

AMENDED IN SENATE JUNE 14, 2013

AMENDED IN SENATE JUNE 13, 2013

AMENDED IN SENATE JUNE 12, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

**ASSEMBLY BILL**

**No. 82**

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

January 10, 2013

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An act to amend Section 680 of the Business and Professions Code, to amend Sections 6254, 26605.6, 26605.7, and 26605.8 of the Government Code, to amend Sections 1180.6, 1250.2, 1254, 1254.1, 1266.1, 1275.1, 1275.5, 1324.9, 1373, 111792, 123870, 123929, 123940, and 123955 of, and to add Section 104151 to, the Health and Safety Code, to amend Sections 10125, 10127, 12693.70, 12698, 12737, and 12739.61 of the Insurance Code, and to amend Sections 359, 708, 4005.7, 4080, 5150, 5151, 5157, 5202, 5326.9, 5358, 5366.1, 5404, 5405, 5585.21, 5585.50, 5585.55, 5675, 5675.1, 5675.2, 5751.7, 5768, 5840, 5845, 5846, 5909, 6007, 6551, 7100, 14105.22, 14105.3, 14131.10, 14134, 14707.5, and 15911 of, to add Sections 14005.275, 14100.3, 14100.51, 14100.52, 14132.86, and 14132.89 to, to add Part 3.3 (commencing with Section 15800) to Division 9 of, to add and repeal Section 14005.281 of, and to repeal Section 14131.07 of, the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

## LEGISLATIVE COUNSEL'S DIGEST

AB 82, as amended, Committee on Budget. Health.

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

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

(2) Existing law establishes the Long-Term Care Quality Assurance Fund in the State Treasury and requires, beginning August 1, 2013, all revenues received by the State Department of Health Care Services categorized by the department as long-term quality assurance fees, including specified fees on certain intermediate care facilities and skilled nursing facilities, as specified, to be deposited into the fund. Existing

law requires the moneys in the fund to be available, upon appropriation by the Legislature, for expenditure by the department to provide supplemental Medi-Cal reimbursement for intermediate care facility services, and to enhance federal financial participation in the Medi-Cal program or to provide additional reimbursement to, and to support facility quality improvement efforts in, licensed skilled nursing facilities.

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

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

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

(4) Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, funds a system of county mental health plans for the provision of mental health services, as specified. Among other things, the act establishes the Mental Health Services Oversight and Accountability Commission to oversee the administration of various parts of the Mental Health Services Act, and requires that the commission administer its operations separate and apart from the State Department of Health Care Services. The act provides that the Legislature may clarify procedures and terms of the act by majority vote.

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

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

This bill would require the department, by January 10 and concurrently with the May Revision of the annual budget, to provide to the fiscal

committees of the Legislature specified fiscal information with respect to the Medi-Cal Specialty Mental Health Services Program and the Drug Medi-Cal Program. The bill also would require the department to post this information on its Internet Web site.

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

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

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

This bill would extend the length of this exemption from 12 months to 21 months. The bill also would extend the date by which laboratory providers are required to submit certain data reports, for the purposes of establishing reimbursement rates, by an additional 5 months. The bill would also make technical changes to those provisions.

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

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

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

This bill would delete these provisions.

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

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

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

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

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

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

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

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

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

(14) Existing law requires the State Department of Health Care Services, subject to federal approval, to authorize a local Low Income Health Program (LIHP) to provide health care services to eligible low-income individuals under certain circumstances. Existing law requires the department, in consultation with participating entities, as defined, to determine actuarially sound per enrollee capitation rates for LIHPs, as specified, and to pay those rates to the participating entity. Existing law requires that, if the participating entity and the department

reach an agreement regarding reimbursement rates, the rate be applied no earlier than the first day of the LIHP year in which the parties agree to the rate. Existing law provides an exception to that provision with respect to the LIHP year ending June 30, 2012.

This bill would delete the above-described exception.

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

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

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

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

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

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

scientific literacy. The bill would require the Internet Web site to include hypertext links to other educational and informational Internet Web sites to enhance consumer understanding.

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

*This bill would require the State Department of Health Care Services to ensure coordination of covered services across all delivery systems of care in order to minimize disruption of services for children transitioning from the Healthy Families Program to Medi-Cal.*

**This**

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

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

(19) Existing law establishes the California Major Risk Medical Insurance Program, which is administered by the Managed Risk Medical Insurance Board, to provide major risk medical coverage to persons



who, among other things, have been rejected for coverage by at least one private health plan. Existing law requires the board to establish program contribution amounts for each category of risk for each participating health plan and requires that these amounts be based on the average amount of subsidy funds required for the program as a whole, to be determined in a specified manner. Existing law, for the period commencing January 1, 2013, to December 31, 2013, inclusive, additionally authorizes the program to further subsidize subscriber contributions based on a specified percentage of the standard average individual risk rate for comparable coverage, as specified. Existing law requires the program to pay program contribution amounts to participating health plans from the Major Risk Medical Insurance Fund, a continuously appropriated fund.

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

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

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

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

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

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

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

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

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

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

This bill would require the State Department of Public Health, by October 1, 2013, to submit to the fiscal and appropriate policy

committees of the Legislature a report describing how it plans to address the findings and recommendations described in a report relating to this program.

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

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

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

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

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

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

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

1 pursuant to subdivision (a) have been developed and implemented  
2 by the respective licensed facilities.

3 (c) For purposes of this article, “health care practitioner” means  
4 any person who engages in acts that are the subject of licensure  
5 or regulation under this division or under any initiative act referred  
6 to in this division.

7 SEC. 2. Section 6254 of the Government Code is amended to  
8 read:

9 6254. Except as provided in Sections 6254.7 and 6254.13,  
10 nothing in this chapter shall be construed to require disclosure of  
11 records that are any of the following:

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

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

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

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

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

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

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

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

36 (e) Geological and geophysical data, plant production data, and  
37 similar information relating to utility systems development, or  
38 market or crop reports, that are obtained in confidence from any  
39 person.

