary dental exception (BDE) process for Medi-Cal beneficiaries mandatorily enrolled in dental health plans in the County of Sacramento, and would require the department to amend contracts with dental health plans

that provide dental services to Medi-Cal beneficiaries who reside in a specified geographic area to meet these additional requirements.

This bill would require the department, by no later than March 15, 2013, and annually thereafter, to provide designated committees of the Legislature a report on dental managed care in the Counties of Sacramento and Los Angeles, and, for reports on the County of Sacramento, data outcomes and findings from the BDE process. This bill would require the Department of Managed Health Care, by no later than January 1, 2013, to provide designated committees of the Legislature with its final report on specified surveys for the dental health plans participating in the Sacramento Geographic Managed Care Program. This bill would authorize the County of Sacramento to establish a stakeholder advisory committee on the delivery of oral health and dental care services, and would require the State Department of Health Care Services to meet periodically with the committee, as specified.

This bill would also require the department to perform specified functions in connection with the Medi-Cal managed care plan default assignment algorithm.

Existing law requires the department to enter into an interagency agreement with the Department of Managed Health Care to conduct financial audits, medical surveys, and a review of the provider networks of the managed care plans participating in a certain demonstration project.

This bill would additionally require the department to enter into the interagency agreement with the Department of Managed Health Care to conduct financial audits, medical surveys, and a review of the provider networks in connection with the expansion of Medi-Cal managed care into rural counties, and to provide consumer assistance to beneficiaries affected by certain provisions.

This bill would make legislative findings and declarations as to the necessity of a special statute for specified counties.

(17) Existing law requires, until January 1, 2013, a hospital that does not have in effect a contract with a Medi-Cal managed care health plan, as defined, that establishes payment amounts for services furnished to a beneficiary enrolled in that plan to accept as payment in full, from all Medi-Cal managed care plans, specified amounts for outpatient services, emergency inpatient services, and poststabilization services following an emergency admission.

This bill would modify the payment amount a hospital subject to these provisions is required to accept as payment in full from Medi-Cal managed care health plans for emergency inpatient services, and would provide that the payment amounts for both emergency inpatient services and poststabilization services related to an emergency medical condition shall remain in effect only until the department implements a specified payment methodology based on diagnosis-related groups, at which time, the hospital shall accept the payment amount established by that methodology for those services. This bill would extend the operative date of these provisions to July 1, 2013, and would make related changes.

(18) Existing federal law requires the state to provide payment for primary care services furnished in the 2013 and 2014 calendar years by Medi-Cal providers with specified primary specialty designations at a rate not less than 100% of the payment rate that applies to those services and physicians under the Medicare Program.

This bill would, only to the extent that the federal medical assistance percentage is equal to 100% and only until January 1, 2015, implement this requirement for both Medi-Cal fee-for-service and managed care plans.

(19) Existing law provides that reimbursement for clinical laboratory or laboratory services under the Medi-Cal program, as defined, may not exceed 80% of the lowest maximum allowance established by the federal Medicare Program for the same or similar services.

This bill would, upon federal approval, change the rate methodology for clinical laboratory or laboratory services, as specified. This bill would also require that rates for clinical laboratory or laboratory services be reduced by 10% until federal approval is obtained for this new rate methodology.

(20) Existing law requires Medi-Cal beneficiaries to make set copayments for specified services. Existing law, subject to federal approval, revises these copayment rates, expands the services for which copayments are due, and requires the department to reduce the amount of the payment to the provider by the amount of the copayment. Existing law provides, upon federal approval and with certain exceptions, that a provider has no obligation to provide services to a beneficiary who does not pay the copayment at the point of service.

This bill would modify these provisions as they relate to emergency and nonemergency services.

(21) Existing law provides that it is the intent of the Legislature to provide appropriate funding to the counties for the effective administration of the Medi-Cal program, except for specified fiscal years in regard to any cost-of-doing-business adjustment.

This bill would additionally provide that it is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2012–13 fiscal year.

(22) Existing law establishes the continuously appropriated Private Hospital Supplemental Fund and the continuously appropriated Nondesignated Public Hospital Supplemental Fund administered by the California Medical Assistance Commission for the purposes of funding the nonfederal share of specified payments to private and nondesignated hospitals. Existing law also provides for stabilization funding for certain hospitals through October 31, 2010, and requires specified amounts of that funding to be transferred to the Private Hospital Supplemental Fund and the Nondesignated Public Hospital Supplemental Fund. Existing law requires that the California Medical Assistance Commission be dissolved after June 30, 2012, and requires the department to develop a staff transition plan, as specified, that will be included in the 2012–13 Governor’s budget. Existing law requires that, upon dissolution of the commission, all powers, duties, and responsibilities of the commission be transferred to the Director of Health Care Services. Existing law provides that upon a determination by the director that a payment system based on diagnosis-related groups, as described, has been developed and implemented, the powers, duties, and responsibilities conferred on the commission and transferred to the director shall no longer be exercised.

This bill, instead, would provide that the powers, duties, and responsibilities conferred on the commission and transferred to the director shall no longer be exercised upon the director’s determination, except for those relating to specified stabilization payments and the ability to negotiate and make payments from the Private Hospital Supplemental Fund and the Nondesignated Public Hospital Supplemental Fund. This bill would also modify the criteria a hospital would have to meet to receive distributions from these funds. This bill would also require, notwithstanding any other law, that stabilization funding payable to nondesignated public hospitals and to project year private DSH hospitals that has not been paid or specifically committed for payment prior to January 1, 2012, be transferred to the General Fund, except as specified, and that funds that would otherwise be drawn

from the General Fund for stabilization payments to these hospitals be retained in the General Fund. This bill would delete the requirement that the department develop a staff transition plan and, instead, would implement the transition of staff positions serving the commission to the department. This bill would provide that after the diagnosis-related groups payment system is implemented, the transferred employees will transfer to civil service classifications within the department, as specified.

(23) Existing law establishes the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, which revises hospital supplemental payment methodologies under the Medi-Cal program in order to maximize the use of federal funds consistent with federal Medicaid law and to stabilize the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients. Existing law requires the department to seek a successor 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. Existing law provides that to the extent the provisions under the Medi-Cal Hospital/Uninsured Care Demonstration Project Act do not conflict with the provisions of, or the Special Terms and Conditions of, this demonstration project, the provisions of the Medi-Cal Hospital/Uninsured Care Demonstration Project Act shall apply. Existing law establishes the continuously appropriated Health Care Support Fund, which consists of federal safety net care pool funds claimed and received by the department under the demonstration project and the successor demonstration project. Existing law also establishes the continuously appropriated Public Hospital Investment, Improvement, and Incentive Fund, which consists of moneys that a county, other political subdivision of the state, or other governmental entity in the state elects to transfer to the department for use as the nonfederal share of investment, improvement, and incentive payments to participating designated hospitals and the governmental entities with which they are affiliated.

This bill would, subject to federal approval, modify the inpatient fee-for-service reimbursement methodology for nondesignated hospitals under the successor demonstration project. This bill would, among other things, provide that beginning with the 2012–13 fiscal year, and if specified conditions are met, nondesignated public hospitals, or governmental entities with which they are affiliated, shall be eligible to receive safety net care pool payments for uncompensated care from

the Health Care Support Fund. By revising the purposes for which moneys in the Health Care Support Fund may be expended, this bill would make an appropriation. This bill would also provide that beginning with the 2012–13 fiscal year, subject to federal approval and if specified conditions are met, nondesignated public hospitals may receive delivery system reform incentive pool funding, as specified. This bill would make related changes to the Public Hospital Investment, Improvement, and Incentive Fund provisions. By revising the purposes for which moneys in the Public Hospital Investment, Improvement, and Incentive Fund may be used, this bill would make an appropriation. This bill would also require designated public hospitals to report and certify specified information for each successor demonstration year beginning with the 2012–13 fiscal year.

(24) Existing law, subject to federal approval, imposes a quality assurance fee, as specified, on certain general acute care hospitals for the period of July 1, 2011, through December 31, 2013. Existing law creates the Hospital Quality Assurance Revenue Fund in the State Treasury and requires that the money collected from the quality assurance fee be deposited into the fund. Existing law, subject to federal approval, provides that the moneys in the Hospital Quality Assurance Revenue Fund shall, upon appropriation by the Legislature, be available only for certain purposes, including, among other things, paying for health care coverage for children, as specified, making supplemental payments to private hospitals, and making direct grants in support of health care expenditures to designated and nondesignated public hospitals.

This bill would revise the definition of “federal approval” for the purposes of those provisions and would make conforming changes. This bill would increase the amount previously allocated for health care coverage for children for each subject fiscal quarter during the 2012–13 and 2013–14 fiscal years, and would, for the 2013–14 fiscal year, additionally require that the amount of \$21,500,000 previously allocated for grants to designated public hospitals be retained by the state to pay for health care coverage of children, as specified.

(25) Existing law requires the department to audit the amounts paid for services provided to Medi-Cal beneficiaries. Existing law requires the Director of Health Care Services to establish administrative appeal processes to review complaints arising from the findings of an audit. Existing law provides that a specified interest rate shall be assessed on amounts when a provider prevails in an appeal of a disallowed payment

that was paid and recovered by the department or when an unrecovered overpayment is due to the department, and in other circumstances.

This bill would modify the applicable interest rate.

(26) Existing law requires the department, pursuant to federal approval of a successor demonstration project, to authorize a local Low Income Health Program (LIHP) to provide health care services to eligible low-income individuals under certain circumstances.

This bill would modify the provisions relating to the application of rates agreed to between the department and the participating entities with respect to the LIHP year ending June 30, 2012.

(27) Existing law authorizes counties meeting certain criteria to elect to participate in the County Medical Services Program (CMSP), for the purpose of providing specified health services to eligible county residents. Counties that elect to participate in the program may establish a CMSP governing board, responsible for the oversight of the participating counties. Existing law permits a CMSP governing board to apply to operate a local LIHP for the purpose of providing health care services, as specified.

This bill would authorize the Director of Finance to require the Controller to draw warrants against General Fund cash to provide cashflow loans of no more than a total of \$100,000,000 in the 2012–13 and 2013–14 fiscal years for CMSP governing board expenses that are associated with a Low Income Health Program operated by the governing board, thereby making an appropriation.

(28) Existing law establishes the Office of AIDS in the State Department of Public Health as the lead agency responsible for coordinating state programs, services, and activities relating to the human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS-related conditions (ARC). Existing federal law, under the federal Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White Act), makes financial assistance available to states and other public and nonprofit entities to provide for the delivery of services to families with HIV.

This bill would require the State Department of Health Care Services, in collaboration with the State Department of Public Health, and in consultation with stakeholders, to develop policies and guidance on the transition of persons diagnosed with HIV/AIDS from programs funded under the federal Ryan White Act to the Low Income Health Program.

(29) Existing law provides for the Health Care Coverage Initiative (HCCI), which is a federal waiver demonstration project established

to expand health care coverage to low-income uninsured individuals who are not currently eligible for the Medi-Cal program, the Healthy Families Program, or the Access for Infants and Mothers Program. Existing law requires the department to annually seek authority from the federal Centers for Medicare and Medicaid Services under the Special Terms and Conditions of the successor demonstration project to redirect HCCI funds within the safety net care pool, as defined, that are not fully utilized by the end of a demonstration year, as defined, to the category of uncompensated care to be used by designated public hospitals, on a voluntary basis, for allowable certified public expenditures, as specified.

This bill would modify the conditions under which designated public hospitals may utilize the redirected safety net care pool funds and would modify the provisions relating to disallowances or deferrals that relate to certified public expenditures for uncompensated care incurred by the designated public hospitals under these provisions.

(30) This bill would incorporate additional changes in Section 123870 of the Health and Safety Code proposed in AB 1494 and SB 1034, that would become operative only if either AB 1494 or SB 1034 and this bill are both chaptered and become effective on or before January 1, 2013, and this bill is chaptered last.

(31) 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 2012.~~

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 7575 of the Government Code is amended
 2 to read:
 3 7575. (a) ~~(1)~~ Notwithstanding any other provision of law, the
 4 State Department of Health Services, or any designated local
 5 agency administering the California Children’s Services, shall be
 6 responsible for the provision of medically necessary occupational
 7 therapy and physical therapy, as specified by Article 5
 8 (commencing with Section 123800) of Chapter 3 of Part 2 of
 9 Division 106 of the Health and Safety Code, by reason of medical
 10 diagnosis and when contained in the child’s individualized

1 ~~education program~~ *all services assessed and determined as*
2 *educationally necessary by the individualized education program*
3 *(IEP) team contained in the child's IEP or individualized education*
4 *plan shall be provided in accordance with the federal Individuals*
5 *with Disabilities Education Act (IDEA; 20 U.S.C. Sec. 1400 et*
6 *seq.).*

7 ~~(2) Related services or designated instruction and services not~~
8 ~~deemed to be medically necessary by the State Department of~~
9 ~~Health Services, that the individualized education program team~~
10 ~~determines are necessary in order to assist a child to benefit from~~
11 ~~special education, shall be provided by the local education agency~~
12 ~~by qualified personnel whose employment standards are covered~~
13 ~~by the Education Code and implementing regulations.~~

14 (b) ~~The department shall determine whether a California~~
15 ~~Children's Services eligible pupil, or a pupil with a private medical~~
16 ~~referral~~ *If a child applies to the California Children's Services*
17 *Program pursuant to Section 123865 or 123875 of the Health and*
18 *Safety Code, the State Department of Health Care Services shall*
19 *determine whether the child needs medically necessary*
20 *occupational therapy or physical therapy. A medical referral to the*
21 *California Children's Services Program shall be based on a written*
22 *report from a licensed physician and surgeon who has examined*
23 *the pupil. The written report shall include the following:*

24 (1) *The diagnosed neuromuscular, musculoskeletal, or physical*
25 *disabling condition prompting the referral.*

26 (2) *The referring physician's treatment goals and objectives.*

27 (3) *The basis for determining the recommended treatment goals*
28 *and objectives, including how these will ameliorate or improve*
29 *the pupil's diagnosed condition.*

30 (4) *The relationship of the medical disability to the pupil's need*
31 *for special education and related services.*

32 (5) *Relevant medical records.*

33 (c) *If the child has an IEP pursuant to the federal IDEA, the*
34 *parents or the estate of the child shall disclose that IEP to the*
35 *California Children's Services Program at the time of application*
36 *and on revision of the child's IEP.*

37 ~~(e)~~

38 (d) *The department shall provide the service directly or by*
39 *contracting with another public agency, qualified individual, or a*
40 *state-certified nonpublic nonsectarian school or agency.*

1 ~~(d)~~
 2 (e) Local education agencies shall provide necessary space and
 3 equipment for the provision of occupational therapy and physical
 4 therapy in the most efficient and effective manner.

5 ~~(e)~~
 6 (f) The department shall also be responsible for providing the
 7 services of a home health aide when the local education agency
 8 considers a less restrictive placement from home to school for a
 9 pupil for whom both of the following conditions exist:

10 (1) The California Medical Assistance Program provides a
 11 life-supporting medical service via a home health agency during
 12 the time in which the pupil would be in school or traveling between
 13 school and home.

14 (2) The medical service provided requires that the pupil receive
 15 the personal assistance or attention of a nurse, home health aide,
 16 parent or guardian, or some other specially trained adult in order
 17 to be effectively delivered.

18 *SEC. 2. Section 7582 of the Government Code is repealed.*
 19 ~~7582. Assessments and therapy treatment services provided~~
 20 ~~under programs of the State Department of Health Care Services,~~
 21 ~~or its designated local agencies, rendered to a child referred by a~~
 22 ~~local education agency for an assessment or a disabled child or~~
 23 ~~youth with an individualized education program, shall be exempt~~
 24 ~~from financial eligibility standards and family repayment~~
 25 ~~requirements for these services when rendered pursuant to this~~
 26 ~~chapter.~~

27 *SEC. 3. Section 12803.3 of the Government Code is amended*
 28 *to read:*

29 12803.3. (a) For purposes of this section, the following
 30 definitions shall apply:

31 (1) “Director” means the Director of the Office of Systems
 32 Integration.

33 (2) “Office” means the Office of Systems Integration.

34 (3) “Services” means all functions, responsibilities, and services
 35 deemed to be functions, responsibilities, and services of the
 36 Systems Integration Division, also known as Systems Management
 37 Services, of the California Health and Human Services Agency
 38 Data Center, as determined by the Secretary of California Health
 39 and Human Services.

1 (b) (1) The Systems Integration Division of the California
2 Health and Human Services Agency Data Center is hereby
3 transferred to the California Health and Human Services Agency
4 and shall be known as the Office of Systems Integration. The Office
5 of Systems Integration shall be the successor to, and is vested with,
6 all of the duties, powers, purposes, responsibilities, and jurisdiction
7 of the Systems Integration Division of the California Health and
8 Human Services Agency Data Center.

9 (2) Notwithstanding any other law, all services of the Systems
10 Integration Division of the California Health and Human Services
11 Agency Data Center shall become the services of the Office of
12 Systems Integration.

13 (c) The office shall be under the supervision of a director, known
14 as the Director of the Office of Systems Integration, who shall be
15 appointed by, and serve at the pleasure of, the Secretary of
16 California Health and Human Services.

17 (d) No contract, lease, license, or any other agreement to which
18 the California Health and Human Services Data Center is a party
19 on the date of the transfer as described in paragraph (1) of
20 subdivision (b) shall be void or voidable by reason of this section,
21 but shall continue in full force and effect. The office shall assume
22 from the California Health and Human Services Data Center all
23 of the rights, obligations, and duties of the Systems Integration
24 Division. This assumption of rights, obligations, and duties shall
25 not affect the rights of the parties to the contract, lease, license, or
26 agreement.

27 (e) All books, documents, records, and property of the Systems
28 Integration Division shall be in the possession and under the control
29 of the office.

30 (f) All officers and employees of the Systems Integration
31 Division shall be designated as officers and employees of the
32 agency. The status, position, and rights of any officer or employee
33 shall not be affected by this designation and all officers and
34 employees shall be retained by the agency pursuant to the
35 applicable provisions of the State Civil Service Act (Part 2
36 commencing with Section 18500) of Division 5), except as to any
37 position that is exempt from civil service.

38 (g) (1) All contracts, leases, licenses, or any other agreements
39 to which the California Health and Human Services Data Center
40 is a party regarding any of the following are hereby assigned from

1 the California Health and Human Services Data Center to the
2 office:

3 (A) Statewide Automated Welfare System (SAWS).

4 (B) Child Welfare Services/Case Management System
5 (CWS/CMS).

6 (C) Electronic Benefit Transfer (EBT).

7 (D) Statewide Fingerprinting Imaging System (SFIS).

8 (E) Case Management Information Payrolling System (CMIPS).

9 (F) Employment Development Department Unemployment
10 Insurance Modernization (UIMOD) Project.

11 (2) All other contracts, leases, or agreements necessary or related
12 to the operation of the Systems Integration Division of the
13 California Health and Human Services Data Center are hereby
14 assigned from the California Health and Human Services Data
15 Center to the office.

16 (h) It is the intent of the Legislature that the transfer of the
17 Systems Integration Division of the California Health and Human
18 Services Agency Data Center pursuant to this section shall be
19 retroactive to the passage and enactment of the Budget Act of 2005
20 and that existing employees of the Systems Integration Division
21 of the California Health and Human Services Agency Data Center
22 and the newly established Office of Systems Integration shall not
23 be negatively impacted by the reorganization and transfer
24 conducted pursuant to this section.

25 (i) It is the intent of the Legislature to review fully implemented
26 information technology projects managed by the office to assess
27 the viability of placing the management responsibility for those
28 projects in the respective program department.

29 (j) On or before April 1, 2006, the Department of Finance shall
30 report to the Chairperson of the Joint Legislative Budget
31 Committee the date that the administration shall conduct an
32 assessment for each of the projects managed by the office. The
33 California Health and Human Services Agency, the California
34 Health and Human Services Agency Data Center, or its successor,
35 the State Department of Social Services, and the office shall
36 provide to the Department of Finance all information and analysis
37 the Department of Finance deems necessary to conduct the
38 assessment required by this section. Each assessment shall consider
39 the costs, benefits, and any associated risks of maintaining the
40 project management responsibility in the office and of moving the

1 project management responsibility to its respective program
2 department.

3 ~~(k) The California Health and Human Services Agency shall~~
4 ~~not place or transfer information technology projects in the office,~~
5 ~~without further legislation authorizing these activities.~~

6 *SEC. 4. Section 15438 of the Government Code is amended to*
7 *read:*

8 15438. The authority may do any of the following:

9 (a) Adopt bylaws for the regulation of its affairs and the conduct
10 of its business.

11 (b) Adopt an official seal.

12 (c) Sue and be sued in its own name.

13 (d) Receive and accept from any agency of the United States,
14 any agency of the state, or any municipality, county, or other
15 political subdivision thereof, or from any individual, association,
16 or corporation gifts, grants, or donations of moneys for achieving
17 any of the purposes of this chapter.

18 (e) Engage the services of private consultants to render
19 professional and technical assistance and advice in carrying out
20 the purposes of this part.

21 (f) Determine the location and character of any project to be
22 financed under this part, and to acquire, construct, enlarge, remodel,
23 renovate, alter, improve, furnish, equip, fund, finance, own,
24 maintain, manage, repair, operate, lease as lessee or lessor, and
25 regulate the same, to enter into contracts for any or all of those
26 purposes, to enter into contracts for the management and operation
27 of a project or other health facilities owned by the authority, and
28 to designate a participating health institution as its agent to
29 determine the location and character of a project undertaken by
30 that participating health institution under this chapter and as the
31 agent of the authority, to acquire, construct, enlarge, remodel,
32 renovate, alter, improve, furnish, equip, own, maintain, manage,
33 repair, operate, lease as lessee or lessor, and regulate the same,
34 and as the agent of the authority, to enter into contracts for any or
35 all of those purposes, including contracts for the management and
36 operation of that project or other health facilities owned by the
37 authority.

38 (g) Acquire, directly or by and through a participating health
39 institution as its agent, by purchase solely from funds provided
40 under the authority of this part, or by gift or devise, and to sell, by

1 installment sale or otherwise, any lands, structures, real or personal
2 property, rights, rights-of-way, franchises, easements, and other
3 interests in lands, including lands lying under water and riparian
4 rights, that are located within the state that the authority determines
5 necessary or convenient for the acquisition, construction, or
6 financing of a health facility or the acquisition, construction,
7 financing, or operation of a project, upon the terms and at the prices
8 considered by the authority to be reasonable and that can be agreed
9 upon between the authority and the owner thereof, and to take title
10 thereto in the name of the authority or in the name of a participating
11 health institution as its agent.

12 (h) Receive and accept from any source loans, contributions,
13 or grants for, or in aid of, the construction, financing, or refinancing
14 of a project or any portion of a project in money, property, labor,
15 or other things of value.

16 (i) Make secured or unsecured loans to, or purchase secured or
17 unsecured loans of, any participating health institution in
18 connection with the financing of a project or working capital in
19 accordance with an agreement between the authority and the
20 participating health institution. However, no loan to finance a
21 project shall exceed the total cost of the project, as determined by
22 the participating health institution and approved by the authority.
23 Funds for secured loans may be provided from the California
24 Health Facilities Financing *Authority* Fund pursuant to subdivision
25 (b) of Section 15439 to small or rural health facilities pursuant to
26 authority guidelines.

27 (j) (1) Make secured or unsecured loans to, or purchase secured
28 or unsecured loans of, any participating health institution in
29 accordance with an agreement between the authority and the
30 participating health institution to refinance indebtedness incurred
31 by that participating health institution or a participating health
32 institution that controls or manages, is controlled or managed by,
33 is under common control or management with, or is affiliated with
34 that participating health institution, in connection with projects
35 undertaken or for health facilities acquired or for working capital.

36 (2) Make secured or unsecured loans to, or purchase secured or
37 unsecured loans of, any participating health institution in
38 accordance with an agreement between the authority and the
39 participating health institution to refinance indebtedness incurred
40 by that participating health institution or a participating health

1 institution that controls or manages, is controlled or managed by,
2 is under common control or management with, or is affiliated with
3 that participating health institution, payable to the authority or
4 assigned or pledged to authority issued bonds.

5 (3) Funds for secured loans may be provided from the California
6 Health Facilities Financing *Authority* Fund pursuant to subdivision
7 (b) of Section 15439 to small or rural health facilities pursuant to
8 authority guidelines.

9 (k) Mortgage all or any portion of interest of the authority in a
10 project or other health facilities and the property on which that
11 project or other health facilities are located, whether owned or
12 thereafter acquired, including the granting of a security interest in
13 any property, tangible or intangible, and to assign or pledge all or
14 any portion of the interests of the authority in mortgages, deeds
15 of trust, indentures of mortgage or trust, or similar instruments,
16 notes, and security interests in property, tangible or intangible, of
17 participating health institutions to which the authority has made
18 loans, and the revenues therefrom, including payments or income
19 from any thereof owned or held by the authority, for the benefit
20 of the holders of bonds issued to finance the project or health
21 facilities or issued to refund or refinance outstanding indebtedness
22 of participating health institutions as permitted by this part.

23 (l) Lease to a participating health institution the project being
24 financed or other health facilities conveyed to the authority in
25 connection with that financing, upon the terms and conditions the
26 authority determines proper, charge and collect rents therefor,
27 terminate the lease upon the failure of the lessee to comply with
28 any of the obligations of the lease, and include in that lease, if
29 desired, provisions granting the lessee options to renew the term
30 of the lease for the period or periods and at the rent, as determined
31 by the authority, purchase any or all of the health facilities or that
32 upon payment of all of the indebtedness incurred by the authority
33 for the financing of that project or health facilities or for refunding
34 outstanding indebtedness of a participating health institution, then
35 the authority may convey any or all of the project or the other
36 health facilities to the lessee or lessees thereof with or without
37 consideration.

38 (m) Charge and equitably apportion among participating health
39 institutions, the administrative costs and expenses incurred by the

1 authority in the exercise of the powers and duties conferred by this
2 part.

3 (n) Obtain, or aid in obtaining, from any department or agency
4 of the United States or of the state, any private company, or any
5 insurance or guarantee as to, of, or for the payment or repayment
6 of, interest or principal, or both, or any part thereof, on any loan,
7 lease, or obligation, or any instrument evidencing or securing the
8 loan, lease, or obligation, made or entered into pursuant to this
9 part; and notwithstanding any other provisions of this part, to enter
10 into any agreement, contract, or any other instrument whatsoever
11 with respect to that insurance or guarantee, to accept payment in
12 the manner and form as provided therein in the event of default
13 by a participating health institution, and to assign that insurance
14 or guarantee as security for the authority's bonds.

15 (o) Enter into any and all agreements or contracts, including
16 agreements for liquidity or credit enhancement, bond exchange
17 agreements, interest rate swaps or hedges, execute any and all
18 instruments, and do and perform any and all acts or things
19 necessary, convenient, or desirable for the purposes of the authority
20 or to carry out any power expressly granted by this part.

21 (p) Invest any moneys held in reserve or sinking funds or any
22 moneys not required for immediate use or disbursement, at the
23 discretion of the authority, in any obligations authorized by the
24 resolution authorizing the issuance of the bonds secured thereof
25 or authorized by law for the investment of trust funds in the custody
26 of the Treasurer.

27 (q) Award grants to any eligible clinic pursuant to Section
28 15438.6.

29 (r) Award grants to any eligible health facility pursuant to
30 Section 15438.7.

31 (s) (1) Notwithstanding any other provision of law, provide a
32 working capital loan of up to five million dollars (\$5,000,000) to
33 assist in the establishment and operation of the California Health
34 Benefit Exchange (Exchange) established under Section 100500.
35 The authority may require any information it deems necessary and
36 prudent prior to providing a loan to the Exchange and may require
37 any term, condition, security, or repayment provision it deems
38 necessary in the event the authority chooses to provide a loan.
39 Under no circumstances shall the authority be required to provide
40 a loan to the Exchange.

1 (2) Prior to the authority providing a loan to the Exchange, a
2 majority of the board of the Exchange shall be appointed and shall
3 demonstrate, to the satisfaction of the authority, that the federal
4 planning and establishment grants made available to the Exchange
5 by the United States Secretary of Health and Human Services are
6 insufficient or will not be released in a timely manner to allow the
7 Exchange to meet the necessary requirements of the federal Patient
8 Protection and Affordable Care Act (Public Law 111-148).

9 (3) The Exchange shall repay a loan made under this subdivision
10 no later than June 30, 2016, and shall pay interest at the rate paid
11 on moneys in the Pooled Money Investment Account.

12 (t) *Award grants pursuant to Section 15438.10.*

13 SEC. 5. *Section 15438.10 is added to the Government Code,*
14 *to read:*

15 *15438.10. (a) The Legislature finds and declares the following:*

16 (1) *Many Californians face serious obstacles in obtaining*
17 *needed health care services, including, but not limited to, medical,*
18 *mental health, dental, and preventive services. The obstacles faced*
19 *by vulnerable populations and communities include existence of*
20 *complex medical, physical, or social conditions, disabilities,*
21 *economic disadvantage, and living in remote or underserved areas*
22 *that make it difficult to access services.*

23 (2) *With the recent passage of national health care reform, there*
24 *is an increased demand for innovative ways to deliver quality*
25 *health care, including preventive services, to individuals in a*
26 *cost-effective manner.*

27 (3) *There is a need to develop new methods of delivering health*
28 *services utilizing innovative models that can be demonstrated to*
29 *be effective and then replicated throughout California and that*
30 *bring community-based health care preventive services to*
31 *individuals where they live or receive education, social, or general*
32 *health services.*

33 (4) *For more than 30 years, the California Health Facilities*
34 *Financing Authority has provided financial assistance through*
35 *tax-exempt bonds, low-interest loans, and grants to health facilities*
36 *in California, assisting in the expansion of the availability of health*
37 *services and health care facilities throughout the state.*

38 (b) (1) *Following the completion of a competitive selection*
39 *process, the authority may award one or more grants that, in the*
40 *aggregate, do not exceed one million five hundred thousand dollars*

1 (\$1,500,000) to one or more projects designed to demonstrate
2 specified new or enhanced cost-effective methods of delivering
3 quality health care services to improve access to quality health
4 care for vulnerable populations or communities, or both, that are
5 effective at enhancing health outcomes and improving access to
6 quality health care and preventive services. These health care
7 services may include, but are not limited to, medical, mental health,
8 or dental services for the diagnosis, care, prevention, and treatment
9 of human illness, or individuals with physical, mental, or
10 developmental disabilities. More than one demonstration project
11 may receive a grant pursuant to this section. It is the intent of the
12 Legislature for a demonstration project that receives a grant to
13 allow patients to receive screenings, diagnosis, or treatment in
14 community settings, including, but not limited to, school-based
15 health centers, adult day care centers, and residential care
16 facilities for the elderly, or for individuals with mental illness or
17 developmental disabilities.

18 (2) A grant awarded pursuant to this subdivision may be
19 allocated in increments to a demonstration project over multiple
20 years to ensure the demonstration project's ability to complete its
21 work, as determined by the authority. Prior to the initial allocation
22 of funds pursuant to this subdivision, the administrators of the
23 demonstration project shall provide evidence that the
24 demonstration project has or will have additional funds sufficient
25 to ensure completion of the demonstration project. If the authority
26 allocates a grant in increments, each subsequent year's allocation
27 shall be provided to the demonstration project only upon
28 submission of research that shows that the project is progressing
29 toward the identification of a high-quality and cost-effective
30 delivery model that improves health outcomes and access to quality
31 health care and preventive services for vulnerable populations or
32 communities, and can be replicated throughout the state in
33 community settings.

34 (3) Except for a health facility that qualifies as a "small and
35 rural hospital" pursuant to Section 124840 of the Health and
36 Safety Code, a health facility that has received tax-exempt bond
37 financing from the authority shall not be eligible to receive funds
38 awarded for a demonstration project. Such a health facility may
39 participate as an uncompensated partner or member of a
40 collaborative effort that is awarded a demonstration project grant.

1 *A health facility that participates in a demonstration project that*
2 *receives funds pursuant to this section may not claim the funding*
3 *provided by the authority toward meeting its community benefit*
4 *and charity care obligations.*

5 *(4) Funds provided to a demonstration project pursuant to this*
6 *subdivision may be used to supplement, but not to supplant, existing*
7 *financial and resource commitments of the grantee or grantees or*
8 *any other member of a collaborative effort that has been awarded*
9 *a demonstration project grant.*

10 *(c) (1) If a demonstration project that receives a grant pursuant*
11 *to subdivision (b) is successful at developing a new method of*
12 *delivering high-quality and cost-effective health care services in*
13 *community settings that result in increased access to quality health*
14 *care and preventive services or improved health care outcomes*
15 *for vulnerable populations or communities, or both, then beginning*
16 *as early as the second year after the initial allocation of moneys*
17 *provided pursuant to subdivision (b), the authority may implement*
18 *a second grant program that awards not more than five million*
19 *dollars (\$5,000,000), in the aggregate, to eligible recipients as*
20 *defined by the authority, to replicate in additional California*
21 *communities the model developed by a demonstration project that*
22 *received a grant pursuant to subdivision (b). Prior to the*
23 *implementation of this second grant program, the authority shall*
24 *prepare and provide a report to the Legislature and the Governor*
25 *on the outcomes of the demonstration project. The report shall be*
26 *made in accordance with Section 9795.*

27 *(2) If the authority implements the second grant program, the*
28 *authority shall also report annually, beginning with the first year*
29 *of implementation of the second grant program, to the Legislature*
30 *and the Governor regarding the program, including, but not limited*
31 *to, the total amount of grants issued pursuant to this subdivision,*
32 *the amount of each grant issued, and a description of each project*
33 *awarded funding for replication of the model.*

34 *(3) Grants under this subdivision may be utilized for eligible*
35 *costs, as defined in subdivision (c) of Section 15432, including*
36 *equipment, information technology, and working capital, as defined*
37 *in subdivision (h) of Section 15432.*

38 *(4) The authority may adopt regulations relating to the grant*
39 *program authorized pursuant to this subdivision, including*

1 regulations that define eligible recipients, eligible costs, and
2 minimum and maximum grant amounts.

3 (d) (1) The authority shall prepare and provide a report to the
4 Legislature and the Governor by January 1, 2014, on the outcomes
5 of the demonstration grant program, including, but not limited to,
6 the following:

7 (A) The total amount of grants issued.

8 (B) The amount of each grant issued.

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

10 (D) A description of each project awarded funding.

11 (E) A description of project outcomes that demonstrate
12 cost-effective delivery of health care services in community settings,
13 that result in improved access to quality health care or improved
14 health care outcomes.

15 (2) A report submitted pursuant to this subdivision shall be
16 submitted in compliance with Section 9795.

17 (e) There is hereby created the California Health Access Model
18 Program Account in the California Health Facilities Financing
19 Authority Fund. All moneys in the account are hereby continuously
20 appropriated to the authority for carrying out the purposes of this
21 section. An amount of up to six million five hundred thousand
22 dollars (\$6,500,000) shall be transferred from funds in the
23 California Health Facilities Financing Authority Fund that are
24 not impressed with a trust for other purposes into the California
25 Health Access Model Program Account for the purpose of issuing
26 grants pursuant to this section. Any moneys remaining in the
27 California Health Access Model Program Account on January 1,
28 2020, shall revert as of that date to the California Health Facilities
29 Financing Authority Fund.

30 (f) Any recipient of a grant provided pursuant to subdivision
31 (b) shall adhere to all applicable laws relating to scope of practice,
32 licensure, staffing, and building codes.

33 *SEC. 6. Section 135 of the Health and Safety Code is repealed.*

34 ~~135. The Office of Women's Health is hereby established~~
35 ~~within the State Department of Health Care Services. For purposes~~
36 ~~of this chapter, "office" means the Office of Women's Health.~~

37 *SEC. 7. Section 136 of the Health and Safety Code is repealed.*

38 ~~136. (a) The California Health and Human Services Agency~~
39 ~~shall establish an interagency task force on women's health~~
40 ~~composed of representatives of the State Department of Health~~

1 Care Services, the State Department of Public Health, the State
2 Department of Developmental Services, the State Department of
3 Social Services, the State Department of Alcohol and Drug
4 Programs, and the Major Risk Medical Insurance Program.

5 (b) The State Department of Education, the Department of
6 Housing and Community Development, the office of the Attorney
7 General, the State Department of Mental Health, and the
8 Department of Corrections may participate with the interagency
9 task force on women's health when necessary to implement the
10 state strategy developed pursuant to Section 137.

11 *SEC. 8. Section 137 of the Health and Safety Code is amended*
12 *to read:*

13 137. (a) The office State Department of Public Health shall
14 develop a coordinated state strategy for addressing the health
15 related health-related needs of women, including implementation
16 of goals and objectives for women's health.

17 (b) The approved programmatic costs of the office shall be
18 shared equally by the State Department of Health Care Services
19 and the State Department of Public Health associated with this
20 strategy shall be the responsibility of the State Department of
21 Public Health unless otherwise provided by law.

22 (c) The office shall report to the Director of Health Care
23 Services.

24 *SEC. 9. Section 138 of the Health and Safety Code is repealed.*

25 138. The office may do any of the following on behalf of the
26 State Department of Health Care Services and the State Department
27 of Public Health jointly or separately:

28 (a) Perform strategic planning within these state departments
29 to develop departmentwide plans for implementation of goals and
30 objectives for women's health.

31 (b) Conduct policy analysis on specific issues related to
32 women's health.

33 (c) Coordinate pilot projects and planning projects funded by
34 the state that are related to women's health.

35 (d) Identify unnecessary duplication of services and future
36 service needs.

37 (e) Communicate and disseminate information and perform a
38 liaison function within these state departments and to providers of
39 health, social, educational, and support services to women.

1 ~~(f) Perform internal staff training for these state departments,~~
2 ~~and training of health care professionals to ensure more~~
3 ~~linguistically and culturally appropriate care.~~

4 ~~(g) Serve as a clearinghouse for information regarding women's~~
5 ~~health data, strategies, and programs that address women's health~~
6 ~~issues, including pregnancy, breast and cervical cancers, AIDS,~~
7 ~~osteoporosis, and menopause, as well as issues that impact~~
8 ~~women's health, including substance abuse, domestic violence,~~
9 ~~housing, teenage pregnancy, and sexual assault.~~

10 ~~(h) Encourage innovative responses by public and private~~
11 ~~entities that are attempting to address women's health issues.~~

12 ~~(i) Provide technical assistance to counties, other public entities,~~
13 ~~and private entities seeking to obtain funds for initiatives in~~
14 ~~women's health, including identification of sources of funding and~~
15 ~~assistance with writing of grants.~~

16 *SEC. 10. Section 138.4 of the Health and Safety Code is*
17 *amended to read:*

18 138.4. (a) ~~The State Department of Health Care Services and~~
19 ~~the State Department of Public Health shall place priority on~~
20 ~~providing information to consumers, patients, and health care~~
21 ~~providers regarding women's gynecological cancers, including,~~
22 ~~signs and symptoms, risk factors, the benefits of early detection~~
23 ~~through appropriate diagnostic testing, and treatment options.~~

24 ~~(b) The information may include, but is not limited to, the~~
25 ~~following elements:~~

26 ~~(1) Educational and informational materials in print, audio,~~
27 ~~video, electronic, or other media.~~

28 ~~(2) Public service announcements and advertisements.~~

29 ~~(c) (1) Each department may produce or contract with others~~
30 ~~to develop the materials described in this section as the director~~
31 ~~of each department deems appropriate, or may survey available~~
32 ~~publications from, among other sources, the National Cancer~~
33 ~~Institute and the American Cancer Society, and may collect and~~
34 ~~formulate a distribution plan and disseminate these publications~~
35 ~~according to the plan. These materials may be made available to~~
36 ~~the public free of charge and may include distribution through the~~
37 ~~Medical Board of California, as well as through other sources~~
38 ~~according to the distribution plan.~~

39 ~~(2) Each department may require, as it deems appropriate, health~~
40 ~~care providers to make these materials available to patients.~~

1 ~~(d)~~

2 ~~(b)~~ In exercising the powers under this section, ~~each department~~
3 ~~the State Department of Public Health~~ shall consult with
4 appropriate health care professionals and providers, consumers,
5 and patients, or organizations representing them.

6 ~~(e)~~ ~~Each department may appoint a Women's Gynecological~~
7 ~~Cancer Information Advisory Council which may include~~
8 ~~representation from health care professionals and providers,~~
9 ~~consumers, patients, and other appropriate interests. Members of~~
10 ~~each council shall receive no compensation for their services, but~~
11 ~~shall be allowed their actual and necessary expenses incurred in~~
12 ~~the performance of their duties.~~

13 ~~(f)~~ ~~Each department's~~

14 ~~(c)~~ ~~The duties of the State Department of Public Health~~ pursuant
15 to this section are contingent upon ~~that department receiving the~~
16 ~~receipt of funds appropriated for this purpose.~~

17 ~~(g)~~ ~~Each department~~

18 ~~(d)~~ ~~The State Department of Public Health~~ may adopt any
19 regulations necessary and appropriate for ~~that department's the~~
20 implementation of this section.

21 *SEC. 11. Section 138.6 of the Health and Safety Code is*
22 *amended to read:*

23 138.6. (a) ~~The department~~ *State Department of Public Health*
24 shall include in any literature that it produces regarding breast
25 cancer information that shall include, but not be limited to, all of
26 the following:

27 (1) Summarized information on risk factors for breast cancer
28 in younger women, including, but not limited to, information on
29 the increased risk associated with a family history of the disease.

30 (2) Summarized information regarding detection alternatives
31 to mammography that may be available and more effective for
32 at-risk women between the ages of 25 and 40 years.

33 (3) Information on Internet Web sites of relevant organizations,
34 government agencies, and research institutions where information
35 on mammography alternatives may be obtained.

36 (b) The information required by subdivision (a) shall be
37 produced consistent with the department's protocols and procedures
38 regarding the production and dissemination of information on
39 breast cancer, including, but not limited to, the following factors:

1 (1) Restrictions imposed by space limitation on materials
2 currently produced and distributed by the department.

3 (2) Future regular production and replacement schedules.

4 (3) Translation standards governing the number of languages
5 and literacy levels.

6 (4) The nature, content, and purpose of the material into which
7 this new information will be incorporated.

8 (c) It is the intent of the Legislature that subdivisions (a) and
9 (b) apply to information that is distributed by any branch of the
10 department, including, but not limited to, the Cancer Detection
11 Section and the Office of ~~Women's Health, which are charged~~
12 ~~with providing information about cancer~~ *Equity*.

13 *SEC. 12. Section 150 of the Health and Safety Code is repealed.*

14 ~~150. The Legislature finds and declares all of the following:~~

15 ~~(a) The health status of California's racial and ethnic~~
16 ~~communities is poor relative to the health status of the white~~
17 ~~population.~~

18 ~~(b) Of the estimated 24 percent of Californians without health~~
19 ~~insurance, approximately 81 percent are from racial and ethnic~~
20 ~~communities.~~

21 ~~(c) Of the uninsured in California, an estimated 38 percent are~~
22 ~~Latino, 24 percent are Asian and Pacific Islander, and 19 percent~~
23 ~~are African-American.~~

24 ~~(d) Racial and ethnic communities suffer from various~~
25 ~~infections and communicable diseases at higher rates than the~~
26 ~~white population, and experience increased mortality from more~~
27 ~~preventable disease relative to the white population. For example,~~
28 ~~the President's Racial and Ethnic Health Disparities Initiative~~
29 ~~recognized that infant mortality rates are 2.5 times higher for~~
30 ~~African-Americans and 1.5 times higher for native Americans than~~
31 ~~for the white population. African men under 65 years of age suffer~~
32 ~~from prostate cancer at nearly five times the rate of white men and~~
33 ~~Vietnamese women suffer from cervical cancer at nearly five times~~
34 ~~the rate of white women. Latinos suffer from stomach cancer at~~
35 ~~two to three times the rate of the white population, and~~
36 ~~African-American men suffer from heart disease at nearly twice~~
37 ~~the rate of white men. Native Americans suffer from diabetes at~~
38 ~~nearly three times the average rate of the white population, while~~
39 ~~African-Americans suffer 70 percent higher rates of diabetes than~~
40 ~~the white population.~~

1 ~~(e) Efforts to reduce and eliminate racial and ethnic disparities~~
2 ~~in health status have received scant attention, both in terms of~~
3 ~~funding for prevention and treatment services, as well as research.~~

4 ~~(f) Program planning and implementation efforts to reduce~~
5 ~~these health disparities have been neither inclusive of racial and~~
6 ~~ethnic communities nor responsive to the needs of these~~
7 ~~communities.~~

8 *SEC. 13. Section 151 of the Health and Safety Code is repealed.*

9 ~~151. (a) The Office of Multicultural Health is hereby~~
10 ~~established within the State Department of Public Health. The~~
11 ~~approved programmatic costs of the Office of Multicultural Health~~
12 ~~shall be shared equally by the State Department of Health Care~~
13 ~~Services and the State Department of Public Health unless~~
14 ~~otherwise provided by law. The Office of Multicultural Health~~
15 ~~shall report to the State Public Health Officer.~~

16 ~~(b) For purposes of this chapter:~~

17 ~~(1) "Department" means the State Department of Health Care~~
18 ~~Services and the State Department of Public Health unless the~~
19 ~~context provides otherwise.~~

20 ~~(2) "Office" means the Office of Multicultural Health.~~

21 *SEC. 14. Section 152 of the Health and Safety Code is amended*
22 *to read:*

23 ~~152. (a) The office shall do all of the following on behalf of~~
24 ~~the State Department of Health Care Services and the State~~
25 ~~Department of Public Health *Office of Health Equity shall do all*~~
26 ~~of the following:~~

27 ~~(1) Perform strategic planning within these departments to~~
28 ~~develop departmentwide plans for implementation of goals and~~
29 ~~objectives to close the gaps in health status and access to care~~
30 ~~among the state's diverse racial and ethnic communities, *women,*~~
31 ~~*persons with disabilities,* and the lesbian, gay, bisexual, and~~
32 ~~transgender (LGBT), *queer, and questioning (LGBTQQ)*~~
33 ~~communities.~~

34 ~~(2) Conduct departmental policy analysis on specific issues~~
35 ~~related to multicultural health.~~

36 ~~(3) Coordinate pilot projects and planning projects funded by~~
37 ~~the state that are related to improving the effectiveness of services~~
38 ~~to ethnic and racial communities, *women,* and the LGBT *LGBTQQ*~~
39 ~~communities.~~

1 (4) Identify the unnecessary duplication of services and future
2 service needs.

3 (5) Communicate and disseminate information and perform a
4 liaison function within the ~~departments~~ *department* and to providers
5 of health, social, educational, and support services to racial and
6 ethnic communities, *women, persons with disabilities*, and the
7 ~~LGBT~~ *LGBTQQ* communities. The ~~office~~ *department* shall consult
8 regularly with representatives from diverse racial and ethnic
9 communities, *women, persons with disabilities*, and the ~~LGBT~~
10 *LGBTQQ* communities, including health providers, advocates, and
11 consumers.

12 (6) Perform internal staff training, an internal assessment of
13 cultural competency, and training of health care professionals to
14 ensure more linguistically and culturally competent care.

15 (7) Serve as a resource for ensuring that programs *collect and*
16 *keep* data and information regarding ethnic and racial health
17 statistics, *including those statistics described in reports released*
18 *by Healthy People 2020*, and information based on sexual
19 orientation, gender identity, and gender expression, strategies and
20 programs that address multicultural health issues, including, but
21 not limited to, infant *and maternal* mortality, cancer, cardiovascular
22 disease, diabetes, human immunodeficiency virus (HIV), acquired
23 immunodeficiency syndrome (AIDS), child and adult
24 immunization, *osteoporosis, menopause, and full reproductive*
25 *health*, asthma, unintentional and intentional injury, and obesity,
26 as well as issues that impact the health of racial and ethnic
27 communities, *women*, and the ~~LGBT~~ *LGBTQQ* communities,
28 including substance abuse, mental health, housing, teenage
29 pregnancy, environmental disparities, immigrant and migrant
30 health, and health insurance and delivery systems.

31 (8) Encourage innovative responses by public and private entities
32 that are attempting to address multicultural health issues.

33 (9) Provide technical assistance to counties, other public entities,
34 and private entities seeking to obtain funds for initiatives in
35 multicultural health, including identification of funding sources
36 and assistance with writing grants.

37 (b) Notwithstanding Section 10231.5 of the Government Code,
38 the ~~office~~ *State Department of Public Health* shall biennially
39 prepare and submit a report to the Legislature on the status of the
40 activities required by this chapter. *This report shall be included*

1 *in the report required under paragraph (1) of subdivision (d) of*
2 *Section 131019.5.*

3 *SEC. 15. Section 1324.8 of the Health and Safety Code is*
4 *amended to read:*

5 1324.8. (a) The quality assurance fee assessed and collected
6 pursuant to this article shall be deposited in the General Fund.

7 (b) *Notwithstanding subdivision (a), commencing August 1,*
8 *2013, the quality assurance fee assessed and collected pursuant*
9 *to this article shall be deposited in the Long-Term Care Quality*
10 *Assurance Fund established pursuant to Section 1324.9.*

11 *SEC. 16. Section 1324.9 is added to the Health and Safety*
12 *Code, to read:*

13 1324.9. (a) *The Long-Term Care Quality Assurance Fund is*
14 *hereby created in the State Treasury. Moneys in the fund shall be*
15 *available, upon appropriation by the Legislature, for expenditure*
16 *by the State Department of Health Care Services for the purposes*
17 *of this article and Article 7.6 (commencing with Section 1324.20).*
18 *Notwithstanding Section 16305.7 of the Government Code, the*
19 *fund shall contain all interest and dividends earned on moneys in*
20 *the fund.*

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

30 *SEC. 17. Section 1324.24 of the Health and Safety Code is*
31 *amended to read:*

32 1324.24. (a) The quality assurance fee assessed and collected
33 pursuant to this article shall be deposited in the State Treasury.

34 (b) *Notwithstanding subdivision (a), commencing August 1,*
35 *2013, the quality assurance fee assessed and collected pursuant*
36 *to this article shall be deposited in the Long-Term Care Quality*
37 *Assurance Fund established pursuant to Section 1324.9.*

38 *SEC. 18. Section 100950 of the Health and Safety Code is*
39 *amended to read:*

1 100950. The department shall administer this part, Section
2 100295, *and* Chapter 3 (commencing with Section 101175) of Part
3 ~~3, and Part 3 (commencing with Section 124300) of Division 106~~
4 and shall adopt necessary regulations. These regulations shall be
5 adopted only after consultation with and approval by the California
6 Conference of Local Health Officers. Approval of these regulations
7 shall be by majority vote of those present at an official session.

8 *SEC. 19. Section 104150 of the Health and Safety Code is*
9 *amended to read:*

10 104150. (a) A provider or entity that participates in the grant
11 made to the department by the federal Centers for Disease Control
12 and Prevention breast and cervical cancer early detection program
13 established under Title XV of the *federal* Public Health Service
14 Act (42 U.S.C. Sec. 300k et seq.) in accordance with requirements
15 of Section 1504 of that act (42 U.S.C. Sec. 300n) may only render
16 screening services under the grant to an individual if the provider
17 or entity determines that the individual's family income does not
18 exceed 200 percent of the federal poverty level.

19 (b) The department shall provide for breast cancer and cervical
20 cancer screening services under the grant at the level of funding
21 budgeted from state and other resources during the fiscal year in
22 which the Legislature has appropriated funds to the department
23 for this purpose. These screening services shall not be deemed to
24 be an entitlement.

25 (c) To implement the federal breast and cervical cancer early
26 detection program specified in this section, the department may
27 contract, to the extent permitted by Section 19130 of the
28 Government Code, with public and private entities, or utilize
29 existing health care service provider enrollment and payment
30 mechanisms, including the Medi-Cal program's fiscal intermediary.
31 However, the Medi-Cal program's fiscal intermediary shall only
32 be utilized if services provided under the program are specifically
33 identified and reimbursed in a manner that does not claim federal
34 financial reimbursement. Any contracts with, and the utilization
35 of, the Medi-Cal program's fiscal intermediary shall not be subject
36 to Chapter 3 (commencing with Section 12100) of Part 2 of
37 Division 2 of the Public Contract Code. Contracts to implement
38 the federal breast and cervical cancer early detection program
39 entered into by the department with entities other than the Medi-Cal
40 program's fiscal intermediary shall not be subject to Part 2

1 (commencing with Section 10100) of Division 2 of the Public
2 Contract Code.

3 *(d) The department shall enter into an interagency agreement*
4 *with the State Department of Health Care Services to transfer that*
5 *portion of the grant made to the department by the federal Centers*
6 *for Disease Control and Prevention breast and cervical cancer*
7 *early detection program established under Title XV of the federal*
8 *Public Health Service Act (42 U.S.C. Sec. 300k et seq.) to the State*
9 *Department of Health Care Services. The department shall have*
10 *no other liability to the State Department of Health Care Services*
11 *under this article.*

12 *SEC. 20. Section 104160 of the Health and Safety Code is*
13 *amended to read:*

14 104160. (a) The State Department of Health Care Services
15 shall develop and maintain the Breast and Cervical Cancer
16 Treatment Program to expand and ensure quality breast and cervical
17 cancer treatment for low-income uninsured and underinsured
18 individuals who are diagnosed with breast or cervical cancer.

19 (b) To implement the program, the ~~department~~ *State Department*
20 *of Health Care Services* may contract with public or private
21 entities, or utilize existing health care service provider enrollment
22 and payment mechanisms, including the Medi-Cal program's fiscal
23 intermediary, only if services provided under the program are
24 specifically identified and reimbursed in a manner that does not
25 claim federal financial reimbursement. The utilization of the
26 Medi-Cal program's fiscal intermediary shall not be subject to
27 Chapter 3 (commencing with Section 12100) of Part 2 of Division
28 2 of the Public Contract Code. Contracts to implement the program
29 entered into by the ~~department~~ *State Department of Health Care*
30 *Services* with entities other than the Medi-Cal program's fiscal
31 intermediary shall not be subject to Part 2 (commencing with
32 Section 10100) of Division 2 of the Public Contract Code.

33 *SEC. 21. Section 104162.1 of the Health and Safety Code is*
34 *amended to read:*

35 104162.1. When an individual is underinsured, as defined in
36 subdivision (g) of Section 104161, the ~~department~~ *State*
37 *Department of Health Care Services* shall be the payer of second
38 resort for treatment services. To the extent necessary for the
39 individual to obtain treatment services under any health care
40 insurance listed in paragraph (2), (3), or (4) of subdivision (f) of

1 Section 104161, the ~~department~~ *State Department of Health Care*
 2 *Services* may do the following:

3 (a) Pay for the individual’s breast or cervical cancer copayments,
 4 premiums, and deductible.

5 (b) Provide only treatment services not otherwise covered by
 6 any health care insurance listed in paragraph (2), (3), or (4) of
 7 subdivision (f) of Section 104161.

8 *SEC. 22. Section 104163 of the Health and Safety Code is*
 9 *amended to read:*

10 104163. The ~~department~~ *State Department of Health Care*
 11 *Services* shall provide for breast cancer and cervical cancer
 12 treatment services pursuant to this article at the level of funding
 13 budgeted from state and other resources during the fiscal year in
 14 which the Legislature has appropriated funds to the department
 15 for this purpose. These treatment services shall not be deemed to
 16 be an entitlement.

17 *SEC. 23. Section 104314 of the Health and Safety Code is*
 18 *amended to read:*

19 104314. (a) The Prostate Cancer Fund is hereby established
 20 in the State Treasury. It is the intent of the Legislature that the
 21 fund be funded by an annual appropriation, when funds are
 22 available, in the Budget Act.

23 (b) The moneys in the Prostate Cancer Fund shall be expended
 24 by the State Department of Health *Care Services*, upon
 25 appropriation by the Legislature, for the purpose of the Prostate
 26 Cancer Screening Program established by Section 104315.

27 (c) *For the purposes of this chapter, “department” means the*
 28 *State Department of Health Care Services.*

29 *SEC. 24. Section 104315 of the Health and Safety Code is*
 30 *amended to read:*

31 104315. (a) The Prostate Cancer Screening Program shall be
 32 established in the State Department of Health *Care Services*.

33 (b) The program shall apply to both of the following:

34 (1) Uninsured men 50 years of age and older.

35 (2) Uninsured men between 40 and 50 years of age who are at
 36 high risk for prostate cancer, upon the advice of a physician or
 37 upon the request of the patient.