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

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

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

36 (1) The full name and occupation of every individual arrested  
37 by the agency, the individual's physical description including date  
38 of birth, color of eyes and hair, sex, height and weight, the time  
39 and date of arrest, the time and date of booking, the location of  
40 the arrest, the factual circumstances surrounding the arrest, the

1 amount of bail set, the time and manner of release or the location  
2 where the individual is currently being held, and all charges the  
3 individual is being held upon, including any outstanding warrants  
4 from other jurisdictions and parole or probation holds.

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

30 (3) Subject to the restrictions of Section 841.5 of the Penal Code  
31 and this subdivision, the current address of every individual  
32 arrested by the agency and the current address of the victim of a  
33 crime, where the requester declares under penalty of perjury that  
34 the request is made for a scholarly, journalistic, political, or  
35 governmental purpose, or that the request is made for investigation  
36 purposes by a licensed private investigator as described in Chapter  
37 11.3 (commencing with Section 7512) of Division 3 of the Business  
38 and Professions Code. However, the address of the victim of any  
39 crime defined by Section 220, 236.1, 261, 261.5, 262, 264, 264.1,  
40 265, 266, 266a, 266b, 266c, 266e, 266f, 266j, 267, 269, 273a,

1 273d, 273.5, 285, 286, 288, 288a, 288.2, 288.3 (as added by  
2 Chapter 337 of the Statutes of 2006), 288.3 (as added by Section  
3 6 of Proposition 83 of the November 7, 2006, statewide general  
4 election), 288.5, 288.7, 289, 422.6, 422.7, 422.75, 646.9, or 647.6  
5 of the Penal Code shall remain confidential. Address information  
6 obtained pursuant to this paragraph may not be used directly or  
7 indirectly, or furnished to another, to sell a product or service to  
8 any individual or group of individuals, and the requester shall  
9 execute a declaration to that effect under penalty of perjury.  
10 Nothing in this paragraph shall be construed to prohibit or limit a  
11 scholarly, journalistic, political, or government use of address  
12 information obtained pursuant to this paragraph.

13 (g) Test questions, scoring keys, and other examination data  
14 used to administer a licensing examination, examination for  
15 employment, or academic examination, except as provided for in  
16 Chapter 3 (commencing with Section 99150) of Part 65 of Division  
17 14 of Title 3 of the Education Code.

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

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

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

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

37 (l) Correspondence of and to the Governor or employees of the  
38 Governor's office or in the custody of or maintained by the  
39 Governor's Legal Affairs Secretary. However, public records shall

1 not be transferred to the custody of the Governor's Legal Affairs  
2 Secretary to evade the disclosure provisions of this chapter.

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

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

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

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

34 (q) (1) Records of state agencies related to activities governed  
35 by Article 2.6 (commencing with Section 14081), Article 2.8  
36 (commencing with Section 14087.5), and Article 2.91  
37 (commencing with Section 14089) of Chapter 7 of Part 3 of  
38 Division 9 of the Welfare and Institutions Code, that reveal the  
39 special negotiator's deliberative processes, discussions,  
40 communications, or any other portion of the negotiations with



1 providers of health care services, impressions, opinions,  
2 recommendations, meeting minutes, research, work product,  
3 theories, or strategy, or that provide instruction, advice, or training  
4 to employees.

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

16 (3) Three years after a contract or amendment is open to  
17 inspection under this subdivision, the portion of the contract or  
18 amendment containing the rates of payment shall be open to  
19 inspection.

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

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

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

35 (t) Records of a local hospital district, formed pursuant to  
36 Division 23 (commencing with Section 32000) of the Health and  
37 Safety Code, or the records of a municipal hospital, formed  
38 pursuant to Article 7 (commencing with Section 37600) or Article  
39 8 (commencing with Section 37650) of Chapter 5 of Part 2 of  
40 Division 3 of Title 4 of this code, that relate to any contract with

1 an insurer or nonprofit hospital service plan for inpatient or  
2 outpatient services for alternative rates pursuant to Section 10133  
3 of the Insurance Code. However, the record shall be open to  
4 inspection within one year after the contract is fully executed.

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

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

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

24 (v) (1) Records of the Managed Risk Medical Insurance Board  
25 and the State Department of Health Care Services related to  
26 activities governed by Part 6.3 (commencing with Section 12695),  
27 Part 6.5 (commencing with Section 12700), Part 6.6 (commencing  
28 with Section 12739.5), and Part 6.7 (commencing with Section  
29 12739.70) of Division 2 of the Insurance Code, and Chapter 2  
30 (commencing with Section 15850) of Part 3.3 of Division 9 of the  
31 Welfare and Institutions Code, and that reveal any of the following:

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

39 (B) The impressions, opinions, recommendations, meeting  
40 minutes, research, work product, theories, or strategy of the board

1 or its staff or the department or its staff, or records that provide  
2 instructions, advice, or training to their employees.

3 (2) (A) Except for the portion of a contract that contains the  
4 rates of payment, contracts entered into pursuant to Part 6.3  
5 (commencing with Section 12695), Part 6.5 (commencing with  
6 Section 12700), Part 6.6 (commencing with Section 12739.5), or  
7 Part 6.7 (commencing with Section 12739.70) of Division 2 of the  
8 Insurance Code, or Chapter 2.2 (commencing with Section 15850)  
9 of Part 3.3 of Division 9 of the Welfare and Institutions Code, on  
10 or after July 1, 1991, shall be open to inspection one year after  
11 their effective dates.

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

16 (3) Three years after a contract or amendment is open to  
17 inspection pursuant to this subdivision, the portion of the contract  
18 or amendment containing the rates of payment shall be open to  
19 inspection.

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

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

35 (2) Except for the portion of a contract that contains the rates  
36 of payment, contracts for health coverage entered into pursuant to  
37 Chapter 8 (commencing with Section 10700) of Part 2 of Division  
38 2 of the Insurance Code, on or after January 1, 1993, shall be open  
39 to inspection one year after they have been fully executed.

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

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

14 (y) (1) Records of the Managed Risk Medical Insurance Board  
15 related to activities governed by Part 6.2 (commencing with Section  
16 12693) or Part 6.4 (commencing with Section 12699.50) of  
17 Division 2 of the Insurance Code, and that reveal any of the  
18 following:

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

25 (B) The impressions, opinions, recommendations, meeting  
26 minutes, research, work product, theories, or strategy of the board  
27 or its staff, or records that provide instructions, advice, or training  
28 to employees.