38 (c) For purposes of this chapter, “uninsured” means not covered
 39 by any of the following:

40 (1) Medi-Cal.

1 (2) Medicare.

2 (3) A health care service plan contract or policy of disability
3 insurance that covers screening for prostate cancer for men 50
4 years of age and older, and for men between 40 and 50 years of
5 age who are at high risk for prostate cancer upon the advice of a
6 physician or upon the request of the patient.

7 (4) Any other form of health care coverage that covers screening
8 for prostate cancer for men 50 years of age and older, and for men
9 between 40 and 50 years of age who are at high risk for prostate
10 cancer upon the advice of a physician or upon the request of the
11 patient.

12 (d) The program shall include all of the following:

13 (1) Screening of men for prostate cancer as an early detection
14 health care measure.

15 (2) After screening, medical referral of screened men and
16 services necessary for definitive diagnosis.

17 (3) If a positive diagnosis is made, then assistance and advocacy
18 shall be provided to help the person obtain necessary treatment.

19 (4) Outreach and health education activities to ensure that
20 uninsured men are aware of and appropriately utilize the services
21 provided by the program.

22 (e) Any entity funded by the program shall coordinate with other
23 local providers of prostate cancer screening, diagnostic, followup,
24 education, and advocacy services to avoid duplication of effort.
25 Any entity funded by the program shall comply with any applicable
26 state and federal standards regarding prostate cancer screening.

27 (f) Administrative costs of the department shall not exceed 10
28 percent of the funds allocated to the program. Indirect costs of the
29 entities funded by this program shall not exceed 12 percent. The
30 department shall define “indirect costs” in accordance with
31 applicable state and federal law.

32 (g) Any entity funded by the program shall collect data and
33 maintain records that are determined by the department to be
34 necessary to facilitate the state department’s ability to monitor and
35 evaluate the effectiveness of the entities and the program.
36 Commencing with the program’s second year of operation, *and*
37 *notwithstanding Section 10231.5 of the Government Code*, the
38 department shall submit an annual report to the Legislature and
39 any other appropriate entity. The report shall describe the activities
40 and effectiveness of the program and shall include, but not be

1 limited to, the following types of information regarding those
2 served by the program:

3 (1) The number.

4 (2) The ethnic, geographic, and age breakdown.

5 (3) The stages of presentation.

6 (4) The diagnostic and treatment status.

7 (h) The department or any entity funded by the program shall
8 collect personal and medical information necessary to administer
9 the program from any individual applying for services under the
10 program. The information shall be confidential and shall not be
11 disclosed other than for purposes directly connected with the
12 administration of the program or except as otherwise provided by
13 law or pursuant to prior written consent of the subject of the
14 information.

15 (i) The department or any entity funded by the program may
16 disclose the confidential information to medical personnel and
17 fiscal intermediaries of the state to the extent necessary to
18 administer the program, and to other state public health agencies
19 or medical researchers if the confidential information is necessary
20 to carry out the duties of those agencies or researchers in the
21 investigation, control, or surveillance of prostate cancer.

22 (j) The department shall adopt regulations to implement the
23 Prostate Cancer Screening Program in accordance with Chapter
24 3.5 (commencing with Section 11340) of Part 1 of Division 3 of
25 Title 2 of the Government Code.

26 (k) This section shall not be implemented unless and until funds
27 are appropriated for this purpose in the annual Budget Act.

28 (l) To implement the Prostate Cancer Screening Program, the
29 department may contract, to the extent permitted by Section 19130
30 of the Government Code, with public and private entities, or utilize
31 existing health care service provider enrollment and payment
32 mechanisms, including the Medi-Cal program's fiscal intermediary.
33 However, the Medi-Cal program's fiscal intermediary shall only
34 be utilized if services provided under the program are specifically
35 identified and reimbursed in a manner that does not claim federal
36 financial reimbursement. Any contracts with, and the utilization
37 of, the Medi-Cal program's fiscal intermediary shall not be subject
38 to Chapter 3 (commencing with Section 12100) of Part 2 of
39 Division 2 of the Public Contract Code. Contracts to implement
40 the Prostate Cancer Screening Program entered into by the

1 department with entities other than the Medi-Cal program's fiscal
2 intermediary shall not be subject to Part 2 (commencing with
3 Section 10100) of Division 2 of the Public Contract Code.

4 *SEC. 25. Section 104322 of the Health and Safety Code is*
5 *amended to read:*

6 104322. (a) (1) The State Department of Health Care Services
7 shall develop and implement a program to provide quality prostate
8 cancer treatment for low-income and uninsured men.

9 (2) ~~The department~~ *State Department of Health Care Services*
10 shall award one or more contracts to provide prostate cancer
11 treatment through private or public nonprofit organizations,
12 including, but not limited to, community-based organizations, local
13 health care providers, the University of California medical centers,
14 and the Charles R. Drew University of Medicine and Science, an
15 affiliate of the David Geffen School of Medicine at the University
16 of California at Los Angeles. Contracts awarded, subsequent to
17 the effective date of the amendments to this section made during
18 the 2005 portion of the ~~2005-06~~ *2005-06* Regular Session, pursuant
19 to this paragraph shall be consistent with both of the following:

20 (A) Eighty-seven percent of the total contract funding shall be
21 used for direct patient care.

22 (B) No less than 70 percent of the total contract funding shall
23 be expended on direct patient care treatment costs, which shall be
24 defined as funding to fee-for-service providers for Medi-Cal
25 eligible services.

26 (3) The contracts described in paragraph (2) shall not be subject
27 to Part 2 (commencing with Section 10100) of Division 2 of the
28 Public Contract Code. Commencing July 1, 2006, those contracts
29 shall be entered into on a competitive bid basis.

30 (4) It is the intent of the Legislature to support the prostate
31 cancer treatment program provided for pursuant to this section,
32 and that the program be cost-effective and maximize the number
33 of men served for the amount of funds appropriated. It is further
34 the intent of the Legislature to ensure that the program has an
35 adequate health care provider network to facilitate reasonable
36 access to treatment.

37 (b) Treatment provided under this chapter shall be provided to
38 uninsured and underinsured men with incomes at or below 200
39 percent of the federal poverty level. Covered services shall be
40 limited to prostate cancer treatment and prostate cancer-related

1 services. Eligible men shall be enrolled in a 12-month treatment
2 regimen.

3 (c) ~~The department~~ *State Department of Health Care Services*
4 shall contract for prostate cancer treatment services only at the
5 level of funding budgeted from state and other sources during a
6 fiscal year in which the Legislature has appropriated funds to the
7 department for this purpose.

8 (d) Notwithstanding subdivision (a) of Section 2.00 of the
9 Budget Act of 2003 and any other provision of law, commencing
10 with the ~~2003-04~~ *2003-04* fiscal year and for each fiscal year
11 thereafter, any amount appropriated to the ~~department~~ *State*
12 *Department of Health Care Services* for the prostate cancer
13 treatment program implemented pursuant to this chapter shall be
14 made available, for purposes of that program, for encumbrance
15 for one fiscal year beyond the year of appropriation and for
16 expenditure for two fiscal years beyond the year of encumbrance.

17 *SEC. 26. Section 110050 of the Health and Safety Code is*
18 *amended to read:*

19 110050. The Food Safety Fund is hereby created as a special
20 fund in the State Treasury. All moneys collected by the department
21 under subdivision (c) of Section 110466 and Sections 110470,
22 110471, 110485, ~~and~~ 111130, *and 113717*, and under Article 7
23 (commencing with Section 110810) of Chapter 5 shall be deposited
24 in the fund, for use by the department, upon appropriation by the
25 Legislature, for the purposes of providing funds necessary to carry
26 out and implement the inspection provisions of this part relating
27 to food, licensing, inspection, enforcement, and other provisions
28 of Article 12 (commencing with Section 111070) relating to water,
29 the provisions relating to education and training in the prevention
30 of microbial contamination pursuant to Section 110485, and the
31 registration provisions of Article 7 (commencing with Section
32 110810) of Chapter 5, *and to carry out and implement the*
33 *provisions of the California Retail Food Code (Part 7 (commencing*
34 *with Section 113700) of Division 104).*

35 *SEC. 27. Section 113717 of the Health and Safety Code is*
36 *amended to read:*

37 113717. (a) Any person requesting the department to undertake
38 any activity pursuant to ~~Sections 114056, paragraph (5) of~~
39 *subdivision (c) of Section 113871, Section 114417, paragraph (2)*
40 *of subdivision (b) of Section 114419, and Section 114419.3 shall*

1 pay the department's costs incurred in undertaking the activity.
2 The department's services shall be assessed at the current hourly
3 cost-recovery rate, and it shall be entitled to recover any other
4 costs reasonably and actually incurred in performing those
5 activities, including, but not limited to, the costs of additional
6 inspection and laboratory testing. For purposes of this section, the
7 department's hourly rate shall be adjusted annually in accordance
8 with Section 100425.

9 (b) The department shall provide to the person paying the
10 required fee a statement, invoice, or similar document that
11 describes in reasonable detail the costs paid.

12 (c) For purposes of this section only, the term "person" does
13 not include any city, county, city and county, or other political
14 subdivision of the state or local government.

15 *SEC. 28. Section 113718 of the Health and Safety Code is*
16 *repealed.*

17 ~~113718. The Retail Food Safety and Defense Fund is hereby~~
18 ~~established as a special fund in the State Treasury. All moneys~~
19 ~~collected by the department under subdivision (a) of Section~~
20 ~~113717 shall be deposited into the fund, for expenditure by the~~
21 ~~department, upon appropriation by the Legislature, solely for the~~
22 ~~purpose of implementing and carrying out this part.~~

23 *SEC. 29. Section 113718 is added to the Health and Safety*
24 *Code, to read:*

25 *113718. Notwithstanding Section 16350 of the Government*
26 *Code, all moneys deposited in the Retail Food Safety and Defense*
27 *Fund shall be transferred to the Food Safety Fund for*
28 *appropriation and expenditure as specified by Section 110050.*

29 *SEC. 30. Section 116064.1 of the Health and Safety Code is*
30 *repealed.*

31 ~~116064.1. The Legislature finds and declares that the public~~
32 ~~health interest requires that there be uniform statewide health and~~
33 ~~safety standards for public swimming pools to prevent physical~~
34 ~~entrapment and serious injury to children and adults. It is the intent~~
35 ~~of the Legislature to occupy the whole field of health and safety~~
36 ~~standards for public swimming pools and the requirements~~
37 ~~established in this article and the regulations adopted pursuant to~~
38 ~~this article shall be exclusive of all local health and safety standards~~
39 ~~relating to public swimming pools.~~

1 *SEC. 31. Section 116064.2 of the Health and Safety Code is*
2 *amended to read:*

3 116064.2. (a) As used in this section, the following words
4 have the following meanings:

5 (1) “ASME/ANSI performance standard” means a standard that
6 is accredited by the American National Standards Institute and
7 published by the American Society of Mechanical Engineers.

8 (2) “ASTM performance standard” means a standard that is
9 developed and published by ASTM International.

10 (3) “Main drain” means a submerged suction outlet typically
11 located at the bottom of a swimming pool that conducts water to
12 a recirculating pump.

13 (4) “Public swimming pool” means an outdoor or indoor
14 structure, whether in-ground or above-ground, intended for
15 swimming or recreational bathing, including a swimming pool,
16 hot tub, spa, or nonportable wading pool, that is any of the
17 following:

18 (A) Open to the public generally, whether for a fee or free of
19 charge.

20 (B) Open exclusively to members of an organization and their
21 guests, residents of a multiunit apartment building, apartment
22 complex, residential real estate development, or other multifamily
23 residential area, or patrons of a hotel or other public
24 accommodations facility.

25 (C) Located on the premises of an athletic club, or public or
26 private school.

27 (5) “Qualified individual” means a contractor who holds a
28 current valid license issued by the State of California or a
29 professional engineer licensed in the State of California who has
30 experience working on public swimming pools.

31 (6) “Safety vacuum release system” means a vacuum release
32 system that ceases operation of the pump, reverses the circulation
33 flow, or otherwise provides a vacuum release at a suction outlet
34 when a blockage is detected.

35 (7) “Skimmer equalizer line” means a suction outlet located
36 below the waterline and connected to the body of a skimmer that
37 prevents air from being drawn into the pump if the water level
38 drops below the skimmer weir. However, a skimmer equalizer line
39 is not a main drain.

1 (8) “Unblockable drain” means a drain of any size and shape
2 that a human body cannot sufficiently block to create a suction
3 entrapment hazard.

4 ~~(b) Subject to subdivision (c), an ASME/ANSI or ASTM~~
5 ~~performance standard relating to antientrapment devices or systems~~
6 ~~or an amendment or successor to, or later published edition of an~~
7 ~~ASME/ANSI or ASTM performance standard relating to~~
8 ~~antientrapment devices or systems shall become the applicable~~
9 ~~standard in California 90 days after publication by ASME/ANSI~~
10 ~~or ASTM, respectively, provided that the performance standard~~
11 ~~or amendment or successor to, or later published edition is~~
12 ~~approved by the department within 90 days of the publication of~~
13 ~~the performance standard by ASME/ANSI or ASTM, respectively.~~
14 ~~Notwithstanding any other law, the department may implement,~~
15 ~~interpret, or make specific the provisions of this section by means~~
16 ~~of a policy letter or similar instruction and this action by the~~
17 ~~department shall not be subject to the rulemaking requirements of~~
18 ~~the Administrative Procedure Act (Chapter 3.5 (commencing with~~
19 ~~Section 11340) of Part 1 of Division 3 of Title 2 of the Government~~
20 ~~Code).~~

21 (e)

22 (b) Subject to subdivision ~~(f)~~ (e), every public swimming pool
23 shall be equipped with antientrapment devices or systems that
24 comply with ~~ASME/ANSI performance standard A112.19.8, as~~
25 ~~in effect December 31, 2009, or any applicable ASME/ANSI~~
26 ~~performance standard that has been adopted by the department~~
27 ~~pursuant to subdivision (b) the ANSI/APSP-16 2011 standard as~~
28 ~~in effect on December 31, 2011.~~

29 ~~(d)~~

30 (c) Subject to subdivisions ~~(e) and (f)~~ (d) and (e), every public
31 swimming pool with a single main drain that is not an unblockable
32 drain shall be equipped with at least one or more of the following
33 devices or systems that are designed to prevent physical entrapment
34 by pool drains:

35 (1) A safety vacuum release system that has been tested by a
36 ~~department-approved independent third party nationally recognized~~
37 ~~testing laboratory~~ and found to conform to ASME/ANSI
38 performance standard A112.19.17, as in effect on December 31,
39 2009, ~~or any applicable ASME/ANSI performance standard that~~
40 ~~has been adopted by the department pursuant to subdivision (b),~~

1 or ASTM performance standard F2387, as in effect on December
2 31, 2009, or any applicable ASTM performance standard that has
3 been adopted by the department pursuant to subdivision (b).

4 (2) A suction-limiting vent system with a tamper-resistant
5 atmospheric opening, provided that it conforms to any applicable
6 ASME/ANSI or ASTM performance standard ~~that has been~~
7 ~~adopted by the department pursuant to subdivision (b).~~

8 (3) A gravity drainage system that utilizes a collector tank,
9 provided that it conforms to any applicable ASME/ANSI or ASTM
10 performance standard ~~that has been adopted by the department~~
11 ~~pursuant to subdivision (b).~~

12 (4) An automatic pump shut-off system tested by a
13 department-approved independent third party and found to conform
14 to any applicable ASME/ANSI or ASTM performance standard
15 ~~that has been adopted by the department pursuant to subdivision~~
16 ~~(b).~~

17 (5) Any other system that is deemed, in accordance with federal
18 law, to be equally effective as, or more effective than, the systems
19 described in ~~paragraphs (1) to (4), inclusive,~~ *paragraph (1)* at
20 preventing or eliminating the risk of injury or death associated
21 with pool drainage systems.

22 (e)

23 (d) Every public swimming pool constructed on or after January
24 1, 2010, shall have at least two main drains per pump that are
25 hydraulically balanced and symmetrically plumbed through one
26 or more “T” fittings, and that are separated by a distance of at least
27 three feet in any dimension between the drains. A public swimming
28 pool constructed on or after January 1, 2010, that meets the
29 requirements of this subdivision, shall be exempt from the
30 requirements of subdivision ~~(d)~~ (c).

31 (f)

32 (e) A public swimming pool constructed prior to January 1,
33 2010, shall be retrofitted to comply with subdivisions ~~(e) and (d)~~
34 ~~(b) and (c)~~ by no later than July 1, 2010, except that no further
35 retrofitting is required for a public swimming pool that completed
36 a retrofit between December 19, 2007, and January 1, 2010, that
37 complied with the Virginia Graeme Baker Pool and Spa Safety
38 Act (15 U.S.C. Sec. 8001 et seq.) as in effect on the date of issue
39 of the construction permit, or for a nonportable wading pool that
40 completed a retrofit prior to January 1, 2010, that complied with

1 state law on the date of issue of the construction permit. A public
2 swimming pool owner who meets the exception described in this
3 subdivision shall do one of the following prior to September 30,
4 2010:

5 (1) File the form issued by the department pursuant to
6 subdivision-~~(g)~~ (f), as otherwise provided in subdivision-~~(i)~~ (h).

7 (2) (A) File a signed statement attesting that the required work
8 has been completed.

9 (B) Provide a document containing the name and license number
10 of the qualified individual who completed the required work.

11 (C) Provide either a copy of the final building permit, if required
12 by the local agency, or a copy of one of the following documents
13 if no permit was required:

14 (i) A document that describes the modification in a manner that
15 provides sufficient information to document the work that was
16 done to comply with federal law.

17 (ii) A copy of the final paid invoice. The amount paid for the
18 services may be omitted or redacted from the final invoice prior
19 to submission.

20 ~~(g)~~

21 (f) Prior to March 31, 2010, the department shall issue a form
22 for use by an owner of a public swimming pool to indicate
23 compliance with this section. The department shall consult with
24 county health officers and directors of departments of
25 environmental health in developing the form and shall post the
26 form on the department's Internet Web site. The form shall be
27 completed by the owner of a public swimming pool prior to filing
28 the form with the appropriate city, county, or city and county
29 department of environmental health. The form shall include, but
30 not be limited to, the following information:

31 (1) A statement of whether the pool operates with a single or
32 split main drain.

33 (2) Identification of the type of antientrapment devices or
34 systems that have been installed pursuant to subdivision-~~(e)~~ (b)
35 and the date or dates of installation.

36 (3) Identification of the type of devices or systems designed to
37 prevent physical entrapment that have been installed pursuant to
38 subdivision-~~(d)~~ (c) in a public swimming pool with a single main
39 drain that is not an unblockable drain and the date or dates of
40 installation or the reason why the requirement is not applicable.

1 (4) A signature and license number of a qualified individual
2 who certifies that the factual information provided on the form in
3 response to paragraphs (1) to (3), inclusive, is true to the best of
4 his or her knowledge.

5 ~~(h)~~

6 (g) A qualified individual who improperly certifies information
7 pursuant to paragraph (4) of subdivision ~~(g)~~ (f) shall be subject to
8 potential disciplinary action at the discretion of the licensing
9 authority.

10 ~~(i)~~

11 (h) Except as provided in subdivision ~~(f)~~ (e), each public
12 swimming pool owner shall file a completed copy of the form
13 issued by the department pursuant to this section with the city,
14 county, or city and county department of environmental health in
15 the city, county, or city and county in which the swimming pool
16 is located. The form shall be filed within 30 days following the
17 completion of the swimming pool construction or installation
18 required pursuant to this section or, if the construction or
19 installation is completed prior to the date that the department issues
20 the form pursuant to this section, within 30 days of the date that
21 the department issues the form. The public swimming pool owner
22 or operator shall not make a false statement, representation,
23 certification, record, report, or otherwise falsify information that
24 he or she is required to file or maintain pursuant to this section.

25 ~~(j)~~

26 (i) In enforcing this section, health officers and directors of city,
27 county, or city and county departments of environmental health
28 shall consider documentation filed on or with the form issued
29 pursuant to this section by the owner of a public swimming pool
30 as evidence of compliance with this section. A city, county, or city
31 and county department of environmental health may verify the
32 accuracy of the information filed on or with the form.

33 ~~(k)~~

34 (j) To the extent that the requirements for public wading pools
35 imposed by Section 116064 conflict with this section, the
36 requirements of this section shall prevail.

37 ~~(l) (1) Until January 1, 2014, the department may assess an~~
38 ~~annual fee on the owners of each public swimming pool, to be~~
39 ~~collected by the applicable local health department, in an amount~~
40 ~~not to exceed the amount necessary to defray the department's~~

1 costs of carrying out its duties under Section 116064.1 and this
2 section but in no case shall this fee exceed six dollars (\$6).

3 (2) The local health department may retain a portion of the fee
4 collected pursuant to paragraph (1) in an amount necessary to cover
5 the administrative costs of collecting the fee, but in no case to
6 exceed one dollar (\$1).

7 (3) The local health department shall bill the owner of each
8 public swimming pool in its jurisdiction for the amount of the state
9 fee. The local health department shall transmit the collected state
10 fee to the Controller for deposit into the Recreational Health Fund,
11 which is hereby created in the State Treasury. The local health
12 department shall not be required to take action to collect an unpaid
13 state fee, but shall submit to the department, every six months, a
14 list containing the name and address of the owner of each public
15 swimming pool who has failed to pay the state fee for more than
16 90 days after the date that the bill was provided to the owner of
17 the public swimming pool.

18 (4) Owners that are exempt from local swimming pool permit
19 fees shall also be exempt from the fees imposed pursuant to this
20 subdivision.

21 (5) Except as provided in paragraph (2), all moneys collected
22 by the department pursuant to this section shall be deposited into
23 the Recreational Health Fund. Notwithstanding Section 16305.7
24 of the Government Code, interest and dividends on moneys in the
25 Recreational Health Fund shall also be deposited in the fund.
26 Moneys in the fund shall, upon appropriation by the Legislature,
27 be available to the department for carrying out its duties under
28 Section 116064.1 and this section and shall not be redirected for
29 any other purpose.

30 (k) *The department shall have no authority to take any*
31 *enforcement action against any person for violation of this section*
32 *and has no responsibility to administer or enforce the provisions*
33 *of this section.*

34 *SEC. 32. Section 123865 of the Health and Safety Code is*
35 *amended to read:*

36 123865. (a) Whenever the parents or estate of a handicapped
37 child is wholly or partly unable to furnish for the child necessary
38 services, the parents or guardian may apply to the agency of the
39 county that has been designated by the board of supervisors of the
40 county of residence under the terms of Section 123850 to

1 administer the provisions for handicapped children. Residence
 2 shall be determined in accordance with Sections 243 and 244 of
 3 the Government Code.

4 *(b) If the child has an individualized education program (IEP)*
 5 *pursuant to the federal Individuals with Disabilities Education*
 6 *Act (IDEA; 20 U.S.C. Sec. 1400 et seq.), that IEP shall be disclosed*
 7 *to the California Children’s Services Program by the parents or*
 8 *the estate of the handicapped child at the time of application*
 9 *provided for in subdivision (a) and on revision of the child’s IEP.*

10 SEC. 33. *Section 123870 of the Health and Safety Code is*
 11 *amended to read:*

12 123870. (a) ~~The department~~ *State Department of Health Care*
 13 *Services shall establish standards of financial eligibility for*
 14 *treatment services under the California Children’s Services*
 15 *Program (CCS program).*

16 (1) Financial eligibility for treatment services under this
 17 program shall be limited to persons in families with an adjusted
 18 gross income of forty thousand dollars (\$40,000) or less in the
 19 most recent tax year, as calculated for California state income tax
 20 purposes. If a person is enrolled in the Healthy Families Program
 21 (Part 6.2 (commencing with Section 12693) of Division 2 of the
 22 Insurance Code), the financial documentation required for that
 23 program in Section 2699.6600 of Title 10 of the California Code
 24 of Regulations may be used instead of the person’s California state
 25 income tax return. However, the director may authorize treatment
 26 services for persons in families with higher incomes if the estimated
 27 cost of care to the family in one year is expected to exceed 20
 28 percent of the family’s adjusted gross income.

29 (2) Children enrolled in the Healthy Families Program who
 30 have a CCS program eligible medical condition under Section
 31 123830, and whose families do not meet the financial eligibility
 32 requirements of paragraph (1), shall be deemed financially eligible
 33 for CCS program benefits.

34 (b) ~~Necessary medical therapy treatment services under the~~
 35 ~~California Children’s Services Program~~ *CCS program* rendered
 36 in the public schools shall be exempt from financial eligibility
 37 standards and enrollment fee requirements for the services when
 38 rendered to any handicapped child whose ~~educational~~ or physical
 39 development would be impeded without the services. *All*
 40 *occupational and physical therapy services assessed and*

1 *determined to be educationally necessary by the individualized*
2 *education program (IEP) team and included in the child's IEP*
3 *developed pursuant to the provisions of the federal Individuals*
4 *with Disabilities Education Act (IDEA; 20 U.S.C. Sec. 1400 et*
5 *seq.), shall be provided in accordance with the provisions of that*
6 *federal act and shall not be paid for by the CCS program.*

7 (c) All counties shall use the uniform standards for financial
8 eligibility and enrollment fees established by the department. All
9 enrollment fees shall be used in support of the ~~California Children's~~
10 ~~Services Program~~ CCS program.

11 (d) Annually, every family with a child eligible to receive
12 services under this article shall pay a fee of twenty dollars (\$20),
13 that shall be in addition to any other program fees for which the
14 family is liable. This assessment shall not apply to any child who
15 is eligible for full scope Medi-Cal benefits without a share of cost,
16 for children receiving therapy ~~through the California Children's~~
17 ~~Services Program~~ in accordance with the federal IDEA as a related
18 service in their individualized education plans, for children from
19 families having incomes of less than 100 percent of the federal
20 poverty level, or for children covered under the Healthy Families
21 Program.

22 SEC. 33.5. *Section 123870 of the Health and Safety Code is*
23 *amended to read:*

24 123870. (a) ~~The department~~ *State Department of Health Care*
25 *Services* shall establish standards of financial eligibility for
26 treatment services under the California Children's Services
27 Program (CCS program).

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

1 *California state income tax return.* However, the director may
2 authorize treatment services for persons in families with higher
3 incomes if the estimated cost of care to the family in one year is
4 expected to exceed 20 percent of the family's adjusted gross
5 income.

6 (2) Children enrolled in the Healthy Families Program, *or*
7 *enrolled in the Medi-Cal program pursuant to Section 14005.26*
8 *of the Welfare and Institutions Code*, who have a CCS program
9 eligible medical condition under Section 123830, and whose
10 families do not meet the financial eligibility requirements of
11 paragraph (1), shall be deemed financially eligible for CCS
12 program benefits.

13 (b) Necessary medical therapy treatment services under the
14 ~~California Children's Services Program~~ *CCS program* rendered
15 in the public schools shall be exempt from financial eligibility
16 standards and enrollment fee requirements for the services when
17 rendered to any handicapped child whose ~~educational~~ or physical
18 development would be impeded without the services. *All*
19 *occupational and physical therapy services assessed and*
20 *determined to be educationally necessary by the individualized*
21 *education program (IEP) team and included in the child's IEP*
22 *developed pursuant to the provisions of the federal Individuals*
23 *with Disabilities Education Act (IDEA; 20 U.S.C. Sec. 1400 et*
24 *seq.), shall be provided in accordance with the provisions of that*
25 *federal act and shall not be paid for by the CCS program.*

26 (c) All counties shall use the uniform standards for financial
27 eligibility and enrollment fees established by the department. All
28 enrollment fees shall be used in support of the ~~California Children's~~
29 ~~Services Program~~ *CCS program.*

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

1 *SEC. 34. Section 123875 of the Health and Safety Code is*
2 *amended to read:*

3 ~~123875. When the California Children's Service medical~~
4 ~~therapy unit conference team, based on a medical referral~~
5 ~~recommending medically necessary occupational or physical~~
6 ~~therapy in accordance with subdivision (b) of Section 7575 of the~~
7 ~~Government Code, finds that a handicapped child, as defined in~~
8 ~~Section 123830, needs medically necessary occupational or~~
9 ~~physical therapy, that child shall be determined to be eligible for~~
10 ~~therapy services.~~

11 *123875. A handicapped child, as defined in Section 123830,*
12 *who applies to the California Children's Services Program in*
13 *accordance with Section 123865, shall be determined to be eligible*
14 *for therapy services when the California Children's Services*
15 *Program's medical therapy unit conference team finds that the*
16 *child needs medically necessary occupational or physical therapy.*
17 *If the California Children's Services medical consultant disagrees*
18 *with the determination of eligibility by the California Children's*
19 *Services medical therapy unit conference team, the medical*
20 *consultant shall communicate with the conference team to ask for*
21 *further justification of its determination, and shall weigh the*
22 *conference team's arguments in support of its decision in reaching*
23 *his or her own determination.*

24 *This section shall not change eligibility criteria for the California*
25 *Children's Services programs as described in Sections 123830 and*
26 *123860.*

27 *This section shall not apply to children diagnosed as specific*
28 *learning disabled, unless they otherwise meet the eligibility criteria*
29 *of the California Children's Services.*

30 *SEC. 35. Section 124300 of the Health and Safety Code is*
31 *amended to read:*

32 *124300. Within any county where 10 percent or more of the*
33 *population, as determined by the Population Research Unit of the*
34 *Department of Finance, speaks any one language other than English*
35 *as its native language, every local health department shall make*
36 *copies of circulars and pamphlets relating to family planning that*
37 *are made available to the public also available in the other*
38 *language.*

39 ~~The department~~ *State Department of Health Care Services, upon*
40 *request, shall make a translation available in other than English*

1 those family planning informational materials normally distributed
2 to the general public.

3 *SEC. 36. Section 125130 of the Health and Safety Code is*
4 *amended to read:*

5 125130. The Director of Health Care Services shall establish
6 and administer a program for the medical care of persons with
7 genetically handicapping conditions, including cystic fibrosis,
8 hemophilia, sickle cell disease, Huntington's disease, Friedreich's
9 Ataxia, Joseph's disease, Von Hippel-Landau syndrome, and the
10 following hereditary metabolic disorders: phenylketonuria,
11 homocystinuria, branched chain amino acidurias, disorders of
12 propionate and methylmalonate metabolism, urea cycle disorders,
13 hereditary orotic aciduria, Wilson's Disease, galactosemia,
14 disorders of lactate and pyruvate metabolism, tyrosinemia,
15 hyperornithinemia, and other genetic organic acidemias that require
16 specialized treatment or service available from only a limited
17 number of program-approved sources.

18 The program shall also provide access to social support services,
19 that may help ameliorate the physical, psychological, and economic
20 problems attendant to genetically handicapping conditions, in order
21 that the genetically handicapped person may function at an optimal
22 level commensurate with the degree of impairment.

23 The medical and social support services may be obtained through
24 physicians and surgeons, genetically handicapped person's program
25 specialized centers, and other providers that qualify pursuant to
26 the regulations of the department to provide the services. "Medical
27 care," as used in this section, is limited to noncustodial medical
28 and support services.

29 ~~The director, with the guidance of the Advisory Committee on~~
30 ~~Genetically Handicapped Person's Program, may, by regulation,~~
31 ~~expand the list of genetically handicapping conditions covered~~
32 ~~under this article. The director shall adopt regulations that are~~
33 ~~necessary for the implementation of this article. The director, with~~
34 ~~the approval of the advisory committee, shall establish priorities~~
35 ~~for the use of funds and provision of services under this article.~~

36 *SEC. 37. Section 125145 of the Health and Safety Code is*
37 *repealed.*

38 ~~125145. The director shall appoint an 11-member Advisory~~
39 ~~Committee on Genetically Handicapped Person's Program~~
40 ~~composed of professional and consumer representatives who shall~~

1 ~~serve without compensation and at the discretion of the director.~~
2 ~~The director shall seek the advice of the advisory committee with~~
3 ~~respect to regulations to be adopted pursuant to this article.~~

4 *SEC. 38. Section 125205 of the Health and Safety Code is*
5 *amended to read:*

6 125205. The department and the State Department of Social
7 Services shall, after consultation with the Genetically Handicapped
8 Persons Program of the department, ~~from the Genetically~~
9 ~~Handicapped Persons Program Advisory Committee, and from~~
10 consumer organizations representing persons with chronic and
11 degenerative conditions, as defined in Section 125210, compile a
12 list of long-term care resources that serve adults with chronic and
13 degenerative conditions, as defined. The list of resources shall
14 include those that have already been identified by the Genetically
15 Handicapped Persons Program as serving persons with
16 Huntington's disease, Joseph's disease, and Friedrich's ataxia, and
17 shall include those that have already been identified by consumer
18 organizations representing persons with chronic and degenerative
19 conditions. The list of resources shall include, but not be limited
20 to, the following:

21 (a) Public and private skilled nursing facilities and intermediate
22 care facilities.

23 (b) Public and private community residential care facilities.

24 (c) Public and private out-of-home long-term care resources
25 such as day activity programs, and in-home support service
26 programs. Nothing in this section shall require the *State* Department
27 of Health *Care* Services to undertake a survey of long-term care
28 facilities or programs in the state for the purposes of carrying out
29 the requirements of this section.

30 The information shall be made available to the public, upon
31 request, through the Genetically Handicapped Persons Program
32 of the department.

33 *SEC. 39. Section 125215 of the Health and Safety Code is*
34 *amended to read:*

35 125215. The department and the State Department of Social
36 Services shall review regulations that currently provide
37 disincentives to providers of in-home and out-of-home long-term
38 care resources, as defined in Section 125205, to accept and serve
39 persons with chronic and degenerative disorders. The review shall
40 be conducted with assistance and input from the Genetically

1 Handicapped Persons Program of the department, ~~and from the~~
 2 ~~Genetically Handicapped Persons Program Advisory Committee.~~
 3 These departments shall provide a list of those regulations to the
 4 Legislature by September 1, 1982. The regulations subject to
 5 review shall be those regulations that do the following:

6 (a) Affect the admission of patients to state-licensed skilled
 7 nursing facilities, intermediate care facilities, and community
 8 residential care facilities.

9 (b) Affect the staffing ratios necessary to care for persons with
 10 chronic and degenerative conditions, as defined, within those
 11 facilities.

12 (c) Affect the likelihood of facilities, or of day care programs
 13 and in-home support service programs, to refuse the admission of
 14 persons with chronic and degenerative conditions, solely on the
 15 basis of anticipated jeopardy to their licensing, or on the basis of
 16 anticipated liability to the facilities arising from instances where
 17 a person's degenerative condition, by its own clinical merits, results
 18 in medical complications that are, in fact, entirely unrelated to the
 19 quality of care provided by the facility or program.

20 *SEC. 40. Section 130060 of the Health and Safety Code is*
 21 *amended to read:*

22 130060. (a) (1) After January 1, 2008, any general acute care
 23 hospital building that is determined to be a potential risk of collapse
 24 or pose significant loss of life shall only be used for nonacute care
 25 hospital purposes. A delay in this deadline may be granted by the
 26 office upon a demonstration by the owner that compliance will
 27 result in a loss of health care capacity that may not be provided
 28 by other general acute care hospitals within a reasonable proximity.
 29 In its request for an extension of the deadline, a hospital shall state
 30 why the hospital is unable to comply with the January 1, 2008,
 31 deadline requirement.

32 (2) Prior to granting an extension of the January 1, 2008,
 33 deadline pursuant to this section, the office shall do all of the
 34 following:

35 (A) Provide public notice of a hospital's request for an extension
 36 of the deadline. The notice, at a minimum, shall be posted on the
 37 office's Internet Web site, and shall include the facility's name
 38 and identification number, the status of the request, and the
 39 beginning and ending dates of the comment period, and shall advise
 40 the public of the opportunity to submit public comments pursuant

1 to subparagraph (C). The office shall also provide notice of all
2 requests for the deadline extension directly to interested parties
3 upon request of the interested parties.

4 (B) Provide copies of extension requests to interested parties
5 within 10 working days to allow interested parties to review and
6 provide comment within the 45-day comment period. The copies
7 shall include those records that are available to the public pursuant
8 to the California Public Records Act (Chapter 3.5 (commencing
9 with Section 6250) of Division 7 of Title 1 of the Government
10 Code).

11 (C) Allow the public to submit written comments on the
12 extension proposal for a period of not less than 45 days from the
13 date of the public notice.

14 (b) (1) It is the intent of the Legislature, in enacting this
15 subdivision, to facilitate the process of having more hospital
16 buildings in substantial compliance with this chapter and to take
17 nonconforming general acute care hospital inpatient buildings out
18 of service more quickly.

19 (2) The functional contiguous grouping of hospital buildings of
20 a general acute care hospital, each of which provides, as the
21 primary source, one or more of the hospital's eight basic services
22 as specified in subdivision (a) of Section 1250, may receive a
23 five-year extension of the January 1, 2008, deadline specified in
24 subdivision (a) of this section pursuant to this subdivision for both
25 structural and nonstructural requirements. A functional contiguous
26 grouping refers to buildings containing one or more basic hospital
27 services that are either attached or connected in a way that is
28 acceptable to the State Department of Health Care Services. These
29 buildings may be either on the existing site or a new site.

30 (3) To receive the five-year extension, a single building
31 containing all of the basic services or at least one building within
32 the contiguous grouping of hospital buildings shall have obtained
33 a building permit prior to 1973 and this building shall be evaluated
34 and classified as a nonconforming, Structural Performance
35 Category-1 (SPC-1) building. The classification shall be submitted
36 to and accepted by the Office of Statewide Health Planning and
37 Development. The identified hospital building shall be exempt
38 from the requirement in subdivision (a) until January 1, 2013, if
39 the hospital agrees that the basic service or services that were

1 provided in that building shall be provided, on or before January
2 1, 2013, as follows:

3 (A) Moved into an existing conforming Structural Performance
4 Category-3 (SPC-3), Structural Performance Category-4 (SPC-4),
5 or Structural Performance Category-5 (SPC-5) and Non-Structural
6 Performance Category-4 (NPC-4) or Non-Structural Performance
7 Category-5 (NPC-5) building.

8 (B) Relocated to a newly built compliant SPC-5 and NPC-4 or
9 NPC-5 building.

10 (C) Continued in the building if the building is retrofitted to a
11 SPC-5 and NPC-4 or NPC-5 building.

12 (4) A five-year extension is also provided to a post-1973
13 building if the hospital owner informs the Office of Statewide
14 Health Planning and Development that the building is classified
15 as SPC-1, SPC-3, or SPC-4 and will be closed to general acute
16 care inpatient service use by January 1, 2013. The basic services
17 in the building shall be relocated into a SPC-5 and NPC-4 or NPC-5
18 building by January 1, 2013.

19 (5) SPC-1 buildings, other than the building identified in
20 paragraph (3) or (4), in the contiguous grouping of hospital
21 buildings shall also be exempt from the requirement in subdivision
22 (a) until January 1, 2013. However, on or before January 1, 2013,
23 at a minimum, each of these buildings shall be retrofitted to a
24 SPC-2 and NPC-3 building, or no longer be used for general acute
25 care hospital inpatient services.

26 (c) On or before March 1, 2001, the office shall establish a
27 schedule of interim work progress deadlines that hospitals shall
28 be required to meet to be eligible for the extension specified in
29 subdivision (b). To receive this extension, the hospital building or
30 buildings shall meet the year 2002 nonstructural requirements.

31 (d) A hospital building that is eligible for an extension pursuant
32 to this section shall meet the January 1, 2030, nonstructural and
33 structural deadline requirements if the building is to be used for
34 general acute care inpatient services after January 1, 2030.

35 (e) Upon compliance with subdivision (b), the hospital shall be
36 issued a written notice of compliance by the office. The office
37 shall send a written notice of violation to hospital owners that fail
38 to comply with this section. The office shall make copies of these
39 notices available on its Internet Web site.

1 (f) (1) A hospital that has received an extension of the January
2 1, 2008, deadline pursuant to subdivision (a) or (b) may request
3 an additional extension of up to two years for a hospital building
4 that it owns or operates and that meets the criteria specified in
5 paragraph (2), (3), or (5).

6 (2) The office may grant the additional extension if the hospital
7 building subject to the extension meets all of the following criteria:

8 (A) The hospital building is under construction at the time of
9 the request for extension under this subdivision and the purpose
10 of the construction is to meet the requirements of subdivision (a)
11 to allow the use of the building as a general acute care hospital
12 building after the extension deadline granted by the office pursuant
13 to subdivision (a) or (b).

14 (B) The hospital building plans were submitted to the office
15 and were deemed ready for review by the office at least four years
16 prior to the applicable deadline for the building. The hospital shall
17 indicate, upon submission of its plans, the SPC-1 building or
18 buildings that will be retrofitted or replaced to meet the
19 requirements of this section as a result of the project.

20 (C) The hospital received a building permit for the construction
21 described in subparagraph (A) at least two years prior to the
22 applicable deadline for the building.

23 (D) The hospital submitted a construction timeline at least two
24 years prior to the applicable deadline for the building demonstrating
25 the hospital's intent to meet the applicable deadline. The timeline
26 shall include all of the following:

27 (i) The projected construction start date.

28 (ii) The projected construction completion date.

29 (iii) Identification of the contractor.

30 (E) The hospital is making reasonable progress toward meeting
31 the timeline set forth in subparagraph (D), but factors beyond the
32 hospital's control make it impossible for the hospital to meet the
33 deadline.

34 (3) The office may grant the additional extension if the hospital
35 building subject to the extension meets all of the following criteria:

36 (A) The hospital building is owned by a health care district that
37 has, as owner, received the extension of the January 1, 2008,
38 deadline, but where the hospital is operated by an unaffiliated
39 third-party lessee pursuant to a facility lease that extends at least
40 through December 31, 2009. The district shall file a declaration

1 with the office with a request for an extension stating that, as of
2 the date of the filing, the district has lacked, and continues to lack,
3 unrestricted access to the subject hospital building for seismic
4 planning purposes during the term of the lease, and that the district
5 is under contract with the county to maintain hospital services
6 when the hospital comes under district control. The office shall
7 not grant the extension if an unaffiliated third-party lessee will
8 operate the hospital beyond December 31, 2010.

9 (B) The hospital building plans were submitted to the office
10 and were deemed ready for review by the office at least four years
11 prior to the applicable deadline for the building. The hospital shall
12 indicate, upon submission of its plans, the SPC-1 building or
13 buildings that will be retrofitted or replaced to meet the
14 requirements of this section as a result of the project.

15 (C) The hospital received a building permit for the construction
16 described in subparagraph (B) by December 31, 2011.

17 (D) The hospital submitted, by December 31, 2011, a
18 construction timeline for the building demonstrating the hospital's
19 intent and ability to meet the deadline of December 31, 2014. The
20 timeline shall include all of the following:

- 21 (i) The projected construction start date.
- 22 (ii) The projected construction completion date.
- 23 (iii) Identification of the contractor.

24 (E) The hospital building is under construction at the time of
25 the request for the extension, the purpose of the construction is to
26 meet the requirements of subdivision (a) to allow the use of the
27 building as a general acute care hospital building after the extension
28 deadline granted by the office pursuant to subdivision (a) or (b),
29 and the hospital is making reasonable progress toward meeting
30 the timeline set forth in subparagraph (D).

31 (F) The hospital granted an extension pursuant to this paragraph
32 shall submit an additional status report to the office, equivalent to
33 that required by subdivision (c) of Section 130061, no later than
34 June 30, 2013.

35 (4) An extension granted pursuant to paragraph (3) shall be
36 applicable only to the health care district applicant and its affiliated
37 hospital while the hospital is operated by the district or an entity
38 under the control of the district.

39 (5) The office may grant the additional extension if the hospital
40 building subject to the extension meets all of the following criteria:

1 (A) The hospital owner submitted to the office, prior to June
2 30, 2009, a request for review using current computer modeling
3 utilized by the office and based upon software developed by the
4 Federal Emergency Management Agency, referred to as Hazards
5 US, and the building was deemed SPC-1 after that review.

6 (B) The hospital building plans for the building are submitted
7 to the office and deemed ready for review by the office prior to
8 July 1, 2010. The hospital shall indicate, upon submission of its
9 plans, the SPC-1 building or buildings that shall be retrofitted or
10 replaced to meet the requirements of this section as a result of the
11 project.

12 (C) The hospital receives a building permit from the office for
13 the construction described in subparagraph (B) prior to January 1,
14 2012.

15 (D) The hospital submits, prior to January 1, 2012, a
16 construction timeline for the building demonstrating the hospital's
17 intent and ability to meet the applicable deadline. The timeline
18 shall include all of the following:

- 19 (i) The projected construction start date.
- 20 (ii) The projected construction completion date.
- 21 (iii) Identification of the contractor.

22 (E) The hospital building is under construction at the time of
23 the request for the extension, the purpose of the construction is to
24 meet the requirements of subdivision (a) to allow the use of the
25 building as a general acute care hospital building after the extension
26 deadline granted by the office pursuant to subdivision (a) or (b),
27 and the hospital is making reasonable progress toward meeting
28 the timeline set forth in subparagraph (D).

29 (F) The hospital owner completes construction such that the
30 hospital meets all criteria to enable the office to issue a certificate
31 of occupancy by the applicable deadline for the building.

32 (6) A hospital denied an extension pursuant to this subdivision
33 may appeal the denial to the Hospital Building Safety Board.

34 (7) The office may revoke an extension granted pursuant to this
35 subdivision for any hospital building where the work of
36 construction is abandoned or suspended for a period of at least one
37 year, unless the hospital demonstrates in a public document that
38 the abandonment or suspension was caused by factors beyond its
39 control.

1 (g) (1) Notwithstanding subdivisions (a), (b), (c), and (f), and
2 Sections 130061.5 and 130064, a hospital that has received an
3 extension of the January 1, 2008, deadline pursuant to subdivision
4 (a) or (b) also may request an additional extension of up to seven
5 years for a hospital building that it owns or operates. The office
6 may grant the extension subject to the hospital meeting the
7 milestones set forth in paragraph (2).

8 (2) The hospital building subject to the extension shall meet all
9 of the following milestones, unless the hospital building is
10 reclassified as SPC-2 or higher as a result of its Hazards US score:

11 (A) The hospital owner submits to the office, no later than ~~March~~
12 ~~31~~ *September 30, 2012*, a letter of intent stating whether it intends
13 to rebuild, replace, or retrofit the building, or remove all general
14 acute care beds and services from the building, and the amount of
15 time necessary to complete the construction.

16 (B) The hospital owner submits to the office, no later than ~~March~~
17 ~~31~~ *September 30, 2012*, a schedule detailing why the requested
18 extension is necessary, and specifically how the hospital intends
19 to meet the requested deadline.

20 (C) The hospital owner submits to the office, no later than
21 September 30, 2012, an application ready for review seeking
22 structural reassessment of each of its SPC-1 buildings using current
23 computer modeling based upon software developed by FEMA,
24 referred to as Hazards US.

25 (D) The hospital owner submits to the office, no later than
26 January 1, 2015, plans ready for review consistent with the letter
27 of intent submitted pursuant to subparagraph (A) and the schedule
28 submitted pursuant to subparagraph (B).

29 (E) The hospital owner submits a financial report to the office
30 at the time the plans are submitted pursuant to subparagraph (D).
31 The report shall demonstrate the hospital owner's financial capacity
32 to implement the construction plans submitted pursuant to
33 subparagraph (D).

34 (F) The hospital owner receives a building permit consistent
35 with the letter of intent submitted pursuant to subparagraph (A)
36 and the schedule submitted pursuant to subparagraph (B), no later
37 than July 1, 2018.

38 (3) To evaluate public safety and determine whether to grant
39 an extension of the deadline, the office shall consider the structural
40 integrity of the hospital's SPC-1 buildings based on its Hazards

1 US scores, community access to essential hospital services, and
2 the hospital owner's financial capacity to meet the deadline as
3 determined by either a bond rating of BBB or below or the financial
4 report on the hospital owner's financial capacity submitted pursuant
5 to subparagraph (E) of paragraph (2). The criteria contained in this
6 paragraph shall be considered by the office in its determination of
7 the length of an extension or whether an extension should be
8 granted.

9 (4) The extension or subsequent adjustments granted pursuant
10 to this subdivision may not exceed the amount of time that is
11 reasonably necessary to complete the construction specified in
12 paragraph (2).

13 (5) If the circumstances underlying the request for extension
14 submitted to the office pursuant to paragraph (2) change, the
15 hospital owner shall notify the office as soon as practicable, but
16 in no event later than six months after the hospital owner
17 discovered the change of circumstances. The office may adjust the
18 length of the extension granted pursuant to paragraphs (2) and (3)
19 as necessary, but in no event longer than the period specified in
20 paragraph (1).

21 (6) A hospital denied an extension pursuant to this subdivision
22 may appeal the denial to the Hospital Building Safety Board.

23 (7) The office may revoke an extension granted pursuant to this
24 subdivision for any hospital building when it is determined that
25 any information submitted pursuant to this section was falsified,
26 or if the hospital failed to meet a milestone set forth in paragraph
27 (2), or where the work of construction is abandoned or suspended
28 for a period of at least six months, unless the hospital demonstrates
29 in a publicly available document that the abandonment or
30 suspension was caused by factors beyond its control.

31 (8) Regulatory submissions made by the office to the California
32 Building Standards Commission to implement this section shall
33 be deemed to be emergency regulations and shall be adopted as
34 emergency regulations.

35 (9) The hospital owner that applies for an extension pursuant
36 to this subdivision shall pay the office an additional fee, to be
37 determined by the office, sufficient to cover the additional
38 reasonable costs incurred by the office for maintaining the
39 additional reporting requirements established under this section,
40 including, but not limited to, the costs of reviewing and verifying

1 the extension documentation submitted pursuant to this subdivision.
2 This additional fee shall not include any cost for review of the
3 plans or other duties related to receiving a building or occupancy
4 permit.

5 (10) This subdivision shall become operative on the date that
6 the State Department of Health Care Services receives all necessary
7 federal approvals for a 2011–12 fiscal year hospital quality
8 assurance fee program that includes three hundred twenty million
9 dollars (\$320,000,000) in fee revenue to pay for health care
10 coverage for children, which is made available as a result of the
11 legislative enactment of a 2011–12 fiscal year hospital quality
12 assurance fee program.

13 *SEC. 41. Section 130316 of the Health and Safety Code is*
14 *amended to read:*

15 130316. Any funds appropriated for the purpose of this division
16 that remain unexpended or unencumbered on ~~January 1, 2013~~ *June*
17 *30, 2016*, shall revert to the General Fund on that date unless a
18 statute that is enacted before ~~January 1, 2013~~ *June 30, 2016*,
19 extends the provisions of this division.

20 *SEC. 42. Section 130317 of the Health and Safety Code is*
21 *amended to read:*

22 130317. This division shall become inoperative on ~~January 1,~~
23 ~~2013~~ *June 30, 2016*, and as of that date is repealed, unless a later
24 enacted statute, that is enacted before ~~January 1, 2013~~ *June 30,*
25 *2016*, deletes or extends the dates on which it becomes inoperative
26 and is repealed.

27 *SEC. 43. Section 131019.5 is added to the Health and Safety*
28 *Code, to read:*

29 131019.5. (a) For purposes of this section, the following
30 definitions shall apply:

31 (1) “Determinants of equity” means social, economic,
32 geographic, political, and physical environmental conditions that
33 lead to the creation of a fair and just society.

34 (2) “Health equity” means efforts to ensure that all people have
35 full and equal access to opportunities that enable them to lead
36 healthy lives.

37 (3) “Health and mental health disparities” means differences
38 in health and mental health status among distinct segments of the
39 population, including differences that occur by gender, age, race
40 or ethnicity, sexual orientation, gender identity, education or

1 *income, disability or functional impairment, or geographic*
2 *location, or the combination of any of these factors.*

3 (4) *“Health and mental health inequities” means disparities in*
4 *health or mental health, or the factors that shape health, that are*
5 *systemic and avoidable and, therefore, considered unjust or unfair.*

6 (5) *“Vulnerable communities” include, but are not limited to,*
7 *women, racial or ethnic groups, low-income individuals and*
8 *families, individuals who are incarcerated and those who have*
9 *been incarcerated, individuals with disabilities, individuals with*
10 *mental health conditions, children, youth and young adults, seniors,*
11 *immigrants and refugees, individuals who are limited-English*
12 *proficient (LEP), and lesbian, gay, bisexual, transgender, queer,*
13 *and questioning (LGBTQQ) communities, or combinations of these*
14 *populations.*

15 (6) *“Vulnerable places” means places or communities with*
16 *inequities in the social, economic, educational, or physical*
17 *environment or environmental health and that have insufficient*
18 *resources or capacity to protect and promote the health and*
19 *well-being of their residents.*

20 (b) *The State Department of Public Health shall establish an*
21 *Office of Health Equity for the purposes of aligning state resources,*
22 *decisionmaking, and programs to accomplish all of the following:*

23 (1) *Achieve the highest level of health and mental health for all*
24 *people, with special attention focused on those who have*
25 *experienced socioeconomic disadvantage and historical injustice,*
26 *including, but not limited to, vulnerable communities and*
27 *culturally, linguistically, and geographically isolated communities.*

28 (2) *Work collaboratively with the Health in All Policies Task*
29 *Force to promote work to prevent injury and illness through*
30 *improved social and environmental factors that promote health*
31 *and mental health.*

32 (3) *Advise and assist other state departments in their mission*
33 *to increase access to, and the quality of, culturally and*
34 *linguistically competent health and mental health care and*
35 *services.*

36 (4) *Improve the health status of all populations and places, with*
37 *a priority on eliminating health and mental health disparities and*
38 *inequities.*

39 (c) *The duties of the Office of Health Equity shall include all of*
40 *the following:*

1 (1) *Conducting policy analysis and developing strategic policies*
2 *and plans regarding specific issues affecting vulnerable*
3 *communities and vulnerable places to increase positive health and*
4 *mental health outcomes for vulnerable communities and decrease*
5 *health and mental health disparities and inequities. The policies*
6 *and plans shall also include strategies to address social and*
7 *environmental inequities and improve health and mental health.*
8 *The office shall assist other departments in their missions to*
9 *increase access to services and supports and improve quality of*
10 *care for vulnerable communities.*

11 (2) *Establishing a comprehensive, cross-sectoral strategic plan*
12 *to eliminate health and mental health disparities and inequities.*
13 *The strategies and recommendations developed shall take into*
14 *account the needs of vulnerable communities to ensure strategies*
15 *are developed throughout the state to eliminate health and mental*
16 *health disparities and inequities. This plan shall be developed in*
17 *collaboration with the Health in All Policies Task Force. This plan*
18 *shall establish goals and benchmarks for specific strategies in*
19 *order to measure and track disparities and the effectiveness of*
20 *these strategies. This plan shall be updated periodically, but not*
21 *less than every two years, to keep abreast of data trends, best*
22 *practices, promising practices, and to more effectively focus and*
23 *direct necessary resources to mitigate and eliminate disparities*
24 *and inequities. This plan shall be included in the report required*
25 *under paragraph (1) of subdivision (d). The Office of Health Equity*
26 *shall seek input from the public on the plan through an inclusive*
27 *public stakeholder process.*

28 (3) *Building upon and informing the work of the Health in All*
29 *Policies Task Force in working with state agencies and*
30 *departments to consider health in appropriate and relevant aspects*
31 *of public policy development to ensure the implementation of goals*
32 *and objectives that close the gap in health status. The Office of*
33 *Health Equity shall work collaboratively with the Health in All*
34 *Policies Task Force to assist state agencies and departments in*
35 *developing policies, systems, programs, and environmental change*
36 *strategies that have population health impacts in all of the*
37 *following ways, within the resources made available:*

38 (A) *Develop intervention programs with targeted approaches*
39 *to address health and mental health inequities and disparities.*

1 (B) Prioritize building cross-sectoral partnerships within and
2 across departments and agencies to change policies and practices
3 to advance health equity.

4 (C) Work with the advisory committee established pursuant to
5 subdivision (f) and through stakeholder meetings to provide a
6 forum to identify and address the complexities of health and mental
7 health inequities and disparities and the need for multiple,
8 interrelated, and multisectoral strategies.

9 (D) Provide technical assistance to state and local agencies
10 and departments with regard to building organizational capacity,
11 staff training, and facilitating communication to facilitate strategies
12 to reduce health and mental health disparities.

13 (E) Highlight and share evidence-based, evidence-informed,
14 and community-based practices for reducing health and mental
15 health disparities and inequities.