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

35 (B) If a contract entered into pursuant to Part 6.2 (commencing  
36 with Section 12693) or Part 6.4 (commencing with Section  
37 12699.50) of Division 2 of the Insurance Code is amended, the  
38 amendment shall be open to inspection one year after the effective  
39 date of the amendment.

1 (3) Three years after a contract or amendment is open to  
2 inspection pursuant to this subdivision, the portion of the contract  
3 or amendment containing the rates of payment shall be open to  
4 inspection.

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

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

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

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

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

37 (ac) All information provided to the Secretary of State by a  
38 person for the purpose of registration in the Advance Health Care  
39 Directive Registry, except that those records shall be released at

1 the request of a health care provider, a public guardian, or the  
2 registrant's legal representative.

3 (ad) The following records of the State Compensation Insurance  
4 Fund:

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

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

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

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

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

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

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

3 (i) Personal papers and correspondence of any person providing  
4 assistance to the fund when that person has requested in writing  
5 that his or her papers and correspondence be kept private and  
6 confidential. Those papers and correspondence shall become public  
7 records if the written request is withdrawn, or upon order of the  
8 fund.

9 (ii) Papers, correspondence, memoranda, or any substantive  
10 information pertaining to any audit not completed or an internal  
11 audit that contains proprietary information.

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

18 (7) (A) Except as provided in subparagraph (C), contracts  
19 entered into pursuant to Chapter 4 (commencing with Section  
20 11770) of Part 3 of Division 2 of the Insurance Code shall be open  
21 to inspection one year after the contract has been fully executed.

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

26 (C) Three years after a contract or amendment is open to  
27 inspection pursuant to this subdivision, the portion of the contract  
28 or amendment containing the rates of payment shall be open to  
29 inspection.

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

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

1 (F) For purposes of this paragraph, “fully executed” means the  
2 point in time when all of the necessary parties to the contract have  
3 signed the contract.

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

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

11 SEC. 3. Section 26605.6 of the Government Code is amended  
12 to read:

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

21 (b) Before the release of any prisoner pursuant to this section,  
22 the sheriff shall notify the presiding judge of the superior court of  
23 his or her intention to release the prisoner. This notification shall  
24 include:

25 (1) The prisoner’s name.

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

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

29 (4) The physician’s diagnosis of the prisoner’s condition.

30 (5) The physician’s prognosis for the prisoner’s recovery.

31 (6) The prisoner’s address after release.

32 (c) (1) This section shall be implemented only to the extent that  
33 a county that releases a prisoner pursuant to this section does both  
34 of the following:

35 (A) Sends a letter to the State Department of Health Care  
36 Services agreeing to do both of the following:

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



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

4 (B) For the period of time that the offender would otherwise  
5 have been incarcerated:

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

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

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

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

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

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

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

1 (f) This section shall not be construed as authorizing the sheriff  
2 to refuse to receive and incarcerate a defendant or sentenced  
3 individual who is not in need of immediate medical care or who  
4 has a terminal medical condition.

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

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

26 SEC. 4. Section 26605.7 of the Government Code is amended  
27 to read:

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

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

39 (2) The prisoner would require acute long-term inpatient  
40 rehabilitation services.

1 (b) Before a prisoner's release to medical probation, the sheriff,  
2 or his or her designee, shall secure a placement option for the  
3 prisoner in the community and, in consultation with the county  
4 welfare department or another applicable county agency, examine  
5 the prisoner's eligibility for federal Medicaid benefits or other  
6 medical coverage that might assist in funding the prisoner's  
7 medical treatment while in the community.

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

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

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

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

33 (A) Sends a letter to the State Department of Health Care  
34 Services agreeing to do both of the following:

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

38 (ii) Notify the State Department of Health Care Services, in  
39 writing, if a probationer released pursuant to this section, who is  
40 Medi-Cal eligible, is returned to the custody of the sheriff. The

1 chief probation officer shall notify the State Department of Health  
2 Care Services, in writing, when a Medi-Cal eligible probationer's  
3 term of medical probation ends.

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

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

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

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

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

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

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

1 SEC. 5. Section 26605.8 of the Government Code is amended  
2 to read:

3 26605.8. Before implementing Sections 26605.6 and 26605.7,  
4 the county board of supervisors shall adopt a process to fund the  
5 nonfederal share of Medi-Cal costs for the period of time that a  
6 prisoner would have otherwise been incarcerated or for the period  
7 of time that a probationer is on medical probation. The county  
8 board of supervisors shall provide the State Department of Health  
9 Care Services with written notification of the process.

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

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

21 SEC. 7. Section 1250.2 of the Health and Safety Code is  
22 amended to read:

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

35 (2) It is the intent of the Legislature that the psychiatric health  
36 facility shall provide a distinct type of service to psychiatric  
37 patients in a 24-hour acute inpatient setting. The State Department  
38 of Health Care Services shall require regular utilization reviews  
39 of admission and discharge criteria and lengths of stay in order to

1 assure that these patients are moved to less restrictive levels of  
2 care as soon as appropriate.

3 (b) (1) The State Department of Health Care Services may issue  
4 a special permit to a psychiatric health facility for it to provide  
5 structured outpatient services (commonly referred to as SOPS)  
6 consisting of morning, afternoon, or full daytime organized  
7 programs, not exceeding 10 hours, for acute daytime care for  
8 patients admitted to the facility. This subdivision shall not be  
9 construed as requiring a psychiatric health facility to apply for a  
10 special permit to provide these alternative levels of care.

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

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

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

30 (1) The facility is a licensed facility.

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

36 (3) The facility meets the definitions and requirements contained  
37 in subdivisions (e) and (f) of Section 1861 of the federal Social  
38 Security Act (42 U.S.C. Sec. 1395x(e) and (f)), including the  
39 approval process specified in Section 1861(e)(7)(B) of the federal  
40 Social Security Act (42 U.S.C. Sec. 1395x(e)(7)(B)), which

1 requires that the state agency responsible for licensing hospitals  
2 has assured that the facility meets licensing requirements.