16 (F) Work with local public health departments, county mental
17 health or behavioral health departments, local social services,
18 and mental health agencies, and other local agencies that address
19 key health determinants, including, but not limited to, housing,
20 transportation, planning, education, parks, and economic
21 development. The Office of Health Equity shall seek to link local
22 efforts with statewide efforts.

23 (4) Consult with community-based organizations and local
24 governmental agencies to ensure that community perspectives and
25 input are included in policies and any strategic plans,
26 recommendations, and implementation activities.

27 (5) Assist in coordinating projects funded by the state that
28 pertain to increasing the health and mental health status of
29 vulnerable communities.

30 (6) Provide consultation and technical assistance to state
31 departments and other state and local agencies charged with
32 providing or purchasing state-funded health and mental health
33 care, in their respective missions to identify, analyze, and report
34 disparities and to identify strategies to address health and mental
35 health disparities.

36 (7) Provide information and assistance to state and local
37 departments in coordinating projects within and across state
38 departments that improve the effectiveness of public health and
39 mental health services to vulnerable communities and that address

1 *community environments to promote health. This information shall*
2 *identify unnecessary duplication of services.*

3 *(8) Communicate and disseminate information within the*
4 *department and with other state departments to assist in developing*
5 *strategies to improve the health and mental health status of persons*
6 *in vulnerable communities and to share strategies that address*
7 *the social and environmental determinants of health.*

8 *(9) Provide consultation and assistance to public and private*
9 *entities that are attempting to create innovative responses to*
10 *improve the health and mental health status of vulnerable*
11 *communities.*

12 *(10) Seek additional resources, including in-kind assistance,*
13 *federal funding, and foundation support.*

14 *(d) In identifying and developing recommendations for strategic*
15 *plans, the Office of Health Equity shall, at a minimum, do all of*
16 *the following:*

17 *(1) Conduct demographic analyses on health and mental health*
18 *disparities and inequities. The report shall include, to the extent*
19 *feasible, an analysis of the underlying conditions that contribute*
20 *to health and well-being. The first report shall be due July 1, 2014.*
21 *This information shall be updated periodically, but not less than*
22 *every two years, and made available through public dissemination,*
23 *including posting on the department's Internet Web site. The report*
24 *shall be developed using primary and secondary sources of*
25 *demographic information available to the office, including the*
26 *work and data collected by the Health in All Policies Task Force.*
27 *Primary sources of demographic information shall be collected*
28 *contingent on the receipt of state, federal, or private funds for this*
29 *purpose.*

30 *(2) Based on the availability of data, including valid data made*
31 *available from secondary sources, the report described in*
32 *paragraph (1) shall address the following key factors as they relate*
33 *to health and mental health disparities and inequities:*

34 *(A) Income security such as living wage, earned income tax*
35 *credit, and paid leave.*

36 *(B) Food security and nutrition such as food stamp eligibility*
37 *and enrollment, assessments of food access, and rates of access*
38 *to unhealthy food and beverages.*

39 *(C) Child development, education, and literacy rates, including*
40 *opportunities for early childhood development and parenting*

1 support, rates of graduation compared to dropout rates, college
2 attainment, and adult literacy.

3 (D) Housing, including access to affordable, safe, and healthy
4 housing, housing near parks and with access to healthy foods, and
5 housing that incorporates universal design and visitability features.

6 (E) Environmental quality, including exposure to toxins in the
7 air, water, and soil.

8 (F) Accessible built environments that promote health and
9 safety, including mixed-used land, active transportation such as
10 improved pedestrian, bicycle, and automobile safety, parks and
11 green space, and healthy school siting.

12 (G) Health care, including accessible disease management
13 programs, access to affordable, quality health and behavioral
14 health care, assessment of the health care workforce, and
15 workforce diversity.

16 (H) Prevention efforts, including community-based education
17 and availability of preventive services.

18 (I) Assessing ongoing discrimination and minority stressors
19 against individuals and groups in vulnerable communities based
20 upon race, gender, gender identity, gender expression, ethnicity,
21 marital status, language, sexual orientation, disability, and other
22 factors, such as discrimination that is based upon bias and negative
23 attitudes of health professionals and providers.

24 (J) Neighborhood safety and collective efficacy, including rates
25 of violence, increases or decreases in community cohesion, and
26 collaborative efforts to improve the health and well-being of the
27 community.

28 (K) The efforts of the Health in All Policies Task Force,
29 including monitoring and identifying efforts to include health and
30 equity in all sectors.

31 (L) Culturally appropriate and competent services and training
32 in all sectors, including training to eliminate bias, discrimination,
33 and mistreatment of persons in vulnerable communities.

34 (M) Linguistically appropriate and competent services and
35 training in all sectors, including the availability of information in
36 alternative formats such as large font, braille, and American Sign
37 Language.

38 (N) Accessible, affordable, and appropriate mental health
39 services.

1 (3) Consult regularly with representatives of vulnerable
2 communities, including diverse racial, ethnic, cultural, and
3 LGBTQQ communities, women's health advocates, mental health
4 advocates, health and mental health providers, community-based
5 organizations and advocates, academic institutions, local public
6 health departments, local government entities, and low-income
7 and vulnerable consumers.

8 (4) Consult regularly with the advisory committee established
9 by subdivision (f) for input and updates on the policy
10 recommendations, strategic plans, and status of cross-sectoral
11 work.

12 (e) The Office of Health Equity shall be organized as follows:

13 (1) A Deputy Director shall be appointed by the Governor or
14 the State Public Health Officer, and is subject to confirmation by
15 the Senate. The salary for the Deputy Director shall be fixed in
16 accordance with state law.

17 (2) The Deputy Director of the Office of Health Equity shall
18 report to the State Public Health Officer and shall work closely
19 with the Director of Health Care Services to ensure compliance
20 with the requirements of the office's strategic plans, policies, and
21 implementation activities.

22 (f) The Office of Health Equity shall establish an advisory
23 committee to advance the goals of the office and to actively
24 participate in decisionmaking. The advisory committee shall be
25 composed of representatives from applicable state agencies and
26 departments, local health departments, community-based
27 organizations working to advance health and mental health equity,
28 vulnerable communities, and stakeholder communities that
29 represent the diverse demographics of the state. The chair of the
30 advisory committee shall be a representative from a nonstate entity.
31 The advisory committee shall be established by no later than
32 October 1, 2013, and shall meet, at a minimum, on a quarterly
33 basis. Subcommittees of this advisory committee may be formed
34 as determined by the chair.

35 (g) An interagency agreement shall be established between the
36 State Department of Public Health and the State Department of
37 Health Care Services to outline the process by which the
38 departments will jointly work to advance the mission of the Office
39 of Health Equity, including responsibilities, scope of work, and
40 necessary resources.

1 SEC. 44. Section 131051 of the Health and Safety Code is
2 amended to read:

3 131051. The duties, powers, functions, jurisdiction, and
4 responsibilities transferred to the State Department of Public Health
5 shall, pursuant to the act that added this section, include all of the
6 following previously performed by the former State Department
7 of Health Services:

8 (a) Under the jurisdiction of the Deputy Director for Prevention
9 Services:

10 (1) The Office of AIDS, including but not limited to:

11 (A) The AIDS Drug Assistance Program (Chapter 6
12 (commencing with Section 120950) of Part 4 of Division 105).

13 (B) The AIDS Early Intervention Program (Chapter 4
14 (commencing with Section 120900) of Part 4 of Division 105).

15 (C) The CARE Services Program, provided for pursuant to the
16 federal Ryan White CARE Act, 42 U.S.C. Section 300ff.

17 (D) The CARE/Health Insurance Premium Payment Program
18 (federal Ryan White CARE Act, 42 U.S.C. Sec. 300ff).

19 (E) The Housing Opportunities for Persons with AIDS Program
20 (Section 100119).

21 (F) The Residential AIDS Licensed Facilities Program (former
22 Section 100119; Chapter 2 (commencing with Section 120815) of
23 Part 4 of Division 105).

24 (G) The AIDS Case Management Program (federal Ryan White
25 CARE Act, 42 U.S.C. Sec. 300ff; Chapter 2 (commencing with
26 Section 120815) of Part 4 of Division 105).

27 (H) The AIDS Medi-Cal Waiver Program (former Section
28 100119; 42 U.S.C. Sec. 1396n(c)).

29 (I) The Bridge Project (former Section 100119).

30 (J) The HIV Therapeutic Monitoring Program (Chapter 16
31 (commencing with Section 121345) of Part 4 of Division 105).

32 (K) The Learning Immune Function Enhancement program
33 (former Section 100119).

34 (L) The San Ysidro Prevention Project (Section 113019).

35 (M) The California Statewide Treatment Education Program
36 (former Section 100119).

37 (N) The HIV Counseling and Testing Program (Section 113019).

38 (O) The Neighborhood Intervention Geared Toward High-Risk
39 Testing program (former Section 100119).

- 1 (P) The Perinatal Transmission Prevention Project (Section
2 113019).
- 3 (Q) The California AIDS Clearinghouse (Section 113019).
- 4 (R) The California Disclosure Assistance and Partner
5 Services/Partner Counseling and Referral Services (Section
6 113019).
- 7 (S) The African-American HIV Initiative (Section 113019;
8 Chapter 13.7 (commencing with Section 120290) of Part 4 of
9 Division 105).
- 10 (T) The Injection Drug User HIV Testing Utilizing Hepatitis C
11 Testing High-Risk Initiative (Section 113019).
- 12 (U) The Prevention with Positives High-Risk Initiative (Section
13 113019).
- 14 (V) The Statewide Technical Assistance Initiatives (Section
15 113019).
- 16 (W) The HIV/AIDS Case Registry (Sections 113019, 120125,
17 and 120130).
- 18 (2) The Office of Binational Border Health, including, but not
19 limited to, all of the following:
- 20 (A) The California-Mexico Health Initiative (Part 3
21 (commencing with Section 475) of Division 1).
- 22 (B) The Early Warning Infectious Disease Surveillance Program
23 (Chapter 2 (commencing with Section 1250) of Division 2; Chapter
24 2 (commencing with Section 120130) of Part 1 of Division 105).
- 25 (3) The Division of Communicable Disease Control, including,
26 but not limited to, all of the following:
- 27 (A) The Infant Botulism Treatment and Prevention Program
28 (Article 2.5 (commencing with Section 123700) of Chapter 3 of
29 Part 2 of Division 106).
- 30 (B) The Sexually Transmitted Disease Control Program (Part
31 3 (commencing with Section 120500) of Division 105).
- 32 (C) The Infectious Disease Program (Chapter 2 (commencing
33 with Section 120130) of Part 1 of Division 105).
- 34 (D) The Bioterrorism Epidemiology Program.
- 35 (E) The Vector Borne Disease (Part 11 (commencing with
36 Section 116100) of Division 104).
- 37 (F) The Tuberculosis Control Program (Part 5 (commencing
38 with Section 121350) of Division 105).
- 39 (G) The Microbial Diseases Laboratory (Chapter 2 (commencing
40 with Section 100250) of Division 101).

1 (H) The Viral and Rickettsial Disease Laboratory (Chapter 2
2 (commencing with Section 100250) of Division 101).

3 (I) The West Nile Human Surveillance Program (Chapter 2
4 (commencing with Section 116110) of Part 11 of Division 104).

5 (J) The Immunization Program (Part 2 (commencing with
6 Section 120325) of Division 105).

7 (K) The Vaccines for Children Program (Part 2 (commencing
8 with Section 120325) of Division 105).

9 (4) The Division of Chronic Disease and Injury Control,
10 including, but not limited to, all of the following:

11 (A) The IMPACT Prostate Cancer Treatment Program (Chapter
12 7 (commencing with Section 104322) of Part 1 of Division 103),
13 *until June 30, 2012. Commencing July 1, 2012, the duties, powers,*
14 *functions, jurisdiction, and responsibilities of the State Department*
15 *of Public Health regarding this program are hereby with the State*
16 *Department of Health Care Services.*

17 (B) The Every Woman Counts program (Breast and Cervical
18 Cancer Screening Program) (Article 1.3 (commencing with Section
19 104150) of Chapter 2 of Part 1 of Division 103; Section 30461.6
20 of the Revenue and Taxation Code), *until June 30, 2012.*
21 *Commencing July 1, 2012, the duties, powers, functions,*
22 *jurisdiction, and responsibilities of the State Department of Public*
23 *Health regarding this program are hereby with the State*
24 *Department of Health Care Services.*

25 (C) The Well-Integrated Screening and Evaluation for Women
26 Across the Nation Demonstration Project (Article 1.3 (commencing
27 with Section 104150) of Chapter 2 of Part 1 of Division 103).

28 (D) The California Nutrition Network (Chapter 2 (commencing
29 with Section 104575) of Part 3 of Division 103).

30 (E) The Cancer Research Program (Article 2 (commencing with
31 Section 104175) of Chapter 2 of Part 1 of Division 103).

32 (F) The Translational Cancer Research and Technology Transfer
33 Program (Article 2 (commencing with Section 104175) of Chapter
34 2 of Part 1 of Division 103).

35 (G) The Ken Maddy California Cancer Registry (Chapter 2
36 (commencing with Section 103875) of Part 2 of Division 102).

37 (H) The California Osteoporosis Prevention and Education
38 Program (Chapter 1 (commencing with Section 125700) of Part 8
39 of Division 106).

- 1 (I) The Preventive Health Care for the Aging Program (Part 4
2 (commencing with Section 104900) of Division 103).
- 3 (J) The California Arthritis Prevention Program (former Section
4 100185).
- 5 (K) The Office of Oral Health (Chapter 3 (commencing with
6 Section 104750) of Part 3 of Division 103).
- 7 (L) The Children’s Dental Disease Prevention Program (Article
8 3 (commencing with Section 104770) of Chapter 3 of Part 3 of
9 Division 103).
- 10 (M) The Community Water Fluoridation Program (Article 3.5
11 (commencing with Section 116409) of Chapter 4 of Part 12 of
12 Division 104).
- 13 (N) The California Asthma Public Health Initiative (Chapter
14 6.5 (commencing with Section 104316) of Part 1 of Division 103).
- 15 (O) The California Obesity Prevention Initiative (Chapter 2
16 (commencing with Section 104575) of Part 3 of Division 103).
- 17 (P) The School Health Connections program (Chapter 2
18 (commencing with Section 104575) of Part 3 of Division 103).
- 19 (Q) The California Project LEAN (Chapter 2 (commencing with
20 Section 104575) of Part 3 of Division 103).
- 21 (R) The California Center for Physical Activity (Section
22 131085).
- 23 (S) The California Diabetes Program (Section 131085).
- 24 (T) The Preventive Medicine Residency Program (Section
25 131090).
- 26 (U) The California Epidemiologic Investigation Service (Article
27 4 (commencing with Section 100325) of Chapter 2 of Part 1 of
28 Division 101).
- 29 (V) The Continuing Professional Education Program (Section
30 131090).
- 31 (W) The Injury Surveillance and Epidemiology Program (Part
32 2 (commencing with Section 104325) of Division 103).
- 33 (X) The State and Local Injury Control Program (Chapter 1
34 (commencing with Section 104325) of Part 2 of Division 103).
- 35 (Y) The Office on Disability and Health (former Section
36 100185).
- 37 (Z) The Alzheimer’s Disease Program (Article 4 (commencing
38 with Section 125275) of Chapter 2 of Part 5 of Division 106).
- 39 (AA) The California Tobacco Control Program (Chapter 1
40 (commencing with Section 104350) of Part 3 of Division 103).

- 1 (5) The Division of Drinking Water and Environmental
2 Management, including, but not limited to, all of the following:
- 3 (A) The Medical Waste Management Program (Part 14
4 (commencing with Section 117600) of Division 104).
- 5 (B) The Department of Defense Oversight Program (Radiologic
6 Guidance and Approvals) (Part 9 (commencing with Section
7 114650) of Division 104).
- 8 (C) The Nuclear Emergency Response Program (Part 9
9 (commencing with Section 114650) of Division 104).
- 10 (D) The Institutions Program (Environmental Surveys) (Article
11 5 (commencing with Section 116025) of Chapter 5 of Part 10 of
12 Division 104).
- 13 (E) The Drinking Water Field Management program (Chapter
14 4 (commencing with Section 116270) of Part 12 of Division 104).
- 15 (F) The Environmental Health Specialist Registration Program
16 (Article 1 (commencing with Section 106600) of Chapter 4 of Part
17 1 of Division 104).
- 18 (G) The Sanitation and Radiation Laboratory (Article 2
19 (commencing with Section 100250) of Chapter 2 of Part 1 of
20 Division 101); Chapter 4 (commencing with Section 116270) of
21 Part 12 of Division 104).
- 22 (H) The Radon Program (Chapter 7 (commencing with Section
23 105400) of Part 5 of Division 103; Chapter 4 (commencing with
24 Section 116270) of Part 12, and Article 2 (commencing with
25 Section 106750) of Chapter 4 of Part 1, of Division 104).
- 26 (I) The Shellfish Sanitation Program (Chapter 5 (commencing
27 with Section 112150) of Part 6 of Division 104).
- 28 (J) The Ocean Beach Safety Programs (Article 2 (commencing
29 with Section 115875) of Chapter 5 of Part 10 of Division 104).
- 30 (K) The Bioterrorism Planning and Response for Drinking
31 Water, Medical Waste, and Environmental Health program (Article
32 6 (commencing with Section 101315) of Chapter 3 of Part 3 of
33 Division 101).
- 34 (L) The Safe Drinking Water State Revolving Fund (Chapter
35 4.5 (commencing with Section 116760) of Part 12 of Division
36 104).
- 37 (M) The Drinking Water Technical Programs (Chapter 4
38 (commencing with Section 16270) of Part 12 of Division 104;
39 Chapter 4.5 (commencing with Section 116760) of Part 12 of
40 Division 104; Article 3 (commencing with Section 106875) of

1 Chapter 4 of Part 1 of Division 104; Chapter 5 (commencing with
2 Section 116775) of Part 12 of Division 104; Chapter 5
3 (commencing with Section 115825) of Part 10 of Division 104;
4 Chapter 7 (commencing with Section 13500) of Division 7 of the
5 Water Code; Section 13411 of the Water Code).

6 (N) The Water Security, Clean Drinking Water, Coastal and
7 Beach Protection Act of 2002 (Proposition 50) (Division 26.5
8 (commencing with Section 79500) of the Water Code).

9 (6) The Division of Environmental and Occupational Disease
10 Control, including, but not limited to, all of the following:

11 (A) The California Birth Defect Monitoring Program (Chapter
12 1 (commencing with Section 103825) of Part 2 of Division 102).

13 (B) The Childhood Lead Poisoning Prevention Program (Chapter
14 5 (commencing with Section 105275) of Part 5 of Division 103;
15 Article 7 (commencing with Section 124125) of Chapter 3 of Part
16 2 of Division 106).

17 (C) The Lead Related Construction Program (Chapter 4
18 (commencing with Section 105250) of Part 5 of Division 103).

19 (D) The Epidemiology Studies Laboratory (Sections 25416,
20 former Section 100170, Section 100325, and Section 104324.25).

21 (E) The Center for Autism and Developmental Disabilities
22 Research and Epidemiology (former Section 100170).

23 (F) The Cancer Cluster/Environmental Investigations (former
24 Section 100170).

25 (G) The Toxic Mold Program (Chapter 18 (commencing with
26 Section 26100) of Division 20).

27 (H) The Federal Agency for Toxic Substances and Disease
28 Registry Health Assessments, Education and Investigations
29 program (former Section 100170).

30 (I) The Fish Contamination Outreach and Education program
31 (former Section 100170).

32 (J) The Air Pollution and Cardiovascular Disease in the
33 California Teachers Study Cohort Project (former Section 100170).

34 (K) The Delta Watershed Fish Project (outreach, education, and
35 training to reduce exposures to mercury in fish) (former Section
36 100170).

37 (L) The Environmental Health Laboratory (former Section
38 100170; Article 2 (commencing with Section 100250) of Chapter
39 2 of Part 1 of Division 101).

- 1 (M) The Indoor Air Quality program (Chapter 7 (commencing
2 with Section 105400) of Part 5 of Division 103).
- 3 (N) The Outdoor Air Quality program (Section 60.9 of the Labor
4 Code).
- 5 (O) The Laboratory Response Network for Chemical Terrorism
6 program (former Section 100170; Article 2 (commencing with
7 Section 100250) of Chapter 2 of Part 1 of Division 101).
- 8 (P) The Air Quality and Human Monitoring Support Program
9 (former Section 100170).
- 10 (Q) The Hazard Evaluation System and Information Service
11 Program (Article 1 (commencing with Section 105175) of Chapter
12 2 of Part 5 of Division 103; Section 147.2 of the Labor Code).
- 13 (R) The Occupational Health Surveillance and Evaluation
14 Program (Article 1 (commencing with Section 105175) of Chapter
15 2 of Part 5 of Division 103).
- 16 (S) The Occupational Lead Poisoning Prevention Program
17 (Article 2 (commencing with Section 105185) of Chapter 2 of Part
18 5 of Division 103).
- 19 (T) The Occupational Blood Lead Registry (Article 2
20 (commencing with Section 105185) of Chapter 2 of Part 5 of
21 Division 103).
- 22 (7) The Division of Food, Drug and Radiation Safety, including,
23 but not limited to, all of the following:
- 24 (A) The Drug Licensing Program (Article 6 (commencing with
25 Section 111615) of Chapter 6 of Part 5 of Division 104).
- 26 (B) The Consumer Product Safety Program (Part 3 (commencing
27 with Section 108100) of Division 104).
- 28 (C) The Export Program (Article 2 (commencing with Section
29 110190) of Chapter 2 of Part 5 of Division 104).
- 30 (D) The Food Safety Inspection Program (Part 5 (commencing
31 with Section 109875) and Part 6 (commencing with Section
32 111940) of Division 104).
- 33 (E) The Foodborne Illness and Tampering Emergency Response
34 Program (Part 5 (commencing with Section 109875) of Division
35 104).
- 36 (F) The Retail Food Safety Program (Part 7 (commencing with
37 Section 113700) of Division 104).
- 38 (G) The Food Safety Industry Education and Training Program
39 (pursuant to Section 110485).

- 1 (H) The Medical Device Licensing Program (Article 6
2 (commencing with Section 111615) of Chapter 6 of Part 5 of
3 Division 104).
- 4 (I) The Medical Device Safety Program (Part 5 (commencing
5 with Section 109875) of Division 104).
- 6 (J) The Stop Tobacco Access to Kids Enforcement Program
7 (STAKE) (Division 8.5 (commencing with Section 22950) of the
8 Business and Professions Code).
- 9 (K) The Food and Drug Laboratory (Chapter 2 (commencing
10 with Section 100250) of Division 101).
- 11 (L) The Drug Safety Program (Part 4 (commencing with Section
12 109250) and Part 5 (commencing with Section 109875) of Division
13 104).
- 14 (M) The General Food Safety Program (Part 5 (commencing
15 with Section 109875) and Part 6 (commencing with Section
16 111940) of Division 104).
- 17 (N) The Food Testing Program (Chapter 2 (commencing with
18 Section 100250) of Division 101).
- 19 (O) The Forensic Alcohol Testing Program (Article 2
20 (commencing with Section 100700) of Chapter 4 of Part 1 of
21 Division 101).
- 22 (P) The Methadone Laboratory Regulating Program (Article 2
23 (commencing with Section 11839.23) of Chapter 10 of Part 2 of
24 Division 10.5).
- 25 (Q) The Radiologic Health Program (Part 9 (commencing with
26 Section 114650) of Division 104).
- 27 (R) The Mammography Program (Chapter 6 (commencing with
28 Section 114840) of Part 9 of Division 104).
- 29 (S) The Radioactive Materials Licensing and Inspection Program
30 (Chapter 8 (commencing with Section 114960) of Part 9 of
31 Division 104).
- 32 (T) The Radiological Technologist Certification Program
33 (Article 5 (commencing with Section 106955) of Part 1, and Article
34 3 (commencing with Section 114855) of Chapter 6 of Part 9 of
35 Division 104).
- 36 (U) The Radioactive Waste Tracking Program (Chapter 8
37 (commencing with Section 114960) of Part 9 of Division 104).
- 38 (V) The Radioactive Waste Minimization Program (Chapter 8
39 (commencing with Section 114960) of Part 9 of Division 104).

1 (W) The Low Level Radioactive Waste Management, Treatment
2 and Disposal Program (Chapter 8 (commencing with Section
3 114960) of Part 9 of Division 104).

4 (X) The Statewide Environmental Radiation Monitoring
5 Program (pursuant to Section 114755).

6 (Y) The Department of Energy Oversight Program (Part 9
7 (commencing with Section 114650) of Division 104).

8 (Z) The X-Ray Machine Inspection and Registration and
9 Mammography Quality Standards Act Inspection Program (Article
10 5 (commencing with Section 106955) of Part 1, and Article 3
11 (commencing with Section 114855) of Chapter 6 of Part 9 of
12 Division 104).

13 (8) The Deputy Director for Laboratory Science, including, but
14 not limited to, all of the following:

15 (A) The Environmental Laboratory Accreditation Program
16 (Article 3 (commencing with Section 100825) of Chapter 4 of Part
17 1 of Division 101).

18 (B) The Laboratory Central Services Program (Article 2
19 (commencing with Section 100250) of Chapter 2 of Part 1 of
20 Division 101).

21 (C) The National Laboratory Training Network (Section
22 131085).

23 (D) The Laboratory Field Services program (Chapter 3
24 (commencing with Section 1200) of Division 2 of the Business
25 and Professions Code).

26 (b) Under the jurisdiction of the Deputy Director for Licensing
27 and Certification:

28 (1) The General Acute Care Hospitals Licensing Program
29 (Chapter 2 (commencing with Section 1250) of Division 2).

30 (2) The Acute Psychiatric Hospitals Licensing Program (Chapter
31 2 (commencing with Section 1250) of Division 2).

32 (3) The Special Hospitals Licensing Program (Chapter 2
33 (commencing with Section 1250) of Division 2).

34 (4) The Chemical Dependency Recovery Hospitals Licensing
35 Program (Chapter 2 (commencing with Section 1250) of Division
36 2).

37 (5) The Skilled Nursing Facilities Licensing Program (Chapter
38 2 (commencing with Section 1250) of Division 2).

39 (6) The Intermediate Care Facilities Licensing Program (Chapter
40 2 (commencing with Section 1250) of Division 2).

- 1 (7) The Intermediate Care Facilities-Developmentally Disabled
2 Licensing Program (Chapter 2 (commencing with Section 1250)
3 of Division 2).
- 4 (8) The Intermediate Care Facilities-Developmentally
5 Disabled-Habilitative Licensing Program (Chapter 2 (commencing
6 with Section 1250) of Division 2).
- 7 (9) The Intermediate Care Facility-Developmentally
8 Disabled-Nursing Licensing Program (Chapter 2 (commencing
9 with Section 1250) of Division 2).
- 10 (10) The Home Health Agencies Licensing Program (Chapter
11 8 (commencing with Section 1725) of Division 2).
- 12 (11) The Referral Agencies Licensing Program (Chapter 2.3
13 (commencing with Section 1400) of Division 2).
- 14 (12) The Adult Day Health Centers Licensing Program (Chapter
15 3.3 (commencing with Section 1570) of Division 2).
- 16 (13) The Congregate Living Health Facilities (Chapter 2
17 (commencing with Section 1250) of Division 2).
- 18 (14) The Psychology Clinics Licensing Program (Chapter 1
19 (commencing with Section 1200) of Division 2).
- 20 (15) The Primary Clinics—Community and Free Licensing
21 Program (Chapter 1 (commencing with Section 1200) of Division
22 2).
- 23 (16) The Specialty Clinics—Rehab Clinics Licensing Program
24 (Chapter 1 (commencing with Section 1200) of Division 2).
- 25 (17) The Dialysis Clinics Licensing Program (Chapter 1
26 (commencing with Section 1200) of Division 2).
- 27 (18) The Pediatric Day Health/Respite Care Licensing Program
28 (Chapter 2 (commencing with Section 1250) of Division 2).
- 29 (19) The Alternative Birthing Centers Licensing Program
30 (Chapter 1 (commencing with Section 1200) of Division 2).
- 31 (20) The Hospice Licensing Program (Chapter 2 (commencing
32 with Section 1339.30) of Division 2).
- 33 (21) The Correctional Treatment Centers Licensing Program
34 (Chapter 2 (commencing with Section 1250) of Division 2).
- 35 (22) The Medicare/Medi-Cal Certification Program (Chapter 7
36 (commencing with Section 14000) of Part 3 of Division 9 of the
37 Welfare and Institutions Code).
- 38 (23) The Nursing Home Administrator Professional Certification
39 Program (Chapter 2.35 (commencing with Section 1416) of
40 Division 2).

1 (24) The Certified Nursing Assistants Professional Certification
2 Program (Chapter 2 (commencing with Section 1337) of Division
3 2).

4 (25) The Home Health Aides Professional Certification Program
5 (Chapter 8 (commencing with Section 1725) of Division 2).

6 (26) The Hemodialysis Technicians Professional Certification
7 Program (Chapter 3 (commencing with Section 1247) of Division
8 2 of the Business and Professions Code; Chapter 10 (commencing
9 with Section 1794) of Division 2).

10 (27) The Criminal Background Clearance Program (Chapter 2
11 (commencing with Section 1337), Chapter 3 (commencing with
12 Section 1520), Chapter 3.01 (commencing with Section 1569.15),
13 Chapter 3.4 (commencing with Section 1496.80) of Division 2,
14 and Chapter 4 (commencing with Section 11150) of Division 8).

15 (c) Under the jurisdiction of the Deputy Director for Health
16 Information and Strategic Planning:

17 (1) The Refugee Health Program (Subpart G of Part 400 of Title
18 45 of the Code of Federal Regulations).

19 (2) The Office of County Health Services (Article 5
20 (commencing with Section 101300) of Chapter 3 of Part 3 of
21 Division 101; Part 4.7 (commencing with Section 16900) of
22 Division 9 of the Welfare and Institutions Code).

23 (3) The Medically Indigent Services Program (Article 5
24 (commencing with Section 101300) of Chapter 3 of Part 3 of
25 Division 101).

26 (4) The Office of Vital Records (Part 1 (commencing with
27 Section 102100) of Division 102).

28 (5) The Office of Health Information and Research (Article 1
29 (commencing with Section 102175) of Chapter 2 of Part 1 of
30 Division 102; Section 128730).

31 (6) The Local Public Health Services Program (Article 5
32 (commencing with Section 101300) of Chapter 3 of Part 3 of
33 Division 101).

34 (7) The Center for Health Statistics (Part 1 (commencing with
35 Section 102100) of Division 102; Section 128730).

36 (8) The Medical Marijuana Program (Article 2.5 (commencing
37 with Section 11362.7) of Chapter 6 of Division 10 of the Health
38 and Safety Code).

39 (d) Under the jurisdiction of the Deputy Director for Primary
40 Care and Family Health:

- 1 (1) The Maternal, Child and Adolescent Health program (Part
2 2 (commencing with Section 123225) of Division 106).
- 3 (2) The Adolescent Family Life Program (Article 1
4 (commencing with Section 124175) of Chapter 4 of Part 2 of
5 Division 106).
- 6 (3) The Advanced Practice Nurse Training program (Part 2
7 (commencing with Section 123225) of Division 106).
- 8 (4) The Black Infant Health Program (Part 2 (commencing with
9 Section 123225) of Division 106).
- 10 (5) The Breastfeeding Program (Article 3 (commencing with
11 Section 123360) of Chapter 1 of Part 2 of Division 6).
- 12 (6) The California Diabetes and Pregnancy Program (Part 2
13 (commencing with Section 123225) of Division 106).
- 14 (7) The California Initiative to Improve Adolescent Health (Part
15 2 (commencing with Section 123225) of Division 106).
- 16 (8) The Childhood Injury Prevention Program (Article 4
17 (commencing with Section 100325) of Chapter 2 of Division 101).
- 18 (9) The Comprehensive Perinatal Services Program (Article 3
19 (commencing with Section 123475) of Chapter 2 of Part 2; Section
20 14134.5 of the Welfare and Institutions Code).
- 21 (10) The Fetal and Infant Mortality Review Program (Article
22 1 (commencing with Section 123650) of Chapter 3 of Part 2 of
23 Division 106).
- 24 (11) The Human Stem Cell Research Program (Chapter 3
25 (commencing with Section 125290.10) of Part 5 of Division 106;
26 Chapter 1 (commencing with Section 125300) of Part 5.5 of
27 Division 106).
- 28 (12) The Local Health Department Maternal, Child and
29 Adolescent Health Program (Section 123255).
- 30 (13) The Maternal Mortality Review Program (Article 4
31 (commencing with Section 100325) of Chapter 2 of Division 101).
- 32 (14) The Oral Health Program (Part 2 (commencing with Section
33 123225) of Division 106).
- 34 (15) The Preconception Health and Health Care Initiative (Part
35 2 (commencing with Section 123225) of Division 106).
- 36 (16) The Regional Perinatal Programs of California (Article 4
37 (commencing with Section 123550) of Chapter 2 of Part 2 of
38 Division 106).

1 (17) The Perinatal Dispatch Centers Outreach and Education
2 Program (Article 4 (commencing with Section 123750) of Chapter
3 3 of Part 2 of Division 106).

4 (18) The State Early Childhood Comprehensive Services
5 program (Part 2 (commencing with Section 123225) of Division
6 106).

7 (19) The Sudden Infant Death Syndrome Program (Article 3
8 (commencing with Section 123725) of Chapter 3 of Part 2 of
9 Division 106).

10 (20) The Youth Pilot Program (Chapter 12.85 (commencing
11 with Section 18987) of Part 6 of Division 9 of the Welfare and
12 Institutions Code).

13 (21) The Office of Family Planning (Chapter 8.5 (commencing
14 with Section 14500) of Part 3 of Division 9 of the Welfare and
15 Institutions Code; Division 24 (commencing with Section 24000)
16 of the Welfare and Institutions Code), *until June 30, 2012.*
17 *Commencing July 1, 2012, the duties, powers, functions,*
18 *jurisdiction, and responsibilities of the State Department of Public*
19 *Health regarding this office are hereby with the State Department*
20 *of Health Care Services.*

21 (22) The Community Challenge Grant Program (Section 14504.1
22 of the Welfare and Institutions Code, and Chapter 14 (commencing
23 with Section 18993) of Part 6 of Division 9 of the Welfare and
24 Institutions Code).

25 (23) The Information and Education Program (Section 14504.3
26 of the Welfare and Institutions Code).

27 (24) The Family PACT Program—(Sections—14132(aa)
28 *(subdivision (aa) of Section 14132 and Section 24005 of the*
29 *Welfare and Institutions Code), until June 30, 2012. Commencing*
30 *July 1, 2012, the duties, powers, functions, jurisdiction, and*
31 *responsibilities of the State Department of Public Health regarding*
32 *this program are hereby with the State Department of Health Care*
33 *Services.*

34 (25) The Male Involvement Program (Section 14504 of the
35 Welfare and Institutions Code).

36 (26) The TeenSMART Outreach Program (Section 14504.2 of
37 the Welfare and Institutions Code).

38 (27) The Battered Women Shelter Program (Chapter 6
39 (commencing with Section 124250) of Part 2 of Division 106).

1 (28) The Women, Infants and Children Program (Article 1
2 (commencing with Section 123275) of Chapter 1 of Part 2 of
3 Division 106).

4 (29) The WIC Supplemental Nutrition Program (Article 1
5 (commencing with Section 123275) of Chapter 1 of Part 2 of
6 Division 106).

7 (30) The Farmers Market Nutrition Program (Section 123279).

8 (31) Genetic Disease Program (Chapter 1 (commencing with
9 Section 124975) of Part 5 of Division 106).

10 (32) The Newborn Screening Program (Chapter 1 (commencing
11 with Section 124975) of Part 5 of Division 106).

12 (33) The Prenatal Screening Program (Chapter 1 (commencing
13 with Section 124975) of Part 5 of Division 106).

14 *SEC. 45. Section 131052 of the Health and Safety Code is*
15 *amended to read:*

16 131052. In implementing the transfer of jurisdiction pursuant
17 to this article, the State Department of Public Health succeeds to
18 and is vested with all the statutory duties, powers, purposes,
19 responsibilities, and jurisdiction of the former State Department
20 of Health Services as they relate to public health as provided for
21 or referred to in all of the following provisions of law:

22 (1) Sections 550, 555, 650, 680, 1241, 1658, 2221.1, 2248.5,
23 2249, 2259, 2259.5, 2541.3, 2585, 2728, 3527, 4017, 4027, 4037,
24 4191, 19059.5, 19120, 22950, 22973.2, and 22974.8 of the
25 Business and Professions Code.

26 (2) Sections 56.17, 1812.508, and 1812.543 of the Civil Code.

27 (3) Sections 8286, 8803, 17613, 32064, 32065, 32066, 32241,
28 49030, 49405, 49414, 49423.5, 49452.6, 49460, 49464, 49565,
29 49565.8, 49531.1, 56836.165, and 76403 of the Education Code.

30 (4) Sections 405, 6021, 6026, 18963, 30852, 41302, and 78486
31 of the Food and Agricultural Code.

32 (5) Sections 307, 355, 422, 7572, 7574, 8706, 8817, and 8909
33 of the Family Code.

34 (6) Sections 217.6, 1507, 1786, 4011, 5671, 5674, 5700, 5701,
35 5701.5, 7715, and 15700 of the Fish and Game Code.

36 (7) Sections 855, 51010, and 551017.1 of the Government Code.
37 For purposes of subdivision (s) of Section 6254 of the Government
38 Code, the term "State Department of Health Services" is here-by
39 deemed to refer to the State Department of Public Health.

- 1 (8) (A) Sections 475, 1180.6, 1418.1, 1422.1, 1428.2, 1457,
2 1505, 1507.1, 1507.5, 1570.7, 1599.2, 1599.60, 1599.75, 1599.87,
3 2002, 2804, 11362.7, 11776, 11839.21, 11839.23, 11839.24,
4 11839.25, 11839.26, 11839.27, 11839.28, 11839.29, 11839.30,
5 11839.31, 11839.32, 11839.33, 11839.34, 17920.10, 17961,
6 18897.2, 24185, 24186, 24187, 24275, 26101, 26122, 26134,
7 26155, 26200, and 26203.
- 8 (B) Chapters 1, 2, 2.05, 2.3, 2.35, 2.4, 3.3, 3.9, 3.93, 3.95, 4,
9 4.1, 4.5, 5, 6, 6.5, 8, 8.3, 8.5, 8.6, 9, and 11 of Division 2.
- 10 (C) Articles 2 and 4 of Chapter 2, Chapter 3, and Chapter 4 of
11 Part 1, Part 2 and Part 3 of Division 101.
- 12 (D) Division 102, including Sections 102230 and 102231.
- 13 (E) Division 103, including Sections 104145, ~~104160~~, 104181,
14 104182, 104182.5, 104187, 104191, *104192*, *104193*, *104316*,
15 *104317*, *104318*, *104319*, *104320*, *104321*, 104324.2, 104324.25,
16 104350, 105191, 105251, 105255, 105280, 105340, and 105430.
- 17 (F) Division 104, including Sections 106615, 106675, 106770,
18 108115, 108855, 109282, 109910, 109915, 112155, 112500,
19 112650, 113355, 114460, 114475, 114650, 114710, 114850,
20 114855, 114985, 115061, 115261, 115340, 115736, 115880,
21 115885, 115915, 116064, 116183, 116270, 116365.5, 116366,
22 116375, 116610, 116751, 116760.20, 116825, 117100, 117924,
23 and 119300.
- 24 (G) Division 105, including Sections 120262, 120381, 120395,
25 120440, 120480, 120956, 120966, 121155, 121285, 121340,
26 121349.1, 121480, 122410, and 122420.
- 27 (H) Part 1, Part 2 excluding Articles 5, 5.5, 6, and 6.5 of Chapter
28 3, Part 3 and Part 5 excluding Articles 1 and 2 of Chapter 2, Part
29 7, and Part 8 of Division 106.
- 30 (9) Sections 799.03, 10123.35, 10123.5, 10123.55, 10123.10,
31 10123.184, and 11520 of the Insurance Code.
- 32 (10) Sections 50.8, 142.3, 144.5, 144.7, 147.2, 4600.6, 6307.1,
33 6359, 6712, 9009, and 9022 of the Labor Code.
- 34 (11) Sections 4018.1, 5008.1, 7501, 7502, 7510, 7511, 7515,
35 7518, 7530, 7550, 7553, 7575, 7576, 11010, 11174.34, and 13990
36 of the Penal Code.
- 37 (12) Section 4806 of the Probate Code.
- 38 (13) Sections 15027, 25912, 28004, 30950, 41781.1, 42830,
39 43210, 43308, 44103, and 71081 of the Public Resources Code.
- 40 (14) Section 10405 of the Public Contract Code.

1 (15) Sections 883, 1507, and 7718 of the Public Utilities Code.

2 (16) Sections 18833, 18838, 18845.2, 18846.2, 18847.2, 18863,
3 30461.6, 43010.1, and 43011.1 of the Revenue and Taxation Code.

4 (17) Section 11020 of the Unemployment Insurance Code.

5 (18) Sections 22511.55, 23158, 27366, and 33000 of the Vehicle
6 Code.

7 (19) Sections 5326.9, 5328, 5328.15, 14132, 16902, and 16909,
8 and Division 24 of the Welfare and Institutions Code. Payment
9 for services provided under the Family Planning, Access, Care,
10 and Treatment (Family PACT) Waiver Program pursuant to
11 subdivision (aa) of Section 14132 and Division 24 shall be made
12 through the State Department of Health Care Services. The State
13 Department of Public Health and the State Department of Health
14 Care Services may enter into an interagency agreement for the
15 administration of those payments. *This paragraph, to the extent*
16 *that it applies to the Family PACT Waiver Program, shall become*
17 *inoperative on June 30, 2012.*

18 (20) Sections 13176, 13177.5, 13178, 13193, 13390, 13392,
19 13392.5, 13393.5, 13395.5, 13396.7, 13521, 13522, 13523, 13528,
20 13529, 13529.2, 13550, 13552.4, 13552.8, 13553, 13553.1, 13554,
21 13554.2, 13816, 13819, 13820, 13823, 13824, 13825, 13827,
22 13830, 13834, 13835, 13836, 13837, 13858, 13861, 13862, 13864,
23 13868, 13868.1, 13868.3, 13868.5, 13882, 13885, 13886, 13887,
24 13891, 13892, 13895.1, 13895.6, 13895.9, 13896, 13896.3,
25 13896.4, 13896.5, 13897, 13897.4, 13897.5, 13897.6, 13898,
26 14011, 14012, 14015, 14016, 14017, 14019, 14022, 14025, 14026,
27 14027, and 14029 of the Water Code.

28 *SEC. 46. Section 131055.1 is added to the Health and Safety*
29 *Code, to read:*

30 *131055.1. (a) Notwithstanding Section 131050, commencing*
31 *on July 1, 2012, the State Department of Health Care Services*
32 *shall succeed to and be vested with all the duties, powers, purposes,*
33 *functions, responsibilities, and jurisdiction of the State Department*
34 *of Public Health as they relate to the Breast and Cervical Cancer*
35 *Screening Program pursuant to Article 1.3 (commencing with*
36 *Section 104150) of Chapter 1, the Breast and Cervical Cancer*
37 *Treatment Program pursuant to Article 1.5 (commencing with*
38 *Section 104160) of Chapter 1, the Prostate Cancer Screening*
39 *Program pursuant to Chapter 6 (commencing with Section*
40 *104310), the IMPACT Prostate Cancer Treatment Program*

1 pursuant to Chapter 7 (commencing with Section 104322) of Part
2 1 of Division 103, translation services pursuant to Part 3
3 (commencing with Section 124300) of Division 106, the Office of
4 Family Planning pursuant to Chapter 8.5 (commencing with
5 Section 14500) of Part 3 of Division 9 of the Welfare and
6 Institutions Code, excluding the Personal Responsibility Education
7 Federal Grant Program, the Family Planning, Access, Care, and
8 Treatment (Family PACT) Program pursuant to subdivision (aa)
9 of Section 14132, and the State-Only Family Planning Program
10 pursuant to Division 24 (commencing with Section 24000) of the
11 Welfare and Institutions Code.

12 (b) Commencing July 1, 2012, any reference to the State
13 Department of Public Health with regard to the Breast and
14 Cervical Cancer Screening Program pursuant to Article 1.3
15 (commencing with Section 104150) of Chapter 1, the Breast and
16 Cervical Cancer Treatment Program pursuant to Article 1.5
17 (commencing with Section 104160) of Chapter 1, the Prostate
18 Cancer Screening Program pursuant to Chapter 6 (commencing
19 with Section 104310), the IMPACT Prostate Cancer Treatment
20 Program pursuant to Chapter 7 (commencing with Section 104322)
21 of Part 1 of Division 103, translation services pursuant to Part 3
22 (commencing with Section 124300) of Division 106, the Office of
23 Family Planning pursuant to Chapter 8.5 (commencing with
24 Section 14500) of Part 3 of Division 9 of the Welfare and
25 Institutions Code, excluding the Personal Responsibility Education
26 Federal Grant Program, the Family Planning, Access, Care, and
27 Treatment (Family PACT) Program pursuant to subdivision (aa)
28 of Section 14132, or the State-Only Family Planning Program
29 pursuant to Division 24 (commencing with Section 24000) of the
30 Welfare and Institutions Code, shall refer to the State Department
31 of Health Care Services.

32 (c) All regulations and orders adopted by the State Department
33 of Public Health and any of its predecessors in effect prior to July
34 1, 2012, shall remain in effect and shall be fully enforceable unless
35 and until readopted, amended, or repealed, or until they expire by
36 their own terms. Any action by or against the State Department of
37 Public Health and any of its predecessors pertaining to matters
38 vested in the State Department of Health Care Services by this act
39 shall not abate but shall continue in the name of the State
40 Department of Health Care Services, and the State Department of

1 *Health Care Services shall be substituted for the State Department*
2 *of Public Health and any of its predecessors by the court wherein*
3 *the action is pending. The substitution shall not in any way affect*
4 *the rights of the parties to the action.*

5 *(d) Commencing July 1, 2012, the unexpended balance of all*
6 *funds available for use by the State Department of Public Health*
7 *or any of its predecessors in carrying out any functions transferred*
8 *to the State Department of Health Care Services shall be available*
9 *for use by the State Department of Health Care Services.*

10 *(e) Commencing July 1, 2012, all books, documents, records,*
11 *and property of the State Department of Public Health pertaining*
12 *to functions transferred to the State Department of Health Care*
13 *Services shall be transferred to the State Department of Health*
14 *Care Services.*

15 *(f) Commencing July 1, 2012, positions filled by appointment*
16 *by the Governor in the State Department of Public Health whose*
17 *principal assignment was to perform functions transferred to the*
18 *State Department of Health Care Services shall be transferred to*
19 *the State Department of Health Care Services. Individuals in*
20 *positions transferred pursuant to this subdivision shall serve at*
21 *the pleasure of the Governor. Salaries of positions transferred*
22 *shall remain at the level established pursuant to law unless*
23 *otherwise provided.*

24 *(g) Commencing July 1, 2012, every officer and employee of*
25 *the State Department of Public Health who is performing a function*
26 *transferred to the State Department of Health Care Services and*
27 *who is serving in the state civil service, other than as a temporary*
28 *employee, shall be transferred to the State Department of Health*
29 *Care Services pursuant to the provisions of Section 19050.9 of the*
30 *Government Code. The status, position, and rights of any officer*
31 *or employee of the State Department of Public Health shall not be*
32 *affected by the transfer and shall be retained by the person as an*
33 *officer or employee of the State Department of Health Care*
34 *Services, as applicable, pursuant to the State Civil Service Act*
35 *(Part 2 (commencing with Section 18500) of Division 5 of Title 2*
36 *of the Government Code), except for a position that is exempt from*
37 *civil service.*

38 *(h) No contract, lease, license, or any other agreement to which*
39 *the State Department of Public Health is a party shall be void or*
40 *voidable by reason of this act, but shall continue in full force and*

1 effect, with State Department of Health Care Services assuming
2 all of the rights, obligations, liabilities, and duties of the State
3 Department of Public Health as relates to the duties, powers,
4 purposes, responsibilities, and jurisdiction vested by this section
5 in the State Department of Health Care Services. The assumption
6 by the State Department of Health Care Services shall not in any
7 way affect the rights of the parties to any contract, lease, license,
8 or agreement.

9 SEC. 47. Section 4024.7 is added to the Welfare and Institutions
10 Code, to read:

11 4024.7. The Governor or the Director of Health Care Services
12 shall appoint, subject to confirmation by the Senate, a Deputy
13 Director of Mental Health and Substance Use Disorder Services
14 of the State Department of Health Care Services. The salary for
15 the deputy director shall be fixed in accordance with law.

16 SEC. 48. Section 4362 of the Welfare and Institutions Code is
17 amended to read:

18 4362. The Legislature finds all of the following:

19 (a) That state public policy discriminates against adults with
20 brain damage or degenerative brain disease, such as Alzheimer’s
21 disease. This damage or disease is referred to as “brain
22 impairments” in this chapter.

23 (b) That the Legislature has declared state public policy and
24 accepted responsibility to ensure that persons under the age of 18
25 years who are developmentally disabled pursuant to Division 4.5
26 (commencing with Section 4500), receive services necessary to
27 meet their needs, which are often similar to those of persons who
28 suffer from brain impairments.

29 (c) That persons over the age of 18 who sustain brain impairment
30 have a variety of program and service needs for which there is no
31 clearly defined, ultimate responsibility vested in any single state
32 agency and for which there are currently a number of different
33 programs attempting to meet their needs.

34 (d) That the lack of clearly defined ultimate responsibility has
35 resulted in severe financial liability and physical and mental strain
36 on brain-impaired persons, their families, and caregivers.

37 (e) That terminology and nomenclature used to describe brain
38 impairments are varied and confusing, in part because of different
39 medical diagnoses and professional opinions, as well as differences
40 in terminology used by the various funding sources for programs

1 and services. Uniformity is required in order to ensure that
2 appropriate programs and services are available throughout the
3 state to serve these persons.

4 (f) That the term “brain damage” covers a wide range of organic
5 and neurological disorders, and that these disorders, as identified
6 below, are not necessarily to be construed as mental illnesses.

7 These disorders include, but are not limited to, all of the following:

8 (1) Progressive, degenerative, and dementing illnesses,
9 including, but not limited to, presenile and senile dementias,
10 Alzheimer’s disease, multiinfarct disease, Pick’s disease, and
11 Kreutzfeldt-Jakob’s disease.

12 (2) Degenerative diseases of the central nervous system that
13 can lead to dementia or severe brain impairment, including, but
14 not limited to, epilepsy, multiple sclerosis, Parkinson’s disease,
15 amyotrophic lateral sclerosis (ALS), and hereditary diseases such
16 as Huntington’s disease.

17 (3) Permanent damage caused by cerebrovascular accidents
18 more commonly referred to as “strokes,” including, but not limited
19 to, cerebral hemorrhage, aneurysm, and embolism.

20 (4) Posttraumatic, postanoxic, and postinfectious damage caused
21 by incidents, including, but not limited to, coma, accidental skull
22 and closed head injuries, loss of oxygen (anoxia), and infections
23 such as encephalitis, herpes simplex, and tuberculosis.

24 (5) Permanent brain damage or temporary or progressive
25 dementia as a result of tumors (neoplasm), hydrocephalus,
26 abscesses, seizures, substance toxicity, and other disorders.

27 (g) That brain damage frequently results in functional
28 impairments that adversely affect personality, behavior, and ability
29 to perform daily activities. These impairments cause dependency
30 on others for care and decisionmaking. The manifestations of brain
31 damage include impairments of memory, cognitive ability,
32 orientation, judgment, emotional response, and social inhibition.
33 Brain damage can strike anyone regardless of age, race, sex,
34 occupation, or economic status.

35 (h) That Family Survival Project for Brain-Damaged Adults of
36 San Francisco, a three-year pilot project established pursuant to
37 former Chapter 4 (commencing with Section 4330), has
38 demonstrated that the most successful, cost-effective service model
39 is one which allows a nonprofit community agency to provide a
40 full array of support services to families that have a member who

1 suffers from a brain impairment. This agency provides direct
2 services, coordinates existing resources, and assists in the
3 development of new programs and services on a regional basis.

4 (i) That respite care services provide a combination of
5 time-limited, in-home, and out-of-home services that significantly
6 decrease the stress of family members and increase their ability to
7 maintain a brain-impaired person at home at less cost than other
8 alternatives. This ability is further increased when complemented
9 by case planning, care training, and other support services for
10 family members.

11 ~~(j) That, since 1977, the State Department of Mental Health has~~
12 ~~attempted to identify service gaps and determine a cost-effective,~~
13 ~~feasible approach to funding and providing services to~~
14 ~~brain-damaged adults, their families, and caregivers. That~~
15 ~~department has the experience of offering more in the continuum~~
16 ~~of programs and services than any other state agency and is willing~~
17 ~~to continue in the lead state agency capacity.~~

18 ~~(k)~~

19 (j) That providing services to brain-impaired adults, and to their
20 families and caregivers, requires the coordinated services of many
21 state departments and community agencies to ensure that no gaps
22 occur in communication, in the availability of programs, or in the
23 provision of services. ~~Although the services may include mental~~
24 ~~health interventions, they cannot be met solely by services of the~~
25 ~~State Department of Mental Health.~~

26 *SEC. 49. Section 4362.5 of the Welfare and Institutions Code*
27 *is amended to read:*

28 4362.5. As used in this chapter:

29 (a) “Brain damage,” “degenerative brain diseases,” and “brain
30 impairment” mean significant destruction of brain tissue with
31 resultant loss of brain function. Examples of causes of the
32 impairments are Alzheimer’s disease, stroke, traumatic brain injury,
33 and other impairments described in subdivision (f) of Section 4330.

34 (b) “Brain-impaired adult” means a person whose brain
35 impairment has occurred after the age of 18.

36 (c) “Respite care” means substitute care or supervision in
37 support of the caregiver for the purposes of providing relief from
38 the stresses of constant care provision and so as to enable the
39 caregiver to pursue a normal routine and responsibilities. Respite
40 care may be provided in the home or in an out-of-home setting,

1 such as day care centers or short-term placements in inpatient
2 facilities.

3 (d) “Family member” means any relative or court appointed
4 guardian or conservator who is responsible for the care of a
5 brain-impaired adult.

6 (e) “Caregiver” means any unpaid family member or individual
7 who assumes responsibility for the care of a brain-impaired adult.

8 (f) “Director” means the Director of Health Care Services.

9 SEC. 50. Section 4364 of the Welfare and Institutions Code is
10 amended to read:

11 4364. The Statewide Resources Consultant shall do all of the
12 following:

13 (a) Serve as the centralized information and technical assistance
14 clearinghouse for brain-impaired adults, their families, caregivers,
15 service professionals and agencies, and volunteer organizations,
16 and in this capacity may assist organizations that serve families
17 with adults with Huntington’s disease and Alzheimer’s disease by
18 reviewing data collected by those organizations in their efforts to
19 determine the means of providing high-quality appropriate care in
20 health facilities and other out-of-home placements; and shall
21 disseminate information, including, but not limited to, the results
22 of research and activities conducted pursuant to its responsibilities
23 set forth in this chapter as determined by the director, and which
24 may include forwarding quality of care and related information to
25 appropriate state departments for consideration.

26 (b) Work closely and coordinate with organizations serving
27 brain-impaired adults, their families, and caregivers in order to
28 ensure, consistent with requirements for quality of services as may
29 be established by the director, that the greatest number of persons
30 are served and that the optimal number of organizations participate.

31 (c) Develop and conduct training that is appropriate for a variety
32 of persons, including, but not limited to, all of the following:

33 (1) Families.

34 (2) Caregivers and service professionals involved with
35 brain-impaired adults.

36 (3) Advocacy and self-help family and caregiver support
37 organizations.

38 (4) Educational institutions.

39 (d) Provide other training services, including, but not limited
40 to, reviewing proposed training curricula regarding the health,

1 psychological, and caregiving aspects of individuals with brain
2 damage as defined in subdivision (f) of Section 4362. The proposed
3 curricula may be submitted by providers or statewide associations
4 representing individuals with brain damage, their families, or
5 caregivers.

6 (e) Provide service and program development consultation to
7 resource centers and to identify funding sources that are available.

8 (f) Assist the appropriate state agencies in identifying and
9 securing increased federal financial participation and third-party
10 reimbursement, including, but not limited to, Title XVIII (42
11 U.S.C. Sec. 1395 and following) and Title XIX (42 U.S.C. Sec.
12 1396 and following) of the federal Social Security Act.