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

5 SEC. 8. Section 1254 of the Health and Safety Code is amended  
6 to read:

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

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

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

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

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

1 (4) All beds licensed to an acute care hospital in a rural area as  
2 defined by Chapter 1010, of the Statutes of 1982, are exempt from  
3 the requirements of subdivision (b), except where there is a  
4 freestanding skilled nursing facility or intermediate care facility  
5 which has experienced an occupancy rate of 95 percent or less  
6 during the past 12 months within a 25-mile radius or which may  
7 be reached within 30 minutes using a motor vehicle.

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 1275.1. (a) Notwithstanding any rules or regulations governing  
27 other health facilities, the regulations developed by the State  
28 Department of Health Care Services, or a predecessor, for  
29 psychiatric health facilities shall prevail. The regulations applying  
30 to psychiatric health facilities shall prescribe standards of adequacy,  
31 safety, and sanitation of the physical plant, of staffing with duly  
32 qualified licensed personnel, and of services based on the needs  
33 of the persons served thereby.

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

36 (1) Involuntary ambulatory psychiatric patients.

37 (2) Voluntary ambulatory psychiatric patients.

38 For purposes of this subdivision, “ambulatory patients” shall  
39 include, but not be limited to, deaf, blind, and physically  
40 handicapped persons. Disoriented persons who are not bedridden

1 or confined to a wheelchair shall also be considered as ambulatory  
2 patients.

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

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

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

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

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

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

28 1275.5. (a) The regulations relating to the licensing of  
29 hospitals, heretofore adopted by the State Department of Public  
30 Health pursuant to former Chapter 2 (commencing with Section  
31 1400) of Division 2, and in effect immediately prior to July 1,  
32 1973, shall remain in effect and shall be fully enforceable with  
33 respect to any hospital required to be licensed by this chapter,  
34 unless and until the regulations are readopted, amended, or repealed  
35 by the director.

36 (b) The regulations relating to private institutions receiving or  
37 caring for any mentally disordered persons, intellectually disabled  
38 persons, and other incompetent persons, heretofore adopted by the  
39 Department of Mental Hygiene pursuant to Chapter 1 (commencing  
40 with Section 7000) of Division 7 of the Welfare and Institutions

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

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

18 (2) The State Department of Health Care Services shall succeed  
19 to and be vested with all duties, powers, purposes, functions,  
20 responsibilities, and jurisdiction as they relate to licensing  
21 psychiatric health facilities.

22 SEC. 13. Section 1324.9 of the Health and Safety Code is  
23 amended to read:

24 1324.9. (a) The Long-Term Care Quality Assurance Fund is  
25 hereby created in the State Treasury. Moneys in the fund shall be  
26 available, upon appropriation by the Legislature, for expenditure  
27 by the State Department of Health Care Services for the purposes  
28 of this article and Article 7.6 (commencing with Section 1324.20).  
29 Notwithstanding Section 16305.7 of the Government Code, the  
30 fund shall contain all interest and dividends earned on moneys in  
31 the fund.

32 (b) Notwithstanding any other law, beginning August 1, 2013,  
33 all revenues received by the State Department of Health Care  
34 Services categorized by the State Department of Health Care  
35 Services as long-term care quality assurance fees shall be deposited  
36 into the Long-Term Care Quality Assurance Fund. Revenue that  
37 shall be deposited into this fund shall include quality assurance  
38 fees imposed pursuant to this article and quality assurance fees  
39 imposed pursuant to Article 7.6 (commencing with Section  
40 1324.20).

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

5 SEC. 14. Section 1373 of the Health and Safety Code is  
6 amended to read:

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

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

16 (3) A plan contract shall not provide an exemption for  
17 enrollment because of an applicant's entitlement to Medi-Cal  
18 benefits under Chapter 7 (commencing with Section 14000) or  
19 Chapter 8 (commencing with Section 14200) of Part 3 of Division  
20 9 of the Welfare and Institutions Code, or Medicaid benefits under  
21 Subchapter 19 (commencing with Section 1396) of Chapter 7 of  
22 Title 42 of the United States Code.

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

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

31 (2) As used in this section, "sterilization operations or  
32 procedures" shall have the same meaning as that specified in  
33 Section 10120 of the Insurance Code.

34 (c) Every plan contract that provides coverage to the spouse or  
35 dependents of the subscriber or spouse shall grant immediate  
36 accident and sickness coverage, from and after the moment of  
37 birth, to each newborn infant of any subscriber or spouse covered  
38 and to each minor child placed for adoption from and after the date  
39 on which the adoptive child's birth parent or other appropriate  
40 legal authority signs a written document, including, but not limited

1 to, a health facility minor release report, a medical authorization  
2 form, or a relinquishment form, granting the subscriber or spouse  
3 the right to control health care for the adoptive child or, absent  
4 this written document, on the date there exists evidence of the  
5 subscriber's or spouse's right to control the health care of the child  
6 placed for adoption. No plan may be entered into or amended if it  
7 contains any disclaimer, waiver, or other limitation of coverage  
8 relative to the coverage or insurability of newborn infants of, or  
9 children placed for adoption with, a subscriber or spouse covered  
10 as required by this subdivision.

11 (d) (1) Every plan contract that provides that coverage of a  
12 dependent child of a subscriber shall terminate upon attainment  
13 of the limiting age for dependent children specified in the plan,  
14 shall also provide that attainment of the limiting age shall not  
15 operate to terminate the coverage of the child while the child is  
16 and continues to meet both of the following criteria:

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

19 (B) Chiefly dependent upon the subscriber for support and  
20 maintenance.

21 (2) The plan shall notify the subscriber that the dependent child's  
22 coverage will terminate upon attainment of the limiting age unless  
23 the subscriber submits proof of the criteria described in  
24 subparagraphs (A) and (B) of paragraph (1) to the plan within 60  
25 days of the date of receipt of the notification. The plan shall send  
26 this notification to the subscriber at least 90 days prior to the date  
27 the child attains the limiting age. Upon receipt of a request by the  
28 subscriber for continued coverage of the child and proof of the  
29 criteria described in subparagraphs (A) and (B) of paragraph (1),  
30 the plan shall determine whether the child meets that criteria before  
31 the child attains the limiting age. If the plan fails to make the  
32 determination by that date, it shall continue coverage of the child  
33 pending its determination.

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

39 (4) If the subscriber changes carriers to another plan or to a  
40 health insurer, the new plan or insurer shall continue to provide

1 coverage for the dependent child. The new plan or insurer may  
2 request information about the dependent child initially and not  
3 more frequently than annually thereafter to determine if the child  
4 continues to satisfy the criteria in subparagraphs (A) and (B) of  
5 paragraph (1). The subscriber shall submit the information  
6 requested by the new plan or insurer within 60 days of receiving  
7 the request.

8 (5) (A) Except as set forth in subparagraph (B), under no  
9 circumstances shall the limiting age be less than 26 years of age  
10 with respect to plan years beginning on or after September 23,  
11 2010.

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

22 (C) (i) With respect to a child (I) whose coverage under a group  
23 or individual plan contract ended, or who was denied or not eligible  
24 for coverage under a group or individual plan contract, because  
25 under the terms of the contract the availability of dependent  
26 coverage of children ended before the attainment of 26 years of  
27 age, and (II) who becomes eligible for that coverage by reason of  
28 the application of this paragraph, the health care service plan shall  
29 give the child an opportunity to enroll that shall continue for at  
30 least 30 days. This opportunity and the notice described in clause  
31 (ii) shall be provided not later than the first day of the first plan  
32 year beginning on or after September 23, 2010, consistent with  
33 the federal Patient Protection and Affordable Care Act (Public  
34 Law 111-148), as amended by the federal Health Care and  
35 Education Reconciliation Act of 2010 (Public Law 111-152), and  
36 any additional federal guidance or regulations issued by the United  
37 States Secretary of Health and Human Services.

38 (ii) The health care service plan shall provide written notice  
39 stating that a dependent described in clause (i) who has not attained  
40 26 years of age is eligible to enroll in the plan for coverage. This

1 notice may be provided to the dependent's parent on behalf of the  
2 dependent. If the notice is included with other enrollment materials  
3 for a group plan, the notice shall be prominent.

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

7 (iv) A dependent enrolling in a group health plan for coverage  
8 pursuant to this subparagraph shall be treated as a special enrollee  
9 as provided under the rules of Section 146.117(d) of Title 45 of  
10 the Code of Federal Regulations. The health care service plan shall  
11 offer the recipient of the notice all of the benefit packages available  
12 to similarly situated individuals who did not lose coverage by  
13 reason of cessation of dependent status. Any difference in benefits  
14 or cost-sharing requirements shall constitute a different benefit  
15 package. A dependent enrolling in a group health plan for coverage  
16 pursuant to this subparagraph shall not be required to pay more  
17 for coverage than similarly situated individuals who did not lose  
18 coverage by reason of cessation of dependent status.

19 (D) Nothing in this section shall require a health care service  
20 plan to make coverage available for a child of a child receiving  
21 dependent coverage. Nothing in this section shall be construed to  
22 modify the definition of "dependent" as used in the Revenue and  
23 Taxation Code with respect to the tax treatment of the cost of  
24 coverage.

25 (e) A plan contract that provides coverage, whether by specific  
26 benefit or by the effect of general wording, for both an employee  
27 and one or more covered persons dependent upon the employee  
28 and provides for an extension of the coverage for any period  
29 following a termination of employment of the employee shall also  
30 provide that this extension of coverage shall apply to dependents  
31 upon the same terms and conditions precedent as applied to the  
32 covered employee, for the same period of time, subject to payment  
33 of premiums, if any, as required by the terms of the policy and  
34 subject to any applicable collective bargaining agreement.

35 (f) A group contract shall not discriminate against handicapped  
36 persons or against groups containing handicapped persons. Nothing  
37 in this subdivision shall preclude reasonable provisions in a plan  
38 contract against liability for services or reimbursement of the  
39 handicap condition or conditions relating thereto, as may be  
40 allowed by rules of the director.



1 (g) Every group contract shall set forth the terms and conditions  
2 under which subscribers and enrollees may remain in the plan in  
3 the event the group ceases to exist, the group contract is terminated,  
4 or an individual subscriber leaves the group, or the enrollees'  
5 eligibility status changes.

6 (h) (1) A health care service plan or specialized health care  
7 service plan may provide for coverage of, or for payment for,  
8 professional mental health services, or vision care services, or for  
9 the exclusion of these services. If the terms and conditions include  
10 coverage for services provided in a general acute care hospital or  
11 an acute psychiatric hospital as defined in Section 1250 and do  
12 not restrict or modify the choice of providers, the coverage shall  
13 extend to care provided by a psychiatric health facility as defined  
14 in Section 1250.2 operating pursuant to licensure by the State  
15 Department of Health Care Services. A health care service plan  
16 that offers outpatient mental health services but does not cover  
17 these services in all of its group contracts shall communicate to  
18 prospective group contractholders as to the availability of outpatient  
19 coverage for the treatment of mental or nervous disorders.

20 (2) No plan shall prohibit the member from selecting any  
21 psychologist who is licensed pursuant to the Psychology Licensing  
22 Law (Chapter 6.6 (commencing with Section 2900) of Division 2  
23 of the Business and Professions Code), any optometrist who is the  
24 holder of a certificate issued pursuant to Chapter 7 (commencing  
25 with Section 3000) of Division 2 of the Business and Professions  
26 Code or, upon referral by a physician and surgeon licensed pursuant  
27 to the Medical Practice Act (Chapter 5 (commencing with Section  
28 2000) of Division 2 of the Business and Professions Code), (A)  
29 any marriage and family therapist who is the holder of a license  
30 under Section 4980.50 of the Business and Professions Code, (B)  
31 any licensed clinical social worker who is the holder of a license  
32 under Section 4996 of the Business and Professions Code, (C) any  
33 registered nurse licensed pursuant to Chapter 6 (commencing with  
34 Section 2700) of Division 2 of the Business and Professions Code,  
35 who possesses a master's degree in psychiatric-mental health  
36 nursing and is listed as a psychiatric-mental health nurse by the  
37 Board of Registered Nursing, (D) any advanced practice registered  
38 nurse certified as a clinical nurse specialist pursuant to Article 9  
39 (commencing with Section 2838) of Chapter 6 of Division 2 of  
40 the Business and Professions Code who participates in expert

1 clinical practice in the specialty of psychiatric-mental health  
2 nursing, to perform the particular services covered under the terms  
3 of the plan, and the certificate holder is expressly authorized by  
4 law to perform these services, or (E) any professional clinical  
5 counselor who is the holder of a license under Chapter 16  
6 (commencing with Section 4999.10) of Division 2 of the Business  
7 and Professions Code.