13 (g) Conduct public social policy research based upon the
14 recommendations of the ~~Director of Mental Health~~ *director*.

15 (h) Assist the director, as the director may require, in conducting
16 directly, or through contract, research in brain damage
17 epidemiology and data collection, and in developing a uniform
18 terminology and nomenclature.

19 (i) Assist the director in establishing criteria for, and in selecting
20 resource centers and in designing a methodology for, the consistent
21 assessment of resources and needs within the geographic areas to
22 be serviced by the resource centers.

23 (j) Conduct conferences, as required by the director, for families,
24 caregivers, service providers, advocacy organizations, educational
25 institutions, business associations, community groups, and the
26 general public, in order to enhance the quality and availability of
27 high-quality, low-cost care and treatment of brain-impaired adults.

28 (k) Make recommendations, after consultation with appropriate
29 state department representatives, to the ~~Director of Mental Health~~
30 *director* and the Secretary of *California Health and Welfare Human*
31 *Services* for a comprehensive statewide policy to support and
32 strengthen family caregivers, including the provision of respite
33 and other support services, in order to implement more fully this
34 chapter. The Statewide Resources Consultant shall coordinate its
35 recommendations to assist the *California Health and Welfare*
36 *Human Services* Agency to prepare its report on long-term care
37 programs pursuant to Chapter 1.5 (commencing with Section
38 100145) of Part 1 of Division 101 of the Health and Safety Code.

1 (l) Conduct an inventory and submit an analysis of California's
2 publicly funded programs serving family caregivers of older
3 persons and functionally impaired adults.

4 *SEC. 51. Section 4364.5 of the Welfare and Institutions Code*
5 *is amended to read:*

6 4364.5. The Statewide Resources Consultant, pursuant to
7 ~~subdivision (e) of Section 4362.5~~ *Section 4364*, shall do the
8 following:

9 (a) Develop respite care training materials, with consultation
10 by other appropriate organizations including the California
11 Association of Homes for the Aging, and under the direction of
12 the director, for distribution to all resource centers established
13 under this chapter.

14 (b) Provide the respite care training materials described in
15 subdivision (a) to other appropriate state entities, ~~including the~~
16 ~~Department of Aging, the State Department of Health Services,~~
17 ~~and the State Job Training Coordinating Council,~~ for distribution
18 to their respective services and programs.

19 (c) Pursuant to the requirements of Section 4365.5, report on
20 the utilization of the respite care training materials, developed
21 pursuant to subdivision (a), by all the resource centers for the
22 period ending December 31, 1990, only, and make
23 recommendations for the future use of these materials.

24 *SEC. 52. Section 4366 of the Welfare and Institutions Code is*
25 *amended to read:*

26 4366. Resource centers shall serve all of the following
27 functions:

28 (a) Provide directly or assist families in securing information,
29 advice, and referral services, legal services and financial
30 consultation, planning and problem-solving consultation, family
31 support services, and respite care services, as specified in Section
32 4338.

33 (b) Provide centralized access to information about, and referrals
34 to, local, state, and federal services and programs in order to assure
35 a comprehensive approach for brain-impaired adults, their families,
36 and caregivers. Nothing in this chapter shall prohibit access to
37 services through other organizations which provide similar
38 programs and services to brain-impaired adults and their families,
39 nor shall other organizations be prevented from providing these
40 programs and services.

1 (c) Assist in the identification and documentation of service
2 needs and the development of necessary programs and services to
3 meet the needs of brain-impaired adults in the geographic area.

4 (d) Cooperate with the Statewide Resources Consultant and the
5 ~~Director of Mental Health~~ *director* in any activities which they
6 deem necessary for the proper implementation of this chapter.

7 (e) Work closely and coordinate with organizations serving
8 brain-impaired adults, their families, and caregivers in order to
9 ensure, consistent with requirements for quality of services as may
10 be established by the director, that the greatest number of persons
11 are served and that the optimal number of organizations participate.

12 *SEC. 53. Section 4367.5 of the Welfare and Institutions Code*
13 *is amended to read:*

14 4367.5. The director shall establish criteria for client eligibility,
15 including financial liability, pursuant to Section 4368. However,
16 persons eligible for services provided by regional centers or the
17 State Department of Developmental Services are not eligible for
18 services provided under this chapter. Income shall not be the sole
19 basis for client eligibility. The director shall assume responsibility
20 for the coordination of existing funds and services for
21 brain-impaired adults, and for the purchase of respite care, as
22 defined in subdivision (c) of Section 4362.5, with other
23 departments that may serve brain-impaired adults, including the
24 Department of Rehabilitation, ~~the State Department of Health~~
25 ~~Services~~, the State Department of Social Services, the State
26 Department of Developmental Services, the Department of Aging,
27 the Office of Statewide Health Planning and Development, and
28 the State Department of Alcohol and Drug Programs.

29 *SEC. 54. Section 4368.5 of the Welfare and Institutions Code*
30 *is amended to read:*

31 4368.5. In considering total service funds available for the
32 project, the director shall utilize funding available from appropriate
33 state departments, including, but not limited to: ~~the State~~
34 ~~Department of Health Services~~, the State Department of Social
35 Services, the Department of Rehabilitation, the *California*
36 Department of Aging, and the State Department of Alcohol and
37 Drug Programs. The director in conjunction with the Statewide
38 Resources Consultant shall coordinate his or her activities with
39 the implementation of the Torres-Felando Long-Term Care Reform
40 Act (Chapter 1453, Statutes of 1982) in order to further the goal

1 of obtaining comprehensive, coordinated public policy and to
 2 maximize the availability of funding for programs and services
 3 for persons with brain impairments.

4 *SEC. 55. Section 5820 of the Welfare and Institutions Code is*
 5 *amended to read:*

6 5820. (a) It is the intent of this part to establish a program with
 7 dedicated funding to remedy the shortage of qualified individuals
 8 to provide services to address severe mental illnesses.

9 (b) Each county mental health program shall submit to the
 10 ~~department~~ *Office of Statewide Health Planning and Development*
 11 a needs assessment identifying its shortages in each professional
 12 and other occupational category in order to increase the supply of
 13 professional staff and other staff that county mental health
 14 programs anticipate they will require in order to provide the
 15 increase in services projected to serve additional individuals and
 16 families pursuant to Part 3 (commencing with Section 5800), Part
 17 3.2 (commencing with Section 5830), Part 3.6 (commencing with
 18 Section 5840), and Part 4 (commencing with Section 5850) of this
 19 division. For purposes of this part, employment in California’s
 20 public mental health system includes employment in private
 21 organizations providing publicly funded mental health services.

22 (c) ~~The department~~ *Office of Statewide Health Planning and*
 23 *Development, in coordination with the California Mental Health*
 24 *Planning Council, shall identify the total statewide needs for each*
 25 *professional and other occupational category utilizing county needs*
 26 *assessment information and develop a five-year education and*
 27 *training development plan.*

28 (d) Development of the first five-year plan shall commence
 29 upon enactment of the initiative. Subsequent plans shall be adopted
 30 every five years, *with the next five-year plan due as of April 1,*
 31 *2014.*

32 (e) Each five-year plan shall be reviewed and approved by the
 33 California Mental Health Planning Council.

34 *SEC. 56. Section 5821 of the Welfare and Institutions Code is*
 35 *amended to read:*

36 5821. (a) The California Mental Health Planning Council shall
 37 advise the ~~State Department of Mental Health~~ *Office of Statewide*
 38 *Health Planning and Development* on education and training policy
 39 development and provide oversight for ~~the department’s~~
 40 and training plan development.

1 (b) ~~The State Department of Mental Health~~ *Office of Statewide*
2 *Health Planning and Development* shall work with the California
3 Mental Health Planning Council *and the State Department of*
4 *Health Care Services* so that council staff is increased appropriately
5 to fulfill its duties required by Sections 5820 and 5821.

6 *SEC. 57. Section 5822 of the Welfare and Institutions Code is*
7 *amended to read:*

8 5822. ~~The State Department of Mental Health~~ *Office of*
9 *Statewide Health Planning and Development* shall include in the
10 five-year plan:

11 (a) Expansion plans for the capacity of postsecondary education
12 to meet the needs of identified mental health occupational
13 shortages.

14 (b) Expansion plans for the forgiveness and scholarship
15 programs offered in return for a commitment to employment in
16 California's public mental health system and make loan forgiveness
17 programs available to current employees of the mental health
18 system who want to obtain Associate of Arts, Bachelor of Arts,
19 master's degrees, or doctoral degrees.

20 (c) Creation of a stipend program modeled after the federal Title
21 IV-E program for persons enrolled in academic institutions who
22 want to be employed in the mental health system.

23 (d) Establishment of regional partnerships ~~among~~ *between* the
24 mental health system and the educational system to expand
25 outreach to multicultural communities, increase the diversity of
26 the mental health workforce, to reduce the stigma associated with
27 mental illness, and to promote the use of web-based technologies,
28 and distance learning techniques.

29 (e) Strategies to recruit high school students for mental health
30 occupations, increasing the prevalence of mental health occupations
31 in high school career development programs such as health science
32 academies, adult schools, and regional occupation centers and
33 programs, and increasing the number of human service academies.

34 (f) Curriculum to train and retrain staff to provide services in
35 accordance with the provisions and principles of Part 3
36 (commencing with Section 5800), Part 3.2 (commencing with
37 Section 5830), Part 3.6 (commencing with Section 5840), and Part
38 4 (commencing with Section 5850) of this division.

39 (g) Promotion of the employment of mental health consumers
40 and family members in the mental health system.

1 (h) Promotion of the meaningful inclusion of mental health
2 consumers and family members and incorporating their viewpoint
3 and experiences in the training and education programs in
4 subdivisions (a) through (f).

5 (i) *Promotion of meaningful inclusion of diverse, racial, and*
6 *ethnic community members who are underrepresented in the mental*
7 *health provider network.*

8 (i)

9 (j) Promotion of the inclusion of cultural competency in the
10 training and education programs in subdivisions (a) through (f).

11 SEC. 58. *Section 5830 of the Welfare and Institutions Code is*
12 *amended to read:*

13 5830. County mental health programs shall develop plans for
14 innovative programs to be funded pursuant to paragraph (6) of
15 subdivision (a) of Section 5892.

16 (a) The innovative programs shall have the following purposes:

17 (1) To increase access to underserved groups.

18 (2) To increase the quality of services, including better
19 outcomes.

20 (3) To promote interagency collaboration.

21 (4) To increase access to services.

22 (b) *All projects included in the innovative program portion of*
23 *the county plan shall meet the following requirements:*

24 (1) *Address one of the following purposes as its primary*
25 *purpose:*

26 (A) *Increase access to underserved groups.*

27 (B) *Increase the quality of services, including measurable*
28 *outcomes.*

29 (C) *Promote interagency and community collaboration.*

30 (D) *Increase access to services.*

31 (2) *Support innovative approaches by doing one of the*
32 *following:*

33 (A) *Introducing new mental health practices or approaches,*
34 *including, but not limited to, prevention and early intervention.*

35 (B) *Making a change to an existing mental health practice or*
36 *approach, including, but not limited to, adaptation for a new setting*
37 *or community.*

38 (C) *Introducing a new application to the mental health system*
39 *of a promising community-driven practice or an approach that*
40 *has been successful in nonmental health contexts or settings.*

1 (c) An innovative project may affect virtually any aspect of
2 mental health practices or assess a new or changed application
3 of a promising approach to solving persistent, seemingly
4 intractable mental health challenges, including, but not limited
5 to, any of the following:

6 (1) Administrative, governance, and organizational practices,
7 processes, or procedures.

8 (2) Advocacy.

9 (3) Education and training for service providers, including
10 nontraditional mental health practitioners.

11 (4) Outreach, capacity building, and community development.

12 (5) System development.

13 (6) Public education efforts.

14 (7) Research.

15 (8) Services and interventions, including prevention, early
16 intervention, and treatment.

17 (d) If an innovative project has proven to be successful and a
18 county chooses to continue it, the project work plan shall transition
19 to another category of funding as appropriate.

20 ~~(b)~~

21 (e) County mental health programs shall ~~receive~~ expend funds
22 for their innovation programs upon approval by the Mental Health
23 Services Oversight and Accountability Commission.

24 SEC. 59. Section 5840 of the Welfare and Institutions Code is
25 amended to read:

26 5840. (a) The State Department of ~~Mental Health Care~~
27 *Services, in coordination with counties*, shall establish a program
28 designed to prevent mental illnesses from becoming severe and
29 disabling. The program shall emphasize improving timely access
30 to services for underserved populations.

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

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

35 (2) Access and linkage to medically necessary care provided
36 by county mental health programs for children with severe mental
37 illness, as defined in Section 5600.3, and for adults and seniors
38 with severe mental illness, as defined in Section 5600.3, as early
39 in the onset of these conditions as practicable.

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

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

5 (c) The program shall include mental health services similar to
6 those provided under other programs effective in preventing mental
7 illnesses from becoming severe, and shall also include components
8 similar to programs that have been successful in reducing the
9 duration of untreated severe mental illnesses and assisting people
10 in quickly regaining productive lives.

11 (d) The program shall emphasize strategies to reduce the
12 following negative outcomes that may result from untreated mental
13 illness:

14 (1) Suicide.

15 (2) Incarcerations.

16 (3) School failure or dropout.

17 (4) Unemployment.

18 (5) Prolonged suffering.

19 (6) Homelessness.

20 (7) Removal of children from their homes.

21 (e) *Prevention and early intervention funds may be used to*
22 *broaden the provision of community-based mental health services*
23 *by adding prevention and early intervention services or activities*
24 *to these services.*

25 ~~(e)~~

26 (f) In consultation with mental health stakeholders, *and*
27 *consistent with guidelines from the Mental Health Services*
28 *Oversight and Accountability Commission, pursuant to Section*
29 *5846, the department shall revise the program elements in Section*
30 *5840 applicable to all county mental health programs in future*
31 *years to reflect what is learned about the most effective prevention*
32 *and intervention programs for children, adults, and seniors.*

33 *SEC. 60. Section 5845 of the Welfare and Institutions Code is*
34 *amended to read:*

35 5845. (a) The Mental Health Services Oversight and
36 Accountability Commission is hereby established to oversee Part
37 3 (commencing with Section 5800), the Adult and Older Adult
38 Mental Health System of Care Act; Part 3.1 (commencing with
39 Section 5820), Human Resources, Education, and Training
40 Programs; Part 3.2 (commencing with Section 5830), Innovative

1 Programs; Part 3.6 (commencing with Section 5840), Prevention
2 and Early Intervention Programs; and Part 4 (commencing with
3 Section 5850), the Children’s Mental Health Services Act. The
4 commission shall replace the advisory committee established
5 pursuant to Section 5814. The commission shall consist of 16
6 voting members as follows:

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

8 (2) The Superintendent of Public Instruction or his or her
9 designee.

10 (3) The Chairperson of the Senate Health and Human Services
11 Committee or another member of the Senate selected by the
12 President pro Tempore of the Senate.

13 (4) The Chairperson of the Assembly Health Committee or
14 another member of the Assembly selected by the Speaker of the
15 Assembly.

16 (5) Two persons with a severe mental illness, a family member
17 of an adult or senior with a severe mental illness, a family member
18 of a child who has or has had a severe mental illness, a physician
19 specializing in alcohol and drug treatment, a mental health
20 professional, a county sheriff, a superintendent of a school district,
21 a representative of a labor organization, a representative of an
22 employer with less than 500 employees and a representative of an
23 employer with more than 500 employees, and a representative of
24 a health care services plan or insurer, all appointed by the
25 Governor. In making appointments, the Governor shall seek
26 individuals who have had personal or family experience with
27 mental illness.

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

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

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

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

39 (2) Within the limit of funds allocated for these purposes,
40 pursuant to the laws and regulations governing state civil service,

1 employ staff, including any clerical, legal, and technical assistance
2 as may appear necessary. The commission shall administer its
3 operations separate and apart from the State Department of ~~Mental~~
4 *Health Care Services*.

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

7 (4) Employ all other appropriate strategies necessary or
8 convenient to enable it to fully and adequately perform its duties
9 and exercise the powers expressly granted, notwithstanding any
10 authority expressly granted to any officer or employee of state
11 government.

12 (5) Enter into contracts.

13 (6) Obtain data and information from the State Department of
14 ~~Mental~~ *Health Care Services, the Office of Statewide Health*
15 *Planning and Development*, or other state or local entities that
16 receive Mental Health Services Act funds, for the commission to
17 utilize in its oversight, review, *training and technical assistance,*
18 *accountability*, and evaluation capacity regarding projects and
19 programs supported with Mental Health Services Act funds.

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

24 (8) Develop strategies to overcome stigma *and discrimination,*
25 and accomplish all other objectives of Part 3.2 (commencing with
26 Section 5830), 3.6 (commencing with Section 5840), and the other
27 provisions of the act establishing this commission.

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

31 (10) If the commission identifies a critical issue related to the
32 performance of a county mental health program, it may refer the
33 issue to the State Department of ~~Mental~~ *Health Care Services*
34 pursuant to Section 5655.

35 (11) *Assist in providing technical assistance to accomplish the*
36 *purposes of the Mental Health Services Act, Part 3 (commencing*
37 *with Section 5800), and Part 4 (commencing with Section 5850)*
38 *in collaboration with the State Department of Health Care Services*
39 *and in consultation with the California Mental Health Directors*
40 *Association.*

1 (12) Work in collaboration with the State Department of Health
2 Care Services and the California Mental Health Planning Council,
3 and in consultation with the California Mental Health Directors
4 Association, in designing a comprehensive joint plan for a
5 coordinated evaluation of client outcomes in the community-based
6 mental health system, including, but not limited to, parts listed in
7 subdivision (a). The California Health and Human Services Agency
8 shall lead this comprehensive joint plan effort.

9 SEC. 61. Section 5846 of the Welfare and Institutions Code is
10 amended to read:

11 5846. (a) The commission shall issue guidelines for
12 expenditures pursuant to Part 3.2 (commencing with Section 5830),
13 for innovative programs, and Part 3.6 (commencing with Section
14 5840), for prevention and early intervention, no later than 180 days
15 before the fiscal year for which the funds will apply.

16 (b) The commission may provide technical assistance to any
17 county mental health plan as needed to address concerns or
18 recommendations of the commission or when local programs could
19 benefit from technical assistance for improvement of their plans.

20 (c) The commission shall ensure that the perspective and
21 participation of *diverse community members reflective of California*
22 *populations* and others suffering from severe mental illness and
23 their family members is a significant factor in all of its decisions
24 and recommendations.

25 SEC. 62. Section 5847 of the Welfare and Institutions Code is
26 amended to read:

27 5847. Integrated Plans for Prevention, Innovation, and System
28 of Care Services.

29 ~~(a) It is the intent of the Legislature to streamline the approval~~
30 ~~processes of the State Department of Mental Health and the Mental~~
31 ~~Health Services Oversight and Accountability Commission of~~
32 ~~programs developed pursuant to Sections 5891 and 5892.~~

33 ~~(b)~~

34 (a) Each county mental health program shall prepare and submit
35 a three-year *program and expenditure plan, and annual updates,*
36 *adopted by the county board of supervisors, to the Mental Health*
37 *Services Oversight and Accountability Commission within 30 days*
38 *after adoption.* ~~The~~

39 (b) *The three-year program and expenditure plan shall be based*
40 *on available unspent funds and estimated revenue allocations*

1 *provided by the state and in accordance with established*
 2 *stakeholder engagement and planning requirements as required*
 3 *in Section 5848. The three-year program and expenditure plan*
 4 *and annual updates shall include all of the following:*

5 (1) A program for prevention and early intervention in
 6 accordance with Part 3.6 (commencing with Section 5840).

7 (2) A program for services to children in accordance with Part
 8 4 (commencing with Section 5850), to include a program pursuant
 9 to Chapter 4 (commencing with Section 18250) of Part 6 of
 10 Division 9 or provide substantial evidence that it is not feasible to
 11 establish a wraparound program in that county.

12 (3) A program for services to adults and seniors in accordance
 13 with Part 3 (commencing with Section 5800).

14 (4) A program for innovations in accordance with Part 3.2
 15 (commencing with Section 5830).

16 (5) A program for technological needs and capital facilities
 17 needed to provide services pursuant to Part 3 (commencing with
 18 Section 5800), Part 3.6 (commencing with Section 5840), and Part
 19 4 (commencing with Section 5850). All plans for proposed facilities
 20 with restrictive settings shall demonstrate that the needs of the
 21 people to be served cannot be met in a less restrictive or more
 22 integrated setting.

23 (6) Identification of shortages in personnel to provide services
 24 pursuant to the above programs and the additional assistance
 25 needed from the education and training programs established
 26 pursuant to Part 3.1 (commencing with Section 5820).

27 (7) Establishment and maintenance of a prudent reserve to
 28 ensure the county program will continue to be able to serve
 29 children, adults, and seniors that it is currently serving pursuant
 30 to Part 3 (commencing with Section 5800), the Adult and Older
 31 Adult Mental Health System of Care Act, Part 3.6 (commencing
 32 with Section 5840), Prevention and Early Intervention Programs,
 33 and Part 4 (commencing with Section 5850), the Children’s Mental
 34 Health Services Act, during years in which revenues for the Mental
 35 Health Services Fund are below recent averages adjusted by
 36 changes in the state population and the California Consumer Price
 37 Index.

38 (8) *Certification by the county mental health director, which*
 39 *ensures that the county has complied with all pertinent regulations,*

1 *laws, and statutes of the Mental Health Services Act, including*
2 *stakeholder participation and nonsupplantation requirements.*

3 *(9) Certification by the county mental health director and by*
4 *the county auditor-controller that the county has complied with*
5 *any fiscal accountability requirements as directed by the State*
6 *Department of Health Care Services, and that all expenditures are*
7 *consistent with the requirements of the Mental Health Services*
8 *Act.*

9 ~~*(e) The State Department of Mental Health shall not issue*~~
10 ~~*guidelines for the Integrated Plans for Prevention, Innovation, and*~~
11 ~~*System of Care Services before January 1, 2012.*~~

12 ~~*(f)*~~

13 *(c) The programs established pursuant to paragraphs (2) and*
14 *(3) of subdivision (b) shall include services to address the needs*
15 *of transition age youth ages 16 to 25. In implementing this*
16 *subdivision, county mental health programs shall consider the*
17 *needs of transition age foster youth.*

18 *(d) Each year, the State Department of Health Care Services*
19 *shall inform the California Mental Health Directors Association*
20 *and the Mental Health Services Oversight and Accountability*
21 *Commission of the methodology used for revenue allocation to the*
22 *counties.*

23 ~~*(e) Each year the State Department of Mental Health, in*~~
24 ~~*consultation with the California Mental Health Directors*~~
25 ~~*Association, the Mental Health Services Oversight and*~~
26 ~~*Accountability Commission, and the Mental Health Planning*~~
27 ~~*Council, shall inform counties of the amounts of funds available*~~
28 ~~*for services to children pursuant to Part 4 (commencing with*~~
29 ~~*Section 5850), and to adults and seniors pursuant to Part 3*~~
30 ~~*(commencing with Section 5800).*~~ Each county mental health
31 program shall prepare expenditure plans pursuant to Part 3
32 (commencing with Section 5800) *for adults and seniors, Part 3.2*
33 *(commencing with Section 5830) for innovative programs, Part*
34 *3.6 (commencing with Section 5840) for prevention and early*
35 *intervention programs, and Part 4 (commencing with Section 5850)*
36 *for services for children, and updates to the plans developed*
37 *pursuant to this section. Each expenditure update shall indicate*
38 *the number of children, adults, and seniors to be served pursuant*
39 *to Part 3 (commencing with Section 5800), and Part 4*
40 *(commencing with Section 5850), and the cost per person. The*

1 expenditure update shall include utilization of unspent funds
2 allocated in the previous year and the proposed expenditure for
3 the same purpose.

4 (f) A county mental health program shall include an allocation
5 of funds from a reserve established pursuant to paragraph (7) of
6 subdivision (b) for services pursuant to paragraphs (2) and (3) of
7 subdivision (b) in years in which the allocation of funds for services
8 pursuant to subdivision (e) are not adequate to continue to serve
9 the same number of individuals as the county had been serving in
10 the previous fiscal year.

11 *SEC. 63. Section 5848 of the Welfare and Institutions Code is*
12 *amended to read:*

13 5848. (a) Each *three-year program and expenditure* plan and
14 update shall be developed with local stakeholders, including adults
15 and seniors with severe mental illness, families of children, adults,
16 and seniors with severe mental illness, providers of services, law
17 enforcement agencies, education, social services agencies, veterans,
18 representatives from veterans organizations, *providers of alcohol*
19 *and drug services, health care organizations*, and other important
20 interests. *Counties shall demonstrate a partnership with*
21 *constituents and stakeholders throughout the process that includes*
22 *meaningful stakeholder involvement on mental health policy,*
23 *program planning, and implementation, monitoring, quality*
24 *improvement, evaluation, and budget allocations.* A draft plan and
25 update shall be prepared and circulated for review and comment
26 for at least 30 days to representatives of stakeholder interests and
27 any interested party who has requested a copy of the draft plans.

28 (b) The mental health board established pursuant to Section
29 5604 shall conduct a public hearing on the draft *three-year program*
30 *and expenditure* plan and annual updates at the close of the 30-day
31 comment period required by subdivision (a). Each adopted
32 *three-year program and expenditure* plan and update shall include
33 any substantive written recommendations for revisions. The
34 adopted *three-year program and expenditure* plan or update shall
35 summarize and analyze the recommended revisions. The mental
36 health board shall review the adopted plan or update and make
37 recommendations to the county mental health department for
38 revisions.

39 (c) ~~The department shall establish requirements for the content~~
40 ~~of the plans.~~ The plans shall include reports on the achievement

1 of performance outcomes for services pursuant to Part 3
2 (commencing with Section 5800), Part 3.6 (commencing with
3 Section 5840), and Part 4 (commencing with Section 5850) funded
4 by the Mental Health Services Fund and established *jointly* by the
5 ~~department~~ *State Department of Health Care Services and the*
6 *Mental Health Services Oversight and Accountability Commission,*
7 *in collaboration with the California Mental Health Directors*
8 *Association.*

9 (d) Mental health services provided pursuant to Part 3
10 (commencing with Section 5800), and Part 4 (commencing with
11 Section 5850), shall be included in the review of program
12 performance by the California Mental Health Planning Council
13 required by paragraph (2) of subdivision (c) of Section 5772 and
14 in the local mental health board's review and comment on the
15 performance outcome data required by paragraph (7) of subdivision
16 (a) of Section 5604.2.

17 *SEC. 64. Section 5878.1 of the Welfare and Institutions Code*
18 *is amended to read:*

19 5878.1. (a) It is the intent of this article to establish programs
20 that ~~assure~~ *ensure* services will be provided to severely mentally
21 ill children as defined in Section 5878.2 and that they be part of
22 the children's system of care established pursuant to this part. It
23 is the intent of this act that services provided under this chapter to
24 severely mentally ill children are accountable, developed in
25 partnership with youth and their families, culturally competent,
26 and individualized to the strengths and needs of each child and
27 ~~their~~ *his or her* family.

28 (b) Nothing in this act shall be construed to authorize any
29 services to be provided to a minor without the consent of the child's
30 parent or legal guardian beyond those already authorized by
31 existing statute.

32 *SEC. 65. Section 5878.3 of the Welfare and Institutions Code*
33 *is amended to read:*

34 5878.3. (a) Subject to the availability of funds as determined
35 pursuant to Part 4.5 (commencing with Section 5890) of this
36 division, county mental health programs shall offer services to
37 severely mentally ill children for whom services under any other
38 public or private insurance or other mental health or entitlement
39 program is inadequate or unavailable. Other entitlement programs
40 include but are not limited to mental health services available

1 pursuant to Medi-Cal, child welfare, and special education
 2 programs. The funding shall cover only those portions of care that
 3 cannot be paid for with public or private insurance, other mental
 4 health funds or other entitlement programs.

5 (b) Funding shall be at sufficient levels to ensure that counties
 6 can provide each child served all of the necessary services set forth
 7 in the applicable treatment plan developed in accordance with this
 8 part, including services where appropriate and necessary to prevent
 9 an out of home placement, such as services pursuant to Chapter 4
 10 (commencing with Section 18250) of Part 6 of Division 9.

11 (c) The State Department of ~~Mental Health~~ *Care Services* shall
 12 contract with county mental health programs for the provision of
 13 services under this article in the manner set forth in Section 5897.

14 *SEC. 66. Section 5890 of the Welfare and Institutions Code is*
 15 *amended to read:*

16 5890. (a) The Mental Health Services Fund is hereby created
 17 in the State Treasury. The fund shall be administered by the state.
 18 Notwithstanding Section 13340 of the Government Code, all
 19 moneys in the fund are, except as provided in subdivision (d) of
 20 Section 5892, continuously appropriated, without regard to fiscal
 21 years, for the purpose of funding the following programs and other
 22 related activities as designated by other provisions of this division:

23 (1) Part 3 (commencing with Section 5800), the Adult and Older
 24 Adult System of Care Act.

25 (2) *Part 3.2 (commencing with Section 5830), Innovative*
 26 *Programs.*

27 ~~(2)~~

28 (3) Part 3.6 (commencing with Section 5840), Prevention and
 29 Early Intervention Programs.

30 ~~(3)~~

31 (4) Part 4 (commencing with Section 5850), the Children’s
 32 Mental Health Services Act.

33 (b) Nothing in the establishment of this fund, nor any other
 34 provisions of the act establishing it or the programs funded shall
 35 be construed to modify the obligation of health care service plans
 36 and disability insurance policies to provide coverage for mental
 37 health services, including those services required under Section
 38 1374.72 of the Health and Safety Code and Section 10144.5 of the
 39 Insurance Code, related to mental health parity. Nothing in this
 40 act shall be construed to modify the oversight duties of the

1 Department of Managed Health Care or the duties of the
2 Department of Insurance with respect to enforcing these obligations
3 of plans and insurance policies.

4 (c) Nothing in this act shall be construed to modify or reduce
5 the existing authority or responsibility of the State Department of
6 ~~Mental Health Care Services~~.

7 (d) The State Department of Health Care Services, ~~in~~
8 ~~consultation with the State Department of Mental Health,~~ shall
9 seek approval of all applicable federal Medicaid approvals to
10 maximize the availability of federal funds and eligibility of
11 participating children, adults, and seniors for medically necessary
12 care.

13 (e) Share of costs for services pursuant to Part 3 (commencing
14 with Section 5800), and Part 4 (commencing with Section 5850)
15 of this division, shall be determined in accordance with the
16 Uniform Method for Determining Ability to Pay applicable to
17 other publicly funded mental health services, unless this Uniform
18 Method is replaced by another method of determining co-payments,
19 in which case the new method applicable to other mental health
20 services shall be applicable to services pursuant to Part 3
21 (commencing with Section 5800), and Part 4 (commencing with
22 Section 5850) of this division.

23 *SEC. 67. Section 5891 of the Welfare and Institutions Code is*
24 *amended to read:*

25 5891. (a) The funding established pursuant to this act shall be
26 utilized to expand mental health services. Except as provided in
27 subdivision (j) of Section 5892 due to the state's fiscal crisis, these
28 funds shall not be used to supplant existing state or county funds
29 utilized to provide mental health services. The state shall continue
30 to provide financial support for mental health programs with not
31 less than the same entitlements, amounts of allocations from the
32 General Fund or from the Local Revenue Fund 2011 in the State
33 Treasury, and formula distributions of dedicated funds as provided
34 in the last fiscal year which ended prior to the effective date of
35 this act. The state shall not make any change to the structure of
36 financing mental health services, which increases a county's share
37 of costs or financial risk for mental health services unless the state
38 includes adequate funding to fully compensate for such increased
39 costs or financial risk. These funds shall only be used to pay for
40 the programs authorized in Section 5892. These funds may not be

1 used to pay for any other program. These funds may not be loaned
 2 to the state General Fund or any other fund of the state, or a county
 3 general fund or any other county fund for any purpose other than
 4 those authorized by Section 5892.

5 (b) Notwithstanding subdivision (a), the Controller may use the
 6 funds created pursuant to this part for loans to the General Fund
 7 as provided in Sections 16310 and 16381 of the Government Code.
 8 Any such loan shall be repaid from the General Fund with interest
 9 computed at 110 percent of the Pooled Money Investment Account
 10 rate, with interest commencing to accrue on the date the loan is
 11 made from the fund. This subdivision does not authorize any
 12 transfer that would interfere with the carrying out of the object for
 13 which these funds were created.

14 (c) Commencing July 1, 2012, on or before the 15th day of each
 15 month, *pursuant to a methodology provided by the State*
 16 *Department of Health Care Services*, the Controller shall distribute
 17 to each Local Mental Health Service Fund established by counties
 18 pursuant to subdivision (f) of Section 5892, all unexpended and
 19 unreserved funds on deposit as of the last day of the prior month
 20 in the Mental Health Services Fund, established pursuant to Section
 21 5890, for the provision of programs and other related activities set
 22 forth in Part 3 (commencing with Section 5800), Part 3.2
 23 (commencing with Section 5830), Part 3.6 (commencing with
 24 Section 5840), and Part 4 (commencing with Section 5850).

25 **Funding distributions**

26 (d) ~~Counties shall be based~~ *base their expenditures* on the
 27 ~~amount specified in the~~ county mental health program’s three-year
 28 *program and expenditure plan or annual update*, as required by
 29 Section 5847. Nothing in this subdivision shall affect subdivision
 30 (a) or (b).

31 *SEC. 68. Section 5892 of the Welfare and Institutions Code is*
 32 *amended to read:*

33 5892. (a) In order to promote efficient implementation of this
 34 ~~act allocate the following portions of funds available in, the county~~
 35 *shall use funds distributed from the Mental Health Services Fund*
 36 ~~in 2005–06 and each year thereafter as follows:~~

37 (1) In 2005–06, 2006–07, and in 2007–08 10 percent shall be
 38 placed in a trust fund to be expended for education and training
 39 programs pursuant to Part 3.1.

1 (2) In 2005–06, 2006–07 and in 2007–08 10 percent for capital
2 facilities and technological needs distributed to counties in
3 accordance with a formula developed in consultation with the
4 California Mental Health Directors Association to implement plans
5 developed pursuant to Section 5847.

6 (3) *Twenty percent of funds distributed to the counties pursuant*
7 *to subdivision (c) of Section 5891 shall be used for prevention and*
8 *early intervention programs distributed to counties in accordance*
9 *with a formula developed in consultation with the California*
10 *Mental Health Directors Association pursuant to Part 3.6*
11 *(commencing with Section 5840) of this division.*

12 (4) ~~The allocation expenditure for prevention and early~~
13 ~~intervention may be increased in any county in which the~~
14 ~~department determines that the increase will decrease the need and~~
15 ~~cost for additional services to severely mentally ill persons in that~~
16 ~~county by an amount at least commensurate with the proposed~~
17 ~~increase. The statewide allocation for prevention and early~~
18 ~~intervention may be increased whenever the Mental Health Services~~
19 ~~Oversight and Accountability Commission determines that all~~
20 ~~counties are receiving all necessary funds for services to severely~~
21 ~~mentally ill persons and have established prudent reserves and~~
22 ~~there are additional revenues available in the fund.~~

23 (5) The balance of funds shall be distributed to county mental
24 health programs for services to persons with severe mental illnesses
25 pursuant to Part 4 (commencing with Section 5850), for the
26 children’s system of care and Part 3 (commencing with Section
27 5800), for the adult and older adult system of care.

28 (6) Five percent of the total funding for each county mental
29 health program for Part 3 (commencing with Section 5800), Part
30 3.6 (commencing with Section 5840), and Part 4 (commencing
31 with Section 5850) of this division, shall be utilized for innovative
32 programs in accordance with Sections 5830, 5847, and 5848.

33 (b) In any year after 2007–08, programs for services pursuant
34 to Part 3 (commencing with Section 5800), and Part 4
35 (commencing with Section 5850) of this division may include
36 funds for technological needs and capital facilities, human resource
37 needs, and a prudent reserve to ensure services do not have to be
38 significantly reduced in years in which revenues are below the
39 average of previous years. The total allocation for purposes
40 authorized by this subdivision shall not exceed 20 percent of the

1 average amount of funds allocated to that county for the previous
2 five years pursuant to this section.

3 (c) The allocations pursuant to subdivisions (a) and (b) shall
4 include funding for annual planning costs pursuant to Section 5848.
5 The total of these costs shall not exceed 5 percent of the total of
6 annual revenues received for the fund. The planning costs shall
7 include funds for county mental health programs to pay for the
8 costs of consumers, family members, and other stakeholders to
9 participate in the planning process and for the planning and
10 implementation required for private provider contracts to be
11 significantly expanded to provide additional services pursuant to
12 Part 3 (commencing with Section 5800), and Part 4 (commencing
13 with Section 5850) of this division.

14 (d) Prior to making the allocations pursuant to subdivisions (a),
15 (b), and (c), funds shall be reserved for the costs for the State
16 Department of ~~Mental Health Care Services~~, the California Mental
17 Health Planning Council, ~~and the Office of Statewide Health~~
18 ~~Planning and Development~~, the Mental Health Services Oversight
19 and Accountability Commission, *the State Department of Public*
20 *Health, and any other state agency* to implement all duties pursuant
21 to the programs set forth in this section. These costs shall not
22 exceed 3.5 percent of the total of annual revenues received for the
23 fund. The administrative costs shall include funds to assist
24 consumers and family members to ensure the appropriate state and
25 county agencies give full consideration to concerns about quality,
26 structure of service delivery, or access to services. The amounts
27 allocated for administration shall include amounts sufficient to
28 ensure adequate research and evaluation regarding the effectiveness
29 of services being provided and achievement of the outcome
30 measures set forth in Part 3 (commencing with Section 5800), Part
31 3.6 (commencing with Section 5840), and Part 4 (commencing
32 with Section 5850) of this division. The amount of funds available
33 for the purposes of this subdivision in any fiscal year shall be
34 subject to appropriation in the annual Budget Act.

35 (e) In 2004–05 funds shall be allocated as follows:

36 (1) Forty-five percent for education and training pursuant to
37 Part 3.1 (commencing with Section 5820) of this division.

38 (2) Forty-five percent for capital facilities and technology needs
39 in the manner specified by paragraph (2) of subdivision (a).

1 (3) Five percent for local planning in the manner specified in
2 subdivision (c).

3 (4) Five percent for state implementation in the manner specified
4 in subdivision (d).

5 (f) Each county shall place all funds received from the State
6 Mental Health Services Fund in a local Mental Health Services
7 Fund. The Local Mental Health Services Fund balance shall be
8 invested consistent with other county funds and the interest earned
9 on the investments shall be transferred into the fund. The earnings
10 on investment of these funds shall be available for distribution
11 from the fund in future years.

12 (g) All expenditures for county mental health programs shall
13 be consistent with a currently approved plan or update pursuant
14 to Section 5847.

15 (h) Other than funds placed in a reserve in accordance with an
16 approved plan, any funds allocated to a county which have not
17 been spent for their authorized purpose within three years shall
18 revert to the state to be deposited into the fund and available for
19 other counties in future years, provided however, that funds for
20 capital facilities, technological needs, or education and training
21 may be retained for up to 10 years before reverting to the fund.

22 (i) If there are still additional revenues available in the fund
23 after the Mental Health Services Oversight and Accountability
24 Commission has determined there are prudent reserves and no
25 unmet needs for any of the programs funded pursuant to this
26 section, including all purposes of the Prevention and Early
27 Intervention Program, the commission shall develop a plan for
28 expenditures of these revenues to further the purposes of this act
29 and the Legislature may appropriate these funds for any purpose
30 consistent with the commission's adopted plan which furthers the
31 purposes of this act.

32 (j) For the 2011–12 fiscal year, General Fund revenues will be
33 insufficient to fully fund many existing mental health programs,
34 including Early and Periodic Screening, Diagnosis, and Treatment
35 (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and
36 mental health services provided for special education pupils. In
37 order to adequately fund those programs for the 2011–12 fiscal
38 year and avoid deeper reductions in programs that serve individuals
39 with severe mental illness and the most vulnerable, medically
40 needy citizens of the state, prior to distribution of funds under

1 paragraphs (1) to (6), inclusive, of subdivision (a), effective July
2 1, 2011, moneys shall be allocated from the Mental Health Services
3 Fund to the counties as follows:

4 (1) Commencing July 1, 2011, one hundred eighty-three million
5 six hundred thousand dollars (\$183,600,000) of the funds available
6 as of July 1, 2011, in the Mental Health Services Fund, shall be
7 allocated in a manner consistent with subdivision (c) of Section
8 5778 and based on a formula determined by the state in
9 consultation with the California Mental Health Directors
10 Association to meet the fiscal year 2011–12 General Fund
11 obligation for Medi-Cal Specialty Mental Health Managed Care.

12 (2) Upon completion of the allocation in paragraph (1), the
13 Controller shall distribute to counties ninety-eight million five
14 hundred eighty-six thousand dollars (\$98,586,000) from the Mental
15 Health Services Fund for mental health services for special
16 education pupils based on a formula determined by the state in
17 consultation with the California Mental Health Directors
18 Association.

19 (3) Upon completion of the allocation in paragraph (2), the
20 Controller shall distribute to counties 50 percent of their 2011–12
21 Mental Health Services Act component allocations consistent with
22 Sections 5847 and 5891, not to exceed four hundred eighty-eight
23 million dollars (\$488,000,000). This allocation shall commence
24 beginning August 1, 2011.

25 (4) Upon completion of the allocation in paragraph (3), and as
26 revenues are deposited into the Mental Health Services Fund, the
27 Controller shall distribute five hundred seventy-nine million dollars
28 (\$579,000,000) from the Mental Health Services Fund to counties
29 to meet the General Fund obligation for EPSDT for fiscal year
30 2011–12. These revenues shall be distributed to counties on a
31 quarterly basis and based on a formula determined by the state in
32 consultation with the California Mental Health Directors
33 Association. These funds shall not be subject to reconciliation or
34 cost settlement.

35 (5) The Controller shall distribute to counties the remaining
36 2011–12 Mental Health Services Act component allocations
37 consistent with Sections 5847 and 5891, beginning no later than
38 April 30, 2012. These remaining allocations shall be made on a
39 monthly basis.

1 (6) The total one-time allocation from the Mental Health
2 Services Fund for EPSDT, Medi-Cal Specialty Mental Health
3 Managed Care, and mental health services provided to special
4 education pupils as referenced shall not exceed eight hundred
5 sixty-two million dollars (\$862,000,000). Any revenues deposited
6 in the Mental Health Services Fund in fiscal year 2011–12 that
7 exceed this obligation shall be distributed to counties for remaining
8 fiscal year 2011–12 Mental Health Services Act component
9 allocations, consistent with Sections 5847 and 5891.

10 (k) Subdivision (j) shall not be subject to repayment.

11 (l) Subdivision (j) shall become inoperative on July 1, 2012.

12 *SEC. 69. Section 5897 of the Welfare and Institutions Code is*
13 *amended to read:*

14 5897. (a) Notwithstanding any other provision of state law,
15 the State Department of ~~Mental Health Care Services~~ shall
16 implement the mental health services provided by Part 3
17 (commencing with Section 5800), Part 3.6 (commencing with
18 Section 5840), and Part 4 (commencing with Section 5850) of this
19 division through contracts with county mental health programs or
20 counties acting jointly. A contract may be exclusive and may be
21 awarded on a geographic basis. As used herein a county mental
22 health program includes a city receiving funds pursuant to Section
23 5701.5.

24 (b) Two or more counties acting jointly may agree to deliver or
25 subcontract for the delivery of such mental health services. The
26 agreement may encompass all or any part of the mental health
27 services provided pursuant to these parts. Any agreement between
28 counties shall delineate each county's responsibilities and fiscal
29 liability.

30 (c) The department shall implement the provisions of Part 3
31 (commencing with Section 5800), Part 3.2 (commencing with
32 Section 5830), Part 3.6 (commencing with Section 5840), and Part
33 4 (commencing with Section 5850) of this division through the
34 annual county mental health services performance contract, as
35 specified in Chapter 2 (commencing with Section 5650) of Part 2
36 of Division 5.

37 (d) When a county mental health program is not in compliance
38 with its performance contract, the department may request a plan
39 of correction with a specific timeline to achieve improvements.

1 (e) Contracts awarded by the State Department of ~~Mental Health~~
 2 *Care Services*, the California Mental Health Planning Council, *the*
 3 *Office of Statewide Health Planning and Development*, and the
 4 Mental Health Services Oversight and Accountability Commission
 5 pursuant to Part 3 (commencing with Section 5800), Part 3.1
 6 (commencing with Section 5820), Part 3.2 (commencing with
 7 Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7
 8 (commencing with Section 5845), Part 4 (commencing with Section
 9 5850), and Part 4.5 (commencing with Section 5890) of this
 10 division, may be awarded in the same manner in which contracts
 11 are awarded pursuant to Section 5814 and the provisions of
 12 subdivisions (g) and (h) of Section 5814 shall apply to such
 13 contracts.

14 (f) For purposes of Section 5775, the allocation of funds
 15 pursuant to Section 5892 which are used to provide services to
 16 Medi-Cal beneficiaries shall be included in calculating anticipated
 17 county matching funds and the transfer to the ~~department~~ *State*
 18 *Department of Health Care Services* of the anticipated county
 19 matching funds needed for community mental health programs.

20 *SEC. 70. Section 5898 of the Welfare and Institutions Code is*
 21 *amended to read:*

22 5898. The ~~state~~ *State Department of Health Care Services*, in
 23 *consultation with the Mental Health Services Oversight and*
 24 *Accountability Commission*, shall develop regulations, as necessary,
 25 for the State Department of ~~Mental Health Care Services~~, the
 26 Mental Health Services Oversight and Accountability Commission,
 27 or designated state and local agencies to implement this act.
 28 Regulations adopted pursuant to this section shall be developed
 29 with the maximum feasible opportunity for public participation
 30 and comments.

31 *SEC. 71. Section 5899 is added to the Welfare and Institutions*
 32 *Code, to read:*

33 5899. (a) *The State Department of Health Care Services*, in
 34 *consultation with the Mental Health Services Oversight and*
 35 *Accountability Commission and the California Mental Health*
 36 *Directors Association*, shall develop and administer instructions
 37 for the Annual Mental Health Services Act Revenue and
 38 Expenditure Report. This report shall be submitted electronically
 39 to the department and to the Mental Health Services Oversight
 40 and Accountability Commission.

1 (b) *The purpose of the Annual Mental Health Services Act*
2 *Revenue and Expenditure Report is as follows:*

3 (1) *Identify the expenditures of Mental Health Services Act*
4 *(MHSA) funds that were distributed to each county.*

5 (2) *Quantify the amount of additional funds generated for the*
6 *mental health system as a result of the MHSA.*

7 (3) *Identify unexpended funds, and interest earned on MHSA*
8 *funds.*

9 (4) *Determine reversion amounts, if applicable, from prior fiscal*
10 *year distributions.*

11 (c) *This report is intended to provide information that allows*
12 *for the evaluation of all of the following:*

13 (1) *Children's systems of care.*

14 (2) *Prevention and early intervention strategies.*

15 (3) *Innovative projects.*

16 (4) *Workforce education and training.*

17 (5) *Adults and older adults systems of care.*

18 (6) *Capital facilities and technology needs.*

19 *SEC. 72. Section 14046.7 of the Welfare and Institutions Code*
20 *is amended to read:*

21 14046.7. (a) *General Fund moneys shall not be used for the*
22 *purposes of this article.*

23 (b) *Notwithstanding subdivision (a), no more than two hundred*
24 *thousand dollars (\$200,000) from the General Fund may be used*
25 *annually for state administrative costs associated with*
26 *implementing this article.*

27 *SEC. 73. Section 14085.6 of the Welfare and Institutions Code*
28 *is amended to read:*

29 14085.6. (a) *Except as stated in subdivision (g), each hospital*
30 *contracting to provide services under this article that meets the*
31 *criteria contained in the state medicaid plan for disproportionate*
32 *share hospital status shall be eligible to negotiate with the*
33 *commission for distributions from the Emergency Services and*
34 *Supplemental Payments Fund, which is hereby created. All*
35 *distributions from the fund shall be pursuant to this section.*

36 (b) (1) *To the extent permitted by federal law, the department*
37 *shall administer the fund in accordance with this section.*

38 (2) *The money in this fund shall be available for expenditure*
39 *by the department for the purposes of this section, subject to*
40 *approval through the regular budget process.*

1 (c) The fund shall include all of the following:

2 (1) Subject to subdivision (l), all public funds transferred by
3 public agencies to the department for deposit in the fund, as
4 permitted under Section 433.51 of Title 42 of the Code of Federal
5 Regulations or any other applicable federal medicaid laws. These
6 transfers shall constitute local government financial participation
7 in Medi-Cal as permitted under Section ~~1902(a)(2)~~ *1902(a)(2)* of
8 the *federal* Social Security Act (Title 42 U.S.C. Sec. ~~1396a(a)(2)~~
9 *1396a(a)(2)*) and other applicable federal ~~medicaid~~ *Medicaid* laws.

10 (2) Subject to subdivision (l), all private donated funds
11 transferred by private individuals or entities for deposit in the fund
12 as permitted under applicable federal ~~medicaid~~ *Medicaid* laws.

13 (3) Any amounts appropriated to the fund by the Legislature.

14 (4) Interest that accrues on amounts in the fund.

15 (5) Moneys appropriated to the fund, or appropriated for poison
16 control center grants and transferred to the fund, pursuant to the
17 annual Budget Act.

18 (d) Amounts in the fund shall be used as the source for the
19 nonfederal share of payments to hospitals under this section.
20 Moneys shall be allocated from the fund by the department and
21 matched by federal funds in accordance with customary Medi-Cal
22 accounting procedures for purposes of payments under this section.

23 (e) Distributions from the fund shall be supplemental to any
24 and all other amounts that hospitals would have received under
25 the contracting program, and under the state medicaid plan,
26 including contract rate increases and supplemental payments and
27 payment adjustments under distribution programs relating to
28 disproportionate share hospitals.

29 (f) Distributions from the fund shall not serve as the state's
30 payment adjustment program under Section 1923 of the *federal*
31 Social Security Act (42 U.S.C. Sec. ~~1396r-4~~; *1396r-4*). To the
32 extent permitted by federal law, and except as otherwise provided
33 in this section, distributions from the fund shall not be subject to
34 requirements contained in or related to Section 1923 of the *federal*
35 Social Security Act (42 U.S.C. Sec. ~~1396r-4~~; *1396r-4*).
36 Distributions from the fund shall be supplemental contract
37 payments and may be structured on any federally permissible basis,
38 as negotiated between the commission and the hospital.

39 (g) In order to qualify for distributions from the fund, a hospital
40 shall meet all of the following criteria:

- 1 (1) Be a contracting hospital under this article.
- 2 (2) Satisfy the state medicaid plan criteria referred to in
3 subdivision (a).
- 4 (3) Be one of the following:
 - 5 (A) A licensed provider of basic emergency services as
6 described in Sections 70411 and following of Title 22 of the
7 California Code of Regulations.
 - 8 (B) A licensed provider of comprehensive emergency medical
9 services as defined in Sections 70451 and following of Title 22 of
10 the California Code of Regulations.
 - 11 (C) A children’s hospital as defined in Section 14087.21 that
12 satisfies subparagraph (A) or (B) or that jointly provides basic or
13 comprehensive emergency services in conjunction with another
14 licensed hospital.
 - 15 (D) A hospital owned and operated by a public agency that
16 operates two or more hospitals that qualify under subparagraph
17 (A) or (B) with respect to the particular state fiscal year.
 - 18 (E) A hospital designated by the National Cancer Institute as a
19 comprehensive or clinical cancer research center that primarily
20 treats acutely ill cancer patients and that is exempt from the federal
21 Medicare prospective payment system pursuant to Section
22 1886(d)(1)(B)(v) of the *federal* Social Security Act (42 U.S.C.
23 Sec. 1395ww(d)(1)(B)(v)).
- 24 (4) Be able to demonstrate a purpose for additional funding
25 under the selective provider contracting program including
26 proposals relating to emergency services and other health care
27 services, including infrequent yet high-cost services, such as
28 anti-AB human antitoxin treatment for infant botulism (human
29 botulinum immune globulin (HBIG), commonly referred to as
30 “Baby-BIG”), that are made available, or will be made available,
31 to Medi-Cal beneficiaries.
- 32 (h) (1) The department shall seek federal financial participation
33 for expenditures made from the fund to the full extent permitted
34 by federal law.
 - 35 (2) The department shall promptly seek any necessary federal
36 approvals regarding this section.
 - 37 (i) Any funds remaining in the fund at the end of a fiscal year
38 shall be carried forward for use in following fiscal years.
 - 39 (j) For purposes of this section, “fund” means the Emergency
40 Services and Supplemental Payments Fund.

1 (k) (1) Any public agency transferring amounts to the fund, as
2 specified in paragraph (1) of subdivision (c), may for that purpose,
3 utilize any revenues, grants, or allocations received from the state
4 for health care programs or purposes, unless otherwise prohibited
5 by law. A public agency may also utilize its general funds or any
6 other public funds or revenues for purposes of transfers to the fund,
7 unless otherwise prohibited by law.

8 (2) Notwithstanding paragraph (1), a public agency may transfer
9 to the fund only those moneys that have a source that will qualify
10 for federal financial participation under the provisions of the
11 Medicaid Voluntary Contribution and Provider-Specific Tax
12 Amendments of 1991—~~P.L.~~ (*Public Law* 102-234) or other
13 applicable federal—~~medicaid~~ *Medicaid* laws.

14 (l) Public funds transferred pursuant to paragraph (1) of
15 subdivision (c), and private donated funds transferred pursuant to
16 paragraph (2) of subdivision (c), shall be deposited into the fund,
17 and expended pursuant to this section. The director may accept
18 only those funds that are certified by the transferring entity as
19 qualifying for federal financial participation under the terms of
20 the Medicaid Voluntary Contributions and Provider-Specific Tax
21 Amendments of 1991—~~P.L.~~ (*Public Law* 102-234) and may return
22 any funds transferred in error.

23 (m) The department may adopt emergency regulations, if
24 necessary, for the purposes of this section.

25 (n) The state shall be held harmless from any federal
26 disallowance resulting from this section. A hospital receiving
27 supplemental reimbursement pursuant to this section shall be liable
28 for any reduced federal financial participation resulting from the
29 implementation of this section with respect to that hospital. The
30 state may recoup that federal disallowance from the hospital in
31 any manner authorized by law or contract.

32 (o) *This section shall become inoperative on June 30, 2013,*
33 *and, as of January 1, 2014, is repealed, unless a later enacted*
34 *statute, that becomes operative on or before January 1, 2014,*
35 *deletes or extends the dates on which it becomes inoperative and*
36 *is repealed.*

37 *SEC. 74. Section 14085.7 of the Welfare and Institutions Code*
38 *is amended to read:*

39 14085.7. (a) The Medi-Cal Medical Education Supplemental
40 Payment Fund is hereby created in the State Treasury.

1 Notwithstanding Section 13340 of the Government Code, the fund
2 shall be continuously appropriated to, and under the administrative
3 control of, the department for the purposes specified in this section.
4 Except as otherwise limited by this section, the fund shall consist
5 of all of the following:

6 (1) All public moneys transferred by public agencies to the
7 department for deposit into the fund, as permitted under Section
8 433.51 of Title 42 of the Code of Federal Regulations or any other
9 applicable federal ~~medicaid~~ *Medicaid* laws.

10 (2) All private moneys donated by private individuals or entities
11 to the department for deposit in the fund as permitted under
12 applicable federal ~~medicaid~~ *Medicaid* laws.

13 (3) Any amounts appropriated to the fund by the Legislature.

14 (4) Any interest that accrues on amounts in the fund.

15 (b) Any public agency transferring moneys to the fund may, for
16 that purpose, utilize any revenues, grants, or allocations received
17 from the state for health care programs or purposes, unless
18 otherwise prohibited by law. A public agency may also utilize its
19 general funds or any other public moneys or revenues for purposes
20 of transfers to the fund, unless otherwise prohibited by law.

21 (c) The department shall have the discretion to accept or not
22 accept moneys offered to the department for deposit in the fund.
23 If the department accepts moneys pursuant to this section, the
24 department shall obtain federal matching funds to the full extent
25 permitted by law. The department shall accept only those funds
26 that are certified by the transferring or donating entity as qualifying
27 for federal financial participation under the terms of the Medicaid
28 Voluntary Contribution and Provider-Specific Tax Amendments
29 of 1991 (~~P.L.~~ *Public Law* 102-234) or Section 433.51 of Title 42
30 of the Code of Federal Regulations, as applicable, and may return
31 any funds transferred or donated in error.

32 (d) Moneys in the fund shall be used as the source for the
33 nonfederal share of payments to hospitals under this section.
34 Moneys shall be allocated from the fund by the department and
35 matched by federal funds in accordance with customary Medi-Cal
36 accounting procedures for purposes of payments under subdivision

37 (e). Distributions from the fund shall be supplemental to any other
38 amounts that hospitals receive under the contracting program.

39 (e) For purposes of recognizing medical education costs incurred
40 for services rendered to Medi-Cal beneficiaries, payments from

1 this fund shall be negotiated between the California Medical
 2 Assistance Commission and hospitals contracting under this article
 3 that meet the definition of university teaching hospitals or major
 4 (nonuniversity) teaching hospitals as set forth on page 51 and as
 5 listed on page 57 of the department’s report dated May 1991,
 6 entitled “Hospital Peer Grouping.” Payments from the fund shall
 7 be used solely for the purposes identified in the contract between
 8 the hospital and the state.

9 (f) The state shall be held harmless from any federal
 10 disallowance resulting from this section. A hospital receiving
 11 supplemental reimbursement pursuant to this section shall be liable
 12 for any reduced federal financial participation resulting from the
 13 implementation of this section with respect to that hospital. The
 14 state may recoup any federal disallowance from the hospital.

15 (g) *This section shall become inoperative on June 30, 2013,*
 16 *and, as of January 1, 2014, is repealed, unless a later enacted*
 17 *statute, that becomes operative on or before January 1, 2014,*
 18 *deletes or extends the dates on which it becomes inoperative and*
 19 *is repealed.*

20 *SEC. 75. Section 14085.8 of the Welfare and Institutions Code*
 21 *is amended to read:*

22 14085.8. (a) The Large Teaching Emphasis Hospital and
 23 Children’s Hospital Medi-Cal Medical Education Supplemental
 24 Payment Fund is hereby created in the State Treasury.

25 (b) Notwithstanding Section 13340 of the Government Code,
 26 the fund shall be continuously appropriated to, and under the
 27 administrative control of, the department for the purposes specified
 28 in this section.

29 (c) Except as otherwise limited by this section, the fund shall
 30 consist of all of the following:

31 (1) All public moneys transferred by public agencies to the
 32 department for deposit into the fund, as permitted under Section
 33 433.51 of Title 42 of the Code of Federal Regulations or any other
 34 applicable federal ~~medieaid~~ *Medicaid* laws.

35 (2) All private moneys donated by private individuals or entities
 36 to the department for deposit in the fund as permitted under
 37 applicable federal ~~medieaid~~ *Medicaid* laws.

38 (3) Any amounts appropriated to the fund by the Legislature.

39 (4) Any interest that accrues on amounts in the fund.

1 (d) Any public agency transferring moneys to the fund may, for
2 that purpose, utilize any revenues, grants, or allocations received
3 from the state for health care programs or purposes, unless
4 otherwise prohibited by law. A public agency may also utilize its
5 general funds or any other public moneys or revenues for purposes
6 of transfers to the fund, unless otherwise prohibited by law.

7 (e) The department may accept or not accept moneys offered
8 to the department for deposit in the fund. If the department accepts
9 moneys pursuant to this section, the department shall obtain federal
10 matching funds to the full extent permitted by law. The department
11 shall accept only those funds that are certified by the transferring
12 or donating entity as qualifying for federal financial participation
13 under the terms of the Medicaid Voluntary Contribution and
14 Provider-Specific Tax Amendments of 1991 ~~(P.L. (Public Law~~
15 ~~102-234)~~ or Section 433.51 of Title 42 of the Code of Federal
16 Regulations, as applicable, and may return any funds transferred
17 or donated in error.

18 (f) Moneys in the fund shall be used as the source for the
19 nonfederal share of payments to hospitals under this section.
20 Moneys shall be allocated from the fund by the department and
21 matched by federal funds in accordance with customary Medi-Cal
22 accounting procedures for purposes of payments under subdivision
23 (g). Distributions from the fund shall be supplemental to any other
24 amounts that hospitals receive under the contracting program.

25 (g) (1) For purposes of recognizing medical education costs
26 incurred for services rendered to Medi-Cal beneficiaries, contracts
27 for payments from the fund may, at the discretion of the California
28 Medical Assistance Commission, be negotiated between the
29 commission and hospitals contracting under this article that are
30 defined as either of the following:

31 (A) A large teaching emphasis hospital, as set forth on page 51
32 and listed on page 57 of the department's report dated May 1991,
33 entitled "Hospital Peer Grouping," and meets the definition of
34 eligible hospital as defined in paragraph (3) of subdivision (a) of
35 Section 14105.98.

36 (B) A children's hospital pursuant to Section 10727 and meets
37 the definition of eligible hospital as defined in paragraph (3) of
38 subdivision (a) of Section 14105.98.

39 (2) Payments from the fund shall be used solely for the purposes
40 identified in the contract between the hospital and the state.

1 (h) The state shall be held harmless from any federal
2 disallowance resulting from this section. A hospital receiving
3 supplemental reimbursement pursuant to this section shall be liable
4 for any reduced federal financial participation resulting from the
5 implementation of this section with respect to that hospital. The
6 state may recoup any federal disallowance from the hospital.

7 (i) *This section shall become inoperative on June 30, 2013, and,*
8 *as of January 1, 2014, is repealed, unless a later enacted statute,*
9 *that becomes operative on or before January 1, 2014, deletes or*
10 *extends the dates on which it becomes inoperative and is repealed.*

11 SEC. 76. *Section 14085.81 of the Welfare and Institutions Code*
12 *is amended to read:*

13 14085.81. (a) Notwithstanding the requirement in
14 subparagraph (A) of paragraph (1) of subdivision ~~(3)~~ (g) of Section
15 14085.8 that a hospital must be listed on page 57 of the
16 department's report dated May 1991, entitled "Hospital Peer
17 Grouping," any hospital whose license pursuant to Chapter 2
18 (commencing with Section 1250) of Division 2 of the Health and
19 Safety Code was consolidated during the 1999 calendar year with
20 a large teaching emphasis hospital that is listed on page 57 of the
21 above described report shall be eligible to negotiate payments
22 pursuant to paragraph (1) of subdivision (g) of Section 14085.8.
23 All other requirements of Section 14085.8 shall continue to apply.

24 (b) *This section shall become inoperative on June 30, 2013,*
25 *and, as of January 1, 2014, is repealed, unless a later enacted*
26 *statute, that becomes operative on or before January 1, 2014,*
27 *deletes or extends the dates on which it becomes inoperative and*
28 *is repealed.*

29 SEC. 77. *Section 14085.9 of the Welfare and Institutions Code*
30 *is amended to read:*

31 14085.9. (a) Except as provided in subdivision (g), each
32 hospital contracting to provide services under this article that meets
33 the criteria contained in the state medicaid plan for disproportionate
34 share hospital status shall be eligible to negotiate with the
35 commission for distributions from the Small and Rural Hospital
36 Supplemental Payments Fund, which is hereby created and,
37 notwithstanding Section 13340 of the Government Code, is
38 continuously appropriated for the purposes specified in this section.
39 All distributions from the fund shall be pursuant to this section.

1 (b) (1) To the extent permitted by federal law, the department
2 shall administer the fund in accordance with this section.

3 (2) The money in this fund shall be available for expenditure
4 by the department for the purposes of this section, subject to
5 approval through the regular budget process.

6 (c) The fund shall include all of the following:

7 (1) Subject to subdivision (l), all public funds transferred by
8 public agencies to the department for deposit in the fund, as
9 permitted under Section 433.51 of Title 42 of the Code of Federal
10 Regulations or any other applicable federal ~~medicaid~~ *Medicaid*
11 laws. These transfers shall constitute local government financial
12 participation in Medi-Cal as permitted under Section 1902(a)(2)
13 of the *federal* Social Security Act (Title 42 U.S.C. Sec.
14 1396a(a)(2)) and other applicable federal ~~medicaid~~ *Medicaid* laws.

15 (2) Subject to subdivision (l), all private donated funds
16 transferred by private individuals or entities for deposit in the fund
17 as permitted under applicable federal ~~medicaid~~ *Medicaid* laws.

18 (3) Any amounts appropriated to the fund by the Legislature.

19 (4) Interest that accrues on amounts in the fund.

20 (d) Amounts in the fund shall be used as the source for the
21 nonfederal share of payments to hospitals under this section.
22 Moneys shall be allocated from the fund by the department and
23 matched by federal funds in accordance with customary Medi-Cal
24 accounting procedures for purposes of payments under this section.

25 (e) Distributions from the fund shall be supplemental to any
26 and all other amounts that hospitals would have received under
27 the contracting program, and under the state medicaid plan,
28 including contract rate increases and supplemental payments and
29 payment adjustments under distribution programs relating to
30 disproportionate share hospitals.

31 (f) Distributions from the fund shall not serve as the state's
32 payment adjustment program under Section 1923 of the *federal*
33 Social Security Act (42 U.S.C. Sec. 1396r-4). To the extent
34 permitted by federal law, and except as otherwise provided in this
35 section, distributions from the fund shall not be subject to
36 requirements contained in or related to Section 1923 of the *federal*
37 Social Security Act (42 U.S.C. Sec. 1396r-4). Distributions from
38 the fund shall be supplemental contract payments and may be
39 structured on any federally permissible basis, as negotiated between
40 the commission and the hospital.

- 1 (g) In order to qualify for distributions from the fund, a hospital
2 shall meet all of the following criteria:
- 3 (1) Be a contracting hospital under this article.
- 4 (2) Satisfy the state ~~medicaid~~ *Medicaid* plan criteria referred to
5 in subdivision (a).
- 6 (3) Be a small and rural hospital as defined in Section 124840
7 of the Health and Safety Code.
- 8 (4) Be a licensed provider of standby emergency services as
9 described in Section 70649 and following of Title 22 of the
10 California Code of Regulations.
- 11 (5) Be able to demonstrate a purpose for additional funding
12 under the selective provider contracting program with proposals
13 relating to health care services that are made available, or will be
14 made available, to Medi-Cal beneficiaries.
- 15 (6) Be determined by the California Medical Assistance
16 Commission to be a hospital that provides an important community
17 service that otherwise would not be provided in the community.
- 18 (h) (1) The department shall seek federal financial participation
19 for expenditures made from the fund to the full extent permitted
20 by federal law.
- 21 (2) The department shall promptly seek any necessary federal
22 approvals regarding this section.
- 23 (i) Any funds remaining in the fund at the end of a fiscal year
24 shall be carried forward for use in following fiscal years.
- 25 (j) For purposes of this section, “fund” means the Small and
26 Rural Hospital Supplemental Payments Fund.
- 27 (k) (1) Any public agency transferring amounts to the fund, as
28 specified in paragraph (1) of subdivision (c), may for that purpose,
29 utilize any revenues, grants, or allocations received from the state
30 for health care programs or purposes, unless otherwise prohibited
31 by law. A public agency may also utilize its general funds or any
32 other public funds or revenues for purposes of transfers to the fund,
33 unless otherwise prohibited by law.
- 34 (2) Notwithstanding paragraph (1), a public agency may transfer
35 to the fund only those moneys that have a source that will qualify
36 for federal financial participation under the provisions of the
37 Medicaid Voluntary Contribution and Provider-Specific Tax
38 Amendments of 1991—~~P.L.~~ (*Public Law* 102-234) or other
39 applicable federal ~~medicaid~~ *Medicaid* laws.

1 (l) Public funds transferred pursuant to paragraph (1) of
2 subdivision (c), and private donated funds transferred pursuant to
3 paragraph (2) of subdivision (c), shall be deposited into the fund,
4 and expended pursuant to this section. The director may accept
5 only those funds that are certified by the transferring entity as
6 qualifying for federal financial participation under the terms of
7 the Medicaid Voluntary Contributions and Provider-Specific Tax
8 Amendments of 1991 ~~(P.L. (Public Law 102-234)~~ and may return
9 any funds transferred in error.

10 (m) The department may adopt emergency regulations for the
11 purposes of this section.

12 (n) The state shall be held harmless from any federal
13 disallowance resulting from this section. A hospital receiving
14 supplemental reimbursement pursuant to this section shall be liable
15 for any reduced federal financial participation resulting from the
16 implementation of this section with respect to that hospital. The
17 state may recoup that federal disallowance from the hospital in
18 any manner authorized by law or contract.

19 (o) *This section shall become inoperative on June 30, 2013,*
20 *and, as of January 1, 2014, is repealed, unless a later enacted*
21 *statute, that becomes operative on or before January 1, 2014,*
22 *deletes or extends the dates on which it becomes inoperative and*
23 *is repealed.*

24 SEC. 78. *Article 2.82 (commencing with Section 14087.98) is*
25 *added to Chapter 7 of Part 3 of Division 9 of the Welfare and*
26 *Institutions Code, to read:*

27

28 *Article 2.82. Managed Health Care Expansion into Rural*
29 *Counties*

30

31 *14087.98. (a) The purpose of this article is to provide a*
32 *comprehensive program of managed health care plan services to*
33 *Medi-Cal recipients residing in the following counties that*
34 *currently receive Medi-Cal services on a fee-for-service basis:*
35 *Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado,*
36 *Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc,*
37 *Nevada, Mono, Placer, Plumas, San Benito, Shasta, Sierra,*
38 *Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.*

39 (b) *The director may enter into exclusive or nonexclusive*
40 *contracts on a bid or negotiated basis with one or more managed*

1 health care plans to provide a comprehensive program of managed
2 health care plan services to Medi-Cal recipients residing in the
3 counties described in subdivision (a). The director shall give
4 special consideration to managed health care plans that meet all
5 of the following:

6 (1) Have demonstrated experience in effectively serving
7 Medi-Cal beneficiaries, including diverse populations.

8 (2) Have demonstrated experience in effectively partnering with
9 public and traditional safety net health care providers.

10 (3) Have demonstrated experience in working with local
11 stakeholders, including consumers, providers, advocates, and
12 county officials, in plan oversight and in delivery of care.

13 (4) Have the lowest administrative costs.

14 (5) Show support from local county officials as demonstrated
15 by an action of the county board of supervisors.

16 (6) Show recent successful experience with expansion of
17 managed care to a rural area.

18 (7) Offer a quality improvement program for primary care
19 providers.

20 (c) Contracts entered into or amended pursuant to this section
21 shall be exempt from the provisions of Chapter 2 (commencing
22 with Section 10290) of Part 2 of Division 2 of the Public Contract
23 Code and Chapter 6 (commencing with Section 14825) of Part 5.5
24 of Division 3 of Title 2 of the Government Code.

25 (d) The managed health care plans that the department contracts
26 with under this article shall comply with the requirements of
27 Section 14087.48 and meet all of the following:

28 (1) Have Medi-Cal managed health care plan contract
29 experience, or evidence of the ability to meet these contracting
30 requirements.

31 (2) Be in good financial standing and meet licensure
32 requirements under the Knox-Keene Health Care Service Plan Act
33 of 1975 (Chapter 2.2 (commencing with Section 1340) of Division
34 2 of the Health and Safety Code), if applicable.

35 (3) Meet quality measures, which may include Medi-Cal and
36 Medicare Healthcare Effectiveness Data and Information Set
37 measures and other quality measures determined or developed by
38 the department and the federal Centers for Medicare and Medicaid
39 Services.

1 (e) *The managed health care plans that the department contracts*
2 *with under this article shall provide Medi-Cal beneficiaries with*
3 *information about enrollment rights and options, plan benefits*
4 *and rules, and care plan elements so that beneficiaries have the*
5 *ability to make informed choices. This information shall be*
6 *delivered in a format and language accessible to beneficiaries.*
7 *The managed health care plans shall provide access to providers*
8 *in compliance with applicable state and federal laws, including,*
9 *but not limited to, physical accessibility and the provision of health*
10 *plan information in alternative formats.*

11 (f) *The department shall conduct a stakeholder process including*
12 *relevant stakeholders to ensure that beneficiaries, health care*
13 *providers, and managed health care plans have an opportunity to*
14 *provide input into the delivery model for these counties and to help*
15 *ensure smooth care transitions for beneficiaries.*

16 (g) *Enrollment in a Medi-Cal managed health care plan or*
17 *plans under this article shall be mandatory in order to receive*
18 *services under Medi-Cal, except as otherwise provided by law.*

19 (h) *Each beneficiary or eligible applicant shall be informed that*
20 *he or she may choose to continue an established patient-provider*
21 *relationship if his or her treating provider is a primary care*
22 *provider or clinic contracting with the managed health care plan,*
23 *has the available capacity, and agrees to continue to treat that*
24 *beneficiary or eligible applicant. The managed health care plans*
25 *shall comply with continuity of care requirements in Section*
26 *1373.96 of the Health and Safety Code.*

27 (i) (1) *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 may implement, interpret, or make specific this*
30 *section and amend regulations and orders adopted by the*
31 *department by means of plan letters, plan or provider bulletins,*
32 *or similar instructions, without taking regulatory action, until the*
33 *time regulations are adopted. It is the intent of the Legislature that*
34 *the department have temporary authority as necessary to implement*
35 *program changes until completion of the regulatory process.*

36 (2) *The department shall adopt emergency regulations no later*
37 *than July 1, 2014. The department may readopt any emergency*
38 *regulation authorized by this section that is the same as or*
39 *substantially equivalent to an emergency regulation previously*
40 *adopted pursuant to this section. The initial adoption of emergency*

1 regulations implementing this section shall be deemed an
2 emergency and necessary for the immediate preservation of the
3 public peace, health, safety, or general welfare. Initial emergency
4 regulations and the one re-adoption of emergency regulations
5 authorized by this section shall be exempt from review by the Office
6 of Administrative Law.

7 (3) The initial emergency regulations and the one re-adoption
8 of emergency regulations authorized by this section shall be
9 submitted to the Office of Administrative Law for filing with the
10 Secretary of State and each shall remain in effect for no more than
11 180 days, by which time final regulations may be adopted.

12 (j) The cost of any program established under this section shall
13 not exceed the total amount that the department estimates it would
14 pay for all services and requirements within the same geographic
15 area under the fee-for-service Medi-Cal program.

16 (k) The department shall have exclusive authority to set the
17 rates, terms, and conditions of managed health care plan contracts
18 and contract amendments under this article. The director may
19 include in the contract a provision for quality assurance
20 withholding from the plan payment, to be paid only if quality
21 measures identified in the plan contract are met.

22 (l) The department shall provide the fiscal and appropriate
23 policy committees of the Legislature with quarterly updates,
24 commencing January 1, 2014, and ending January 1, 2016,
25 regarding the expansion of Medi-Cal managed care into the new
26 counties authorized pursuant to this section. These updates shall
27 include, but not be limited to, continuity of care requests, grievance
28 and appeal rates, and utilization reports for the new counties.

29 (m) The department shall seek all necessary federal approvals
30 to allow for federal financial participation in expenditures under
31 this article. This article shall not be implemented until all necessary
32 federal approvals have been obtained.

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

35 (o) Notwithstanding subdivision (q) of Section 6254 of the
36 Government Code, a contract or contract amendments executed
37 by both parties after the effective date of the act adding this
38 subdivision shall be considered a public record for purposes of
39 the California Public Records Act (Chapter 3.5 (commencing with
40 Section 6250) of Division 7 of Title 1 of the Government Code)

1 *and shall be disclosed upon request. This subdivision applies to*
2 *contracts that reveal the department's rates of payment for health*
3 *care services, the rates themselves, and rate manuals.*

4 *(p) To implement this section, the department may contract with*
5 *public or private entities. Contracts or amendments entered into*
6 *under this section may be on an exclusive or nonexclusive basis*
7 *and a noncompetitive bid basis and shall be exempt from the*
8 *following:*

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

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

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

16 *SEC. 79. Section 14089.08 is added to the Welfare and*
17 *Institutions Code, to read:*

18 *14089.08. (a) Sacramento County may establish a stakeholder*
19 *advisory committee to provide input on the delivery of oral health*
20 *and dental care services, including prevention and education*
21 *services, dental managed care, and fee-for-service Denti-Cal. The*
22 *advisory committee shall include, but not be limited to, local*
23 *nonprofit organizations, representatives from the First Five*
24 *Sacramento Commission, representatives and members of the local*
25 *dental society, local health and human services representatives,*
26 *representatives of Medi-Cal dental managed care plans, Medi-Cal*
27 *enrollees, and other interested individuals. The advisory committee*
28 *may meet on a monthly basis.*

29 *(b) The advisory committee may submit written input to the*
30 *State Department of Health Care Services or the Sacramento*
31 *County Board of Supervisors, as applicable, regarding policies*
32 *that improve the delivery of oral health and dental services in*
33 *Sacramento under the Medi-Cal program or county-administered*
34 *health care system.*

35 *(c) The State Department of Health Care Services shall meet*
36 *periodically, but at least on a quarterly basis, with the advisory*
37 *committee to facilitate communication, dissemination of*
38 *information, and improvements in the provision of oral health and*
39 *dental care services under the Medi-Cal program in the County*
40 *of Sacramento. The dissemination of information shall include*

1 data reported from performance measures and benchmarks used
2 by the department.

3 (d) The advisory committee may meet periodically, but at least
4 twice annually, with the Sacramento County Department of Health
5 and Human Services advisory committee established pursuant to
6 Section 14089.07.

7 (e) No state General Fund moneys shall be used to fund advisory
8 committee costs or to fund any related administrative costs
9 incurred by the county.

10 SEC. 80. Section 14089.09 is added to the Welfare and
11 Institutions Code, to read:

12 14089.09. (a) It is the intent of the Legislature to improve
13 access to oral health and dental care services provided to Medi-Cal
14 beneficiaries enrolled in dental health managed care plans in the
15 Counties of Sacramento and Los Angeles through implementation
16 of performance contracting to ensure dental health plans meet
17 quality criteria and timely access to dental care, as contained in
18 Section 14459.6, and implementation of a beneficiary dental
19 exception process for Medi-Cal beneficiaries in the County of
20 Sacramento to access dental care through fee-for-service Denti-Cal
21 when applicable.

22 (b) (1) The Director of Health Care Services shall exercise his
23 or her authority under Section 14131.15 to establish a beneficiary
24 dental exception (BDE) process, as described in paragraph (2),
25 for Medi-Cal beneficiaries mandatorily enrolled in dental health
26 plans in the County of Sacramento. The BDE process shall be
27 implemented no later than July 1, 2012, and shall be in effect for
28 as long as mandatory enrollment for dental care is in effect in the
29 County of Sacramento. The department shall consult with the
30 advisory committee established pursuant to Section 14089.08
31 regarding potential modifications to the BDE process. For
32 purposes of emergency access to dental care issues, the department
33 shall establish specific processes under the BDE to accommodate
34 for these issues.

35 (2) The BDE shall be available to Medi-Cal dental managed
36 care beneficiaries in the County of Sacramento who are unable to
37 secure access to services through their managed care plan, in
38 accordance with applicable contractual timeframes and in
39 accordance with the Knox-Keene Health Care Service Plan Act
40 of 1975 (Chapter 2.2 (commencing with Section 1340) of Division

1 2 of the Health and Safety Code). The BDE shall allow a
2 beneficiary to opt-out of Medi-Cal dental managed care and move
3 into fee-for-service Denti-Cal where the beneficiary may select
4 his or her own dental provider on an ongoing basis. The
5 beneficiary shall remain in fee-for-service Denti-Cal until the time
6 he or she chooses to opt-in to a dental managed care arrangement.

7 (3) Beneficiaries shall be notified of the BDE option, which
8 shall include the process for access to emergency visits, through
9 a letter from the department detailing the process, directions on
10 how to fill out the BDE form, and where to access the BDE form.
11 A hard copy of the BDE form shall accompany the letter from the
12 department. The BDE form, directions on how to fill out the BDE
13 form, and a description of the process shall also be posted on the
14 department's Internet Web site for easy access by beneficiaries
15 and the public. The department shall also notify and inform dental
16 managed care plans of the BDE process and its operation.

17 (4) Upon receipt of the BDE form, the department shall have
18 no more than three business days to contact the beneficiary. The
19 department shall, within five business days from the date of contact
20 with the beneficiary, work with the beneficiary and the dental plan
21 to schedule an appointment within the applicable contractual
22 timeframes and in accordance with the Knox-Keene Health Care
23 Service Plan Act of 1975 (Chapter 2.2 (commencing with Section
24 1340) of Division 2 of the Health and Safety Code).

25 (A) If an appointment is not available, the department shall
26 approve and process the BDE and move the beneficiary into
27 fee-for-service Denti-Cal.

28 (B) If an appointment is available, the beneficiary shall receive
29 from the department a followup telephone call after the
30 appointment to assess how the visit went and to determine if there
31 is a need for any additional followup.

32 (5) Based on the followup as identified in subparagraph (B) of
33 paragraph (4), to the extent no additional access issues to
34 contractually required services are identified, the BDE shall be
35 closed and the beneficiary shall remain in the selected dental plan.

36 (c) The department shall take all necessary steps to implement
37 the BDE process as described in this section and shall, monthly,
38 publicly report on the department's Internet Web site the number
39 of individuals requesting the BDE and the specific outcome of each
40 request, including, but not limited to, summary data on the types

1 of visits subject to the BDE process, the services provided,
2 description of timely access to care, the delivery system in which
3 services were provided, beneficiary satisfaction, and the
4 department's perspective of the outcome. The information provided
5 on the department's Internet Web site shall be deidentified in
6 accordance with the Health Insurance Portability and Availability
7 Act of 1996 (HIPAA), including Section 164.514 of Title 45 of the
8 Code of Federal Regulations, and shall not contain any personally
9 identifiable information according to the Information Practices
10 Act of 1977 (Chapter 1 (commencing with Section 1798) of Title
11 1.8 of Part 4 of Division 3 of the Civil Code).

12 (d) The department shall consult with stakeholders in the
13 development of the BDE form and related materials.

14 SEC. 81. Section 14091.3 of the Welfare and Institutions Code
15 is amended to read:

16 14091.3. (a) For purposes of this section, the following
17 definitions shall apply:

18 (1) "Medi-Cal managed care plan contracts" means those
19 contracts entered into with the department by any individual,
20 organization, or entity pursuant to Article 2.7 (commencing with
21 Section 14087.3), Article 2.8 (commencing with Section 14087.5),
22 or Article 2.91 (commencing with Section 14089) of this chapter,
23 or Article 1 (commencing with Section 14200) or Article 7
24 (commencing with Section 14490) of Chapter 8, or Chapter 8.75
25 (commencing with Section 14591).

26 (2) "Medi-Cal managed care health plan" means an individual,
27 organization, or entity operating under a Medi-Cal managed care
28 plan contract with the department under this chapter, Chapter 8
29 (commencing with Section 14200), or Chapter 8.75 (commencing
30 with Section 14591).

31 (b) The department shall take all appropriate steps to amend the
32 Medicaid State Plan, if necessary, to carry out this section. This
33 section shall be implemented only to the extent that federal
34 financial participation is available. ~~The department shall adopt
35 rules and regulations to carry out this section. Until January 1,
36 2010, any rules and regulations adopted pursuant to this subdivision
37 may be adopted as emergency regulations in accordance with the
38 Administrative Procedure Act (Chapter 3.5 (commencing with
39 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
40 Code). The adoption of these regulations shall be deemed an~~

1 emergency and necessary for the immediate preservation of the
2 public peace, health, and safety or general welfare. The regulations
3 shall become effective immediately upon filing with the Secretary
4 of State.

5 (c) (1) Any hospital that does not have in effect a contract with
6 a Medi-Cal managed care health plan, as defined in paragraph (2)
7 of subdivision (a), that establishes payment amounts for services
8 furnished to a beneficiary enrolled in that plan shall accept as
9 payment in full, from all these plans, the following amounts:

10 (1)

11 (A) For outpatient services, the Medi-Cal fee-for-service (FFS)
12 payment amounts.

13 (2)

14 (B) For emergency inpatient services, the average per diem
15 contract rate specified in paragraph (2) of subdivision (b) of Section
16 14166.245, except that the payment amount shall not be reduced
17 by 5 percent, *until July 1, 2013, and thereafter, the average*
18 *contract rate specified in Section 1396u-2(b)(2) of Title 42 of the*
19 *United States Code*. For the purposes of this ~~paragraph~~
20 *subparagraph*, this payment amount shall apply to all hospitals,
21 including hospitals that contract with the department under the
22 Medi-Cal Selective Provider Contracting Program described in
23 Article 2.6 (commencing with Section 14081), and small and rural
24 hospitals specified in Section 124840 of the Health and Safety
25 Code.

26 (3)

27 (C) For poststabilization services following an emergency
28 admission, payment amounts shall be consistent with ~~subdivision~~
29 ~~(e) of Section 438.114~~ *Section 438.114(e)* of Title 42 of the Code
30 of Federal Regulations. This paragraph shall only be implemented
31 to the extent that contract amendment language providing for these
32 payments is approved by CMS. For purposes of this ~~paragraph~~
33 *subparagraph*, this payment amount shall apply to all hospitals,
34 including hospitals that contract with the department under the
35 Medi-Cal Selective Provider Contracting Program pursuant to
36 Article 2.6 (commencing with Section 14081).

37 (2) *The rates established in paragraph (1) for emergency*
38 *inpatient services and poststabilization services shall remain in*
39 *effect only until the department implements the payment*

1 methodology based on diagnosis-related groups pursuant to
2 Section 14105.28.

3 (3) Upon implementation of the payment methodology based
4 on diagnosis-related groups pursuant to Section 14105.28, any
5 hospital described in paragraph (1) shall accept as payment in
6 full for inpatient hospital services, including both emergency
7 inpatient services and poststabilization services related to an
8 emergency medical condition, the payment amount established
9 pursuant to the methodology developed under Section 14105.28.

10 (d) Medi-Cal managed care health plans that, pursuant to the
11 department's encouragement in All Plan Letter 07003, have been
12 paying out-of-network hospitals the most recent California Medical
13 Assistance Commission regional average per diem rate as a
14 temporary rate for purposes of Section 1932(b)(2)(D) of the *federal*
15 Social Security Act (SSA), which became effective January 1,
16 2007, shall make reconciliations and adjustments for all hospital
17 payments made since January 1, 2007, based upon rates published
18 by the department pursuant to Section 1932(b)(2)(D) of the SSA
19 and effective January 1, 2007, to June 30, 2008, inclusive, and, if
20 applicable, provide supplemental payments to hospitals as
21 necessary to make payments that conform with Section
22 1932(b)(2)(D) of the SSA. In order to provide managed care health
23 plans with 60 working days to make any necessary supplemental
24 payments to hospitals prior to these payments becoming subject
25 to the payment of interest, Section 1300.71 of Title 28 of the
26 California Code of Regulations shall not apply to these
27 supplemental payments until 30 working days following the
28 publication by the department of the rates.

29 (e) (1) The department shall provide a written report to the
30 policy and fiscal committees of the Legislature on October 1, 2009,
31 and May 1, 2010, on the implementation and impact made by this
32 section, including the impact of these changes on access to
33 hospitals by managed care enrollees and on contracting between
34 hospitals and managed care health plans, including the increase
35 or decrease in the number of these contracts.

36 (2) Not later than August 1, 2010, the department shall report
37 to the Legislature on the implementation of this section. The report
38 shall include, but not be limited to, information and analyses
39 addressing managed care enrollee access to hospital services, the
40 impact of this section on managed care health plan capitation rates,

1 the impact of this section on the extent of contracting between
2 managed care health plans and hospitals, and fiscal impact on the
3 state.

4 (3) For the purposes of preparing the ~~annual~~ status reports and
5 the final evaluation report required pursuant to this subdivision,
6 Medi-Cal managed care health plans shall provide the department
7 with all data and documentation, including contracts with providers,
8 including hospitals, as deemed necessary by the department to
9 evaluate the impact of the implementation of this section. In order
10 to ensure the confidentiality of managed care health plan
11 proprietary information, and thereby enable the department to have
12 access to all of the data necessary to provide the Legislature with
13 accurate and meaningful information regarding the impact of this
14 section, all information and documentation provided to the
15 department pursuant to this section shall be considered proprietary
16 and shall be exempt from disclosure as official information
17 pursuant to subdivision (k) of Section 6254 of the Government
18 Code as contained in the California Public Records Act (~~Division~~
19 ~~7~~ (*Chapter 3.5* (commencing with Section 6250) of *Division 7* of
20 Title 1 of the Government Code).

21 ~~(f) This section shall remain in effect only until January 1, 2013,~~
22 ~~and as of that date is repealed, unless a later enacted statute, that~~
23 ~~is enacted before January 1, 2013, deletes or extends that date.~~

24 *(f) Notwithstanding the rulemaking provisions of the*
25 *Administrative Procedure Act (Chapter 3.5 (commencing with*
26 *Section 11340) of Part 1 of Division 3 of Title 2 of the Government*
27 *Code), the department may implement, interpret, or make specific*
28 *this section and applicable federal waivers and state plan*
29 *amendments by means of all-county letters, plan letters, plan or*
30 *provider bulletins, or similar instructions, without taking*
31 *regulatory action. Prior to issuing any letter or similar instrument*
32 *authorized pursuant to this section, the department shall notify*
33 *and consult with stakeholders, including advocates, providers,*
34 *and beneficiaries.*

35 *(g) This section shall become inoperative on July 1, 2013, and,*
36 *as of January 1, 2014, is repealed, unless a later enacted statute,*
37 *that becomes operative on or before January 1, 2014, deletes or*
38 *extends the dates on which it becomes inoperative and is repealed.*

39 *SEC. 82. Section 14105.196 is added to the Welfare and*
40 *Institutions Code, to read:*

1 14105.196. (a) *It is the intent of the Legislature to comply with*
2 *the provisions of the federal Health Care and Education*
3 *Reconciliation Act of 2010 (Public Law 111-152) and temporarily*
4 *increase reimbursement to certain primary care providers at the*
5 *same levels as Medicare rates for the 2013 and 2014 calendar*
6 *years for specified services.*

7 (b) (1) *Notwithstanding any other law, to the extent required*
8 *by federal law and regulations, beginning January 1, 2013, through*
9 *and including December 31, 2014, payments for primary care*
10 *services provided by a physician with a primary specialty*
11 *designation of family medicine, general internal medicine, or*
12 *pediatric medicine shall not be less than 100 percent of the*
13 *payment rate that applies to those services and physicians as*
14 *established by the Medicare Program, for both fee-for-service and*
15 *managed care plans.*

16 (2) *Notwithstanding any other law, to the extent required by*
17 *federal law and regulations, beginning January 1, 2013, through*
18 *and including December 31, 2014, the payments for primary care*
19 *services implemented pursuant to this section shall be exempt from*
20 *the payment reductions under Sections 14105.191 and 14105.192.*

21 (c) *For purposes of this section, “primary care services” and*
22 *“primary specialty” means the services and primary specialties*
23 *defined in Section 1202 of the federal Health Care and Education*
24 *Reconciliation Act of 2010 (Public Law 111-152; 42 U.S.C. Sec.*
25 *1396a(a)(13)(C)) and related federal regulations.*

26 (d) *Notwithstanding any other law, effective on or after January*
27 *1, 2013, the payment increase implemented pursuant to this section*
28 *shall apply to managed care health plans that contract with the*
29 *department pursuant to Chapter 8.75 (commencing with Section*
30 *14591) and to contracts with the Senior Care Action Network and*
31 *the AIDS Healthcare Foundation, and to the extent that the services*
32 *are provided through any of these contracts, payments shall be*
33 *increased by the actuarial equivalent amount of the payment*
34 *increases pursuant to contract amendments or change orders*
35 *effective on or after January 1, 2013.*

36 (e) *Notwithstanding Chapter 3.5 (commencing with Section*
37 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*
38 *the department shall implement, clarify, make specific, and define*
39 *the provisions of this section by means of provider bulletins or*
40 *similar instructions, without taking regulatory action.*

1 (f) Notwithstanding paragraph (1) of subdivision (b), if a final
2 judicial determination is made by any state or federal court that
3 is not appealed, in any action by any party, or a final determination
4 is made by the administrator of the federal Centers for Medicare
5 and Medicaid Services, that any payments pursuant to this section
6 are invalid, unlawful, or contrary to any provision of federal law
7 or regulations, or of state law, this section shall become
8 inoperative.

9 (g) (1) The director shall implement the increased payments
10 for primary care services and primary specialties provided for in
11 this section only to the extent that the federal medical assistance
12 percentage is equal to 100 percent.

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

18 (3) To the extent that the director determines that the payments
19 do not comply with applicable federal Medicaid requirements, the
20 director shall retain the discretion not to implement the changes
21 and may revise the payments as necessary to comply with the
22 federal Medicaid requirements.

23 (h) This section shall remain in effect only until January 1, 2015,
24 and as of that date is repealed, unless a later enacted statute, that
25 is enacted before January 1, 2015, deletes or extends that date.

26 SEC. 83. Section 14105.22 of the Welfare and Institutions Code
27 is amended to read:

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

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

36 (b) (1) It is the intent of the Legislature that the department
37 develop payment rates for clinical laboratory or laboratory
38 services that are comparable to the payment amounts received
39 from other payers for laboratory services. Development of these
40 rates will enable the department to reimburse clinical laboratory

1 or laboratory service providers in compliance with state and
2 federal law.

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

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

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

14 (A) The amount billed.

15 (B) The charge to the general public.

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

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

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

29 (5) (A) For purposes of establishing reimbursement rates for
30 clinical laboratory or laboratory services based on the lowest
31 amounts other payers are paying providers for similar laboratory
32 services, laboratory service providers shall submit data reports
33 within six months of the date the act that added this paragraph
34 becomes effective and annually thereafter. The data provided shall
35 be based on the previous calendar year and shall specify the
36 provider's usual and customary payments, reflecting Medi-Cal,
37 other state Medicaid programs, private insurance, and Medicare
38 payment data, minus discounts and rebates.

39 (B) The data submitted pursuant to subparagraph (A) may be
40 used to determine reimbursement rates by procedure code based

1 on an average of the lowest amount other payers are paying
2 providers for similar laboratory services, excluding significant
3 deviations of cost or volume factors and with consideration to
4 geographical areas.

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

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

13 (E) Data reports submitted to the department shall be certified
14 by the provider's certified financial officer or an authorized
15 individual.

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

20 (6) Data reports provided to the department pursuant to this
21 section shall be confidential and shall be exempt from disclosure
22 under the California Public Records Act (Chapter 3.5 (commencing
23 with Section 6250) of Division 7 of Title 1 of the Government
24 Code).

25 (7) The department shall seek stakeholder input on the rate
26 setting methodology.

27 (8) (A) 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, without taking any further regulatory action,
30 implement, interpret, or make specific this section by means of
31 provider bulletins or similar instructions until regulations are
32 adopted. It is the intent of the Legislature that the department have
33 temporary authority as necessary to implement program changes
34 until completion of the regulatory process.

35 (B) The department shall adopt emergency regulations no later
36 than July 1, 2014. The department may readopt any emergency
37 regulation authorized by this section that is the same as or
38 substantially equivalent to an emergency regulation previously
39 adopted pursuant to this section. The initial adoption of emergency
40 regulations implementing the amendments to this section and the

1 *one readoption of emergency regulations authorized by this section*
2 *shall be deemed an emergency and necessary for the immediate*
3 *preservation of the public peace, health, safety, or general welfare.*
4 *Initial emergency regulations and the one readoption of emergency*
5 *regulations authorized by this section shall be exempt from review*
6 *by the Office of Administrative Law.*

7 *(C) The initial emergency regulations and the one readoption*
8 *of emergency regulations authorized by this section shall be*
9 *submitted to the Office of Administrative Law for filing with the*
10 *Secretary of State and each shall remain in effect for no more than*
11 *180 days, by which time final regulations may be adopted.*

12 *(9) To the extent that the director determines that the new*
13 *methodology or payment reductions are not consistent with the*
14 *requirements of Section 1396a(a)(30)(A) of Title 42 of the United*
15 *States Code, the department may revert to the methodology under*
16 *subdivision (a) to ensure access to care is not compromised.*

17 *(10) (A) The department shall implement this section in a*
18 *manner that is consistent with federal Medicaid law and*
19 *regulations. The director shall seek any necessary federal*
20 *approvals for the implementation of this section. This section shall*
21 *be implemented only to the extent that federal approval is obtained.*

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

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

36 *SEC. 84. Section 14134 of the Welfare and Institutions Code,*
37 *as amended by Chapter 3 of the Statutes of 2011, is amended to*
38 *read:*

39 *14134. (a) Except for any prescription, refill, visit, service,*
40 *device, or item for which the program's payment is ten dollars*

1 (\$10) or less, in which case no copayment shall be required, a
2 recipient of services under this chapter shall be required to make
3 copayments not to exceed the maximum permitted under federal
4 regulations or federal waivers as follows:

5 (1) Copayment of five dollars (\$5) shall be made for
6 nonemergency services received in an *emergency department or*
7 *emergency room when the services do not result in the treatment*
8 *of an emergency medical condition or inpatient admittance.* For
9 the purposes of this section, “nonemergency services” means ~~any~~
10 ~~services not required for the alleviation of severe pain or the~~
11 ~~immediate diagnosis and treatment of severe medical conditions~~
12 ~~which, if not immediately diagnosed and treated, would lead to~~
13 ~~disability or death.~~ *to, as appropriate, medically screen, examine,*
14 *evaluate, or stabilize an emergency medical condition that*
15 *manifests itself by acute symptoms of sufficient severity, including*
16 *severe pain, such that the absence of immediate medical attention*
17 *could reasonably be expected to result in any of the following:*

18 (A) *Placing the individual’s health, or, with respect to a*
19 *pregnant woman, the health of the woman or her unborn child, in*
20 *serious jeopardy.*

21 (B) *Serious impairment to bodily functions.*

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

23 (2) Copayment of one dollar (\$1) shall be made for each drug
24 prescription or refill.

25 (3) Copayment of one dollar (\$1) shall be made for each visit
26 for services under subdivisions (a) and (h) of Section 14132.

27 (4) The copayment amounts set forth in paragraphs (1), (2), and
28 (3) may be collected and retained or waived by the provider.

29 (5) The department shall not reduce the reimbursement otherwise
30 due to providers as a result of the copayment. The copayment
31 amounts shall be in addition to any reimbursement otherwise due
32 the provider for services rendered under this program.

33 (6) This section does not apply to emergency services, family
34 planning services, or to any services received by:

35 (A) Any child in AFDC-Foster Care, as defined in Section
36 11400.

37 (B) Any person who is an inpatient in a health facility, as defined
38 in Section 1250 of the Health and Safety Code.

39 (C) Any person 18 years of age or under.

40 (D) Any woman receiving perinatal care.

1 (7) Paragraph (2) does not apply to any person 65 years of age
2 or over.

3 (8) A provider of service shall not deny care or services to an
4 individual solely because of that person's inability to copay under
5 this section. An individual shall, however, remain liable to the
6 provider for any copayment amount owed.

7 (9) The department shall seek any federal waivers necessary to
8 implement this section. The provisions for which appropriate
9 federal waivers cannot be obtained shall not be implemented, but
10 provisions for which waivers are either obtained or found to be
11 unnecessary shall be unaffected by the inability to obtain federal
12 waivers for the other provisions.

13 (10) The director shall adopt any regulations necessary to
14 implement this section as emergency regulations in accordance
15 with Chapter 3.5 (commencing with Section 11340) of Part 1 of
16 Division 3 of Title 2 of the Government Code. The adoption of
17 the regulations shall be deemed to be an emergency and necessary
18 for the immediate preservation of the public peace, health and
19 safety, or general welfare. The director shall transmit these
20 emergency regulations directly to the Secretary of State for filing
21 and the regulations shall become effective immediately upon filing.
22 Upon completion of the formal regulation adoption process and
23 prior to the expiration of the 120 day duration period of emergency
24 regulations, the director shall transmit directly to the Secretary of
25 State for filing the adopted regulations, the rulemaking file, and
26 the certification of compliance as required by subdivision (e) of
27 Section 11346.1 of the Government Code.

28 (b) This section, *or subdivisions thereof, if applicable*, shall
29 become inoperative on the implementation date for copayments
30 stated in the declaration executed by the director pursuant to
31 Section 14134 as added by Section 101.5 of the act that added this
32 subdivision, ~~and is repealed on January 1 of the following year.~~

33 *SEC. 85. Section 14134 of the Welfare and Institutions Code,*
34 *as added by Chapter 3 of the Statutes of 2011, is amended to read:*

35 14134. (a) The Legislature finds and declares all of the
36 following:

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

1 (2) In order to minimize the need for drastically cutting
2 enrollment standards or benefits or imposing further reductions
3 on Medi-Cal providers during times of economic crisis, it is crucial
4 to find areas within the program where beneficiaries can share
5 responsibility for utilization of health care, whether they are
6 participating in the fee-for-service or the managed care model of
7 service delivery.

8 (3) The establishment of cost-sharing obligations within the
9 Medi-Cal program is complex and is subject to close supervision
10 by the United States Department of Health and Human Services.

11 (4) As the single state agency for Medicaid in California, the
12 State Department of Health Care Services has unique expertise
13 that can inform decisions that set or adjust cost-sharing
14 responsibilities for Medi-Cal beneficiaries receiving health care
15 services.

16 (b) Therefore, it is the intent of the Legislature for the
17 department to obtain federal approval to implement cost-sharing
18 for Medi-Cal beneficiaries and permit providers to require that
19 individuals meet their cost-sharing obligation prior to receiving
20 care or services.

21 (c) A Medi-Cal beneficiary shall be required to make
22 copayments as described in this section. These copayments
23 represent a contribution toward the rate of payment made to
24 providers of Medi-Cal services and shall be as follows:

25 (1) Copayment of up to fifty dollars (\$50) shall be made for
26 nonemergency services received in an *emergency department or*
27 *emergency room when the services do not result in the treatment*
28 *of an emergency condition or inpatient admittance.* For the
29 purposes of this section, “nonemergency services” means services
30 ~~not required for the alleviation of severe pain or the immediate~~
31 ~~diagnosis and treatment of unforeseen medical conditions that, if~~
32 ~~not immediately diagnosed and treated, would lead to disability~~
33 ~~or death.~~ *to, as appropriate, medically screen, examine, evaluate,*
34 *or stabilize an emergency medical condition that manifests itself*
35 *by acute symptoms of sufficient severity, including severe pain,*
36 *such that the absence of immediate medical attention could*
37 *reasonably be expected to result in any of the following:*

38 (A) *Placing the individual’s health, or, with respect to a*
39 *pregnant woman, the health of the woman or her unborn child, in*
40 *serious jeopardy.*

1 (B) *Serious impairment to bodily functions.*

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

3 (2) Copayment of up to fifty dollars (\$50) shall be made for
4 emergency services received in an *emergency department or*
5 *emergency room when the services result in the treatment of an*
6 *emergency medical condition or inpatient admittance.* For purposes
7 of this section, “emergency services” means services required ~~for~~
8 ~~the alleviation of severe pain or the immediate diagnosis and~~
9 ~~treatment of unforeseen medical conditions that, if not immediately~~
10 ~~diagnosed and treated, would lead to disability or death.~~ *to, as*
11 *appropriate, medically screen, examine, evaluate, or stabilize an*
12 *emergency medical condition that manifests itself by acute*
13 *symptoms of sufficient severity, including severe pain, such that*
14 *the absence of immediate medical attention could reasonably be*
15 *expected to result in any of the following:*

16 (A) *Placing the individual’s health, or, with respect to a*
17 *pregnant woman, the health of the woman or her unborn child, in*
18 *serious jeopardy.*

19 (B) *Serious impairment to bodily functions.*

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

21 (3) Copayment of up to one hundred dollars (\$100) shall be
22 made for each hospital inpatient day, up to a maximum of two
23 hundred dollars (\$200) per admission.

24 (4) Copayment of up to three dollars (\$3) shall be made for each
25 preferred drug prescription or refill. A copayment of up to five
26 dollars (\$5) shall be made for each nonpreferred drug prescription
27 or refill. Except as provided in subdivision (g), “preferred drug”
28 shall have the same meaning as in Section 1916A of the Social
29 Security Act (42 U.S.C. Sec. 1396o-1).

30 (5) Copayment of up to five dollars (\$5) shall be made for each
31 visit for services under subdivision (a) of Section 14132 and for
32 dental services received on an outpatient basis provided as a
33 Medi-Cal benefit pursuant to this chapter or Chapter 8
34 (commencing with Section 14200), as applicable.

35 (6) This section does not apply to services provided pursuant
36 to subdivision (aa) of Section 14132.

37 (d) The copayments established pursuant to subdivision (c) shall
38 be set by the department, at the maximum amount provided for in
39 the applicable paragraph, except that each copayment amount shall

1 not exceed the maximum amount allowable pursuant to the state
2 plan amendments or other federal approvals.

3 (e) The copayment amounts set forth in subdivision (c) may be
4 collected and retained or waived by the provider. The department
5 shall deduct the amount of the copayment from the payment the
6 department makes to the provider whether retained, waived, or not
7 collected by the provider.

8 (f) Notwithstanding any other provision of law, and only to the
9 extent allowed pursuant to federal law, a provider of service has
10 no obligation to provide services to a Medi-Cal beneficiary who
11 does not, at the point of service, pay the copayment assessed
12 pursuant to this section. If the provider provides services without
13 collecting the copayment, and has not waived the copayment, the
14 provider may hold the beneficiary liable for the copayment amount
15 owed.

16 (g) (1) Notwithstanding any other provision of law, except as
17 described in paragraph (2), this section shall apply to Medi-Cal
18 beneficiaries enrolled in a health plan contracting with the
19 department pursuant to this chapter or Chapter 8 (commencing
20 with Section 14200), except for *the* Senior Care Action Network
21 or AIDS Healthcare Foundation. To the extent permitted by federal
22 law and pursuant to any federal waivers or state plan adjustments
23 obtained, a managed care health plan may establish a lower
24 copayment or no copayment.

25 (2) For the purpose of paragraph (4) of subdivision (c),
26 copayments assessed against a beneficiary who receives Medi-Cal
27 services through a health plan described in paragraph (1) shall be
28 based on the plan's designation of a drug as preferred or
29 nonpreferred.

30 (3) To the extent provided by federal law, capitation payments
31 shall be calculated on an actuarial basis as if copayments described
32 in this section were collected.

33 (h) This section shall be implemented only to the extent that
34 federal financial participation is available. The department shall
35 seek and obtain any federal waivers or state plan amendments
36 necessary to implement this section. The provisions for which
37 appropriate federal waivers or state plan amendments cannot be
38 obtained shall not be implemented, but provisions for which
39 waivers or state plan amendments are either obtained or found to

1 be unnecessary shall be unaffected by the inability to obtain federal
2 waivers or state plan amendments for the other provisions.

3 (i) 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 may implement, interpret, or make specific this
6 section by means of all-county letters, all-plan letters, provider
7 bulletins, or similar instructions, without taking further regulatory
8 actions.

9 (j) (1) This section shall become operative on the date that the
10 act adding this section is effective, but shall not be implemented
11 until the date in the declaration executed by the director pursuant
12 to paragraph (2). In no event shall the director set an
13 implementation date prior to the date federal approval is received.

14 (2) The director shall execute a declaration that states the date
15 that implementation of the copayments described in this section
16 *or subdivisions thereof, if applicable*, will commence and shall
17 post the declaration on the department's Internet Web site and
18 provide a copy of the declaration to the Chair of the Joint
19 Legislative Budget Committee, the Chief Clerk of the Assembly,
20 the Secretary of the Senate, the Office of the Legislative Counsel,
21 and the Secretary of State.

22 *SEC. 86. Section 14134.1 of the Welfare and Institutions Code*
23 *is amended to read:*

24 14134.1. (a) Except as provided in paragraph (2) of subdivision
25 (a) of Section 14134, no provider under this chapter may deny care
26 or services to an individual eligible for care or services under this
27 chapter because of the individual's inability to pay a copayment,
28 as defined in Section 14134. The requirements of this section shall
29 not extinguish the liability of the individual to whom the care or
30 services were furnished for payment of the copayment.

31 (b) 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 may implement, interpret, or make specific this
34 section by means of all-county letters, provider bulletins, or similar
35 instructions, without taking further regulatory action.

36 (c) This section shall become inoperative *to the extent, and on*
37 *the implementation date for, copayments as stated in the declaration*
38 *executed by the director pursuant to Section 14134 as added by*
39 *Section 101.5 of the act that added this subdivision, and is repealed*
40 *on January 1 of the following year.*

1 *SEC. 87. Section 14154 of the Welfare and Institutions Code*
2 *is amended to read:*

3 14154. (a) (1) The department shall establish and maintain a
4 plan whereby costs for county administration of the determination
5 of eligibility for benefits under this chapter will be effectively
6 controlled within the amounts annually appropriated for that
7 administration. The plan, to be known as the County Administrative
8 Cost Control Plan, shall establish standards and performance
9 criteria, including workload, productivity, and support services
10 standards, to which counties shall adhere. The plan shall include
11 standards for controlling eligibility determination costs that are
12 incurred by performing eligibility determinations at county
13 hospitals, or that are incurred due to the outstationing of any other
14 eligibility function. Except as provided in Section 14154.15,
15 reimbursement to a county for outstationed eligibility functions
16 shall be based solely on productivity standards applied to that
17 county's welfare department office.

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

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

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

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

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

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

16 (5) The department shall provide a clear narrative description
17 along with fiscal detail in the Medi-Cal estimate package, submitted
18 to the Legislature in January and May of each year, of each
19 component of the county administrative funding for the Medi-Cal
20 program. This shall describe how the information obtained from
21 the county budget survey documents was utilized and, where
22 applicable, modified and the rationale for the changes.

23 (6) Notwithstanding any other provision of law, the department
24 shall develop and implement, in consultation with county program
25 and fiscal representatives, a new budgeting methodology for
26 Medi-Cal county administrative costs. The new budgeting
27 methodology shall be used to reimburse counties for eligibility
28 determinations for applicants and beneficiaries, including one-time
29 eligibility processing and ongoing case maintenance.

30 (A) The budgeting methodology shall include, but is not limited
31 to, identification of the costs of eligibility determinations for
32 applicants, and the costs of eligibility redeterminations and case
33 maintenance activities for recipients, for different groupings of
34 cases. The groupings of cases shall be based on variations in time
35 and resources needed to conduct eligibility determinations. The
36 calculation of time and resources shall be based on the following
37 factors: complexity of eligibility rules, ongoing eligibility
38 requirements, and other factors as determined appropriate by the
39 department.

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

5 (C) The department may develop a process for counties to phase
6 in the requirements of the new budgeting methodology.

7 (D) To the extent a county does not submit the requested data
8 pursuant to subparagraph (B), the new budgeting methodology
9 may include a process to use peer-based proxy costs in developing
10 the county budget.

11 (E) The department shall provide the new budgeting
12 methodology to the legislative fiscal committees by March 1, 2012,
13 and may include the methodology in the May Medi-Cal Local
14 Assistance Estimate, beginning with the May 2012 estimate, for
15 the 2012–13 fiscal year and each fiscal year thereafter.

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

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

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

1 (2) It is the intent of the Legislature to not appropriate funds for
2 the cost-of-doing-business adjustment for the 2008–09, 2009–10,
3 2010–11, ~~and~~ 2011–12, *and 2012–13* fiscal years.

4 (d) The department is responsible for the Medi-Cal program in
5 accordance with state and federal law. A county shall determine
6 Medi-Cal eligibility in accordance with state and federal law. If
7 in the course of its duties the department becomes aware of
8 accuracy problems in any county, the department shall, within
9 available resources, provide training and technical assistance as
10 appropriate. Nothing in this section shall be interpreted to eliminate
11 any remedy otherwise available to the department to enforce
12 accurate county administration of the program. In administering
13 the Medi-Cal eligibility process, each county shall meet the
14 following performance standards each fiscal year:

15 (1) Complete eligibility determinations as follows:

16 (A) Ninety percent of the general applications without applicant
17 errors and are complete shall be completed within 45 days.

18 (B) Ninety percent of the applications for Medi-Cal based on
19 disability shall be completed within 90 days, excluding delays by
20 the state.