8 (3) Nothing in this section shall be construed to allow any  
9 certificate holder or licensee enumerated in this section to perform  
10 professional mental health services beyond his or her field or fields  
11 of competence as established by his or her education, training, and  
12 experience.

13 (4) For the purposes of this section:

14 (A) “Marriage and family therapist” means a licensed marriage  
15 and family therapist who has received specific instruction in  
16 assessment, diagnosis, prognosis, and counseling, and  
17 psychotherapeutic treatment of premarital, marriage, family, and  
18 child relationship dysfunctions, which is equivalent to the  
19 instruction required for licensure on January 1, 1981.

20 (B) “Professional clinical counselor” means a licensed  
21 professional clinical counselor who has received specific  
22 instruction in assessment, diagnosis, prognosis, counseling, and  
23 psychotherapeutic treatment of mental and emotional disorders,  
24 which is equivalent to the instruction required for licensure on  
25 January 1, 2012.

26 (5) Nothing in this section shall be construed to allow a member  
27 to select and obtain mental health or psychological or vision care  
28 services from a certificate holder or licensee who is not  
29 directly affiliated with or under contract to the health care service  
30 plan or specialized health care service plan to which the member  
31 belongs. All health care service plans and individual practice  
32 associations that offer mental health benefits shall make reasonable  
33 efforts to make available to their members the services of licensed  
34 psychologists. However, a failure of a plan or association to comply  
35 with the requirements of the preceding sentence shall not constitute  
36 a misdemeanor.

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

1 (7) Health care service plan coverage for professional mental  
2 health services may include community residential treatment  
3 services that are alternatives to inpatient care and that are directly  
4 affiliated with the plan or to which enrollees are referred by  
5 providers affiliated with the plan.

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

9 (j) A plan contract that provides benefits that accrue after a  
10 certain time of confinement in a health care facility shall specify  
11 what constitutes a day of confinement or the number of consecutive  
12 hours of confinement that are requisite to the commencement of  
13 benefits.

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

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

20 (2) If the dependent child takes a medical leave of absence, and  
21 the nature of the dependent child's injury, illness, or condition  
22 would render the dependent child incapable of self-sustaining  
23 employment, the provisions of subdivision (d) shall apply if the  
24 dependent child is chiefly dependent on the subscriber for support  
25 and maintenance.

26 (3) (A) If the dependent child takes a medical leave of absence  
27 from school, but the nature of the dependent child's injury, illness,  
28 or condition does not meet the requirements of paragraph (2), the  
29 dependent child's coverage shall not terminate for a period not to  
30 exceed 12 months or until the date on which the coverage is  
31 scheduled to terminate pursuant to the terms and conditions of the  
32 plan, whichever comes first. The period of coverage under this  
33 paragraph shall commence on the first day of the medical leave of  
34 absence from the school or on the date the physician and surgeon  
35 determines the illness prevented the dependent child from attending  
36 school, whichever comes first. Any break in the school calendar  
37 shall not disqualify the dependent child from coverage under this  
38 paragraph.

39 (B) Documentation or certification of the medical necessity for  
40 a leave of absence from school shall be submitted to the plan at

1 least 30 days prior to the medical leave of absence from the school,  
 2 if the medical reason for the absence and the absence are  
 3 foreseeable, or 30 days after the start date of the medical leave of  
 4 absence from school and shall be considered prima facie evidence  
 5 of entitlement to coverage under this paragraph.

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

8 SEC. 15. Section 104151 is added to the Health and Safety  
 9 Code, to read:

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

26 SEC. 16. Section 111792 of the Health and Safety Code is  
 27 amended to read:

28 111792. (a) The manufacturer of any cosmetic product subject  
 29 to regulation by the federal Food and Drug Administration that is  
 30 sold in this state shall, on a schedule and in electronic or other  
 31 format, as determined by the division, provide the division with a  
 32 complete and accurate list of its cosmetic products that, as of the  
 33 date of submission, are sold in the state and that contain any  
 34 ingredient that is a chemical identified as causing cancer or  
 35 reproductive toxicity, including any chemical that meets either of  
 36 the following conditions:

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

39 (2) A chemical identified by the phrase “and other ingredients”  
 40 and determined to be a trade secret pursuant to the procedure

1 established in Part 20 and Section 720.8 of Part 720 of Title 21 of  
2 the Code of Federal Regulations. Any ingredient identified pursuant  
3 to this paragraph shall be considered to be a trade secret and shall  
4 be treated by the division in a manner consistent with the  
5 requirements of Part 20 and Part 720 of Title 21 of the Code of  
6 Federal Regulations. Any ingredients considered to be a trade  
7 secret shall not be subject to the California Public Records Act  
8 (Chapter 3.5 (commencing with Section 6250) of Division 7 of  
9 Title 1 of the Government Code) for the purposes of this section.

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

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

28 (d) This section shall not apply to any manufacturer of cosmetic  
29 products with annual aggregate sales of cosmetic products, both  
30 within and outside of California, of less than one million dollars  
31 (\$1,000,000), based on the manufacturer's most recent tax year  
32 filing.

33 (e) On or before December 31, 2013, the State Department of  
34 Public Health shall develop and make operational a  
35 consumer-friendly, public Internet Web site that creates a database  
36 of the information collected pursuant to this section. The database  
37 shall be searchable to accommodate a wide range of users,  
38 including users with limited technical and scientific literacy. Data  
39 shall be presented in an educational manner with, among other  
40 things, hypertext links that explain the meanings of technical terms,

1 including, but not limited to, “carcinogenic” and “reproductive  
2 toxicity.” The Internet Web site shall be designed to be easily  
3 navigable and to enable users to compare and contrast products  
4 and reportable ingredients. The Internet Web site shall include  
5 hypertext links to other educational and informational Internet  
6 Web sites to enhance consumer understanding.