21 (2) (A) The department shall establish best-practice guidelines
22 for expedited enrollment of newborns into the Medi-Cal program,
23 preferably with the goal of enrolling newborns within 10 days after
24 the county is informed of the birth. The department, in consultation
25 with counties and other stakeholders, shall work to develop a
26 process for expediting enrollment for all newborns, including those
27 born to mothers receiving CalWORKs assistance.

28 (B) Upon the development and implementation of the
29 best-practice guidelines and expedited processes, the department
30 and the counties may develop an expedited enrollment timeframe
31 for newborns that is separate from the standards for all other
32 applications, to the extent that the timeframe is consistent with
33 these guidelines and processes.

34 (3) Perform timely annual redeterminations, as follows:

35 (A) Ninety percent of the annual redetermination forms shall
36 be mailed to the recipient by the anniversary date.

37 (B) Ninety percent of the annual redeterminations shall be
38 completed within 60 days of the recipient's annual redetermination
39 date for those redeterminations based on forms that are complete

1 and have been returned to the county by the recipient in a timely
2 manner.

3 (C) Ninety percent of those annual redeterminations where the
4 redetermination form has not been returned to the county by the
5 recipient shall be completed by sending a notice of action to the
6 recipient within 45 days after the date the form was due to the
7 county.

8 (D) When a child is determined by the county to change from
9 no share of cost to a share of cost and the child meets the eligibility
10 criteria for the Healthy Families Program established under Section
11 12693.98 of the Insurance Code, the child shall be placed in the
12 Medi-Cal-to-Healthy Families Bridge Benefits Program, and these
13 cases shall be processed as follows:

14 (i) Ninety percent of the families of these children shall be sent
15 a notice informing them of the Healthy Families Program within
16 five working days from the determination of a share of cost.

17 (ii) Ninety percent of all annual redetermination forms for these
18 children shall be sent to the Healthy Families Program within five
19 working days from the determination of a share of cost if the parent
20 has given consent to send this information to the Healthy Families
21 Program.

22 (iii) Ninety percent of the families of these children placed in
23 the Medi-Cal-to-Healthy Families Bridge Benefits Program who
24 have not consented to sending the child's annual redetermination
25 form to the Healthy Families Program shall be sent a request,
26 within five working days of the determination of a share of cost,
27 to consent to send the information to the Healthy Families Program.

28 (E) Subparagraph (D) shall not be implemented until 60 days
29 after the Medi-Cal and Joint Medi-Cal and Healthy Families
30 applications and the Medi-Cal redetermination forms are revised
31 to allow the parent of a child to consent to forward the child's
32 information to the Healthy Families Program.

33 (e) The department shall develop procedures in collaboration
34 with the counties and stakeholder groups for determining county
35 review cycles, sampling methodology and procedures, and data
36 reporting.

37 (f) On January 1 of each year, each applicable county, as
38 determined by the department, shall report to the department on
39 the county's results in meeting the performance standards specified
40 in this section. The report shall be subject to verification by the

1 department. County reports shall be provided to the public upon
2 written request.

3 (g) If the department finds that a county is not in compliance
4 with one or more of the standards set forth in this section, the
5 county shall, within 60 days, submit a corrective action plan to the
6 department for approval. The corrective action plan shall, at a
7 minimum, include steps that the county shall take to improve its
8 performance on the standard or standards with which the county
9 is out of compliance. The plan shall establish interim benchmarks
10 for improvement that shall be expected to be met by the county in
11 order to avoid a sanction.

12 (h) (1) If a county does not meet the performance standards for
13 completing eligibility determinations and redeterminations as
14 specified in this section, the department may, at its sole discretion,
15 reduce the allocation of funds to that county in the following year
16 by 2 percent. Any funds so reduced may be restored by the
17 department if, in the determination of the department, sufficient
18 improvement has been made by the county in meeting the
19 performance standards during the year for which the funds were
20 reduced. If the county continues not to meet the performance
21 standards, the department may reduce the allocation by an
22 additional 2 percent for each year thereafter in which sufficient
23 improvement has not been made to meet the performance standards.

24 (2) No reduction of the allocation of funds to a county shall be
25 imposed pursuant to this subdivision for failure to meet
26 performance standards during any period of time in which the
27 cost-of-doing-business increase is suspended.

28 (i) The department shall develop procedures, in collaboration
29 with the counties and stakeholders, for developing instructions for
30 the performance standards established under subparagraph (D) of
31 paragraph (3) of subdivision (d), no later than September 1, 2005.

32 (j) No later than September 1, 2005, the department shall issue
33 a revised annual redetermination form to allow a parent to indicate
34 parental consent to forward the annual redetermination form to
35 the Healthy Families Program if the child is determined to have a
36 share of cost.

37 (k) The department, in coordination with the Managed Risk
38 Medical Insurance Board, shall streamline the method of providing
39 the Healthy Families Program with information necessary to
40 determine Healthy Families eligibility for a child who is receiving

1 services under the Medi-Cal-to-Healthy Families Bridge Benefits
2 Program.

3 (l) 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, without taking any further regulatory action,
6 implement, interpret, or make specific this section and any
7 applicable federal waivers and state plan amendments by means
8 of all-county letters or similar instructions.

9 *SEC. 88. Section 14165 of the Welfare and Institutions Code*
10 *is amended to read:*

11 14165. (a) There is hereby created in the Governor's office
12 the California Medical Assistance Commission, for the purpose
13 of contracting with health care delivery systems for the provision
14 of health care services to recipients under the California Medical
15 Assistance program.

16 (b) Notwithstanding any other provision of law, the commission
17 created pursuant to subdivision (a) shall continue through June 30,
18 2012, after which, it shall be dissolved and the term of any
19 commissioner serving at that time shall end.

20 (1) Upon dissolution of the commission, all powers, duties, and
21 responsibilities of the commission shall be transferred to the
22 Director of Health Care Services. These powers, duties, and
23 responsibilities shall include, but are not limited to, those exercised
24 in the operation of the selective provider contracting program
25 pursuant to Article 2.6 (commencing with Section 14081).

26 ~~(2) On or before July 1, 2012, the position of executive director~~
27 ~~described in Section 14165.5 and all other staff positions serving~~
28 ~~the commission shall be transferred to the State Department of~~
29 ~~Health Care Services. The Department of Health Care Services~~
30 ~~shall consult with the commission, the Department of Finance,~~
31 ~~and the Department of Personnel Administration to develop a staff~~
32 ~~transition plan that will be included in the 2012-13 Governor's~~
33 ~~Budget. The transition plan shall outline the transition of staff~~
34 ~~positions serving the commission to the State Department of Health~~
35 ~~Care Services.~~

36 (2) (A) *On July 1, 2012, notwithstanding any other law,*
37 *employees of the California Medical Assistance Commission as*
38 *of June 30, 2012, excluding commissioners, shall transfer to the*
39 *State Department of Health Care Services.*

1 (B) Employees who transfer pursuant to subparagraph (A) shall
 2 be subject to the same conditions of employment under the
 3 department as they were under the California Medical Assistance
 4 Commission, including retention of their exempt status, until the
 5 diagnosis-related groups payment system described in Section
 6 14105.28 replaces the contract-based payment system described
 7 in this article.

8 (C) (i) Notwithstanding any other law or rule, persons employed
 9 by the department who transferred to the department pursuant to
 10 subparagraph (A) shall be eligible to apply for civil service
 11 examinations. Persons receiving passing scores shall have their
 12 names placed on lists resulting from these examinations, or
 13 otherwise gain eligibility for appointment. In evaluating minimum
 14 qualifications, related California Medical Assistance Commission
 15 experience shall be considered state civil service experience in a
 16 class deemed comparable by the State Personnel Board, based on
 17 the duties and responsibilities assigned.

18 (ii) On the date the diagnosis-related groups payment system
 19 described in Section 14105.28 replaces the contract-based system
 20 described in this article, employees who transferred to the
 21 department pursuant to subparagraph (A) shall transfer to civil
 22 service classifications within the department for which they are
 23 eligible.

24 (3) Upon a determination by the ~~director~~ Director of Health
 25 Care Services that a payment system based on diagnosis-related
 26 groups as described in Section 14105.28 that is sufficient to replace
 27 the contract-based payment system described in ~~subdivision (a)~~
 28 this article has been developed and implemented, the powers,
 29 duties, and responsibilities conferred on the commission and
 30 transferred to the ~~director~~ Director of Health Care Services shall
 31 no longer be exercised, excluding both of the following:

32 (A) Stabilization payments made or committed from Sections
 33 14166.14 and 14166.19 for services rendered prior to the director's
 34 determination pursuant to this paragraph.

35 (B) The ability to negotiate and make payments from the Private
 36 Hospital Supplemental Fund, established pursuant to Section
 37 14166.12, and the Nondesignated Public Hospital Supplemental
 38 Fund, established pursuant to Section 14166.17.

39 (4) Protections afforded to the negotiations and contracts of the
 40 commission ~~of~~ by the California Public Records Act (Chapter 3.5

1 (commencing with Section 6250) of Division 7 of Title 1 of the
2 Government Code) shall be applicable to the negotiations and
3 contracts conducted or entered into pursuant to this section by the
4 State Department of Health Care Services.

5 (c) Notwithstanding the rulemaking provisions of Chapter 3.5
6 (commencing with Section 11340) of Part 1 of Division 3 of Title
7 2 of the Government Code, or any other provision of law, the State
8 Department of Health Care Services may implement and administer
9 this section by means of provider bulletins or other similar
10 instructions, without taking regulatory action. The authority to
11 implement this section as set forth in this subdivision shall include
12 the authority to give notice by provider bulletin or other similar
13 instruction of a determination made pursuant to paragraph (3) of
14 subdivision (b) and to modify or supersede existing regulations in
15 Title 22 of the California Code of Regulations that conflict with
16 implementation of this section.

17 *SEC. 89. Section 14166.8 of the Welfare and Institutions Code*
18 *is amended to read:*

19 14166.8. (a) Within five months after the end of each project
20 year or successor demonstration year, each of the designated public
21 hospitals shall submit to the department all of the following reports:

22 (1) The hospital's Medicare cost report for the project year or
23 successor demonstration year.

24 (2) Other cost reporting and statistical data necessary for the
25 determination of amounts due the hospital under the demonstration
26 project or successor demonstration project, as requested by the
27 department.

28 (b) For each project year or successor demonstration year, the
29 reports shall identify all of the following:

30 (1) The costs incurred in providing inpatient hospital services
31 to Medi-Cal beneficiaries on a fee-for-service basis and physician
32 and nonphysician practitioner services costs, as identified in
33 subdivision (e) of Section 14166.4.

34 (2) The amount of uncompensated costs incurred in providing
35 hospital services to Medi-Cal beneficiaries, including managed
36 care enrollees.

37 (3) The costs incurred in providing hospital services to uninsured
38 individuals.

39 (4) (A) Discharge data, commencing with successor
40 demonstration year 6, and retrospectively for prior periods as

1 necessary to establish interim payment determinations, for the
2 following patient categories:

- 3 (i) Uninsured patients.
- 4 (ii) Low Income Health Program patients.
- 5 (iii) Medi-Cal patients, excluding discharges for which Medicare
6 payments were received.

7 (B) The department shall consult with the designated public
8 hospitals regarding a methodology for adjusting prior period
9 discharge data to reflect the projected number of discharges relating
10 to Low Income Health Program patients for the period at issue.

11 (c) (1) Each designated public hospital, or governmental entity
12 with which it is affiliated, that operates nonhospital clinics or
13 provides physician, nonphysician practitioner, or other health care
14 services that are not identified as hospital services under the Special
15 Terms and Conditions for the demonstration project and successor
16 demonstration project, may report and certify all, or a portion, of
17 the uncompensated Medi-Cal and uninsured costs of the services
18 furnished. ~~The~~

19 (2) *Notwithstanding paragraph (1), beginning with the 2012–13*
20 *fiscal year, and for each successor demonstration year thereafter,*
21 *each designated public hospital, or governmental entity with which*
22 *it is affiliated, that operates nonhospital clinics or provides*
23 *physician, nonphysician practitioner, or other health care services*
24 *that are not identified as hospital services under the Special Terms*
25 *and Conditions for the successor demonstration project, shall*
26 *report and certify all of the uncompensated uninsured costs of the*
27 *services furnished that meet the requirements of subdivisions (d)*
28 *and (e).*

29 (3) *The amount of these uncompensated costs to be claimed by*
30 *the department shall be determined by the department in*
31 *consultation with the governmental entity so as to optimize the*
32 *level of claimable federal Medicaid funding.*

33 (d) Reports submitted under this section shall include all
34 allowable costs.

35 (e) The appropriate public official shall certify to all of the
36 following:

37 (1) The accuracy of the reports required under this section.

38 (2) That the expenditures to meet the reported costs comply
39 with Section 433.51 of Title 42 of the Code of Federal Regulations.

1 (3) That the sources of funds used to make the expenditures
2 certified under this section do not include impermissible provider
3 taxes or donations as defined under Section 1396b(w) of Title 42
4 of the United States Code or other federal funds. For this purpose,
5 federal funds do not include delivery system reform incentive pool
6 payments, patient care revenue received as payment for services
7 rendered under programs such as designated state health programs,
8 the Low Income Health Program, Medicare, or Medicaid.

9 (f) The certification of public expenditures made pursuant to
10 this section shall be based on a schedule established by the
11 department. The director may require the designated public
12 hospitals to submit quarterly estimates of anticipated expenditures,
13 if these estimates are necessary to obtain interim payments of
14 federal Medicaid funds. All reported expenditures shall be subject
15 to reconciliation to allowable costs, as determined in accordance
16 with applicable implementing documents for the demonstration
17 project and successor demonstration project.

18 ~~(g) Except as provided in subdivision (e), the~~ *Subject to the*
19 *determination made under paragraph (3) of subdivision (c), the*
20 director shall seek Medicaid federal financial participation for all
21 certified public expenditures reported by the designated public
22 hospitals and recognized under the demonstration project and
23 successor demonstration project, to the extent consistent with
24 Section 14166.9.

25 (h) Governmental or public entities other than those that operate
26 a designated public hospital may, at the request of a governmental
27 or public entity, certify uncompensated Medi-Cal and uninsured
28 costs in accordance with this section, subject to the department's
29 discretion and prior approval of the federal Centers for Medicare
30 and Medicaid Services.

31 (i) The timeframes for data submission and reporting periods
32 may be adjusted as necessary with respect to the 2010–11 project
33 year through October 31, 2010, and successor demonstration years
34 6 and 10.

35 *SEC. 90. Section 14166.12 of the Welfare and Institutions Code*
36 *is amended to read:*

37 14166.12. (a) The California Medical Assistance Commission
38 shall negotiate payment amounts, in accordance with the selective
39 provider contracting program established pursuant to Article 2.6
40 (commencing with Section 14081), from the Private Hospital

1 Supplemental Fund established pursuant to subdivision (b) for
2 distribution to private hospitals that satisfy the criteria of ~~Section~~
3 ~~14085.6, 14085.7, 14085.8, or 14085.9.~~ *subdivision (s). Pursuant*
4 *to Section 14165, on and after July 1, 2012, the Director of Health*
5 *Care Services shall exercise the discretion granted to the*
6 *California Medical Assistance Commission.*

7 (b) The Private Hospital Supplemental Fund is hereby
8 established in the State Treasury. For purposes of this section,
9 “fund” means the Private Hospital Supplemental Fund.

10 (c) Notwithstanding Section 13340 of the Government Code,
11 the fund shall be continuously appropriated to the department for
12 the purposes specified in this section.

13 (d) Except as otherwise limited by this section, the fund shall
14 consist of all of the following:

15 (1) One hundred eighteen million four hundred thousand dollars
16 (\$118,400,000), which shall be transferred annually from General
17 Fund amounts appropriated in the annual Budget Act for the
18 Medi-Cal program, except as follows:

19 (A) For the 2008–09 fiscal year, this amount shall be reduced
20 by thirteen million six hundred thousand dollars (\$13,600,000)
21 and by an amount equal to one-half of the difference between
22 eighteen million three hundred thousand dollars (\$18,300,000)
23 and the amount of any reduction in the additional payments for
24 distressed hospitals calculated pursuant to subparagraph (B) of
25 paragraph (3) of subdivision (b) of Section 14166.20.

26 (B) For the 2012–13 fiscal year, this amount shall be reduced
27 by seventeen million five hundred thousand dollars (\$17,500,000).

28 (C) For the 2013–14 fiscal year, this amount shall be reduced
29 by eight million seven hundred fifty thousand dollars (\$8,750,000).

30 (2) Any additional moneys appropriated to the fund.

31 (3) All stabilization funding transferred to the fund pursuant to
32 paragraph (2) of subdivision (a) of Section 14166.14.

33 (4) Any moneys that any county, other political subdivision of
34 the state, or other governmental entity in the state may elect to
35 transfer to the department for deposit into the fund, as permitted
36 under Section 433.51 of Title 42 of the Code of Federal Regulations
37 or any other applicable federal Medicaid laws.

38 (5) All private moneys donated by private individuals or entities
39 to the department for deposit in the fund as permitted under
40 applicable federal Medicaid laws.

1 (6) Any interest that accrues on amounts in the fund.

2 (e) Any public agency transferring moneys to the fund may, for
3 that purpose, utilize any revenues, grants, or allocations received
4 from the state for health care programs or purposes, unless
5 otherwise prohibited by law. A public agency may also utilize its
6 general funds or any other public moneys or revenues for purposes
7 of transfers to the fund, unless otherwise prohibited by law.

8 (f) The department may accept or not accept moneys offered to
9 the department for deposit in the fund. If the department accepts
10 moneys pursuant to this section, the department shall obtain federal
11 financial participation to the full extent permitted by law. With
12 respect to funds transferred or donated from private individuals or
13 entities, the department shall accept only those funds that are
14 certified by the transferring or donating entity that qualify for
15 federal financial participation under the terms of the Medicaid
16 Voluntary Contribution and Provider-Specific Tax Amendments
17 of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the
18 Code of Federal Regulations, as applicable. The department may
19 return any funds transferred or donated in error.

20 (g) Moneys in the fund shall be used as the source for the
21 nonfederal share of payments to hospitals under this section.

22 (h) Any funds remaining in the fund at the end of a fiscal year
23 shall be carried forward for use in the following fiscal year.

24 (i) Moneys shall be allocated from the fund by the department
25 and shall be applied to obtain federal financial participation in
26 accordance with customary Medi-Cal accounting procedures for
27 purposes of payments under this section. Distributions from the
28 fund shall be supplemental to any other Medi-Cal reimbursement
29 received by the hospitals, including amounts that hospitals receive
30 under the selective provider contracting program (Article 2.6
31 (commencing with Section 14081)), and shall not affect provider
32 rates paid under the selective provider contracting program.

33 (j) Each private hospital that was a private hospital during the
34 2002–03 fiscal year, received payments for the 2002–03 fiscal
35 year from any of the prior supplemental funds, and, during the
36 project year, satisfies the criteria in ~~Section 14085.6, 14085.7,~~
37 ~~14085.8, or 14085.9 subdivision (s)~~ to be eligible to negotiate for
38 distributions under any of those sections, shall receive no less from
39 the Private Hospital Supplemental Fund for the project year than
40 100 percent of the amount the hospital received from the prior

1 supplemental funds for the 2002–03 fiscal year. Each private
2 hospital described in this subdivision shall be eligible for additional
3 payments from the fund pursuant to subdivision (k).

4 (k) All amounts that are in the fund for a project year in excess
5 of the amount necessary to make the payments under subdivision
6 (j) shall be available for negotiation by the California Medical
7 Assistance Commission, along with corresponding federal financial
8 participation, for supplemental payments to private hospitals, which
9 for the project year satisfy the criteria under ~~Section 14085.6,~~
10 ~~14085.7, 14085.8, or 14085.9~~ *subdivision (s)* to be eligible to
11 negotiate for distributions under any of those sections, and paid
12 for services rendered during the project year pursuant to the
13 selective provider contracting program established under Article
14 2.6 (commencing with Section 14081).

15 (l) The amount of any stabilization funding transferred to the
16 fund, or the amount of intergovernmental transfers deposited to
17 the fund pursuant to subdivision (o), together with the associated
18 federal reimbursement, with respect to a particular project year,
19 may, in the discretion of the California Medical Assistance
20 Commission, *until its dissolution on June 30, 2012*, be paid for
21 services furnished in the same project year regardless of when the
22 stabilization funds or intergovernmental transfer funds, and the
23 associated federal reimbursement, become available, provided the
24 payment is consistent with other applicable federal or state law
25 requirements and does not result in a hospital exceeding any
26 applicable reimbursement limitations. *On and after July 1, 2012,*
27 *the Director of Health Care Services shall exercise the discretion*
28 *granted to the California Medical Assistance Commission by this*
29 *subdivision.*

30 (m) The department shall pay amounts due to a private hospital
31 from the fund for a project year, with the exception of stabilization
32 funding, in up to four installment payments, unless otherwise
33 provided in the hospital's contract negotiated with the California
34 Medical Assistance Commission, except that hospitals that are not
35 described in subdivision (j) shall not receive the first installment
36 payment. The first payment shall be made as soon as practicable
37 after the issuance of the tentative disproportionate share hospital
38 list for the project year, and in no event later than January 1 of the
39 project year. The second and subsequent payments shall be made
40 after the issuance of the final disproportionate hospital list for the

1 project year, and shall be made only to hospitals that are on the
2 final disproportionate share hospital list for the project year. The
3 second payment shall be made by February 1 of the project year
4 or as soon as practicable after the issuance of the final
5 disproportionate share hospital list for the project year. The third
6 payment, if scheduled, shall be made by April 1 of the project year.
7 The fourth payment, if scheduled, shall be made by June 30 of the
8 project year. This subdivision does not apply to hospitals that are
9 scheduled to receive payments from the fund because they meet
10 the criteria under ~~Section 14085.7 paragraph (2) of subdivision~~
11 ~~(s)~~ and do not meet the criteria under ~~Section 14085.6, 14085.8,~~
12 ~~or 14085.9 paragraph (1), (3), or (4) of subdivision (s)~~, which
13 shall be paid in accordance with the applicable contract or contract
14 amendment negotiated by the California Medical Assistance
15 Commission.

16 (n) The department shall pay stabilization funding transferred
17 to the fund in amounts negotiated by the California Medical
18 Assistance Commission and shall pay the scheduled payments in
19 accordance with the applicable contract or contract amendment.

20 (o) Payments to private hospitals that are eligible to receive
21 payments pursuant to ~~Section 14085.6, 14085.7, 14085.8, or~~
22 ~~14085.9 subdivision (s)~~ may be made using funds transferred from
23 governmental entities to the state, at the option of the governmental
24 entity. Any payments funded by intergovernmental transfers shall
25 remain with the private hospital and shall not be transferred back
26 to any unit of government. An amount equal to 25 percent of the
27 amount of any intergovernmental transfer made in the project year
28 that results in a supplemental payment made for the same project
29 year to a project year private DSH hospital designated by the
30 governmental entity that made the intergovernmental transfer shall
31 be deposited in the fund for distribution as determined by the
32 California Medical Assistance Commission. An amount equal to
33 75 percent shall be deposited in the fund and distributed to the
34 private hospitals designated by the governmental entity.

35 (p) A private hospital that receives payment pursuant to this
36 section for a particular project year shall not submit a notice for
37 the termination of its participation in the selective provider
38 contracting program established pursuant to Article 2.6
39 (commencing with Section 14081) until the later of the following
40 dates:

1 (1) On or after December 31 of the next project year.
 2 (2) The date specified in the hospital’s contract, if applicable.
 3 (q) (1) For the 2007–08, 2008–09, and 2009–10 project years,
 4 the County of Los Angeles shall make intergovernmental transfers
 5 to the state to fund the nonfederal share of increased Medi-Cal
 6 payments to those private hospitals that serve the South Los
 7 Angeles population formerly served by Los Angeles County Martin
 8 Luther King, Jr.-Harbor Hospital. The intergovernmental transfers
 9 required under this subdivision shall be funded by county tax
 10 revenues and shall total five million dollars (\$5,000,000) per
 11 project year, except that, in the event that the director determines
 12 that any amount is due to the County of Los Angeles under the
 13 demonstration project for services rendered during the portion of
 14 a project year during which Los Angeles County Martin Luther
 15 King, Jr.-Harbor Hospital was operational, the amount of
 16 intergovernmental transfers required under this subdivision shall
 17 be reduced by a percentage determined by reducing 100 percent
 18 by the percentage reduction in Los Angeles County Martin Luther
 19 King, Jr.-Harbor Hospital’s baseline, as determined under
 20 subdivision (c) of Section 14166.5 for that project year.
 21 (2) Notwithstanding subdivision (o), an amount equal to 100
 22 percent of the county’s intergovernmental transfers under this
 23 subdivision shall be deposited in the fund and, within 30 days after
 24 receipt of the intergovernmental transfer, shall be distributed,
 25 together with related federal financial participation, to the private
 26 hospitals designated by the county in the amounts designated by
 27 the county. The director shall disregard amounts received pursuant
 28 to this subdivision in calculating the OBRA 1993 payment
 29 limitation, as defined in paragraph (24) of subdivision (a) of
 30 Section 14105.98, for purposes of determining the amount of
 31 disproportionate share hospital replacement payments due a private
 32 hospital under Section 14166.11.
 33 (r) (1) The reductions in supplemental payments under this
 34 section that result from the reductions in the amounts transferred
 35 from the General Fund to the Private Hospital Supplemental Fund
 36 for the 2012–13 and 2013–14 fiscal years under subparagraphs
 37 (B) and (C) of paragraph (1) of subdivision (d) shall be allocated
 38 equally in the aggregate between children’s hospitals eligible for
 39 supplemental payments under this section and other hospitals
 40 eligible for supplemental payments under this section. When

1 negotiating payment amounts to a hospital under this section for
2 the 2012–13 and 2013–14 fiscal years, the California Medical
3 Assistance Commission, or its successor agency, shall identify
4 both a payment amount that would have been made absent the
5 funding reductions in subparagraphs (B) and (C) of paragraph (1)
6 of subdivision (d) and the payment amount that will be made taking
7 into account the funding reductions under subparagraphs (B) and
8 (C) of paragraph (1) of subdivision (d). For purposes of this
9 subdivision, “children’s hospital” shall have the meaning set forth
10 in paragraph (13) of subdivision (a) of Section 14105.98.

11 (2) This subdivision shall not preclude the department from
12 including some or all of the reductions under this section within
13 the payments made under a new diagnosis-related group payment
14 methodology for the 2012–13 fiscal year or the 2013–14 fiscal
15 year. In the event the department includes some or all of the
16 amounts, including reductions, within the payments made under
17 a new diagnosis-related group payment methodology for the
18 ~~2012–12~~ 2012–13 fiscal year or the 2013–14 fiscal year, the
19 department, in implementing the reductions in paragraph (1) of
20 subdivision (d), shall, to the extent feasible, utilize the allocation
21 specified in paragraph (1).

22 (s) *In order for a hospital to receive distributions pursuant to*
23 *this section, the hospital shall satisfy the eligibility criteria in*
24 *paragraph (1), (2), (3), or (4) of this subdivision.*

25 (1) *The hospital meets all of the following criteria:*

26 (A) *The hospital is contracting under this article.*

27 (B) *The hospital meets the criteria contained in the Medicaid*
28 *State Plan for disproportionate share hospital status.*

29 (C) *The hospital is one of the following:*

30 (i) *A licensed provider of basic emergency services as described*
31 *in Section 70411 of Title 22 of the California Code of Regulations.*

32 (ii) *A licensed provider of comprehensive emergency medical*
33 *services as defined in Section 70451 of Title 22 of the California*
34 *Code of Regulations.*

35 (iii) *A children’s hospital, as defined in Section 14087.21, that*
36 *satisfies clause (i) or (ii), or that jointly provides basic or*
37 *comprehensive emergency services in conjunction with another*
38 *licensed hospital.*

1 (iv) A hospital owned and operated by a public agency that
2 operates two or more hospitals that qualify under subparagraph
3 (A) or (B) with respect to the particular state fiscal year.

4 (v) A hospital designated by the National Cancer Institute as a
5 comprehensive or clinical cancer research center that primarily
6 treats acutely ill cancer patients and that is exempt from the federal
7 Medicare prospective payment system pursuant to Section
8 1886(d)(1)(B)(v) of the federal Social Security Act (42 U.S.C. Sec.
9 1395ww(d)(1)(B)(v)).

10 (D) The hospital is able to demonstrate a purpose for additional
11 funding under the selective provider contracting program including
12 proposals relating to emergency services and other health care
13 services, including infrequent yet high-cost services, such as
14 anti-AB human antitoxin treatment for infant botulism (human
15 botulinum immune globulin (HBIG), commonly referred to as
16 “Baby-BIG”), that are made available, or will be made available,
17 to Medi-Cal beneficiaries.

18 (2) The hospital is contracting under this article and meets the
19 definition of a university teaching hospital or major, nonuniversity,
20 teaching hospital as set forth on page 51 and as listed on page 57
21 of the department’s report dated May 1991, entitled “Hospital
22 Peer Grouping.” Payments from the fund shall be used solely for
23 the purposes identified in the contract between the hospital and
24 the state.

25 (3) The hospital is contracting under this article, and meets the
26 definition of any of the following:

27 (A) A large teaching emphasis hospital, as set forth on page 51
28 and listed on page 57 of the department’s report dated May 1991,
29 entitled “Hospital Peer Grouping,” and also meets the definition
30 of eligible hospital as defined in paragraph (3) of subdivision (a)
31 of Section 14105.98.

32 (B) A children’s hospital pursuant to Section 10727, and also
33 meets the definition of eligible hospital as defined in paragraph
34 (3) of subdivision (a) of Section 14105.98.

35 (C) Notwithstanding the requirement in subparagraph (A) that
36 a hospital must be listed on page 57 of the department’s report
37 dated May 1991, entitled “Hospital Peer Grouping,” any hospital
38 whose license pursuant to Chapter 2 (commencing with Section
39 1250) of Division 2 of the Health and Safety Code was consolidated
40 during the 1999 calendar year with a large teaching emphasis

1 hospital that is listed on page 57 of the above-described report
2 shall be eligible. All other requirements of paragraph (3) shall
3 continue to apply.

4 (4) The hospital meets all of the following criteria:

5 (A) The hospital is contracting under this article.

6 (B) The hospital satisfies the Medicaid State Plan criteria for
7 disproportionate share hospital status.

8 (C) The hospital is a small and rural hospital as defined in
9 Section 124840 of the Health and Safety Code.

10 (D) The hospital is a licensed provider of standby emergency
11 services as described in Section 70649 of Title 22 of the California
12 Code of Regulations.

13 (E) The hospital is able to demonstrate a purpose for additional
14 funding under the selective provider contracting program with
15 proposals relating to health care services that are made available,
16 or will be made available, to Medi-Cal beneficiaries.

17 (F) The hospital is determined by the California Medical
18 Assistance Commission to be a hospital that provides an important
19 community service that otherwise would not be provided in the
20 community.

21 SEC. 91. Section 14166.14 of the Welfare and Institutions Code
22 is amended to read:

23 14166.14. The amount of any stabilization funding payable to
24 the project year private DSH hospitals under Section 14166.20 for
25 a project year, which amount shall not include the amount of
26 stabilization funding paid or payable to hospitals prior to the
27 computation of the stabilization funding under Section 14166.20,
28 plus any amount payable to project year private DSH hospitals
29 under paragraph (1) of subdivision (b) of Section 14166.21, shall
30 be allocated as follows:

31 (a) (1) To fund any shortfall due under Section 14166.11.

32 (2) An amount shall be transferred to the Private Hospital
33 Supplemental Fund established pursuant to Section 14166.12, as
34 may be necessary so that the amount for the Private Hospital
35 Supplemental Fund for the project year, including all funds
36 previously transferred to, or deposited in, the Private Hospital
37 Supplemental Fund for the project year, is not less than the Private
38 Hospital Supplemental Fund base amount determined pursuant to
39 subdivision (j) of Section 14166.12.

1 (3) The amounts paid or transferred under paragraphs (1) and
 2 (2) shall be reduced pro rata if there is not sufficient funding
 3 described under paragraphs (1) and (2).

4 (b) Of the stabilization funding remaining, after allocations
 5 pursuant to subdivision (a), that are payable to project year private
 6 DSH hospitals, 66.4 percent shall be allocated and distributed
 7 among those hospitals pro rata based on the amounts determined
 8 in accordance with Section 14166.11, and 33.6 percent shall be
 9 transferred to the Private Hospital Supplemental Fund.

10 (c) (1) *Notwithstanding any other law, the stabilization funding*
 11 *payable to project year private DSH hospitals under Section*
 12 *14166.20 for a project year as determined under this section that*
 13 *has not been paid, or specifically committed for payment, to*
 14 *hospitals prior to January 1, 2012, may be utilized by the director*
 15 *to make payments to hospitals that received underpayments*
 16 *pursuant to Section 14166.11 due to improper peer group*
 17 *classifications for the 2005–06 and 2006–07 payment adjustment*
 18 *years.*

19 (2) *The balance after payments made pursuant to paragraph*
 20 *(1), if any, of the stabilization funding payable to project year*
 21 *private DSH hospitals under Section 14166.20 shall not be paid*
 22 *to the project year private DSH hospitals pursuant to Section*
 23 *14166.20. The funds that would otherwise be paid from the Private*
 24 *Hospital Supplemental Fund shall be transferred to the General*
 25 *Fund, and funds that would otherwise be drawn from the General*
 26 *Fund for payments to the private DSH hospitals pursuant to Section*
 27 *14166.20 shall be retained in the General Fund.*

28 SEC. 92. *Section 14166.151 is added to the Welfare and*
 29 *Institutions Code, to read:*

30 *14166.151. (a) It is the intent of the Legislature to reform the*
 31 *inpatient fee-for-service reimbursement methodology for*
 32 *nondesignated public hospitals based on their public structure in*
 33 *order to provide new opportunities for nondesignated public*
 34 *hospitals to receive reimbursement under the successor*
 35 *demonstration project for care provided to the uninsured and to*
 36 *receive new incentive payments for achievement related to delivery*
 37 *system reform.*

38 (b) *Subject to subdivision (c), beginning with services provided*
 39 *on or after July 1, 2012, fee-for-service payments to nondesignated*
 40 *public hospitals for inpatient services shall be governed by this*

1 *subdivision. Each nondesignated public hospital shall receive as*
2 *payment for inpatient hospital services provided to Medi-Cal*
3 *beneficiaries during any successor demonstration year, the federal*
4 *financial participation claimed by the department based on the*
5 *hospital's allowable costs incurred in providing those services,*
6 *subject to all of the following:*

7 *(1) Nondesignated public hospitals shall comply with the*
8 *requirements of Section 14166.152. The payments authorized in*
9 *this section shall be subject to audit and a final reconciliation*
10 *where an overpayment to the nondesignated public hospital shall*
11 *result in a collection of the overpayment and an underpayment to*
12 *the nondesignated public hospital shall result in a corrective*
13 *payment.*

14 *(2) (A) Nondesignated public hospitals shall be eligible to*
15 *receive safety net care pool payments for uncompensated care*
16 *costs to the extent that additional federal funding is made available*
17 *pursuant to the Special Terms and Conditions for the safety net*
18 *care pool uncompensated care limit of the successor demonstration*
19 *project and if they comply with the requirements set forth in Section*
20 *14166.154.*

21 *(B) The amount of funds that may be claimed pursuant to*
22 *subparagraph (A) shall not exceed the additional federal funding*
23 *made available under the safety net care pool for nondesignated*
24 *public hospital uncompensated care costs, and shall not reduce*
25 *the amounts of federal funding for safety net care pool*
26 *uncompensated care costs that would otherwise be made available*
27 *to designated public hospitals in the absence of this paragraph,*
28 *including the amounts available under the Special Terms and*
29 *Conditions in effect as of April 1, 2012, and amounts available*
30 *pursuant to Section 15916.*

31 *(C) (i) Notwithstanding subparagraph (B), if the designated*
32 *public hospitals do not have sufficient certified public expenditures*
33 *to claim the full amount of federal funding made available to the*
34 *designated public hospitals as referenced in subparagraph (B),*
35 *including consideration of the potential for the designated public*
36 *hospitals to have sufficient certified public expenditures in a*
37 *subsequent year, the department may authorize the funding to be*
38 *claimed by the nondesignated public hospitals.*

39 *(ii) The department may determine whether designated public*
40 *hospitals do not have sufficient certified public expenditures to*

1 *claim the full amount of federal funding pursuant to clause (i) no*
2 *sooner than after the submission of the cost reporting information*
3 *required pursuant to Section 14166.8 for the applicable successor*
4 *demonstration year.*

5 *(iii) If the department makes the determination identified in*
6 *clause (ii) based on as-filed cost reporting information submitted*
7 *prior to a final audit, the department shall make the determination*
8 *in consultation with the designated public hospitals and shall apply*
9 *an audit cushion of at least 5 percent to the as-filed cost*
10 *information. If the department makes the determination identified*
11 *in clause (ii) based on audited cost reporting information, no audit*
12 *cushion shall be applied.*

13 *(3) (A) Nondesignated public hospitals shall be eligible to*
14 *receive delivery system reform incentive pool payments to the*
15 *extent additional federal funding is made available for this purpose*
16 *under the delivery system reform incentive pool in the successor*
17 *demonstration project and if the nondesignated public hospitals*
18 *comply with the delivery system reform incentive pool funding*
19 *requirements set forth in Section 14166.155.*

20 *(B) The amount of funds that may be received shall not exceed*
21 *the additional federal funding made available for delivery system*
22 *reform incentive pool payments to nondesignated public hospitals,*
23 *and shall not reduce the amounts that would otherwise be made*
24 *available to designated public hospitals in the absence of this*
25 *paragraph, including the amounts that designated public hospitals*
26 *would be eligible to receive under their delivery system reform*
27 *incentive pool plans approved as of January 1, 2012.*

28 *(C) Notwithstanding subparagraph (B), if the designated public*
29 *hospitals are unable to claim the full amount of federal funding*
30 *made available to the designated public hospitals pursuant to*
31 *Section 14166.77 and the Special Terms and Conditions, including*
32 *through reallocations made pursuant to paragraph (3) of*
33 *subdivision (a) of Section 14166.77 as authorized by the Special*
34 *Terms and Conditions, and the unused amount of federal funding*
35 *made available to the designated public hospitals cannot be used*
36 *in a later demonstration year, the department may authorize such*
37 *unused funding to be made available to the nondesignated public*
38 *hospitals.*

39 *(c) (1) (A) The reimbursement methodology developed pursuant*
40 *to subdivision (b) shall be effective beginning July 1, 2012. If all*

1 necessary federal approvals have not been received by July 1,
2 2012, then the effective date shall be retroactive to July 1, 2012.
3 Between July 1, 2012, and when all necessary federal approvals
4 have been received, any payments made pursuant to any
5 methodology replaced by subdivision (b) shall be deemed as
6 interim payments subject to offsetting and recoupment against
7 payments made under subdivision (b) pursuant to Section 51047
8 of Title 22 of the California Code of Regulations.

9 (B) Subject to paragraph (2), beginning January 1, 2014, the
10 reimbursement methodology developed pursuant to subdivision
11 (b), which shall be in effect July 1, 2012, through and including
12 December 31, 2013, shall continue for those nondesignated public
13 hospitals that certify voluntary participation as described in clause
14 (i), if the director executes a declaration on or before December
15 31, 2013, certifying all of the following:

16 (i) The governmental entities that own or operate a
17 nondesignated public hospital, or hospitals, have provided
18 certifications of voluntary participation in the reimbursement
19 methodology pursuant to subdivision (b).

20 (ii) Any necessary federal approvals have been obtained.

21 (iii) Continuation of the reimbursement methodology for those
22 nondesignated public hospitals certifying voluntary participation
23 would be cost beneficial to the state.

24 (2) On December 31, 2013, if one or more of the nondesignated
25 public hospitals subject to the reimbursement methodology
26 described in subdivision (b) have not provided written certification
27 of voluntariness described in clause (i) of subparagraph (B) of
28 paragraph (1), or if the director determines, for any reason, that
29 the reimbursement methodology described in subdivision (b) cannot
30 be implemented on or after January 1, 2014, then the director shall
31 execute a declaration certifying that the reimbursement
32 methodology described in subdivision (b) cannot continue to be
33 implemented for all or one or more of the nondesignated public
34 hospitals, in which case subdivision (e) shall be implemented on
35 January 1, 2014.

36 (d) Upon implementation of subparagraph (A) of paragraph
37 (1) of subdivision (c), implementation of the laws and regulations
38 listed in paragraphs (1) to (4), inclusive, shall be suspended with
39 respect to fee-for-service payments to all nondesignated public
40 hospitals for inpatient services through and including December

1 31, 2013. Implementation of the laws and regulations listed in
2 paragraphs (1) to (4), inclusive, shall also be suspended with
3 respect to fee-for-service payments to nondesignated public
4 hospitals that certify voluntary participation if a declaration is
5 executed pursuant to subparagraph (B) of paragraph (1) of
6 subdivision (c), beginning on January 1, 2014, and until the
7 expiration of the successor demonstration project.

8 (1) The Nondesignated Public Hospital Medi-Cal Rate
9 Stabilization Act in Article 5.17 (commencing with Section
10 14165.55).

11 (2) The inpatient fee-for-service per diem rate authorized in
12 Article 2.6 (commencing with Section 14081).

13 (3) The reimbursement methodology for fee-for-service inpatient
14 services in Sections 14105 and 14105.15, and Article 7.5
15 (commencing with Section 51536) of Title 22 of the California
16 Code of Regulations.

17 (4) Section 14166.17.

18 (e) Subject to the conditions in paragraph (2) of subdivision
19 (c), on January 1, 2014, the percentage of each intergovernmental
20 transfer amount retained pursuant to subdivision (j) of Section
21 14165.57 shall be increased to 20 percent to reimburse the
22 department, or transferred to the General Fund, for the
23 administrative costs of operating the Nondesignated Public
24 Hospital Intergovernmental Transfer Program and for the benefit
25 of the Medi-Cal program.

26 (f) This section and Sections 14166.152, 14166.153, 14166.154,
27 and 14166.155 shall become operative on the date all necessary
28 federal approvals have been obtained to implement all of these
29 sections.

30 SEC. 93. Section 14166.152 is added to the Welfare and
31 Institutions Code, to read:

32 14166.152. (a) Pursuant to subdivision (b) of Section
33 14166.151, and notwithstanding any other law, fee-for-service
34 payments to nondesignated public hospitals for inpatient services
35 to Medi-Cal beneficiaries shall be governed by this section. The
36 hospitals' allowable costs shall be determined, certified, and
37 claimed in accordance with Section 14166.153. The Medicaid
38 federal financial participation received by the state for the certified
39 public expenditures of the hospital, or the governmental entity

1 *with which the hospital is affiliated, for inpatient hospital services*
2 *rendered to Medi-Cal beneficiaries shall be paid to the hospital.*

3 *(b) With respect to each successor demonstration year, each of*
4 *the nondesignated public hospitals shall receive an interim payment*
5 *for each day of inpatient hospital services rendered to Medi-Cal*
6 *beneficiaries based upon claims filed by the hospital in accordance*
7 *with the claiming process set forth in Division 3 (commencing with*
8 *Section 50000) of Title 22 of the California Code of Regulations.*
9 *The interim per diem payment amount shall be based on estimated*
10 *costs, which shall be derived from statistical data from the*
11 *following sources and which shall be multiplied by the federal*
12 *medical assistance percentage:*

13 *(1) For allowable costs reflected in the Medicare cost report,*
14 *the cost report most recently audited by the hospital's Medicare*
15 *fiscal intermediary adjusted by a trend factor to reflect increased*
16 *costs, as approved by the federal Centers for Medicare and*
17 *Medicaid Services for the successor demonstration project.*

18 *(2) For allowable costs not reflected in the Medicare cost report,*
19 *each hospital shall provide hospital-specific cost data requested*
20 *by the department. The department shall adjust the data by a trend*
21 *factor as necessary to reflect project year allowable costs.*

22 *(c) Until the department commences making payments pursuant*
23 *to subdivision (b), the department may continue to make*
24 *fee-for-service per diem payments to the nondesignated public*
25 *hospitals pursuant to the selective provider contracting program*
26 *in accordance with Article 2.6 (commencing with Section 14081),*
27 *for services rendered on and after July 1, 2012. Per diem payments*
28 *shall be adjusted retroactively to the amounts determined under*
29 *the payment methodology prescribed in this section.*

30 *(d) No later than April 1 following the end of the relevant*
31 *reporting period for the successor demonstration year, the*
32 *department shall undertake an interim reconciliation of payments*
33 *made pursuant to subdivisions (a) to (c), inclusive, based on*
34 *Medicare and other cost and statistical data submitted by the*
35 *hospital for the year and shall adjust payments to the hospital*
36 *accordingly.*

37 *(e) (1) The nondesignated public hospitals shall receive*
38 *supplemental reimbursement for the costs incurred for physician*
39 *and nonphysician practitioner services provided to Medi-Cal*
40 *beneficiaries who are patients of the hospital, to the extent that*

1 *those services are not claimed as inpatient hospital services by*
2 *the hospital and the costs of those services are not otherwise*
3 *recognized under subdivision (a).*

4 *(2) Expenditures made by the nondesignated public hospital,*
5 *or a governmental entity with which it is affiliated, for the services*
6 *identified in paragraph (1) shall be reduced by any payments*
7 *received pursuant to Article 7 (commencing with Section 51501)*
8 *of Title 22 of the California Code of Regulations. The remainder*
9 *shall be certified by the appropriate public official and claimed*
10 *by the department in accordance with Section 14166.153. These*
11 *expenditures may include any of the following:*

12 *(A) Compensation to physicians or nonphysician practitioners*
13 *pursuant to contracts with the nondesignated public hospital.*

14 *(B) Salaries and related costs for employed physicians and*
15 *nonphysician practitioners.*

16 *(C) The costs of interns, residents, and related teaching*
17 *physician and supervision costs.*

18 *(D) Administrative costs associated with the services described*
19 *in subparagraphs (A) to (C), inclusive, including billing costs.*

20 *(3) Nondesignated public hospitals shall receive federal*
21 *financial participation based on the expenditures identified and*
22 *certified in paragraph (2).*

23 *(4) The federal financial participation received by the*
24 *department for the certified public expenditures identified in*
25 *paragraph (2) shall be paid to the nondesignated public hospital,*
26 *or a governmental entity with which it is affiliated.*

27 *(5) Supplemental reimbursement under this subdivision may be*
28 *distributed as part of the interim payments under subdivision (b),*
29 *on a per-visit basis, on a per-procedure basis, or on any other*
30 *federally permissible basis.*

31 *(6) The department shall submit for federal approval, by*
32 *September 30, 2012, a proposed amendment to the Medi-Cal state*
33 *plan to implement this subdivision, retroactive to July 1, 2012, to*
34 *the extent permitted by the federal Centers for Medicare and*
35 *Medicaid Services. If necessary to obtain federal approval, the*
36 *department may limit the application of this subdivision to costs*
37 *determined allowable by the federal Centers for Medicare and*
38 *Medicaid Services. If federal approval is not obtained, this*
39 *subdivision shall not be implemented.*

1 (f) This section shall become operative as provided in
2 subdivision (f) of Section 14166.151.

3 SEC. 94. Section 14166.153 is added to the Welfare and
4 Institutions Code, to read:

5 14166.153. (a) Beginning in the 2012–13 fiscal year, within
6 five months after the end of a successor demonstration year, each
7 of the nondesignated public hospitals shall submit to the
8 department all of the following reports:

9 (1) The hospital’s Medicare cost report for the project year or
10 successor demonstration year.

11 (2) Other cost reporting and statistical data necessary for the
12 determination of amounts due the hospital under the demonstration
13 project or successor demonstration project, as requested by the
14 department.

15 (b) For each project year or successor demonstration year, the
16 reports shall identify all of the following:

17 (1) To the extent applicable, the costs incurred in providing
18 inpatient hospital services to Medi-Cal beneficiaries on a
19 fee-for-service basis and physician and nonphysician practitioner
20 services costs, as identified in subdivision (e) of Section 14166.152.

21 (2) The costs incurred in providing hospital services to
22 uninsured individuals.

23 (c) Each nondesignated public hospital, or governmental entity
24 with which it is affiliated, that operates nonhospital clinics or
25 provides physician, nonphysician practitioner, or other health
26 care services that are not identified as hospital services under the
27 Special Terms and Conditions for the demonstration project and
28 successor demonstration project, shall report and certify all of the
29 uncompensated Medi-Cal and uninsured costs of the services
30 furnished. The amount of these uncompensated costs to be claimed
31 by the department shall be determined by the department in
32 consultation with the governmental entity so as to optimize the
33 level of claimable federal Medicaid reimbursement.

34 (d) Reports submitted under this section shall include all
35 allowable costs.

36 (e) The appropriate public official shall certify to all of the
37 following:

38 (1) The accuracy of the reports required under this section.

39 (2) That the expenditures to meet the reported costs comply with
40 Section 433.51 of Title 42 of the Code of Federal Regulations.

1 (3) That the sources of funds used to make the expenditures
2 certified under this section do not include impermissible provider
3 taxes or donations as defined under Section 1396b(w) of Title 42
4 of the United States Code or other federal funds. For this purpose,
5 federal funds do not include delivery system reform incentive pool
6 payments or patient care revenue received as payment for services
7 rendered under programs such as nondesignated state health
8 programs, the Low Income Health Program, Medicare, or
9 Medicaid.

10 (f) The certification of public expenditures made pursuant to
11 this section shall be based on a schedule established by the
12 department in accordance with federal requirements.

13 (1) The director may require the nondesignated public hospitals
14 to submit quarterly estimates of anticipated expenditures, if these
15 estimates are necessary to obtain interim payments of federal
16 Medicaid funds.

17 (2) All reported expenditures shall be subject to reconciliation
18 to allowable costs, as determined in accordance with applicable
19 implementing documents for the demonstration project and
20 successor demonstration project.

21 (g) The director shall seek Medicaid federal financial
22 participation for all certified public expenditures reported by the
23 nondesignated public hospitals and recognized under the successor
24 demonstration project.

25 (h) The timeframes for data submission and reporting periods
26 may be adjusted as necessary in accordance with federal
27 requirements.

28 (i) This section shall become operative as provided in
29 subdivision (f) of Section 14166.151.

30 SEC. 95. Section 14166.154 is added to the Welfare and
31 Institutions Code, to read:

32 14166.154. (a) (1) Beginning in the 2012–13 fiscal year, if
33 the reimbursement methodology in subdivision (b) of Section
34 14166.151 is in effect and federal approval is obtained for an
35 amendment to the successor demonstration project that was
36 submitted pursuant to subdivision (d), then, with respect to each
37 successor demonstration year, nondesignated public hospitals, or
38 governmental entities with which they are affiliated, shall be
39 eligible to receive safety net care pool payments for uncompensated
40 care from the Health Care Support Fund established pursuant to

1 Section 14166.21. Safety net care pool payments for
2 uncompensated care shall be allocated to nondesignated public
3 hospitals as follows:

4 (A) The department shall determine the maximum amount of
5 safety net care pool payments for uncompensated care that is
6 available to nondesignated public hospitals for the successor
7 demonstration year pursuant to paragraph (2) of subdivision (b)
8 of Section 14166.151. This determination shall be made solely
9 with respect to allowable uncompensated care costs incurred by
10 nondesignated public hospitals and reported pursuant to Section
11 14166.153.

12 (B) The department shall establish, in consultation with the
13 nondesignated public hospitals, an allocation methodology to
14 determine the amount of safety net care pool payments to be made
15 to each hospital. The allocation methodology shall be implemented
16 when the director issues a declaration stating that the methodology
17 complies with all applicable federal requirements for federal
18 financial participation.

19 (2) A safety net care pool payment amount may be paid to a
20 nondesignated public hospital, or governmental entity with which
21 it is affiliated, pursuant to this section independent of the amount
22 of uncompensated Medi-Cal and uninsured costs that is certified
23 as public expenditures pursuant to Section 14166.153, provided
24 that, in accordance with the Special Terms and Conditions for the
25 successor demonstration project, the recipient hospital does not
26 return any portion of the funds received to any unit of government,
27 excluding amounts recovered by the state or federal government.

28 (3) In establishing the amount to be paid to each nondesignated
29 public hospital under this subdivision, the department shall
30 minimize to the extent possible the redistribution of federal funds
31 that are based on certified public expenditures as described in
32 paragraph (2).

33 (b) Each nondesignated public hospital, or governmental entity
34 with which it is affiliated, shall receive the amount established
35 pursuant to subdivision (a) in quarterly interim payments during
36 the successor demonstration year. The determination of the interim
37 payments shall be made on an interim basis prior to the start of
38 each successor demonstration year. The department shall use the
39 same cost and statistical data that is used in determining the

1 *interim payments for Medi-Cal inpatient hospital services under*
2 *Section 14166.152.*

3 *(c) (1) No later than April 1 following the end of the relevant*
4 *reporting period for the successor demonstration year, the*
5 *department shall undertake an interim reconciliation of the*
6 *payment amount established pursuant to subdivision (a) for each*
7 *nondesignated public hospital using Medicare and other cost,*
8 *payment, and statistical data submitted by the hospital for the*
9 *successor demonstration year, and shall adjust payments to the*
10 *hospital accordingly.*

11 *(2) The final payment to a nondesignated public hospital, for*
12 *purposes of subdivision (b) and paragraph (1) of this subdivision,*
13 *shall be subject to final audits of all applicable Medicare and other*
14 *cost, payment, discharge, and statistical data for the successor*
15 *demonstration year.*

16 *(d) The department shall submit for federal approval a proposed*
17 *amendment to the successor demonstration project to implement*
18 *this section.*

19 *(e) This section shall become operative as provided in*
20 *subdivision (f) of Section 14166.151.*

21 *SEC. 96. Section 14166.155 is added to the Welfare and*
22 *Institutions Code, to read:*

23 *14166.155. (a) (1) Beginning in the 2012–13 fiscal year, if*
24 *the reimbursement methodology in subdivision (b) of Section*
25 *14166.151 is in effect and federal approval is obtained for an*
26 *amendment to the successor demonstration project that was*
27 *submitted pursuant to subdivision (c), then nondesignated public*
28 *hospitals may receive payments pursuant to this section. The*
29 *amount of delivery system reform incentive pool funding, consisting*
30 *of both the federal and nonfederal share of payments, that is made*
31 *available to each nondesignated public hospital system in the*
32 *aggregate for the term of the successor demonstration project shall*
33 *be based initially on the delivery system reform proposals that are*
34 *submitted by the nondesignated public hospitals to the department*
35 *for review and submission to the federal Centers for Medicare and*
36 *Medicaid Services for final approval. The initial percentages of*
37 *delivery system reform incentive pool funding among the*
38 *nondesignated public hospitals for each successor demonstration*
39 *year shall be determined based on the annual components as*
40 *contained in the approved proposals.*

1 (2) *The actual receipt of funds shall be conditioned on the*
2 *nondesignated public hospital's progress toward, and achievement*
3 *of, the specified milestones and other metrics established in its*
4 *approved delivery system reform incentive pool proposal. A*
5 *nondesignated public hospital may carry forward available*
6 *incentive pool funding associated with milestones and metrics from*
7 *one year to a subsequent period as authorized by the Special Terms*
8 *and Conditions and the final delivery system reform incentive pool*
9 *protocol.*

10 (3) *The department may reallocate the incentive pool funding*
11 *available under this section pursuant to conditions specified, and*
12 *as authorized by, the Special Terms and Conditions and the final*
13 *delivery system reform incentive pool protocol.*

14 (b) *Each nondesignated public hospital shall be individually*
15 *responsible for progress toward, and achievement of, milestones*
16 *and other metrics in its proposal, as well as other applicable*
17 *requirements specified in the Special Terms and Conditions and*
18 *the final delivery system reform incentive pool protocol, in order*
19 *to receive its specified allocation of incentive pool funding under*
20 *this section.*

21 (1) *The nondesignated public hospital shall submit semiannual*
22 *reports and requests for payment to the department by March 31*
23 *and the September 30 following the end of the second and fourth*
24 *quarters of the successor demonstration year; or comply with any*
25 *other process as approved by the federal Centers for Medicare*
26 *and Medicaid Services.*

27 (2) *Within 14 days after the semiannual report due date, the*
28 *nondesignated public hospital system or its affiliated governmental*
29 *entity shall make an intergovernmental transfer of funds equal to*
30 *the nonfederal share that is necessary to claim the federal funding*
31 *for the pool payment related to the achievement or progress metric*
32 *that is certified. The intergovernmental transfers shall be deposited*
33 *into the Public Hospital Investment, Improvement, and Incentive*
34 *Fund, established pursuant to Section 14182.4.*

35 (3) *The department shall claim the federal funding and pay both*
36 *the nonfederal and federal shares of the incentive payment to the*
37 *nondesignated public hospital system or other affiliated*
38 *governmental provider, as applicable. If the intergovernmental*
39 *transfer is made within the appropriate 14-day timeframe, the*
40 *incentive payment shall be disbursed within seven days with the*

1 expedited payment process as approved by the federal Centers for
2 Medicare and Medicaid Services, otherwise the payment shall be
3 disbursed within 20 days of when the transfer is made.

4 (4) The nondesignated public hospital system or other affiliated
5 governmental provider is responsible for any fee or cost required
6 to implement the expedited payment process in accordance with
7 Section 8422.1 of the State Administrative Manual.

8 (c) The department shall submit for federal approval an
9 amendment to the successor demonstration project to implement
10 this section.

11 (d) In the event of a conflict between any provision of this section
12 and the Special Terms and Conditions for the successor
13 demonstration project and the final delivery system reform
14 incentive pool protocol, the Special Terms and Conditions and the
15 final delivery system reform incentive pool protocol shall control.

16 (e) This section shall become operative as provided in
17 subdivision (f) of Section 14166.151.

18 SEC. 97. Section 14166.17 of the Welfare and Institutions Code
19 is amended to read:

20 14166.17. (a) The California Medical Assistance Commission
21 shall negotiate payment amounts in accordance with the selective
22 provider contracting program established pursuant to Article 2.6
23 (commencing with Section 14081) from the Nondesignated Public
24 Hospital Supplemental Fund established pursuant to subdivision
25 (b) for distribution to nondesignated public hospitals that satisfy
26 the criteria of ~~Section 14085.6, 14085.7, 14085.8, or 14085.9.~~
27 *subdivision (o). Pursuant to Section 14165, on and after July 1,*
28 *2012, the Director of Health Care Services shall exercise the*
29 *discretion granted to the California Medical Assistance*
30 *Commission.*

31 (b) The Nondesignated Public Hospital Supplemental Fund is
32 hereby established in the State Treasury. For purposes of this
33 section, “fund” means the Nondesignated Public Hospital
34 Supplemental Fund.

35 (c) Notwithstanding Section 13340 of the Government Code,
36 the fund shall be continuously appropriated to the department for
37 the purposes specified in this section.

38 (d) Except as otherwise limited by this section, the fund shall
39 consist of all of the following:

1 (1) One million nine hundred thousand dollars (\$1,900,000),
2 which shall be transferred annually from General Fund amounts
3 appropriated in the annual Budget Act for the fund.

4 (2) Any additional moneys appropriated to the fund.

5 (3) All stabilization funding transferred to the fund.

6 (4) All private moneys donated by private individuals or entities
7 to the department for deposit in the fund as permitted under
8 applicable federal Medicaid laws.

9 (5) Any interest that accrues on amounts in the fund.

10 (e) The department may accept or not accept moneys offered
11 to the department for deposit in the fund. If the department accepts
12 moneys pursuant to this section, the department shall obtain federal
13 financial participation to the full extent permitted by law. With
14 respect to funds transferred or donated from private individuals or
15 entities, the department shall accept only those funds that are
16 certified by the transferring or donating entity as qualifying for
17 federal financial participation under the terms of the Medicaid
18 Voluntary Contribution and Provider-Specific Tax Amendments
19 of 1991 (~~P.L.~~ *Public Law* 102-234) or Section 433.51 of Title 42
20 of the Code of Federal Regulations, as applicable. The department
21 may return any funds transferred or donated in error.

22 (f) Moneys in the funds shall be used as the source for the
23 nonfederal share of payments to hospitals under this section.

24 (g) Any funds remaining in the fund at the end of a fiscal year
25 shall be carried forward for use in the following fiscal year.

26 (h) Moneys shall be allocated from the fund by the department
27 and shall be applied to obtain federal financial participation in
28 accordance with customary Medi-Cal accounting procedures for
29 purposes of payments under this section. Distributions from the
30 fund shall be supplemental to any other Medi-Cal reimbursement
31 received by the hospitals, including amounts that hospitals receive
32 under the selective provider contracts negotiated under Article 2.6
33 (commencing with Section 14081), and shall not affect provider
34 rates paid under the selective provider contracting program.

35 (i) Each nondesignated public hospital that was a nondesignated
36 public hospital during the 2002–03 fiscal year, received payments
37 for the 2002–03 fiscal year from any of the prior supplemental
38 funds, and, during the project year satisfies the criteria in ~~Section~~
39 ~~14085.6, 14085.7, 14085.8, or 14085.9 subdivision (o)~~ to be eligible
40 to negotiate for distributions under any of those sections shall

1 receive no less from the Nondesignated Public Hospital
2 Supplemental Fund for the project year than 100 percent of the
3 amount the hospital received from the prior supplemental funds
4 for the 2002–03 fiscal year, minus the total amount of
5 intergovernmental transfers made by or on behalf of the hospital
6 pursuant to ~~Sections 14085.6, 14085.7, 14085.8, and 14085.9~~
7 *subdivision (o)* for the same fiscal year. Each hospital described
8 in this subdivision shall be eligible for additional payments from
9 the fund pursuant to subdivision (j).

10 (j) All amounts that are in the fund for a project year in excess
11 of the amount necessary to make the payments under subdivision
12 (i) shall be available for negotiation by the California Medical
13 Assistance Commission, along with corresponding federal financial
14 participation, for supplemental payments to nondesignated public
15 hospitals that for the project year satisfy the criteria under ~~Section~~
16 ~~14085.6, 14085.7, 14085.8, or 14085.9~~ *subdivision (o)* to be eligible
17 to negotiate for distributions under any of those sections, and paid
18 for services rendered during the project year pursuant to the
19 selective provider contracting program under Article 2.6
20 (commencing with Section 14081).

21 (k) The amount of any stabilization funding transferred to the
22 fund with respect to a project year may in the discretion of the
23 California Medical Assistance Commission, *until its dissolution*
24 *on June 30, 2012*, to be paid for services furnished in the same
25 project year regardless of when the stabilization funds become
26 available, provided the payment is consistent with other applicable
27 federal or state legal requirements and does not result in a hospital
28 exceeding any applicable reimbursement limitations. *On and after*
29 *July 1, 2012, the Director of Health Care Services shall exercise*
30 *the discretion granted to the California Medical Assistance*
31 *Commission by this subdivision.*

32 (l) The department shall pay amounts due to a nondesignated
33 hospital from the fund for a project year, with the exception of
34 stabilization funding, in up to four installment payments, unless
35 otherwise provided in the hospital's contract negotiated with the
36 California Medical Assistance Commission, except that hospitals
37 that are not described in subdivision (i) shall not receive the first
38 installment payment. The first payment shall be made as soon as
39 practicable after the issuance of the tentative disproportionate share
40 hospital list for the project year, and in no event later than January

1 1 of the project year. The second and subsequent payments shall
2 be made after the issuance of the final disproportionate hospital
3 list for the project year, and shall be made only to hospitals that
4 are on the final disproportionate share hospital list for the project
5 year. The second payment shall be made by February 1 of the
6 project year or as soon as practicable after the issuance of the final
7 disproportionate share hospital list for the project year. The third
8 payment, if scheduled, shall be made by April 1 of the project year.
9 The fourth payment, if scheduled, shall be made by June 30 of the
10 project year. This subdivision does not apply to hospitals that are
11 scheduled to receive payments from the fund because they meet
12 the criteria under ~~Section 14085.7 paragraph (2) of subdivision~~
13 ~~(o)~~ but do not meet the criteria under ~~Section 14085.6, 14085.8,~~
14 ~~or 14085.9 paragraph (1), (3), or (4) of subdivision (o).~~

15 (m) The department shall pay stabilization funding transferred
16 to the fund in amounts negotiated by the California Medical
17 Assistance Commission and paid in accordance with the applicable
18 contract or contract amendment.

19 (n) A nondesignated public hospital that receives payment
20 pursuant to this section for a particular project year shall not submit
21 a notice for the termination of its participation in the selective
22 provider contracting program established pursuant to Article 2.6
23 (commencing with Section 14081) until the later of the following
24 dates:

25 (1) On or after December 31 of the next project year.

26 (2) The date specified in the hospital's contract, if applicable.

27 (o) *In order for a hospital to receive distributions pursuant to*
28 *this section, the hospital shall satisfy the eligibility criteria in*
29 *paragraph (1), (2), (3), or (4) of this subdivision.*

30 (1) *The hospital meets all of the following criteria:*

31 (A) *The hospital is contracting under this article.*

32 (B) *The hospital meets the criteria contained in the Medicaid*
33 *State Plan for disproportionate share hospital status.*

34 (C) *The hospital is one of the following:*

35 (i) *A licensed provider of basic emergency services as described*
36 *in Section 70411 of Title 22 of the California Code of Regulations.*

37 (ii) *A licensed provider of comprehensive emergency medical*
38 *services as defined in Section 70451 of Title 22 of the California*
39 *Code of Regulations.*

1 (iii) A children's hospital, as defined in Section 14087.21, that
2 satisfies clause (i) or (ii), or that jointly provides basic or
3 comprehensive emergency services in conjunction with another
4 licensed hospital.

5 (iv) A hospital owned and operated by a public agency that
6 operates two or more hospitals that qualify under subparagraph
7 (A) or (B) with respect to the particular state fiscal year.

8 (v) A hospital designated by the National Cancer Institute as a
9 comprehensive or clinical cancer research center that primarily
10 treats acutely ill cancer patients and that is exempt from the federal
11 Medicare prospective payment system pursuant to Section
12 1886(d)(1)(B)(v) of the federal Social Security Act (42 U.S.C. Sec.
13 1395ww(d)(1)(B)(v)).

14 (D) (1) The hospital is able to demonstrate a purpose for
15 additional funding under the selective provider contracting
16 program including proposals relating to emergency services and
17 other health care services, including infrequent yet high-cost
18 services, such as anti-AB human antitoxin treatment for infant
19 botulism (human botulinum immune globulin (HBIG), commonly
20 referred to as "Baby-BIG"), that are made available, or will be
21 made available, to Medi-Cal beneficiaries.

22 (2) The hospital is contracting under this article and meets the
23 definition of a university teaching hospital or major, nonuniversity,
24 teaching hospital as set forth on page 51 and as listed on page 57
25 of the department's report dated May 1991, entitled "Hospital
26 Peer Grouping." Payments from the fund shall be used solely for
27 the purposes identified in the contract between the hospital and
28 the state.

29 (3) The hospital is contracting under this article and meets the
30 definition of any of the following:

31 (A) A large teaching emphasis hospital, as set forth on page 51
32 and listed on page 57 of the department's report dated May 1991,
33 entitled "Hospital Peer Grouping," and also meets the definition
34 of eligible hospital as defined in paragraph (3) of subdivision (a)
35 of Section 14105.98.

36 (B) A children's hospital pursuant to Section 10727, and also
37 meets the definition of eligible hospital as defined in paragraph
38 (3) of subdivision (a) of Section 14105.98.

39 (C) Notwithstanding the requirement in subparagraph (A) of
40 paragraph (3) that a hospital must be listed on page 57 of the

1 department's report dated May 1991, entitled "Hospital Peer
2 Grouping," any hospital whose license pursuant to Chapter 2
3 (commencing with Section 1250) of Division 2 of the Health and
4 Safety Code was consolidated during the 1999 calendar year with
5 a large teaching emphasis hospital that is listed on page 57 of the
6 above-described report shall be eligible. All other requirements
7 of paragraph (3) shall continue to apply.

8 (4) The hospital meets all of the following criteria:

9 (A) The hospital is contracting under this article.

10 (B) The hospital satisfies the Medicaid State Plan criteria for
11 disproportionate share hospital status.

12 (C) The hospital is a small and rural hospital as defined in
13 Section 124840 of the Health and Safety Code.

14 (D) The hospital is a licensed provider of standby emergency
15 services as described in Section 70649 of Title 22 of the California
16 Code of Regulations.

17 (E) The hospital is able to demonstrate a purpose for additional
18 funding under the selective provider contracting program with
19 proposals relating to health care services that are made available,
20 or will be made available, to Medi-Cal beneficiaries.

21 (F) The hospital is determined by the California Medical
22 Assistance Commission to be a hospital that provides an important
23 community service that otherwise would not be provided in the
24 community.

25 SEC. 98. Section 14166.19 of the Welfare and Institutions Code
26 is amended to read:

27 14166.19. The amount of any stabilization funding payable to
28 the nondesignated public hospitals under paragraph (4) of
29 subdivision (b) of Section 14166.20 for a project year, which
30 amount shall not include the amount of stabilization funding paid
31 or payable to hospitals prior to the computation of the stabilization
32 funding under Section 14166.20, shall be allocated in the following
33 priority:

34 (a) An amount shall be transferred to the Nondesignated Public
35 Hospital Supplemental Fund, as may be necessary so that the
36 amount for the Nondesignated Public Hospital Supplemental Fund
37 for the project year, including all funds previously transferred to,
38 or deposited in, the Nondesignated Public Hospital Supplemental
39 Fund for the project year, is not less than one million nine hundred
40 thousand dollars (\$1,900,000).

1 (b) Of the remaining stabilization funding payable to
2 nondesignated public hospitals, 75 percent shall be allocated,
3 distributed, and paid in accordance with Section 14166.16, and 25
4 percent shall be transferred to the Nondesignated Public Hospital
5 Supplemental Fund.

6 (c) *Notwithstanding any other law, the amount of any*
7 *stabilization funding payable to nondesignated public hospitals*
8 *under Section 14166.20 for a project year as determined under*
9 *this section that has not been paid, or specifically committed for*
10 *payment, to nondesignated public hospitals before January 1,*
11 *2012, shall not be paid pursuant to Section 14166.20. The funds*
12 *that would otherwise be paid from the Nondesignated Public*
13 *Hospital Supplemental Fund shall be transferred to the General*
14 *Fund, and funds that would otherwise be drawn from the General*
15 *Fund for payments to the nondesignated public hospitals pursuant*
16 *to Section 14166.20 shall be retained in the General Fund.*

17 SEC. 99. *Section 14169.7 of the Welfare and Institutions Code*
18 *is amended to read:*

19 14169.7. (a) (1) Designated public hospitals shall be paid
20 direct grants in support of health care expenditures, which shall
21 not constitute Medi-Cal payments, and which shall be funded by
22 the quality assurance fee set forth in Article 5.229 (commencing
23 with Section 14169.31). The aggregate amount of the grants to
24 designated public hospitals shall be fifty million dollars
25 (\$50,000,000) for the 2011–12 fiscal year, forty-three million
26 dollars (\$43,000,000) for the 2012–13 fiscal year, and twenty-one
27 million five hundred thousand dollars (\$21,500,000) for the
28 2013–14 fiscal year. The director shall allocate the amounts
29 specified in this subdivision ~~among the designated public hospitals~~
30 ~~pursuant to a methodology developed in consultation with the~~
31 ~~designated public hospitals~~ *paragraph pursuant to paragraph (2).*

32 (2) *For the 2011–12 fiscal year, the director shall allocate the*
33 *fifty million dollars (\$50,000,000) identified in paragraph (1)*
34 *among the designated public hospitals pursuant to a methodology*
35 *developed in consultation with the designated public hospitals.*
36 *For the 2012–13 fiscal year, the director shall allocate the*
37 *forty-three million dollars (\$43,000,000) identified in paragraph*
38 *(1) among the designated public hospitals pursuant to a*
39 *methodology developed in consultation with the designated public*
40 *hospitals. For the 2013–14 fiscal year, the state shall retain the*

1 *twenty-one million five hundred thousand dollars (\$21,500,000)*
2 *identified in paragraph (1) to pay for health care coverage for*
3 *children in addition to the amounts identified in Section 14169.33.*

4 (b) Nondesignated public hospitals shall be paid direct grants
5 in support of health care expenditures, and shall be funded by the
6 quality assurance fee set forth in Article 5.229 (commencing with
7 Section 14169.31). The aggregate amount of the grants to
8 nondesignated public hospitals for each subject fiscal year shall
9 be ten million dollars (\$10,000,000), except that for the 2013–14
10 subject fiscal year, the aggregate amount of the grants shall be five
11 million dollars (\$5,000,000). The director shall allocate the
12 amounts specified in this subdivision among the nondesignated
13 public hospitals pursuant to a methodology developed in
14 consultation with the nondesignated public hospitals.

15 *SEC. 100. Section 14169.7.5 of the Welfare and Institutions*
16 *Code is amended to read:*

17 14169.7.5. (a) The Low Income Health Program MCE
18 Out-of-Network Emergency Care Services Fund is hereby
19 established in the State Treasury. The moneys in the fund shall,
20 upon appropriation by the Legislature to the department, be used
21 solely for the purposes specified in this section. Notwithstanding
22 Section 16305.7 of the Government Code, any and all interest and
23 dividends earned on money in the fund shall be used exclusively
24 for the purposes of this section.

25 (b) The fund shall consist of the following:

26 (1) Funds transferred from governmental entities, at the option
27 of the governmental entity, to the state for deposit into the fund in
28 an aggregate amount of twenty million dollars (\$20,000,000) per
29 subject fiscal year, except that for the 2013–14 subject fiscal year,
30 the aggregate amount of the transfer shall be ten million dollars
31 (\$10,000,000).

32 (2) Proceeds of the quality assurance fee set forth in Article
33 5.229 (commencing with Section 14169.31) that, subject to
34 paragraph (1) of subdivision (a) of Section 14169.36, are
35 transferred from the Hospital Quality Assurance Revenue Fund
36 and deposited into the fund in an aggregate amount of seventy-five
37 million dollars (\$75,000,000) per subject fiscal year, except that
38 for the 2013–14 subject fiscal year, the aggregate amount of the
39 proceeds of the quality assurance fee deposited into the fund shall

1 be thirty-seven million five hundred thousand dollars
2 (\$37,500,000).

3 (c) Any amounts of the quality assurance fee deposited to the
4 fund in excess of the funds required to implement this section shall
5 be returned to the Hospital Quality Assurance Revenue Fund.

6 (d) Any amounts deposited to the fund as described in paragraph
7 (1) of subdivision (b) that are in excess of the funds required to
8 implement this section shall be returned to the transferring entity.

9 (e) Consistent with the Special Terms and Conditions for the
10 California's Bridge to Reform Section 1115(a) Medicaid
11 Demonstration (11-W-00193/9), moneys in the fund shall be used
12 with respect to Low Income Health Programs (LIHPs) operating
13 pursuant to Part 3.6 (commencing with Section 15909) as the
14 source for the nonfederal share of expenditures for coverage for
15 the Medi-Cal coverage expansion (MCE) population of medically
16 necessary hospital emergency services for emergency medical
17 conditions and required poststabilization care furnished by private
18 hospitals and nondesignated public hospitals that are outside the
19 LIHP coverage network, subject to the following:

20 (1) Moneys in the fund shall only be used to fund the nonfederal
21 share of supplemental payments made to private hospital and
22 nondesignated public hospital out-of-network emergency care
23 services providers by the LIHP for the MCE population in
24 accordance with this section.

25 (2) Supplemental payments under this section shall supplement
26 but shall not supplant amounts that would have been paid absent
27 the provisions of this section.

28 (f) Moneys in the fund shall be allocated with respect to each
29 subject fiscal year as follows:

30 (1) Within 60 days after the last day of each subject fiscal year,
31 each LIHP shall report utilization data to the department on
32 approved hospital emergency services for emergency medical
33 conditions and required poststabilization care, in accordance with
34 Paragraph 63.f.ii of the Special Terms and Conditions of
35 California's Bridge to Reform Section 1115(a) Demonstration
36 (11-W-00193/9), provided to MCE enrollees by out-of-network
37 private hospitals and nondesignated public hospitals during that
38 year. The reported data shall be as specified by the department,
39 and shall include the number of emergency room encounters and
40 the number of inpatient hospital days.

1 (2) The department shall, in consultation with the hospital
2 community, determine the amount of funding for the nonfederal
3 share of supplemental payments available for each reported
4 emergency room encounter or inpatient day by dividing the total
5 funds available by the total number of inpatient days or emergency
6 visits in accordance with subparagraphs (A) and (B).

7 (A) Seventy percent of the moneys in the fund shall be allocated
8 for the nonfederal share of supplemental payments to private
9 hospitals and nondesignated public hospitals for approved
10 out-of-network inpatient hospital emergency and poststabilization
11 care, in accordance with Paragraph 63.f.ii of the Special Terms
12 and Conditions of California’s Bridge to Reform Section 1115(a)
13 Demonstration (11-W-00193/9).

14 (B) Thirty percent of the available funds shall be allocated for
15 the nonfederal share of supplemental payments to private hospitals
16 and nondesignated public hospitals for approved out-of-network
17 hospital emergency room services (excluding emergency room
18 visits, in accordance with Paragraph 63.f.ii of the Special Terms
19 and Conditions of California’s Bridge to Reform Section 1115(a)
20 Demonstration (11-W-00193/9), that resulted in an approved
21 out-of-network inpatient hospital stay), provided that for any
22 emergency room visit that results in a hospital stay for which a
23 supplemental payment is available under subparagraph (A), no
24 supplemental payment shall be available under this subparagraph.

25 (C) The allocations and total available fund amount shall be
26 adjusted as necessary so as to be consistent with the requirement
27 in paragraph (1) of subdivision (g).

28 (g) (1) The department shall obtain federal financial
29 participation for moneys in the fund to the full extent permitted
30 by federal law. Moneys shall be allocated from the fund by the
31 department to be matched by federal funds in accordance with the
32 Special Terms and Conditions for the Medicaid Demonstration,
33 or pursuant to other federal approvals or waivers as necessary.

34 (2) The department shall disburse moneys from the fund to the
35 LIHPs in accordance with the calculations in subdivision (f) within
36 60 days after completing the calculations. The moneys shall be
37 distributed to the LIHPs solely for purposes of funding the
38 nonfederal portion of the supplemental out-of-network amounts
39 determined for each service in subdivision (f) to out-of-network
40 hospital emergency care services providers.

1 (3) The LIHPs shall make the supplemental payments described
 2 in paragraph (2) within 30 days of receiving the nonfederal share
 3 from the department.

4 (h) It is the intent of the Legislature that for each subject fiscal
 5 year, the first twenty million dollars (\$20,000,000), or, for subject
 6 fiscal year 2013–14, the first ten million dollars (\$10,000,000), of
 7 the nonfederal share for the emergency hospital services payments
 8 are funded with intergovernmental transfers described in paragraph
 9 (1) of subdivision (b).

10 (i) This section shall be implemented only if, and to the extent
 11 that, both of the following conditions exist:

12 (1) All necessary federal approvals have been obtained *for the*
 13 *implementation of this section* and federal financial participation
 14 is available.

15 (2) The ability of the department to maximize federal funding
 16 is not jeopardized.

17 (j) In designing and implementing the program for supplemental
 18 payments created under this section, the director shall have
 19 discretion, after consultation with the hospital community and the
 20 LIHPs, to modify timelines and to make modifications to the
 21 operational requirements of this section, but only to the extent
 22 necessary to secure federal approval or to ensure successful
 23 operation of the program and to effectuate the intent of this section.

24 (k) Notwithstanding any other provision of this article or Article
 25 5.229 (commencing with Section 14169.31), federal disapproval
 26 of the program developed pursuant to the requirements of this
 27 section shall not affect the implementation of the remainder of this
 28 article or Article 5.229 (commencing with Section 14169.31).

29 *SEC. 101. Section 14169.13 of the Welfare and Institutions*
 30 *Code is amended to read:*

31 14169.13. (a) The director shall do all of the following:

32 (1) Promptly submit any state plan amendment or waiver request
 33 that may be necessary to implement this article.

34 (2) Promptly seek federal approvals or waivers as may be
 35 necessary to implement this article and to obtain federal financial
 36 participation to the maximum extent possible for the payments
 37 under this article.

38 (3) Amend the contracts between the managed health care plans
 39 and the department as necessary to incorporate the provisions of
 40 Sections 14169.5 and 14169.6 and promptly seek all necessary

1 federal approvals of those amendments. The department shall
2 pursue amendments to the contracts as soon as possible after the
3 effective date of this article and Article 5.229 (commencing with
4 Section 14169.31), and shall not wait for federal approval of this
5 article or Article 5.229 (commencing with Section 14169.31) prior
6 to pursuing amendments to the contracts. The amendments to the
7 contracts shall, among other provisions, set forth an agreement to
8 increase capitation payments to managed health care plans under
9 Section 14169.5 and increase payments to hospitals under Section
10 14169.6 in a manner that relates back to July 1, 2011, or as soon
11 thereafter as possible, conditioned on obtaining all federal
12 approvals necessary for federal financial participation for the
13 increased capitation payments to the managed health care plans.

14 (b) In implementing this article, the department may utilize the
15 services of the Medi-Cal fiscal intermediary through a change
16 order to the fiscal intermediary contract to administer this program,
17 consistent with the requirements of Sections 14104.6, 14104.7,
18 14104.8, and 14104.9. Contracts entered into for purposes of
19 implementing this article or Article 5.229 (commencing with
20 Section 14169.31) shall not be subject to Part 2 (commencing with
21 Section 10100) of Division 2 of the Public Contract Code.

22 (c) This article shall become inoperative if either of the
23 following occurs:

24 (1) In the event, and on the effective date, of a final judicial
25 determination made by any court of appellate jurisdiction or a final
26 determination by the federal Department of Health and Human
27 Services or the federal Centers for Medicare and Medicaid Services
28 that ~~any element of this article~~ *Section 14169.2, Section 14169.3,*
29 or any provision of Section 14166.115 cannot be implemented.

30 (2) In the event both of the following conditions exist:

31 (A) The federal Centers for Medicare and Medicaid Services
32 denies approval for, or does not approve before January 1, 2013,
33 the implementation of *Section 14169.2, Section 14169.3, or the*
34 *quality assurance fee established pursuant to Article 5.229*
35 *(commencing with Section 14169.31) or this article.*

36 (B) ~~Either or both articles~~ *Section 14169.2, Section 14169.3,*
37 *or Article 5.229 (commencing with Section 14169.31)* cannot be
38 modified by the department pursuant to subdivision (e) of Section
39 14169.33 in order to meet the requirements of federal law or to
40 obtain federal approval.

1 (d) If this article becomes inoperative pursuant to paragraph (1)
2 of subdivision (c) and the determination applies to any period or
3 periods of time prior to the effective date of the determination, the
4 department shall have authority to recoup all payments made
5 pursuant to this article during that period or those periods of time.

6 (e) In the event any hospital, or any party on behalf of a hospital,
7 shall initiate a case or proceeding in any state or federal court in
8 which the hospital seeks any relief of any sort whatsoever,
9 including, but not limited to, monetary relief, injunctive relief,
10 declaratory relief, or a writ, based in whole or in part on a
11 contention that any or all of this article or Article 5.229
12 (commencing with Section 14169.31) is unlawful and may not be
13 lawfully implemented, both of the following shall apply:

14 (1) Payments shall not be made to the hospital pursuant to this
15 article until the case or proceeding is finally resolved, including
16 the final disposition of all appeals.

17 (2) Any amount computed to be payable to the hospital pursuant
18 to this section for a project year shall be withheld by the department
19 and shall be paid to the hospital only after the case or proceeding
20 is finally resolved, including the final disposition of all appeals.

21 (f) Subject to Section 14169.34, no payment shall be made under
22 this article until all necessary federal approvals for the payment
23 and for the fee provisions in Article 5.229 (commencing with
24 Section 14169.31) have been obtained and the fee has been
25 imposed and collected. Notwithstanding any other provision of
26 law, payments under this article shall be made only to the extent
27 that the fee established in Article 5.229 (commencing with Section
28 14169.31) is collected and available to cover the nonfederal share
29 of the payments.

30 (g) A hospital's receipt of payments under this article for
31 services rendered prior to the effective date of this article is
32 conditioned on the hospital's continued participation in Medi-Cal
33 for at least 30 days after the effective date of this article.

34 (h) All payments made by the department to hospitals, managed
35 health care plans, and mental health plans under this article shall
36 be made only from the following:

37 (1) The quality assurance fee set forth in Article 5.229
38 (commencing with Section 14169.31) and due and payable on or
39 before December 31, 2013, along with any interest or other
40 investment income thereon.

1 (2) Federal reimbursement and any other related federal funds.
2 *SEC. 102. Section 14169.31 of the Welfare and Institutions*
3 *Code is amended to read:*

4 14169.31. For the purposes of this article, the following
5 definitions shall apply:

6 (a) (1) “Aggregate quality assurance fee” means, with respect
7 to a hospital that is not a prepaid health plan hospital, the sum of
8 all of the following:

9 (A) The annual fee-for-service days for an individual hospital
10 multiplied by the fee-for-service per diem quality assurance fee
11 rate.

12 (B) The annual managed care days for an individual hospital
13 multiplied by the managed care per diem quality assurance fee
14 rate.

15 (C) The annual Medi-Cal days for an individual hospital
16 multiplied by the Medi-Cal per diem quality assurance fee rate.

17 (2) “Aggregate quality assurance fee” means, with respect to a
18 hospital that is a prepaid health plan hospital, the sum of all of the
19 following:

20 (A) The annual fee-for-service days for an individual hospital
21 multiplied by the fee-for-service per diem quality assurance fee
22 rate.

23 (B) The annual managed care days for an individual hospital
24 multiplied by the prepaid health plan hospital managed care per
25 diem quality assurance fee rate.

26 (C) The annual Medi-Cal managed care days for an individual
27 hospital multiplied by the prepaid health plan hospital Medi-Cal
28 managed care per diem quality assurance fee rate.

29 (D) The annual Medi-Cal fee-for-service days for an individual
30 hospital multiplied by the Medi-Cal per diem quality assurance
31 fee rate.

32 (3) “Aggregate quality assurance fee after the application of the
33 fee percentage” means the aggregate quality assurance fee
34 multiplied by the fee percentage for each subject fiscal year.

35 (b) “Annual fee-for-service days” means the number of
36 fee-for-service days of each hospital subject to the quality assurance
37 fee, as reported on the days data source.

38 (c) “Annual managed care days” means the number of managed
39 care days of each hospital subject to the quality assurance fee, as
40 reported on the days data source.

- 1 (d) “Annual Medi-Cal days” means the number of Medi-Cal
2 days of each hospital subject to the quality assurance fee, as
3 reported on the days data source.
- 4 (e) “Converted hospital” shall mean a hospital described in
5 subdivision (b) of Section 14169.1.
- 6 (f) “Days data source” means the hospital’s Annual Financial
7 Disclosure Report filed with the Office of Statewide Health
8 Planning and Development as of May 5, 2011, for its fiscal year
9 ending during 2009.
- 10 (g) “Designated public hospital” shall have the meaning given
11 in subdivision (d) of Section 14166.1 as of January 1, 2011.
- 12 (h) “Exempt facility” means any of the following:
- 13 (1) A public hospital, which shall include either of the following:
- 14 (A) A hospital, as defined in paragraph (25) of subdivision (a)
15 of Section 14105.98.
- 16 (B) A tax-exempt nonprofit hospital that is licensed under
17 subdivision (a) of Section 1250 of the Health and Safety Code and
18 operating a hospital owned by a local health care district, and is
19 affiliated with the health care district hospital owner by means of
20 the district’s status as the nonprofit corporation’s sole corporate
21 member.
- 22 (2) With the exception of a hospital that is in the Charitable
23 Research Hospital peer group, as set forth in the 1991 Hospital
24 Peer Grouping Report published by the department, a hospital that
25 is a hospital designated as a specialty hospital in the hospital’s
26 Office of Statewide Health Planning and Development Hospital
27 Annual Financial Disclosure Report for the hospital’s fiscal year
28 ending in the 2009 calendar year.
- 29 (3) A hospital that satisfies the Medicare criteria to be a
30 long-term care hospital.
- 31 (4) A small and rural hospital as specified in Section 124840
32 of the Health and Safety Code designated as that in the hospital’s
33 Office of Statewide Health Planning and Development Hospital
34 Annual Financial Disclosure Report for the hospital’s fiscal year
35 ending in the 2009 calendar year.
- 36 (i) “Federal approval” means the ~~last~~ approval by the federal
37 government ~~required for the implementation of this article and~~
38 ~~Article 5.228 (commencing with Section 14169.1) of both the~~
39 *quality assurance fee established pursuant to this article and the*

1 *supplemental payments to private hospitals described in Sections*
2 *14169.2 and 14169.3.*

3 (j) (1) “Fee-for-service per diem quality assurance fee rate”
4 means a fixed daily fee on fee-for-service days.

5 (2) The fee-for-service per diem quality assurance fee rate shall
6 be three hundred nine dollars and eighty-six cents (\$309.86) per
7 day.

8 (3) Upon federal approval or conditional federal approval
9 described in Section 14169.34, the director shall determine the
10 fee-for-service per diem quality assurance fee rate based on the
11 funds required to make the payments specified in Article 5.228
12 (commencing with Section 14169.1), in consultation with the
13 hospital community.

14 (k) “Fee-for-service days” means inpatient hospital days where
15 the service type is reported as “acute care,” “psychiatric care,” and
16 “rehabilitation care,” and the payer category is reported as
17 “Medicare traditional,” “county indigent programs-traditional,”
18 “other third parties-traditional,” “other indigent,” and “other
19 payers,” for purposes of the Annual Financial Disclosure Report
20 submitted by hospitals to the Office of Statewide Health Planning
21 and Development.

22 (l) “Fee percentage” means a fraction, expressed as a percentage,
23 the numerator of which is the amount of payments for each subject
24 fiscal year under Sections 14169.2, 14169.3, 14169.5, and
25 14169.7.5, for which federal financial participation is available
26 and the denominator of which is four billion eight hundred
27 ninety-seven million eight hundred sixty-six thousand nine hundred
28 thirty-seven dollars (\$4,897,866,937).

29 (m) “General acute care hospital” means any hospital licensed
30 pursuant to subdivision (a) of Section 1250 of the Health and Safety
31 Code.

32 (n) “Hospital community” means any hospital industry
33 organization or system that represents hospitals.

34 (o) “Managed care days” means inpatient hospital days where
35 the service type is reported as “acute care,” “psychiatric care,” and
36 “rehabilitation care,” and the payer category is reported as
37 “Medicare managed care,” “county indigent programs-managed
38 care,” and “other third parties-managed care,” for purposes of the
39 Annual Financial Disclosure Report submitted by hospitals to the
40 Office of Statewide Health Planning and Development.

1 (p) “Managed care per diem quality assurance fee rate” means
2 a fixed fee on managed care days of eighty-six dollars and forty
3 cents (\$86.40) per day.

4 (q) “Medi-Cal days” means inpatient hospital days where the
5 service type is reported as “acute care,” “psychiatric care,” and
6 “rehabilitation care,” and the payer category is reported as
7 “Medi-Cal traditional” and “Medi-Cal managed care,” for purposes
8 of the Annual Financial Disclosure Report submitted by hospitals
9 to the Office of Statewide Health Planning and Development.

10 (r) “Medi-Cal fee-for-service days” means inpatient hospital
11 days where the service type is reported as “acute care,” “psychiatric
12 care,” and “rehabilitation care,” and the payer category is reported
13 as “Medi-Cal traditional” for purposes of the Annual Financial
14 Disclosure Report submitted by hospitals to the Office of Statewide
15 Health Planning and Development.

16 (s) “Medi-Cal managed care days” means inpatient hospital
17 days as reported on the days data source where the service type is
18 reported as “acute care,” “psychiatric care,” and “rehabilitation
19 care,” and the payer category is reported as “Medi-Cal managed
20 care” for purposes of the Annual Financial Disclosure Report
21 submitted by hospitals to the Office of Statewide Health Planning
22 and Development.

23 (t) “Medi-Cal per diem quality assurance fee rate” means a fixed
24 fee on Medi-Cal days of three hundred eighty-three dollars and
25 twenty cents (\$383.20) per day.

26 (u) “New hospital” means a hospital operation, business, or
27 facility functioning under current or prior ownership as a private
28 hospital that does not have a days data source or a hospital that
29 has a days data source in whole, or in part, from a previous operator
30 where there is an outstanding monetary liability owed to the state
31 in connection with the Medi-Cal program and the new operator
32 did not assume liability for the outstanding monetary obligation.

33 (v) “Nondesignated public hospital” means either of the
34 following:

35 (1) A public hospital that is licensed under subdivision (a) of
36 Section 1250 of the Health and Safety Code, is not designated as
37 a specialty hospital in the hospital’s Annual Financial Disclosure
38 Report for the hospital’s latest fiscal year ending in 2009, and
39 satisfies the definition in paragraph (25) of subdivision (a) of
40 Section 14105.98, excluding designated public hospitals.

1 (2) A tax-exempt nonprofit hospital that is licensed under
2 subdivision (a) of Section 1250 of the Health and Safety Code, is
3 not designated as a specialty hospital in the hospital's Annual
4 Financial Disclosure Report for the hospital's latest fiscal year
5 ending in 2009, is operating a hospital owned by a local health
6 care district, and is affiliated with the health care district hospital
7 owner by means of the district's status as the nonprofit
8 corporation's sole corporate member.

9 (w) "Prepaid health plan hospital" means a hospital owned by
10 a nonprofit public benefit corporation that shares a common board
11 of directors with a nonprofit health care service plan.

12 (x) "Prepaid health plan hospital managed care per diem quality
13 assurance fee rate" means a fixed fee on non-Medi-Cal managed
14 care days for prepaid health plan hospitals of forty-eight dollars
15 and thirty-eight cents (\$48.38) per day.

16 (y) "Prepaid health plan hospital Medi-Cal managed care per
17 diem quality assurance fee rate" means a fixed fee on Medi-Cal
18 managed care days for prepaid health plan hospitals of two hundred
19 fourteen dollars and fifty-nine cents (\$214.59) per day.

20 (z) "Prior fiscal year data" means any data taken from sources
21 that the department determines are the most accurate and reliable
22 at the time the determination is made, or may be calculated from
23 the most recent audited data using appropriate update factors. The
24 data may be from prior fiscal years, current fiscal years, or
25 projections of future fiscal years.

26 (aa) "Private hospital" means a hospital that meets all of the
27 following conditions:

28 (1) Is licensed pursuant to subdivision (a) of Section 1250 of
29 the Health and Safety Code.

30 (2) Is in the Charitable Research Hospital peer group, as set
31 forth in the 1991 Hospital Peer Grouping Report published by the
32 department, or is not designated as a specialty hospital in the
33 hospital's Office of Statewide Health Planning and Development
34 Annual Financial Disclosure Report for the hospital's latest fiscal
35 year ending in 2009.

36 (3) Does not satisfy the Medicare criteria to be classified as a
37 long-term care hospital.

38 (4) Is a nonpublic hospital, nonpublic converted hospital, or
39 converted hospital as those terms are defined in paragraphs (26)

1 to (28), inclusive, respectively, of subdivision (a) of Section
 2 14105.98.

3 (ab) “Program period” means the period from July 1, 2011, to
 4 December 31, 2013, inclusive.

5 (ac) “Subject fiscal quarter” means a state fiscal quarter during
 6 the program period.

7 (ad) “Subject fiscal year” means a state fiscal year that ends
 8 after July 1, 2011, and begins before January 1, 2014.

9 (ae) “Upper payment limit” means a federal upper payment
 10 limit on the amount of the Medicaid payment for which federal
 11 financial participation is available for a class of service and a class
 12 of health care providers, as specified in Part 447 of Title 42 of the
 13 Code of Federal Regulations. The applicable upper payment limit
 14 shall be separately calculated for inpatient and outpatient hospital
 15 services.

16 *SEC. 103. Section 14169.32 of the Welfare and Institutions*
 17 *Code is amended to read:*

18 14169.32. (a) There shall be imposed on each general acute
 19 care hospital that is not an exempt facility a quality assurance fee,
 20 provided that a quality assurance fee under this article shall not be
 21 imposed on a converted hospital.

22 (b) The quality assurance fee shall be computed starting on July
 23 1, 2011, and continue through and including December 31, 2013.

24 (c) Subject to Section 14169.34, upon receipt of federal
 25 approval, the following shall become operative:

26 (1) Within 10 business days following receipt of the notice of
 27 federal approval from the federal government, the department shall
 28 send notice to each hospital subject to the quality assurance fee,
 29 and publish on its Internet Web site, the following information:

30 (A) The date that the state received notice of federal approval.

31 (B) The fee percentage for each subject fiscal year.

32 (2) The notice to each hospital subject to the quality assurance
 33 fee shall also state the following:

34 (A) The aggregate quality assurance fee after the application of
 35 the fee percentage for each subject fiscal year.

36 (B) The aggregate quality assurance fee.

37 (C) The amount of each payment due from the hospital with
 38 respect to the aggregate quality assurance fee.

39 (D) The date on which each payment is due.

1 (3) The hospitals shall pay the aggregate quality assurance fee
2 in 10 equal installments. The department shall establish the date
3 that each installment is due, provided that the first installment shall
4 be due no earlier than 20 days following the department sending
5 the notice pursuant to paragraph (1), and the installments shall be
6 paid at least one month apart, but if possible, the installments shall
7 be paid on a quarterly basis.

8 (4) Notwithstanding paragraph (3), the amount of each hospital's
9 aggregate quality assurance fee after the application of the fee
10 percentage that has not been paid by the hospital before December
11 15, 2013, pursuant to paragraph (3), shall be paid by the hospital
12 no later than December 15, 2013.

13 (d) The quality assurance fee, as paid pursuant to this section,
14 shall be paid by each hospital subject to the fee to the department
15 for deposit in the Hospital Quality Assurance Revenue Fund.
16 Deposits may be accepted at any time and will be credited toward
17 the program period.

18 (e) This section shall become inoperative if the federal Centers
19 for Medicare and Medicaid Services denies approval for, or does
20 not approve before July 1, 2014, the implementation of *the quality*
21 *assurance fee pursuant to this article or Article 5.228 (commencing*
22 ~~with Section 14169.1)~~ *the supplemental payments to private*
23 *hospitals described in Sections 14169.2 and 14169.3, and either*
24 ~~or both articles provisions~~ *cannot be modified by the department*
25 *pursuant to subdivision (d) of Section 14169.33 in order to meet*
26 *the requirements of federal law or to obtain federal approval.*

27 (f) In no case shall the aggregate fees collected in a federal fiscal
28 year pursuant to this section, Section 14167.32, and Section
29 14168.32 exceed the maximum percentage of the annual aggregate
30 net patient revenue for hospitals subject to the fee that is prescribed
31 pursuant to federal law and regulations as necessary to preclude a
32 finding that an indirect guarantee has been created.

33 (g) (1) Interest shall be assessed on quality assurance fees not
34 paid on the date due at the greater of 10 percent per annum or the
35 rate at which the department assesses interest on Medi-Cal program
36 overpayments to hospitals that are not repaid when due. Interest
37 shall begin to accrue the day after the date the payment was due
38 and shall be deposited in the Hospital Quality Assurance Revenue
39 Fund.

1 (2) In the event that any fee payment is more than 60 days
2 overdue, a penalty equal to the interest charge described in
3 paragraph (1) shall be assessed and due for each month for which
4 the payment is not received after 60 days.

5 (h) When a hospital fails to pay all or part of the quality
6 assurance fee on or before the date that payment is due, the
7 department may immediately begin to deduct the unpaid assessment
8 and interest from any Medi-Cal payments owed to the hospital,
9 or, in accordance with Section 12419.5 of the Government Code,
10 from any other state payments owed to the hospital until the full
11 amount is recovered. All amounts, except penalties, deducted by
12 the department under this subdivision shall be deposited in the
13 Hospital Quality Assurance Revenue Fund. The remedy provided
14 to the department by this section is in addition to other remedies
15 available under law.

16 (i) The payment of the quality assurance fee shall not be
17 considered as an allowable cost for Medi-Cal cost reporting and
18 reimbursement purposes.

19 (j) The department shall work in consultation with the hospital
20 community to implement this article and Article 5.228
21 (commencing with Section 14169.1).

22 (k) This subdivision creates a contractually enforceable promise
23 on behalf of the state to use the proceeds of the quality assurance
24 fee, including any federal matching funds, solely and exclusively
25 for the purposes set forth in this article as they existed on the
26 effective date of this article, to limit the amount of the proceeds
27 of the quality assurance fee to be used to pay for the health care
28 coverage of children to the amounts specified in this article, to
29 limit any payments for the department's costs of administration
30 to the amounts set forth in this article on the effective date of this
31 article, to maintain and continue prior reimbursement levels as set
32 forth in Section 14169.12 on the effective date of that article, and
33 to otherwise comply with all its obligations set forth in Article
34 5.228 (commencing with Section 14169.1) and this article provided
35 that amendments that arise from, or have as a basis, a decision,
36 advice, or determination by the federal Centers for Medicare and
37 Medicaid Services relating to federal approval of the quality
38 assurance fee or the payments set forth in this article or Article
39 5.228 (commencing with Section 14169.1) shall control for the
40 purposes of this subdivision.

1 ~~(l) For the purpose of this article, references to the receipt of~~
2 ~~notice by the state of federal approval of the implementation of~~
3 ~~this article shall refer to the last date that the state receives notice~~
4 ~~of all federal approval or waivers required for implementation of~~
5 ~~this article and Article 5.228 (commencing with Section 14169.1).~~

6 ~~(m)~~

7 (l) (1) Effective January 1, 2014, the rates payable to hospitals
8 and managed health care plans under Medi-Cal shall be the rates
9 then payable without the supplemental and increased capitation
10 payments set forth in Article 5.228 (commencing with Section
11 14169.1).

12 (2) The supplemental payments and other payments under
13 Article 5.228 (commencing with Section 14169.1) shall be regarded
14 as quality assurance payments, the implementation or suspension
15 of which does not affect a determination of the adequacy of any
16 rates under federal law.

17 ~~(n)~~

18 (m) (1) Subject to paragraph (2), the director may waive any
19 or all interest and penalties assessed under this article in the event
20 that the director determines, in his or her sole discretion, that the
21 hospital has demonstrated that imposition of the full quality
22 assurance fee on the timelines applicable under this article has a
23 high likelihood of creating a financial hardship for the hospital or
24 a significant danger of reducing the provision of needed health
25 care services.

26 (2) Waiver of some or all of the interest or penalties under this
27 subdivision shall be conditioned on the hospital's agreement to
28 make fee payments, or to have the payments withheld from
29 payments otherwise due from the Medi-Cal program to the hospital,
30 on a schedule developed by the department that takes into account
31 the financial situation of the hospital and the potential impact on
32 services.

33 (3) A decision by the director under this subdivision shall not
34 be subject to judicial review.

35 (4) If fee payments are remitted to the department after the date
36 determined by the department to be the final date for calculating
37 the final supplemental payments under this article and Article
38 5.228 (commencing with Section 14169.1), the fee payments shall
39 be retained in the fund for purposes of funding supplemental
40 payments supported by a hospital quality assurance fee program

1 implemented under subsequent legislation, provided, however,
 2 that if supplemental payments are not implemented under
 3 subsequent legislation, then those fee payments shall be deposited
 4 in the Distressed Hospital Fund.

5 (5) If during the implementation of this article, fee payments
 6 that were due under Article 5.21 (commencing with Section
 7 14167.1) and Article 5.22 (commencing with Section 14167.31),
 8 or Article 5.226 (commencing with Section 14168.1) and Article
 9 5.227 (commencing with Section 14168.31), are remitted to the
 10 department under a payment plan or for any other reason, and the
 11 final date for calculating the final supplemental payments under
 12 those articles has passed, then those fee payments shall be
 13 deposited in the fund to support the uses established by this article.

14 *SEC. 104. Section 14169.33 of the Welfare and Institutions*
 15 *Code is amended to read:*

16 14169.33. (a) (1) All fees required to be paid to the state
 17 pursuant to this article shall be paid in the form of remittances
 18 payable to the department.

19 (2) The department shall directly transmit the fee payments to
 20 the Treasurer to be deposited in the Hospital Quality Assurance
 21 Revenue Fund, created pursuant to Section 14167.35.
 22 Notwithstanding Section 16305.7 of the Government Code, any
 23 interest and dividends earned on deposits in the fund from the
 24 proceeds of the fee assessed pursuant to this article shall be retained
 25 in the fund for purposes specified in subdivision (b).

26 (b) Notwithstanding subdivision (c) of Section 14167.35 and
 27 subdivision (b) of Section 14168.33, all funds from the proceeds
 28 of the fee assessed pursuant to this article in the Hospital Quality
 29 Assurance Revenue Fund, together with any interest and dividends
 30 earned on money in the fund, shall, upon appropriation by the
 31 Legislature, continue to be used exclusively to enhance federal
 32 financial participation for hospital services under the Medi-Cal
 33 program, to provide additional reimbursement to, and to support
 34 quality improvement efforts of, hospitals, and to minimize
 35 uncompensated care provided by hospitals to uninsured patients,
 36 as well as to pay for the state’s administrative costs and to provide
 37 funding for children’s health coverage, in the following order of
 38 priority:

39 (1) To pay for the department’s staffing and administrative costs
 40 directly attributable to implementing Article 5.228 (commencing

1 with Section 14169.1) and this article, not to exceed two million
2 five hundred thousand dollars (\$2,500,000) for the program period.

3 (2) To pay for the health care coverage for children in the
4 amount of eighty-five million dollars (\$85,000,000) for each
5 subject fiscal quarter during the 2011–12 subject fiscal year, ~~and~~
6 ~~in the amount of ninety-six million seven hundred fifty thousand~~
7 ~~dollars (\$96,750,000) for each subject fiscal quarter during the~~
8 ~~2012–13 and 2013–14 subject fiscal years~~ *in the amount of one*
9 *hundred thirty-four million two hundred fifty thousand dollars*
10 *(\$134,250,000) for each subject fiscal quarter during the 2012–13*
11 *subject fiscal year, and in the amount of one hundred forty-four*
12 *million two hundred fifty thousand dollars (\$144,250,000) for each*
13 *subject fiscal quarter during the 2013–14 subject fiscal year.*

14 (3) To make increased capitation payments to managed health
15 care plans pursuant to Article 5.228 (commencing with Section
16 14169.1).

17 (4) To reimburse the General Fund for the increase in the overall
18 compensation to a private hospital that is attributable to its change
19 in status from contract hospital to noncontract hospital, pursuant
20 to subdivision (a) of Section 14169.10.

21 (5) To make increased payments or grants to hospitals pursuant
22 to Article 5.228 (commencing with Section 14169.1).

23 (6) To make increased payments to mental health plans pursuant
24 to Article 5.228 (commencing with Section 14169.1).

25 (7) To make supplemental payments for out-of-network
26 emergency and poststabilization services provided by private
27 hospitals and nondesignated public hospitals to Medi-Cal expansion
28 enrollees in the Low Income Health Program in the amount of
29 thirty-seven million five hundred thousand dollars (\$37,500,000)
30 for each fiscal quarter pursuant to Section 14169.7.5.

31 (c) Any amounts of the quality assurance fee collected in excess
32 of the funds required to implement subdivision (b), including any
33 funds recovered under subdivision (d) of Section 14169.13 or
34 subdivision (e) of Section 14169.38, shall be refunded to general
35 acute care hospitals, pro rata with the amount of quality assurance
36 fee paid by the hospital, subject to the limitations of federal law.
37 If federal rules prohibit the refund described in this subdivision,
38 the excess funds shall be deposited in the Distressed Hospital Fund
39 to be used for the purposes described in Section 14166.23, and
40 shall be supplemental to and not supplant existing funds.

1 (d) Any methodology or other provision specified in Article
2 5.228 (commencing with Section 14169.1) or this article may be
3 modified by the department, in consultation with the hospital
4 community, to the extent necessary to meet the requirements of
5 federal law or regulations to obtain federal approval or to enhance
6 the probability that federal approval can be obtained, provided the
7 modifications do not violate the spirit and intent of Article 5.228
8 (commencing with Section 14169.1) or this article and are not
9 inconsistent with the conditions of implementation set forth in
10 Section 14169.40.

11 (e) The department, in consultation with the hospital community,
12 shall make adjustments, as necessary, to the amounts calculated
13 pursuant to Section 14169.32 in order to ensure compliance with
14 the federal requirements set forth in Section 433.68 of Title 42 of
15 the Code of Federal Regulations or elsewhere in federal law.

16 (f) The department shall request approval from the federal
17 Centers for Medicare and Medicaid Services for the implementation
18 of this article. In making this request, the department shall seek
19 specific approval from the federal Centers for Medicare and
20 Medicaid Services to exempt providers identified in this article as
21 exempt from the fees specified, including the submission, as may
22 be necessary, of a request for waiver of the broad-based
23 requirement, waiver of the uniform fee requirement, or both,
24 pursuant to paragraphs (1) and (2) of subdivision (e) of Section
25 433.68 of Title 42 of the Code of Federal Regulations.

26 (g) Notwithstanding Chapter 3.5 (commencing with Section
27 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
28 the department may implement this article or Article 5.228
29 (commencing with Section 14169.1) by means of provider
30 bulletins, all plan letters, or other similar instruction, without taking
31 regulatory action. The department shall also provide notification
32 to the Joint Legislative Budget Committee and to the appropriate
33 policy and fiscal committees of the Legislature within five working
34 days when the above-described action is taken in order to inform
35 the Legislature that the action is being implemented.

36 *SEC. 105. Section 14169.34 of the Welfare and Institutions*
37 *Code is amended to read:*

38 14169.34. (a) Notwithstanding any other provision of this
39 article or Article 5.228 (commencing with Section 14169.1)
40 requiring federal approvals, the department may impose and collect

1 the quality assurance fee and may make payments under this article
2 and Article 5.228 (commencing with Section 14169.1), including
3 increased capitation payments, based upon receiving a letter from
4 the federal Centers for Medicare and Medicaid Services or the
5 United States Department of Health and Human Services that
6 indicates likely federal approval, but only if and to the extent that
7 the letter is sufficient as set forth in subdivision (b).

8 (b) In order for the letter to be sufficient under this section, the
9 director shall find that the letter meets both of the following
10 requirements:

11 (1) The letter is in writing and signed by an official of the federal
12 Centers for Medicare and Medicaid Services or an official of the
13 United States Department of Health and Human Services.

14 (2) The director, after consultation with the hospital community,
15 has determined, in the exercise of his or her sole discretion, that
16 the letter provides a sufficient level of assurance to justify advanced
17 implementation of the fee and payment provisions.

18 (c) Nothing in this section shall be construed as modifying the
19 requirement under Section 14169.13 that payments shall be made
20 only to the extent a sufficient amount of funds collected as the
21 quality assurance fee are available to cover the nonfederal share
22 of those payments.

23 (d) Upon notice from the federal government that final federal
24 approval for the fee model under this article or for ~~any payment~~
25 ~~method under Article 5.228 (commencing with Section 14169.1)~~
26 *the supplemental payments to private hospitals under Section*
27 *14169.2 or 14169.3* has been denied, any fees collected pursuant
28 to this section shall be refunded and any payments made pursuant
29 to this article or Article 5.228 (commencing with Section 14169.1)
30 shall be recouped, including, but not limited to, supplemental
31 payments, increased capitation payments, payments to hospitals
32 by health care plans resulting from the increased capitation
33 payments, increased payments to mental health plans, and payments
34 for the health care coverage of children. To the extent fees were
35 paid by a hospital that also received payments under this section,
36 the payments may first be recouped from fees that would otherwise
37 be refunded to the hospital prior to the use of any other recoupment
38 method allowed under law.

39 (e) Any payment made pursuant to this section shall be a
40 conditional payment until ~~all final federal approvals necessary to~~

1 ~~fully implement this article and Article 5.228 (commencing with~~
2 ~~Section 14169.1) have approval has~~ been received.

3 (f) The director shall have broad authority under this section to
4 collect the quality assurance fee for an interim period after receipt
5 of the letter described in subdivision (a) pending receipt of all
6 necessary federal approvals. This authority shall include discretion
7 to determine both of the following:

8 (1) Whether the quality assurance fee should be collected on a
9 full or pro rata basis during the interim period.

10 (2) The dates on which payments of the quality assurance fee
11 are due.

12 (g) The department may draw against the Hospital Quality
13 Assurance Revenue Fund for all administrative costs associated
14 with implementation under this article or Article 5.228
15 (commencing with Section 14169.1).

16 (h) This section shall be implemented only to the extent federal
17 financial participation is not jeopardized by implementation prior
18 to the receipt of all necessary final federal approvals.