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

9 123870. (a) The department shall establish standards of  
10 financial eligibility for treatment services under the California  
11 Children’s Services Program (CCS program).

12 (1) Financial eligibility for treatment services under this program  
13 shall be limited to persons in families with an adjusted gross  
14 income of forty thousand dollars (\$40,000) or less in the most  
15 recent tax year, as calculated for California state income tax  
16 purposes. If a person is enrolled in the Healthy Families Program  
17 (Part 6.2 (commencing with Section 12693) of Division 2 of the  
18 Insurance Code), the financial documentation required for that  
19 program in Section 2699.6600 of Title 10 of the California Code  
20 of Regulations may be used instead of the person’s California state  
21 income tax return. If a person is enrolled in the Medi-Cal program  
22 pursuant to Section 14005.26 of the Welfare and Institutions Code,  
23 or enrolled in the AIM-Linked Infants Program pursuant to Chapter  
24 2 (commencing with Section 15850) of Part 3.3 of Division 9 of  
25 the Welfare and Institutions Code, the financial documentation  
26 required to establish eligibility for the respective programs may  
27 be used instead of the person’s California state income tax return.  
28 However, the director may authorize treatment services for persons  
29 in families with higher incomes if the estimated cost of care to the  
30 family in one year is expected to exceed 20 percent of the family’s  
31 adjusted gross income.

32 (2) Children enrolled in the Healthy Families Program, the  
33 Medi-Cal program pursuant to Section 14005.26 of the Welfare  
34 and Institutions Code, or the AIM-Linked Infants Program pursuant  
35 to Chapter 2 (commencing with Section 15850) of Part 3.3 of  
36 Division 9 of the Welfare and Institutions Code, who have a CCS  
37 program eligible medical condition under Section 123830, and  
38 whose families do not meet the financial eligibility requirements  
39 of paragraph (1), shall be deemed financially eligible for CCS  
40 program benefits.

1 (b) Necessary medical therapy treatment services under the  
2 California Children’s Services Program rendered in the public  
3 schools shall be exempt from financial eligibility standards and  
4 enrollment fee requirements for the services when rendered to any  
5 handicapped child whose educational or physical development  
6 would be impeded without the services.

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.

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 as a related service in their individualized  
18 education plans, for children from families having incomes of less  
19 than 100 percent of the federal poverty level, or for children  
20 covered under the Healthy Families Program or the AIM-Linked  
21 Infants Program.

22 SEC. 18. Section 123929 of the Health and Safety Code is  
23 amended to read:

24 123929. (a) Except as otherwise provided in this section and  
25 Section 14133.05 of the Welfare and Institutions Code, California  
26 Children’s Services Program services provided pursuant to this  
27 article require prior authorization by the department or its designee.  
28 Prior authorization is contingent on determination by the  
29 department or its designee of all of the following:

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

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

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

36 (b) The department or its designee may approve a request for a  
37 treatment authorization that is otherwise in conformance with  
38 subdivision (a) for services for a child participating in the Healthy  
39 Families Program or the AIM-Linked Infants Program pursuant  
40 to clause (ii) of subparagraph (A) of paragraph (6) of subdivision

1 (a) of Section 12693.70 of the Insurance Code or Chapter 2  
2 (commencing with Section 15850) of Part 3.3 of Division 9 of the  
3 Welfare and Institutions Code, received by the department or its  
4 designee after the requested treatment has been provided to the  
5 child.

6 (c) If a provider of services who meets the requirements of  
7 paragraph (2) of subdivision (a) incurs costs for services described  
8 in paragraph (3) of subdivision (a) to treat a child described in  
9 subdivision (b) who is subsequently determined to be medically  
10 eligible for the CCS program as determined by the department or  
11 its designee, the department may reimburse the provider for those  
12 costs. Reimbursement under this section shall conform to the  
13 requirements of Section 14105.18 of the Welfare and Institutions  
14 Code.

15 SEC. 19. Section 123940 of the Health and Safety Code is  
16 amended to read:

17 123940. (a) (1) Annually, the board of supervisors shall  
18 appropriate a sum of money for services for handicapped children  
19 of the county, including diagnosis, treatment, and therapy services  
20 for physically handicapped children in public schools, equal to 25  
21 percent of the actual expenditures for the county program under  
22 this article for the 1990–91 fiscal year, except as specified in  
23 paragraph (2).

24 (2) If the state certifies that a smaller amount is needed in order  
25 for the county to pay 25 percent of costs of the county's program  
26 from this source. The smaller amount certified by the state shall  
27 be the amount that the county shall appropriate.

28 (b) In addition to the amount required by subdivision (a), the  
29 county shall allocate an amount equal to the amount determined  
30 pursuant to subdivision (a) for purposes of this article from  
31 revenues allocated to the county pursuant to Chapter 6  
32 (commencing with Section 17600) of Division 9 of the Welfare  
33 and Institutions Code.

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

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

39 (d) The county may appropriate and expend moneys in addition  
40 to those set forth in subdivision (a) and (b) and the state shall match



1 the expenditures, on a dollar-for-dollar basis, to the extent that  
2 state funds are available for this article.

3 (e) County appropriations under subdivisions (a) and (b) shall  
4 include county financial participation in the nonfederal share of  
5 expenditures for services for children who are enrolled in the  
6 Medi-Cal program pursuant to Section 14005.26 of the Welfare  
7 and Institutions Code, or the AIM-Linked Infants Program pursuant  
8 to Chapter 2 (commencing with Section 15850) of Part 3.3 of  
9 Division 9 of the Welfare and Institutions Code, and who are  
10 eligible for services under this article pursuant to paragraph (1) of  
11 subdivision (a) of Section 123870, to the extent that federal  
12 financial participation is available at the enhanced federal  
13 reimbursement rate under Title XXI of the federal Social Security  
14 Act (42 U.S.C. Sec. 1397aa et seq.) and funds are appropriated for  
15 the California Children’s Services Program in the State Budget.