19 *SEC. 106. Section 14169.36 of the Welfare and Institutions*
20 *Code is amended to read:*

21 14169.36. (a) Upon receipt of a letter that indicates likely
22 federal approval that the director determines is sufficient for
23 implementation under Section 14169.34, or upon the receipt of ~~all~~
24 ~~final federal approvals necessary for the implementation of this~~
25 ~~article and Article 5.228 (commencing with Section 14169.1)~~
26 *approval*, the following shall occur:

27 (1) To the maximum extent possible, and consistent with the
28 availability of funds in the Hospital Quality Assurance Revenue
29 Fund, the department shall make all of the payments under Sections
30 14169.2, 14169.3, 14169.5, 14169.7, and 14169.7.5, including,
31 but not limited to, supplemental payments and increased capitation
32 payments, prior to January 1, ~~2014~~ 2014, *except that the increased*
33 *capitation payments under Section 14169.5 shall not be made until*
34 *federal approval is obtained for these payments.*

35 (2) The department shall make supplemental payments to
36 hospitals under Article 5.228 (commencing with Section 14169.1)
37 consistent with the timeframe described in Section 14169.11 or a
38 modified timeline developed pursuant to Section 14169.35.

39 (b) Notwithstanding any other provision of this article or Article
40 5.228 (commencing with Section 14169.1), if the director

1 determines, on or after December 15, 2013, that there are
2 insufficient funds available in the Hospital Quality Assurance
3 Revenue Fund to make all scheduled payments under Article 5.228
4 (commencing with Section 14169.1) before January 1, 2014, he
5 or she shall consult with representatives of the hospital community
6 to develop an acceptable plan for making additional payments to
7 hospitals and managed health care plans to maximize the use of
8 delinquent fee payments or other deposits or interest projected to
9 become available in the fund after December 15, 2013, but before
10 June 15, 2014.

11 (c) Nothing in this section shall require the department to
12 continue to make payments under Article 5.228 (commencing with
13 Section 14169.1) if, after the consultation required under
14 subdivision (b), the director determines in the exercise of his or
15 her sole discretion that a workable plan for the continued payments
16 cannot be developed.

17 (d) Subdivisions (b) and (c) shall be implemented only if and
18 to the extent federal financial participation is available for
19 continued supplemental payments and to providers and continued
20 increased capitation payments to managed health care plans.

21 (e) If any payment or payments made pursuant to this section
22 are found to be inconsistent with federal law, the department shall
23 recoup the payments by means of withholding or any other
24 available remedy.

25 (f) Nothing in this section shall be read as affecting the
26 department's ongoing authority to continue, after December 31,
27 2013, to collect quality assurance fees imposed on or before
28 December 31, 2013.

29 *SEC. 107. Section 14169.38 of the Welfare and Institutions*
30 *Code is amended to read:*

31 14169.38. (a) This article shall be implemented only as long
32 as all of the following conditions are met:

33 (1) Subject to Section 14169.33, the quality assurance fee is
34 established in a manner that is fundamentally consistent with this
35 article.

36 (2) The quality assurance fee, including any interest on the fee
37 after collection by the department, is deposited in a segregated
38 fund apart from the General Fund.

1 (3) The proceeds of the quality assurance fee, including any
 2 interest and related federal reimbursement, may only be used for
 3 the purposes set forth in this article.

4 (b) No hospital shall be required to pay the quality assurance
 5 fee to the department unless and until the state receives and
 6 maintains federal approval ~~of the quality assurance fee as set forth~~
 7 ~~in this article and Article 5.228 (commencing with Section~~
 8 ~~14169.1) from the federal Centers for Medicare and Medicaid~~
 9 ~~Services.~~

10 (c) Hospitals shall be required to pay the quality assurance fee
 11 to the department as set forth in this article only as long as all of
 12 the following conditions are met:

13 (1) The federal Centers for Medicare and Medicaid Services
 14 allows the use of the quality assurance fee as set forth in this article
 15 *in accordance with federal approval.*

16 (2) Article 5.228 (commencing with Section 14169.1) is enacted
 17 and remains in effect and hospitals are reimbursed the increased
 18 rates for services during the program period, as defined in Section
 19 14169.1.

20 (3) The full amount of the quality assurance fee assessed and
 21 collected pursuant to this article remains available only for the
 22 purposes specified in this article.

23 (d) This article shall become inoperative if either of the
 24 following occurs:

25 (1) In the event, and on the effective date, of a final judicial
 26 determination made by any court of appellate jurisdiction or a final
 27 determination by the United States Department of Health and
 28 Human Services or the federal Centers for Medicare and Medicaid
 29 Services ~~that any element of the quality assurance fee established~~
 30 ~~pursuant to this article or any provision of Section 14166.115~~
 31 ~~cannot be implemented.~~

32 (2) In the event both of the following conditions exist:

33 (A) The federal Centers for Medicare and Medicaid Services
 34 denies approval for, or does not approve before January 1, 2014,
 35 the implementation of ~~Article 5.228 (commencing with Section~~
 36 ~~14169.1) Sections 14169.2 and 14169.3~~ or this article.

37 (B) ~~Either or both articles Section 14169.2, Section 14169.3, or~~
 38 ~~this article~~ cannot be modified by the department pursuant to
 39 subdivision (d) of Section 14169.33 in order to meet the
 40 requirements of federal law or to obtain federal approval.

1 (e) If this article becomes inoperative pursuant to paragraph (1)
2 of subdivision (d) and the determination applies to any period or
3 periods of time prior to the effective date of the determination, the
4 department may recoup all payments made pursuant to Article
5 5.228 (commencing with Section 14169.1) during that period or
6 those periods of time.

7 (f) (1) In the event that all necessary final federal approvals are
8 not received as described and anticipated under this article or
9 Article 5.228 (commencing with Section 14169.1), the director
10 shall have the discretion and authority to develop procedures for
11 recoupment from managed health care plans, and from hospitals
12 under contract with managed health care plans, of any amounts
13 received pursuant to this article or Article 5.228 (commencing
14 with Section 14169.1).

15 (2) Any procedure instituted pursuant to this subdivision shall
16 be developed in consultation with representatives from managed
17 health care plans and representatives of the hospital community.

18 (3) Any procedure instituted pursuant to this subdivision shall
19 be in addition to all other remedies made available under the law,
20 pursuant to contracts between the department and the managed
21 health care plans, or pursuant to contracts between the managed
22 health care plans and the hospitals.

23 *SEC. 108. Section 14171 of the Welfare and Institutions Code*
24 *is amended to read:*

25 14171. (a) The director shall establish administrative appeal
26 processes to review grievances or complaints arising from the
27 findings of an audit or examination made pursuant to Sections
28 10722 and 14170 and for final settlements, including, in the case
29 of hospitals, the application of Sections 51536, 51537, and 51539
30 of Title 22 of the California Code of Regulations. All these
31 processes shall be established by regulation, pursuant to, and
32 consistent with, Section 100171 of the Health and Safety Code.

33 (b) Different administrative appeal processes may be established
34 by the director for grievances or complaints arising from the
35 determinations of a tentative or final settlement based on audit or
36 examination findings made by or on behalf of the department
37 pursuant to Sections 10722 and 14170. However, consistent with
38 existing practice, no administrative appeal shall be available for
39 tentative settlement of cost reports.

1 (c) The administrative appeal process established by the director
2 for tentative settlements, including, in the case of hospitals, the
3 application of Sections 51536, 51537, and 51539 of Title 22 of
4 the California Code of Regulations shall be an informal process
5 which, however, guarantees a provider the right to present any
6 grievance or complaint to the department in writing. Any
7 subsequent hearings shall be conducted in an informal manner and
8 shall be held at the discretion of the department.

9 (d) The time limitations in subdivisions (e) and (f) for the
10 impartial hearing and the final decisions are mandatory. If the
11 department fails to conduct the hearing or to adopt a final decision
12 thereon within the time limitations provided in subdivisions (e)
13 and (f), the amount of any overpayment which is ultimately
14 determined by the department to be due shall be reduced by 10
15 percent for each 30-day period, or portion thereof, that the hearing
16 or the decision, or both, are delayed beyond the time limitations
17 provided in subdivisions (e) and (f). However, the time period
18 shall be extended by either of the following:

19 (1) Delay caused by a provider.

20 (2) Extensions of time granted a provider at its sole request or
21 at the joint request of the provider and the department.

22 (e) (1) The administrative appeal process established by the
23 director shall commence with an informal conference with the
24 provider, a representative of the department, and the administrative
25 law judge. The informal conference shall be conducted no later
26 than 90 days after the filing of a timely and specific statement of
27 disputed issues by the provider. The administrative law judge,
28 when appropriate, may assign the administrative appeal to an
29 informal level of review where efforts could be made to resolve
30 facts and issues in dispute in a fair and equitable manner, subject
31 to the requirements of state and federal law. The review conducted
32 at this informal level shall be completed no later than 180 days
33 after the filing of a timely and specific statement of disputed issues
34 by the provider.

35 (2) Nothing in this subdivision shall prohibit the provider from
36 presenting any unresolved grievances or complaints at an impartial
37 hearing pursuant to subdivision (a). The impartial hearing shall be
38 conducted no later than 300 days after the filing of a timely and
39 specific statement of disputed issues by the provider.

1 (3) (A) Subject to subdivision (f), a final decision in a
2 noninstitutional provider appeal shall be adopted within 180 days
3 after the closure of the record of the impartial hearing, and a final
4 decision in an institutional provider appeal shall be adopted within
5 300 days after the closure of the record of the impartial hearing.

6 (B) The department shall mail a copy of the adopted decision
7 to all parties within 30 days of the date of adoption of the decision.

8 (f) In the event the director intends to modify a proposed
9 decision, on or before the 180th day following the closure of the
10 record of the hearing for noninstitutional providers or the 300th
11 day following the closure of the record of the hearing for
12 institutional providers, the director shall provide written notice of
13 his or her intention to the parties and shall afford the parties an
14 opportunity to present written argument. Following this notice, on
15 or before the 240th day following the closure of the record of the
16 hearing for noninstitutional providers or the 420th day following
17 closure of the record of the hearing for institutional providers, or
18 within that additional time period as is granted pursuant to the sole
19 request of a provider or at the joint request of the provider and the
20 department, the director shall issue a final decision.

21 (g) In the event recovery of a disallowed payment has been
22 made by the department, a provider who prevails in an appeal of
23 a disallowed payment shall be entitled to interest at the rate equal
24 to the monthly average received on investments in the Surplus
25 Money Investment Fund, *or simple interest at the rate of 7 percent*
26 *per annum, whichever is higher*, commencing on the date the
27 appeal is formally accepted by the department or the date payment
28 is received by the department, whichever is later.

29 (h) Except as provided in subdivision (i), commencing 60 days
30 after issuance of the first statement of account status or demand
31 for repayment resulting from an audit or examination made
32 pursuant to Sections 10722 and 14170, interest at the rate equal to
33 the monthly average received on investments in the Surplus Money
34 Investment Fund during the month the first statement of account
35 status or demand for repayment was issued, *or simple interest at*
36 *the rate of 7 percent per annum, whichever is higher*, shall be
37 assessed against any unrecovered overpayment due to the
38 department.

39 (i) (1) Commencing on the day following the last day of the
40 period covered by an audit or examination made pursuant to

1 Sections 10722 and 14170, interest at the rate established under
2 Section 19269 of the Revenue and Taxation Code which is in effect
3 on the date of the commencement of that interest shall be assessed
4 against any unrecovered overpayment due to the department by
5 providers of durable medical equipment or incontinence supplies.

6 (2) Interest which accrues under this subdivision for recoupment
7 of an overpayment based on the lack of medical necessity for a
8 previously approved claim shall commence to accrue on the date
9 of written demand by the department.

10 (j) The final decision of the director shall be reviewable in
11 accordance with Section 1094.5 of the Code of Civil Procedure
12 within six months of the issuance of the director's final decision.

13 *SEC. 109. Section 14182.4 of the Welfare and Institutions Code*
14 *is amended to read:*

15 14182.4. (a) To the extent authorized under a federal waiver
16 or demonstration project described in Section 14180 that is
17 approved by the federal Centers for Medicare and Medicaid
18 Services, the department shall establish a program of investment,
19 improvement, and incentive payments for designated public
20 hospitals *and, to the extent federal approval is obtained pursuant*
21 *to subdivision (c) of Section 14166.155, for nondesignated public*
22 *hospitals* to encourage and incentivize delivery system
23 transformation and innovation in preparation for the
24 implementation of federal health care reform.

25 (b) The Public Hospital Investment, Improvement, and Incentive
26 Fund is hereby established in the State Treasury. Notwithstanding
27 Section 13340 of the Government Code, moneys in the fund shall
28 be continuously appropriated, without regard to fiscal years, to the
29 department for the purposes specified in this section.

30 (c) The fund shall consist of any moneys that a county, other
31 political subdivision of the state, or other governmental entity in
32 the state that may elect to transfer to the department for deposit
33 into the fund, as permitted under Section 433.51 of Title 42 of the
34 Code of Federal Regulations or any other applicable federal
35 Medicaid laws.

36 (d) Moneys in the fund shall be used as the source for the
37 nonfederal share of investment, improvement, and incentive
38 payments as authorized under a federal waiver or demonstration
39 project to participating designated public hospitals *and, to the*
40 *extent federal approval is obtained pursuant to subdivision (c) of*

1 *Section 14166.155, to nondesignated public hospitals, defined in*
2 ~~subdivision (d) subdivisions (d) and (f) of Section 14166.1~~
3 *respectively, and the governmental entities with which they are*
4 *affiliated, that provide the intergovernmental transfers for deposit*
5 *into the fund, and to nondesignated public hospitals and private*
6 ~~disproportionate share hospitals as authorized under Section~~
7 ~~14182.45, as long as the payments are made to support and reward~~
8 ~~the pursuit of delivery system improvements.~~

9 (e) The department shall obtain federal financial participation
10 for moneys in the fund to the full extent permitted by law. Moneys
11 shall be allocated from the fund by the department and ~~matched~~
12 ~~by used as the nonfederal share for claiming federal funds in~~
13 *accordance with the Special Terms and Conditions of the waiver*
14 *or demonstration project and Section 14167.77, and in accordance*
15 ~~with Section 14182.45~~ *Sections 14166.77 and 14166.155, to the*
16 *extent federal approval is obtained pursuant to subdivision (c) of*
17 *Section 14166.151, as applicable. The moneys disbursed from the*
18 *fund, and all associated federal financial participation, shall be*
19 *distributed solely only to the designated public hospitals and the*
20 *governmental entities with which they are affiliated, and to other*
21 ~~eligible hospitals as may be provided for under Section 14182.45~~
22 *the extent federal approval is obtained pursuant to subdivision (c)*
23 *of Section 14166.155, to nondesignated public hospitals as*
24 *described in subdivision (a) and the governmental entities with*
25 *which they are affiliated.*

26 (f) Participation under this section is voluntary on the part of
27 the county or other political subdivision for purposes of all
28 applicable federal laws. As part of its voluntary participation in
29 the nonfederal share of payments under this section, the county or
30 other political subdivision agrees to reimburse the state for the
31 nonfederal share of state staffing or administrative costs directly
32 attributable to implementation of this section. This section shall
33 be implemented only to the extent federal financial participation
34 is not jeopardized.

35 (g) Notwithstanding the rulemaking provisions of Chapter 3.5
36 (commencing with Section 11340) of Part 1 of Division 3 of Title
37 2 of the Government Code, the department may clarify, interpret,
38 or implement the provisions of this section by means of provider
39 bulletins or similar instructions. The department shall notify the
40 fiscal and appropriate policy committees of the Legislature of its

1 intent to issue instructions under this section at least five days in
2 advance of the issuance.

3 *SEC. 110. Section 14182.45 of the Welfare and Institutions*
4 *Code is amended to read:*

5 14182.45. (a) In consultation with the designated public
6 hospitals, as defined in subdivision (d) of Section 14166.1, and to
7 the extent it does not impede the ability of the designated public
8 hospitals to meet the requirements and conditions for delivery
9 system reform incentive payments authorized under Sections
10 14166.77 and 14182.4, the state may provide for milestone
11 incentive payments to private disproportionate share hospitals and
12 nondesignated public disproportionate share hospitals to create
13 incentives for improvement activities towards, and achievement
14 of, delivery system transformation. The milestone incentive
15 payments to private disproportionate share hospitals and
16 nondesignated public disproportionate share hospitals shall be
17 structured in accordance with the requirements and conditions for
18 delivery system reform incentive payments set forth in the Special
19 Terms and Conditions and as approved by the federal Centers for
20 Medicare and Medicaid Services. Incentive payments may be
21 funded by voluntary intergovernmental transfers made by the
22 designated public hospitals and nondesignated public hospitals.
23 All incentive pool funding, including any potential private and
24 nondesignated public hospital subpools, shall be limited to the
25 total amount of incentive pool funding allowed for delivery system
26 reform incentive payments as set forth in the Special Terms and
27 Conditions.

28 (b) *Upon federal approval of the reimbursement methodology*
29 *in subdivision (b) of Section 14166.151, this section shall become*
30 *inoperative.*

31 *SEC. 111. Section 14183.6 of the Welfare and Institutions Code*
32 *is amended to read:*

33 14183.6. The department shall enter into an interagency
34 agreement with the Department of Managed Health Care to have
35 the Department of Managed Health Care, on behalf of the
36 department, conduct financial audits, medical surveys, and a review
37 of the provider networks of the managed care health plans
38 participating in the demonstration project *and the Medi-Cal*
39 *managed care expansion into rural counties, and to provide*
40 *consumer assistance to beneficiaries affected by Sections 14182.16*

1 *and 14182.17.* The interagency agreement shall be updated, as
2 necessary, on an annual basis in order to maintain functional clarity
3 regarding the roles and responsibilities of these core activities. The
4 department shall not delegate its authority under this division to
5 the Department of Managed Health Care.

6 *SEC. 112. Section 14204 of the Welfare and Institutions Code*
7 *is amended to read:*

8 14204. (a) Pursuant to the provisions of this chapter, the
9 department may contract with one or more prepaid health plans in
10 order to provide the benefits authorized under this chapter and
11 Chapter 7 (commencing with Section 14000) of this part. The
12 department may contract with one or more children's hospitals on
13 an exclusive basis for a specified population in a specified
14 geographic area. Contracts entered into pursuant to this chapter
15 may be awarded on a bid or nonbid basis.

16 (b) In order to achieve maximum cost savings the Legislature
17 hereby determines that expedited contract process for contracts
18 under this chapter is necessary. Therefore, contracts under this
19 chapter shall be exempt from Chapter 2 (commencing with Section
20 10290) of Part 2 of Division 2 of the Public Contract Code.

21 (c) *The department shall amend contracts with dental health*
22 *plans in effect on the date the act that added this subdivision and*
23 *Section 14459.6 become effective to provide Medi-Cal dental*
24 *services authorized under this chapter and Chapter 7 (commencing*
25 *with Section 14000) to Medi-Cal beneficiaries who reside in a*
26 *specified geographic area to meet the requirements of Sections*
27 *14089.09 and 14459.6.*

28 *SEC. 113. Section 14301.1 of the Welfare and Institutions Code*
29 *is amended to read:*

30 14301.1. (a) For rates established on or after August 1, 2007,
31 the department shall pay capitation rates to health plans
32 participating in the Medi-Cal managed care program using actuarial
33 methods and may establish health-plan- and county-specific rates.
34 The department shall utilize a county- and model-specific rate
35 methodology to develop Medi-Cal managed care capitation rates
36 for contracts entered into between the department and any entity
37 pursuant to Article 2.7 (commencing with Section 14087.3), Article
38 2.8 (commencing with Section 14087.5), and Article 2.91
39 (commencing with Section 14089) of Chapter 7 that includes, but
40 is not limited to, all of the following:

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

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

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

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

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

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

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

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

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

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

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

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

1 (h) For the purposes of developing capitation rates through
2 implementation of this ratesetting methodology, Medi-Cal managed
3 care health plans shall provide the department with financial and
4 utilization data in a form and substance as deemed necessary by
5 the department to establish rates. This data shall be considered
6 proprietary and shall be exempt from disclosure as official
7 information pursuant to subdivision (k) of Section 6254 of the
8 Government Code as contained in the California Public Records
9 Act (Division 7 (commencing with Section 6250) of Title 1 of the
10 Government Code).

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

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

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

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

28 SEC. 114. *Section 14459.6 is added to the Welfare and*
29 *Institutions Code, to read:*

30 14459.6. (a) *The department shall establish a list of*
31 *performance measures to ensure dental health plans meet quality*
32 *criteria required by the department. The list shall specify the*
33 *benchmarks used by the department to determine whether and the*
34 *extent to which a dental health plan meets each performance*
35 *measure. Commencing January 1, 2013, and quarterly thereafter,*
36 *the list of performance measures established by the department*
37 *along with each plan's performance shall be posted on the*
38 *department's Internet Web site. The Department of Managed*
39 *Health Care and the advisory committee established pursuant to*
40 *Section 14089.08 shall have access to all performance measures*

1 *and benchmarks used by the department as described in this*
2 *section.*

3 *(1) The performance measures established by the department*
4 *shall include, but not be limited to, all of the following: provider*
5 *network adequacy, overall utilization of dental services, annual*
6 *dental visits, use of preventive dental services, use of dental*
7 *treatment services, use of examinations and oral health evaluations,*
8 *sealant to restoration ratio, filling to preventive services ratio,*
9 *treatment to caries prevention ratio, use of dental sealants, use of*
10 *diagnostic services, and survey of member satisfaction with plans*
11 *and providers.*

12 *(2) The survey of member satisfaction with plans and providers*
13 *shall be the same dental version of the Consumer Assessment of*
14 *Healthcare Providers and Systems (CAHPS) survey as used by*
15 *the Healthy Families Program.*

16 *(3) The department shall notify dental health plans at least 30*
17 *days prior to the implementation date of these performance*
18 *measures.*

19 *(4) The department shall include the initial list of performance*
20 *measures and benchmarks in any dental health contracts entered*
21 *into between the department and a dental health plan pursuant to*
22 *Section 14204.*

23 *(5) The department shall update performance measures and*
24 *benchmarks and establish additional performance measures and*
25 *benchmarks in accordance with all of the following:*

26 *(A) The department shall consider performance measures and*
27 *benchmarks established by other states, the federal government,*
28 *and national organizations developing dental program*
29 *performance and quality measures.*

30 *(B) The department shall notify dental health plans at least 30*
31 *days prior to the implementation date of updates or changes to*
32 *performance measures and benchmarks. The department shall*
33 *also post these updates or changes on its Internet Web site at least*
34 *30 days prior to implementation in order to provide transparency*
35 *to the public.*

36 *(C) To ensure that the dental health needs of Medi-Cal*
37 *beneficiaries are met, the department shall, when evaluating*
38 *performance measures and benchmarks for retention on, addition*
39 *to, or deletion from the list, consider all of the following criteria:*

1 (i) Monthly, quarterly, annual, and multiyear Medi-Cal dental
2 managed care trended data.

3 (ii) County and statewide Medi-Cal dental fee-for-service
4 performance and quality ratings.

5 (iii) Other state and national dental program performance and
6 quality measures.

7 (iv) Other state and national performance ratings.

8 (b) In establishing and updating the performance measures and
9 benchmarks, the department shall consult the advisory committee
10 established pursuant to Section 14089.08, as well as dental health
11 plan representatives and other stakeholders, including
12 representatives from counties, local dental societies, nonprofit
13 entities, legal aid entities, and other interested parties.

14 (c) In evaluating a dental health plan's ability to meet the
15 criteria established through the performance measures and
16 benchmarks, the department shall select specific performance
17 measures from those established by the department in subdivision
18 (a) as the basis for establishing financial or other incentives or
19 disincentives, including, but not limited to, bonuses, payment
20 withholds, and adjustments to beneficiary assignment to plan
21 algorithms. These incentives and disincentives shall be included
22 in the dental health plan contracts.

23 (d) (1) The department shall designate an external quality
24 review organization (EQRO) that shall conduct external quality
25 reviews for any dental health plan contracting with the department
26 pursuant to Section 14204.

27 (2) As determined by the department, but at least annually,
28 dental health plans shall arrange for an external quality of care
29 review with the EQRO designated by the department that evaluates
30 the dental health plan's performance in meeting the performance
31 measures established in this section. Dental health plans shall
32 cooperate with and assist the EQRO in this review. The Department
33 of Managed Health Care shall have direct access to all external
34 quality of care review information upon request to the department.

35 (3) An external quality of care review shall include, but not be
36 limited to, all of the following: performance on the selected
37 performance measures and benchmarks established and updated
38 by the department, the CAHPS member or consumer satisfaction
39 survey referenced in paragraph (2) of subdivision (a), reporting
40 systems, and methodologies for calculating performance measures.

1 *An external quality of care review that includes all of the above*
2 *components shall be paid for by the dental health plan and posted*
3 *online annually, or at any other frequency specified by the*
4 *department, on the department's Internet Web site.*

5 *(e) All marketing methods and activities to be used by dental*
6 *plans shall comply with subdivision (b) of Section 10850, Sections*
7 *14407.1, 14408, 14409, 14410, and 14411, and Title 22 of the*
8 *California Code of Regulations, including Sections 53880 and*
9 *53881. Each dental plan shall submit its marketing plan to the*
10 *department for review and approval.*

11 *(f) Each dental plan shall submit its member services*
12 *procedures, beneficiary informational materials, and any updates*
13 *to those procedures or materials to the department for review and*
14 *approval. The department shall ensure that member services*
15 *procedures and beneficiary informational materials are clear and*
16 *provide timely and fair processes for accepting and acting upon*
17 *complaints, grievances, and disenrollment requests, including*
18 *procedures for appealing decisions regarding coverage or benefits.*

19 *(g) Each dental plan shall submit its provider compensation*
20 *agreements to the department for review and approval.*

21 *(h) The department shall post to its Internet Web site a copy of*
22 *all final reports completed by the Department of Managed Health*
23 *Care regarding dental managed care plans.*

24 *SEC. 115. Section 14459.8 is added to the Welfare and*
25 *Institutions Code, to read:*

26 *14459.8. (a) By no later than March 15, 2013, with annual*
27 *updates thereafter, the department shall provide the fiscal and*
28 *appropriate policy committees of the Legislature with either a*
29 *comprehensive report or separate reports on dental managed care*
30 *in the Counties of Sacramento and Los Angeles. This report shall*
31 *articulate specific changes and improvements implemented to*
32 *increase Medi-Cal beneficiary access to preventive services and*
33 *dental treatment, the utilization of services, and beneficiary*
34 *satisfaction. Key measures, outcomes, and department findings*
35 *pertaining to participating dental managed care plans and provider*
36 *networks shall also be included.*

37 *(b) Any report provided pursuant to subdivision (a) on the*
38 *County of Sacramento shall also provide data regarding the*
39 *outcomes and findings from the beneficiary dental exception (BDE)*
40 *process implemented by the department pursuant to Section*

1 14089.09, including the consideration of voluntary enrollment in
2 the County of Sacramento as compared to the existing mandatory
3 enrollment.

4 (c) The department may seek foundation funding or federal
5 grant funding to facilitate data analysis and reporting as applicable
6 for this purpose.

7 SEC. 116. Section 14500.5 of the Welfare and Institutions Code
8 is amended to read:

9 14500.5. (a) It is the intent of the Legislature that family
10 planning includes, but is not limited to, an effective means to
11 improve reproductive health by disease prevention and treatment,
12 to reduce the incidence of unintended pregnancies, and to reduce
13 the demand for abortions. It is the intent of the Legislature that no
14 family planning shall be expended other than for the services
15 enumerated in this chapter. It is also the intent of the Legislature
16 that no funds received pursuant to this chapter be used for abortions
17 or services ancillary to abortions.

18 (b) For purposes of this chapter, the following definitions shall
19 apply:

20 (1) “Family planning” means the process of establishing
21 objectives for the number and spacing of children, and selecting
22 the means by which those objectives may be achieved. These
23 means include a broad range of acceptable and effective methods
24 and services to limit or enhance fertility, including contraceptive
25 methods, natural family planning, abstinence methods, and the
26 management of infertility. Family planning services include
27 preconceptional counseling, maternal and fetal health counseling,
28 and general reproductive health care, including diagnosis and
29 treatment of infections and conditions, including cancer, that
30 threaten reproductive capability, and other services as described
31 in Section 14503, except for abortions and services ancillary to
32 abortions as prohibited in Section 14509. Family planning does
33 not include abortion, pregnancy testing solely for the purposes of
34 referral for abortion or services ancillary to abortions, or pregnancy
35 care which is not incident to the diagnosis of a pregnancy, except
36 as otherwise provided for in this chapter.

37 (2) “Abortion as a method of family planning” means the
38 deliberate choice of abortion over other methods to limit the
39 number, gender, and spacing of children, including, but not limited
40 to, contraception, abstinence, and natural family planning methods.

1 (3) “Department” means the State Department of Health Care
2 Services.

3 (4) “Director” means the Director of Health Care Services.

4 (5) “Grantee” means an agency, institution, or organization
5 approved by the department to provide family planning services
6 pursuant to this chapter.

7 *SEC. 117. Section 15911 of the Welfare and Institutions Code*
8 *is amended to read:*

9 15911. (a) Funding for each LIHP shall be based on all of the
10 following:

11 (1) The amount of funding that the participating entity
12 voluntarily provides for the nonfederal share of LIHP expenditures.

13 (2) For a LIHP that had in operation a Health Care Coverage
14 Initiative program under Part 3.5 (commencing with Section 15900)
15 as of November 1, 2010, and elects to continue funding the
16 program, the amount of funds requested to ensure that eligible
17 enrollees continue to receive health care services for persons
18 enrolled in the Health Care Coverage Initiative program as of
19 November 1, 2010.

20 (3) Any limitations imposed by the Special Terms and
21 Conditions of the demonstration project.

22 (4) The total allocations requested by participating entities for
23 Health Care Coverage Initiative eligible individuals.

24 (5) Whether funding under this part would result in the reduction
25 of other payments under the demonstration project.

26 (b) Nothing in this part shall be construed to require a political
27 subdivision of the state to participate in a LIHP as set forth in this
28 part, and those local funds expended or transferred for the
29 nonfederal share of LIHP expenditures under this part shall be
30 considered voluntary contributions for purposes of the federal
31 Patient Protection and Affordable Care Act (Public Law 111-148),
32 as amended by the federal Health Care and Education
33 Reconciliation Act of 2010 (Public Law 111-152), and the federal
34 American Recovery and Reinvestment Act of 2009 (Public Law
35 111-5), as amended by the federal Patient Protection and
36 Affordable Care Act.

37 (c) No state General Fund moneys shall be used to fund LIHP
38 services, nor to fund any related administrative costs incurred by
39 counties or any other political subdivision of the state.

1 (d) Subject to the Special Terms and Conditions of the
2 demonstration project, if a participating entity elects to fund the
3 nonfederal share of a LIHP, the nonfederal funding and payments
4 to the LIHP shall be provided through one of the following
5 mechanisms, at the options of the participating entity:

6 (1) On a quarterly basis, the participating entity shall transfer
7 to the department for deposit in the LIHP Fund established for the
8 participating counties and pursuant to subparagraph (A), the
9 amount necessary to meet the nonfederal share of estimated
10 payments to the LIHP for the next quarter under subdivision (g)
11 Section 15910.3.

12 (A) The LIHP Fund is hereby created in the State Treasury.
13 Notwithstanding Section 13340 of the Government Code, all
14 moneys in the fund shall be continuously appropriated to the
15 department for the purposes specified in this part. The fund shall
16 contain all moneys deposited into the fund in accordance with this
17 paragraph.

18 (B) The department shall obtain the related federal financial
19 participation and pay the rates established under Section 15910.3,
20 provided that the intergovernmental transfer is transferred in
21 accordance with the deadlines imposed under the Medi-Cal
22 Checkwrite Schedule, no later than the next available warrant
23 release date. This payment shall be a nondiscretionary obligation
24 of the department, enforceable under a writ of mandate pursuant
25 to Section 1085 of the Code of Civil Procedure. Participating
26 entities may request expedited processing within seven business
27 days of the transfer as made available by the ~~State Controllers~~
28 *Controller's* office, provided that the participating entity prepay
29 the department for the additional administrative costs associated
30 with the expedited processing.

31 (C) Total quarterly payment amounts shall be determined in
32 accordance with estimates of the number of enrollees in each rate
33 category, subject to annual reconciliation to final enrollment data.

34 (2) If a participating entity operates its LIHP through a contract
35 with another entity, the participating entity may pay the operating
36 entity based on the per enrollee rates established under Section
37 15910.3 on a quarterly basis in accordance with estimates of the
38 number of enrollees in each rate category, subject to annual
39 reconciliation to final enrollment data.

1 (A) (i) On a quarterly basis, the participating entity shall certify
2 the expenditures made under this paragraph and submit the report
3 of certified public expenditures to the department.

4 (ii) The department shall report the certified public expenditures
5 of a participating entity under this paragraph on the next available
6 quarterly report as necessary to obtain federal financial
7 participation for the expenditures. The total amount of federal
8 financial participation associated with the participating entity's
9 expenditures under this paragraph shall be reimbursed to the
10 participating entity.

11 (B) At the option of the participating entity, the LIHP may be
12 reimbursed on a cost basis in accordance with the methodology
13 applied to Health Care Coverage Initiative programs established
14 under Part 3.5 (commencing with Section 15900) including interim
15 quarterly payments.

16 (e) (1) Notwithstanding Section 15910.3 and subdivision (d)
17 of this section, if the participating entity cannot reach an agreement
18 with the department as to the appropriate rate to be paid under
19 Section 15910.3, at the option of the participating entity, the LIHP
20 shall be reimbursed on a cost basis in accordance with the
21 methodology applied to Health Care Coverage Initiative programs
22 established under Part 3.5 (commencing with Section 15900),
23 including interim quarterly payments. If the participating entity
24 and the department reach an agreement as to the appropriate rate,
25 the rate shall be applied no earlier than the first day of the LIHP
26 year in which the parties agree to the rate, *except that for the LIHP*
27 *year ending June 30, 2012, the rate may apply as early as July 1,*
28 *2011, without regard to the date of the agreement between the*
29 *participating entity and the department.*

30 (2) (A) *The department finds and declares all of the following:*

31 (i) *The department, in consultation with a number of the LIHPs,*
32 *has proposed LIHP capitation rates for federal approval.*

33 (ii) *There is some concern that federal approval of the proposed*
34 *rates will not be received, and implementing contracts may not be*
35 *signed, before June 30, 2012.*

36 (iii) *The amendments made to this subdivision by the act that*
37 *added this clause would allow the federally approved capitation*
38 *rates to apply to the LIHP year, which is July 1, 2011, to June 30,*
39 *2012, inclusive, even if federal approval and the necessary contract*
40 *amendments are not finalized until after June 30, 2012.*

1 (B) Therefore, it is the intent of the Legislature in amending
2 this subdivision to allow the LIHP capitation rates to apply for
3 the 2011–12 fiscal year even if final agreements on the capitation
4 rates are delayed while awaiting federal approval and are not
5 finalized until after June 30, 2012.

6 (f) If authorized under the Special Terms and Conditions of the
7 demonstration project, pending the department’s development of
8 rates in accordance with Section 15910.3, the department shall
9 make interim quarterly payments to approved LIHPs for
10 expenditures based on estimated costs submitted for rate setting.

11 (g) Participating entities that operate a LIHP directly or through
12 contract with another entity shall be entitled to any federal financial
13 participation available for administrative expenditures incurred in
14 the operation of the Medi-Cal program or the demonstration
15 project, including, but not limited to, outreach, screening and
16 enrollment, program development, data collection, reporting and
17 quality monitoring, and contract administration, but only to the
18 extent that the expenditures are allowable under federal law and
19 only to the extent the expenditures are not taken into account in
20 the determination of the per enrollee rates under Section 15910.3.

21 (h) On and after January 1, 2014, the state shall implement
22 comprehensive health care reform for the populations targeted by
23 the LIHP in compliance with federal health care reform law,
24 regulation, and policy, including the federal Patient Protection and
25 Affordable Care Act (Public Law 111-148), as amended by the
26 federal Health Care and Education Reconciliation Act of 2010
27 (Public Law 111-152), and subsequent amendments.

28 (i) Subject to the Special Terms and Conditions of the
29 demonstration project, a participating entity may elect to include,
30 in collaboration with the department, as the nonfederal share of
31 LIHP expenditures, voluntary intergovernmental transfers or
32 certified public expenditures of another governmental entity, as
33 long as the intergovernmental transfer or certified public
34 expenditure is consistent with federal law.

35 (j) Participation in the LIHP under this part is voluntary on the
36 part of the eligible entity for purposes of all applicable federal
37 laws. As part of its voluntary participation under this article, the
38 participating entity shall agree to reimburse the state for the
39 nonfederal share of state staffing and administrative costs directly
40 attributable to the cost of administering that LIHP, including, but

1 not limited to, the state administrative costs related to certified
2 public expenditures and intergovernmental transfers. This section
3 shall be implemented only to the extent federal financial
4 participation is not jeopardized.

5 *SEC. 118. Section 15911.1 is added to the Welfare and
6 Institutions Code, to read:*

7 *15911.1. Upon the order of the Director of Finance, the
8 Controller shall draw warrants against General Fund cash to
9 provide cashflow loans as follows:*

10 *(a) The Director of Finance may approve cashflow loans of no
11 more than a total of one hundred million dollars (\$100,000,000)
12 in the 2012–13 and 2013–14 fiscal years for County Medical
13 Services Program governing board expenses that are associated
14 with a Low Income Health Program operated by the governing
15 board pursuant to this part.*

16 *(b) The terms and conditions of any cashflow loan provided
17 pursuant to this section shall be subject to approval by the Director
18 of Finance. Interest shall be charged at the rate earned by moneys
19 in the Pooled Money Investment Account.*

20 *(c) The Department of Finance shall notify the Legislature
21 within 15 days of authorizing a cashflow loan pursuant to this
22 section, unless prior notification of the cashflow loan was included
23 when the Medi-Cal estimates were submitted pursuant to Section
24 14100.5.*

25 *(d) Any cashflow loans made pursuant to this section shall be
26 short term and shall not constitute General Fund expenditures.
27 These loans and the repayment of these loans shall not affect the
28 General Fund reserve.*

29 *SEC. 119. Section 15912.1 is added to the Welfare and
30 Institutions Code, to read:*

31 *15912.1. (a) The department, in collaboration with the State
32 Department of Public Health, shall develop policies and guidance
33 on the transition of persons diagnosed with HIV/AIDS from federal
34 Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan
35 White Act) funded programs, pursuant to Section 131019 of the
36 Health and Safety Code, to the Low Income Health Program
37 (LIHP) pursuant to Part 3.6 (commencing with Section 15909).
38 These policies and guidance shall be provided to local LIHPs,
39 federal Ryan White Act providers, and to persons receiving services
40 pursuant to the federal Ryan White Act, as applicable. Guidance*

1 shall include, but not be limited to, operational processes and
2 procedures supporting the transition of persons receiving services
3 pursuant to the federal Ryan White Act in order to minimize
4 disruption of access to and availability of care and services.

5 (b) The department, in collaboration with the State Department
6 of Public Health, shall consult with stakeholders, including
7 administrators, advocates, providers, and persons receiving
8 services pursuant to the federal Ryan White Act, to obtain advice
9 in forming the policy decisions regarding the transition of persons
10 receiving services pursuant to the federal Ryan White Act to the
11 local LIHPs.

12 SEC. 120. Section 15916 of the Welfare and Institutions Code
13 is amended to read:

14 15916. (a) It is the intent of the Legislature that the State
15 Department of Health Care Services and all other departments take
16 all appropriate steps to fully maximize and claim all available
17 expenditures for Designated State Health Programs listed in the
18 Special Terms and Conditions of California’s Bridge to Reform
19 Section 1115(a) Demonstration under the safety net care pool
20 (SNCP) for an applicable demonstration year.

21 (b) For the purposes of this section, the following definitions
22 apply:

23 (1) “California’s Bridge to Reform Section 1115(a)
24 Demonstration” means the Section 1115(a) Medicaid demonstration
25 project, No. 11-W-00193/9, as approved by the federal Centers
26 for Medicare and Medicaid Services (CMS), effective for the period
27 of November 1, 2010, through October 31, 2015.

28 (2) “Demonstration year” means a specific period of time during
29 California’s Bridge to Reform Section 1115(a) Waiver as identified
30 in the Special Terms and Conditions. “*Demonstration year*” may
31 be denominated in yearly increments, which correspond with the
32 yearly increments identified in the Special Terms and Conditions.

33 (3) “Designated public hospital” has the meaning given in
34 subdivision (d) of Section 14166.1.

35 (4) “Excess certified public expenditures” means the amount
36 of allowable uncompensated care expenditures reported and
37 certified for the applicable demonstration year under Section
38 14166.8 by designated public hospitals (DPHs), including the
39 governmental entities with which they are affiliated, that is in
40 excess of the amount necessary to draw the maximum amount of

1 federal funding for DPHs for uncompensated care under the safety
2 net care pool and for disproportionate share hospital payments
3 without regard to subdivision (c) or to the amount authorized
4 pursuant to paragraph (5).

5 (5) “Reserved SNCP funds for DSHP” means the amount of
6 SNCP uncompensated care funds used to fund expenditures for
7 the Designated State Health Programs, as specified in the Special
8 Terms and Conditions of California’s Bridge to Reform Section
9 1115(a) Demonstration.

10 (6) “Redirected SNCP funds” means the amount of federal
11 funding available for a specified demonstration year that would
12 otherwise be restricted for expenditures associated with the Health
13 Care Coverage Initiative (HCCI) program, for which there are
14 insufficient HCCI expenditures to draw the federal funds and which
15 CMS has authorized to be available for uncompensated care
16 expenditures under the safety net care pool in either the
17 demonstration year for which the funds were initially reserved or
18 a subsequent demonstration year.

19 (7) “Safety net care pool” or “SNCP” means the federal funds
20 available under the Medi-Cal Hospital/Uninsured Care
21 Demonstration Project and the successor demonstration project,
22 California’s Bridge to Reform, to ensure continued government
23 support for the provision of health care services to uninsured
24 populations.

25 (c) Notwithstanding any other provision of law, the state shall
26 annually seek authority from CMS under the Special Terms and
27 Conditions of California’s Bridge to Reform Section 1115(a)
28 Demonstration to redirect to the uncompensated care category
29 within the SNCP the portion of the restricted funds used to fund
30 expenditures under the HCCI that will not be fully utilized by the
31 end of the demonstration year *for use in any demonstration year*.

32 (d) Designated public hospitals may utilize the redirected SNCP
33 funds described in subdivision (c) as follows:

34 (1) Designated public hospitals may opt to utilize excess
35 certified public expenditures to claim the redirected SNCP funds.

36 (2) As a condition of exercising the option in paragraph (1),
37 DPHs voluntarily agree that ~~to the extent the state is unable to fully~~
38 ~~claim the maximum annual amount of reserved SNCP funds for~~
39 ~~DSHP, up to the amount of redirected SNCP funds available~~, the
40 excess certified public expenditures are to be allocated equally

1 between the state and the DPHs, such that for every dollar of excess
2 certified public expenditure used by the DPHs, the DPHs will
3 voluntarily allow the state to use a corresponding excess certified
4 public expenditure amount for claiming purposes. ~~The amount in
5 excess certified public expenditures that may be used by the state
6 shall be limited to that amount necessary to enable the state to
7 receive total SNCP uncompensated care funds, in conjunction with
8 its claims for expenditures for DSHP, to the maximum amount
9 described in paragraph (5) of subdivision (b).~~

10 ~~(3) After the state achieves its maximum claiming amount
11 described in paragraph (5) of subdivision (b), or to the extent the
12 condition in subdivision (c) is not satisfied, the DPHs may use any
13 remaining excess certified public expenditures to claim SNCP
14 uncompensated care funds as authorized by the Special Terms and
15 Conditions of California's Bridge to Reform Section 1115(a)
16 Demonstration.~~

17 ~~(e) As a condition for the state's use of the excess certified
18 public expenditures pursuant to paragraph (2) of subdivision (d),
19 the department shall seek any necessary authorization from the
20 federal Centers for Medicare and Medicaid Services.~~

21 ~~(3) As a condition of receiving any of the funding in paragraph
22 (2), DPHs voluntarily agree that, to the extent the state is unable
23 to fully claim the maximum annual amount of reserved SNCP funds
24 for DSHP, the excess certified public expenditures will be used to
25 enable the state to receive total SNCP uncompensated care funds,
26 in conjunction with its claims for expenditures for DSHP, to the
27 maximum amount described in paragraph (5) of subdivision (b).~~

28 ~~(f)~~

29 ~~(e) Participation in the utilization of the excess certified public
30 expenditures and redirected SNCP funds under this section is
31 voluntary on the part of the DPHs for the purpose of all applicable
32 federal laws.~~

33 ~~(g)~~

34 ~~(f) The department shall consult with DPH representatives
35 regarding the availability of excess certified public expenditures,
36 how to optimize the level of claimable federal Medicaid funding,
37 and the appropriate allocation of SNCP funds under paragraph
38 paragraphs (2) and (3) of subdivision (d). The department may
39 make interim determinations and allocations of such SNCP funds,
40 provided that the interim determinations and allocations take into~~

1 account adjustments to reported expenditures for possible audit
 2 disallowances, consistent with the type of adjustments applied in
 3 prior projects years under Article 5.2 (commencing with Section
 4 14166). Any interim determinations and allocations of redirected
 5 SNCP funds based on excess certified public expenditures shall
 6 be subject to interim and final reconciliations.

7 ~~(h)~~

8 (g) Notwithstanding any other provision of law, upon the receipt
 9 of a notice of disallowance or deferral from the federal government
 10 related to any certified public expenditures for uncompensated
 11 care incurred by DPHs that are used for federal claiming under
 12 the SNCP pursuant to California’s Bridge to Reform Section
 13 1115(a) Demonstration after this section is implemented, and
 14 subject to the processes described in subdivisions (a) through (d)
 15 of Section 14166.24, the following shall apply with respect to the
 16 disallowance or deferral:

17 ~~(1) First, the DPH shall be solely responsible for the repayment~~
 18 ~~of the federal portion of any federal disallowance or deferral related~~
 19 ~~to the claiming of a certified public expenditure in a particular year~~
 20 ~~up to the amount claimed pursuant to paragraph (3) of subdivision~~
 21 ~~(d), after paragraph (2) of subdivision (d) was satisfied for that~~
 22 ~~particular year.~~

23 ~~(2) Second, if there are additional disallowances or deferrals~~
 24 ~~beyond those described in paragraph (1), the~~

25 (1) The department and the DPH shall each be responsible for
 26 half of the repayment of the federal portion of any federal
 27 disallowance or deferral for the applicable demonstration year, up
 28 to the amount claimed and allocated pursuant to paragraph (2) of
 29 subdivision (d) for that particular year.

30 (2) *If there are additional disallowances or deferrals beyond*
 31 *those described in paragraph (1), the department shall be solely*
 32 *responsible for the repayment of the federal portion of any federal*
 33 *disallowance or deferral for the applicable demonstration year,*
 34 *up to the amount claimed and allocated pursuant to paragraph*
 35 *(3) of subdivision (d) for that particular year.*

36 (3) ~~Third, if~~ *If* there are additional disallowances or deferrals
 37 beyond those described in paragraphs (1) and (2) for the applicable
 38 demonstration year, the DPH shall be solely responsible for the
 39 repayment of the federal portion of all remaining federal
 40 disallowances or deferrals for that particular year.

1 (i)

2 (h) The department shall obtain federal approvals or waivers as
3 necessary to implement this section and to obtain federal ~~matching~~
4 ~~funds~~ *financial participation* to the maximum extent permitted by
5 federal law. This section shall be implemented only to the extent
6 *other* federal financial participation is not jeopardized.

7 *SEC. 121. Section 24000 of the Welfare and Institutions Code*
8 *is amended to read:*

9 24000. There is established in the State Department of Health
10 *Care Services* the State-Only Family Planning Program to provide
11 comprehensive clinical family planning services to low-income
12 men and women. This division shall be known and may be cited
13 as the State-Only Family Planning Program.

14 *SEC. 122. Section 24001 of the Welfare and Institutions Code*
15 *is amended to read:*

16 24001. (a) (1) For purposes of this division, “family planning”
17 means the process of establishing objectives for the number and
18 spacing of children, and selecting the means by which those
19 objectives may be achieved. These means include a broad range
20 of acceptable and effective methods and services to limit or
21 enhance fertility, including contraceptive methods, natural family
22 planning, abstinence methods and basic, limited fertility
23 management. Family planning services include, but are not limited
24 to, preconception counseling, maternal and fetal health counseling,
25 general reproductive health care, including diagnosis and treatment
26 of infections and conditions, including cancer, that threaten
27 reproductive capability, medical family planning treatment and
28 procedures, including supplies and followup, and informational,
29 counseling, and educational services. Family planning shall not
30 include abortion, pregnancy testing solely for the purposes of
31 referral for abortion or services ancillary to abortions, not including
32 contraceptives, or pregnancy care that is not incident to the
33 diagnosis of pregnancy.

34 (2) Family planning services for males shall be expanded to
35 include laboratory tests for sexually transmitted infections and
36 comprehensive physical examinations. Within 60 days of approval
37 of the Family Planning, Access, Care, and Treatment (Family
38 PACT) Waiver Program, provided for pursuant to subdivision (aa)
39 of Section 14132, the department shall seek to amend the waiver
40 to add this expansion. The implementation of this paragraph shall

1 be dependent upon federal approval and receipt of federal financial
2 participation.

3 (b) For purposes of this division, “department” means the State
4 Department of Health Care Services.

5 *SEC. 123. (a) It is the intent of the Legislature that the State*
6 *Department of Education and the State Department of Health Care*
7 *Services modify or repeal regulations that are no longer supported*
8 *by statute due to the amendments in Sections 1, 2, 32, 33, 33.5,*
9 *and 34 of this act.*

10 (b) *The State Department of Education shall review regulations*
11 *to ensure the appropriate implementation of educationally*
12 *necessary occupational and physical therapy services required by*
13 *the federal Individuals with Disabilities Education Act (20 U.S.C.*
14 *Sec. 1400 et seq.) and Sections 1, 2, 32, 33, 33.5, and 34 of this*
15 *act.*

16 (c) *The State Department of Education may adopt regulations*
17 *to implement Sections 1, 2, 32, 33, 33.5, and 34 of this act. The*
18 *adoption, amendment, repeal, or readoption of a regulation*
19 *authorized by this section is deemed to address an emergency, for*
20 *purposes of Sections 11346.1 and 11349.6 of the Government*
21 *Code, and the State Department of Education is hereby exempted,*
22 *for this purpose, from the requirements of subdivision (a) of Section*
23 *11346.1 of the Government Code. For purposes of subdivision (e)*
24 *of Section 11346.1 of the Government Code, the 180-day period,*
25 *as applicable to the effective period of an emergency regulatory*
26 *action and submission of specified materials to the Office of*
27 *Administrative Law, is hereby extended to one year.*

28 (d) *Implementation of Sections 1, 2, 32, 33, 33.5, and 34 of this*
29 *act shall occur no later than October 1, 2012.*

30 (e) *The State Department of Health Care Services shall report*
31 *in the November 2012 and May 2013 Family Health Estimate on*
32 *the status of the implementation of the provisions of Sections 1, 2,*
33 *32, 33, 33.5, and 34 of this act. The report shall include, but not*
34 *be limited to, the following:*

35 (1) *The number of children enrolled in the California Children’s*
36 *Services by county known to the county California Children’s*
37 *Services Programs to be receiving physical and occupational*
38 *therapy services from the California Children’s Services Medical*
39 *Therapy Program assessed and determined to be educationally*

1 *necessary by the individualized education program team and*
2 *included in a child's individualized education program.*

3 *(2) The estimated California Children's Services Program*
4 *savings from implementation of Sections 1, 2, 32, 33, 33.5, and 34*
5 *of this act.*

6 *(3) An update on the implementation of Sections 1, 2, 32, 33,*
7 *33.5, and 34 of this act, including a description of implementation*
8 *successes and challenges.*

9 *(f) The State Department of Education and the State Department*
10 *of Health Care Services shall work together to collect the relevant*
11 *data necessary for the report described in subdivision (e).*

12 *SEC. 124. By no later than January 1, 2013, the Department*
13 *of Managed Health Care shall provide the fiscal and appropriate*
14 *policy committees of the Legislature with its final report on surveys*
15 *conducted under the requirements of the Knox-Keene Health Care*
16 *Service Plan Act of 1975 (Chapter 2.2 (commencing with Section*
17 *1340) of Division 2 of the Health and Safety Code) and the*
18 *department's contractual requirements, for the dental plans*
19 *participating in the Sacramento Geographic Managed Care*
20 *Program.*

21 *SEC. 125. Given the uncertainty within which persons*
22 *diagnosed with HIV/AIDS from federal Ryan White HIV/AIDS*
23 *Treatment Extension Act of 2009 funded programs may transition*
24 *to the Low Income Health Program pursuant to Part 3.6*
25 *(commencing with Section 15909) of the Welfare and Institutions*
26 *Code, the State Department of Public Health shall report to the*
27 *Joint Legislative Budget Committee by October 1, 2012, on whether*
28 *any of the projections or assumptions used to develop the AIDS*
29 *Drug Assistance Program (ADAP) estimated budget for the Budget*
30 *Act of 2012 may result in an inability of ADAP to provide services*
31 *to eligible ADAP clients. If this occurs before October 1, 2012,*
32 *and ADAP is unable to provide services to eligible ADAP clients,*
33 *the State Department of Public Health shall provide notification*
34 *to the Joint Legislative Budget Committee within 15 calendar days*
35 *of this determination.*

36 *SEC. 126. Notwithstanding the amendments made in Sections*
37 *18 to 25, inclusive, and Sections 35, 116, 121, and 122 of this act,*
38 *if this act becomes effective before July 1, 2012, it is the intent of*
39 *the Legislature that the transfer of duties, powers, functions,*
40 *responsibilities, and jurisdiction described in those sections from*

1 *the State Department of Public Health to the State Department of*
2 *Health Care Services shall occur in accordance with Sections*
3 *131051, 131052, and 131055.1 of the Health and Safety Code, as*
4 *amended or added by this act.*

5 *SEC. 127. The Legislature finds and declares that Sections 55*
6 *to 63, inclusive, 66 to 68, inclusive, and 70 and 71 of this act clarify*
7 *procedures and terms of the Mental Health Services Act within*
8 *the meaning of Section 18 of the Mental Health Services Act.*

9 *SEC. 128. The Legislature finds and declares that, for the*
10 *purposes of Sections 78 and 111 of this act, a special law is*
11 *necessary and that a general law cannot be made applicable within*
12 *the meaning of Section 16 of Article IV of the California*
13 *Constitution because the counties listed in subdivision (a) of*
14 *Section 14087.98 of the Welfare and Institutions Code, as added*
15 *by this act, are Medi-Cal fee-for-service counties and this act*
16 *would provide expansion of Medi-Cal managed care to these*
17 *counties.*

18 *SEC. 129. The Legislature finds and declares that, for the*
19 *purposes of Sections 79, 80, 112, 114, 115, and 124 of this act, a*
20 *special law is necessary and that a general law cannot be made*
21 *applicable within the meaning of Section 16 of Article IV of the*
22 *California Constitution because the Counties of Los Angeles and*
23 *Sacramento are the only counties that have Medi-Cal dental*
24 *managed care arrangements and the County of Sacramento is the*
25 *only county with mandatory dental managed care enrollment.*

26 *SEC. 130. Section 33.5 of this bill incorporates amendments*
27 *to Section 123870 of the Health and Safety Code proposed by this*
28 *bill and Assembly Bill 1494 and Senate Bill 1034. It shall only*
29 *become operative if (1) either Assembly Bill 1494 or Senate Bill*
30 *1034 and this bill are enacted and become effective on or before*
31 *January 1, 2013, (2) each bill amends Section 123870 of the Health*
32 *and Safety Code, and (3) this bill is enacted after either Assembly*
33 *Bill 1494 or Senate Bill 1034, in which case Section 33 of this bill*
34 *shall not become operative.*

35 *SEC. 131. This act is a bill providing for appropriations related*
36 *to the Budget Bill within the meaning of subdivision (e) of Section*
37 *12 of Article IV of the California Constitution, has been identified*
38 *as related to the budget in the Budget Bill, and shall take effect*
39 *immediately.*

1 ~~SECTION 1. It is the intent of the Legislature to enact statutory~~
2 ~~changes relating to the Budget Act of 2012.~~

O