16 (f) Nothing in this section shall require the county to expend  
17 more than the amount set forth in subdivision (a) plus the amount  
18 set forth in subdivision (b) nor shall it require the state to expend  
19 more than the amount of the match set forth in subdivision (c).

20 (g) Notwithstanding Chapter 3.5 (commencing with Section  
21 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
22 the department, without taking further regulatory action, shall  
23 implement this section by means of California Children’s Services  
24 numbered letters.

25 SEC. 20. Section 123955 of the Health and Safety Code is  
26 amended to read:

27 123955. (a) The state and the counties shall share in the cost  
28 of administration of the California Children’s Services Program  
29 at the local level.

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

34 (2) The standards shall allow necessary flexibility in the  
35 administration of county programs, taking into account the  
36 variability of county needs and resources, and shall be developed  
37 and revised jointly with state and county representatives.

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

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

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

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

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

26 (3) On or before September 15 of each year, each county  
27 program implementing this article shall submit an application for  
28 the subsequent fiscal year that provides information as required  
29 by the state to determine if the county administrative staff and  
30 budget meet state standards.

31 (4) The state shall determine the maximum amount of state  
32 funds available for each county from state funds appropriated for  
33 CCS county administration. If the amount appropriated for any  
34 fiscal year in the Budget Act for county administration under this  
35 article differs from the amounts approved by the department, each  
36 county shall submit a revised application in a form and at the time  
37 specified by the department.

38 (f) The department and counties shall maximize the use of  
39 federal funds for administration of the programs implemented  
40 pursuant to this article, including using state and county funds to

1 match funds claimable under Title XIX or Title XXI of the federal  
2 Social Security Act (42 U.S.C. Sec. 1396 et seq.; 42 U.S.C. Sec.  
3 1397aa et seq.).

4 SEC. 21. Section 10125 of the Insurance Code is amended to  
5 read:

6 10125. (a) On and after January 1, 1974, every insurer issuing  
7 group disability insurance which covers hospital, medical, or  
8 surgical expenses shall offer coverage for expenses incurred as a  
9 result of mental or nervous disorders, under the terms and  
10 conditions which may be agreed upon between the group  
11 policyholder and the insurer. If the terms and conditions include  
12 coverage for inpatient care for nervous or mental disorders, the  
13 coverage shall extend to treatment provided at all of the following  
14 facilities:

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

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

19 (3) A psychiatric health facility as defined by Section 1250.2  
20 of the Health and Safety Code operating pursuant to licensure by  
21 the State Department of Health Care Services.

22 Nothing in this subdivision prohibits an insurer that negotiates  
23 and enters into a contract with a professional or institutional  
24 provider for alternative rates of payment pursuant to Section 10133  
25 from restricting or modifying the choice of providers.

26 (b) Every insurer shall communicate to prospective group  
27 policyholders as to the availability of outpatient coverage for the  
28 treatment of mental or nervous disorders. Every insurer shall  
29 communicate the availability of that coverage to all group  
30 policyholders and to all prospective group policyholders with  
31 whom they are negotiating. This coverage may include community  
32 residential treatment services, as described in former Section 5458  
33 of the Welfare and Institutions Code, that are alternatives to  
34 institutional care.

35 SEC. 22. Section 10127 of the Insurance Code is amended to  
36 read:

37 10127. On and after January 1, 1974, every self-insured  
38 employee welfare benefit plan that provides coverage for hospital,  
39 medical, or surgical expenses shall offer coverage for expenses  
40 incurred as a result of mental or nervous disorders, under the terms

1 and conditions which may be agreed upon between the self-insured  
2 welfare benefit plan and the member. If the terms and conditions  
3 include coverage for services provided in a general acute care  
4 hospital, or an acute psychiatric hospital as defined in Section 1250  
5 of the Health and Safety Code, and do not restrict or modify the  
6 choice of providers, the coverage shall extend to care provided by  
7 a psychiatric health facility, as defined by Section 1250.2 of the  
8 Health and Safety Code, operating pursuant to licensure by the  
9 State Department of Health Care Services. Every plan shall  
10 communicate to prospective members as to the availability of  
11 outpatient coverage for the treatment of mental or nervous  
12 disorders. Every self-insured welfare benefit plan shall  
13 communicate the availability of this coverage to all members and  
14 prospective members. This coverage may include community  
15 residential treatment services, as described in former Section 5458  
16 of the Welfare and Institutions Code, that are alternatives to  
17 institutional care.

18 SEC. 23. Section 12693.70 of the Insurance Code is amended  
19 to read:

20 12693.70. To be eligible to participate in the program, an  
21 applicant shall meet all of the following requirements:

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

24 (1) Less than 19 years of age. An application may be made on  
25 behalf of a child not yet born up to three months prior to the  
26 expected date of delivery. Coverage shall begin as soon as  
27 administratively feasible, as determined by the board, after the  
28 board receives notification of the birth. However, no child less  
29 than 12 months of age shall be eligible for coverage until 90 days  
30 after the enactment of the Budget Act of 1999.

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

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

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

38 (5) A resident of the State of California pursuant to Section 244  
39 of the Government Code; or, if not a resident pursuant to Section  
40 244 of the Government Code, is physically present in California

1 and entered the state with a job commitment or to seek  
2 employment, whether or not employed at the time of application  
3 to or after acceptance in, the program.

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

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

7 (ii) (I) When implemented by the board, subject to subdivision  
8 (b) of Section 12693.765 and pursuant to this section, a child under  
9 the age of two years who was delivered by a mother enrolled in  
10 the Access for Infants and Mothers Program as described in Part  
11 6.3 (commencing with Section 12695). Commencing July 1, 2007,  
12 eligibility under this subparagraph shall not include infants during  
13 any time they are enrolled in employer-sponsored health insurance  
14 or are subject to an exclusion pursuant to Section 12693.71 or  
15 12693.72, or are enrolled in the full scope of benefits under the  
16 Medi-Cal program at no share of cost. For purposes of this clause,  
17 any infant born to a woman whose enrollment in the Access for  
18 Infants and Mothers Program begins after June 30, 2004, shall be  
19 automatically enrolled in the Healthy Families Program, except  
20 during any time on or after July 1, 2007, that the infant is enrolled  
21 in employer-sponsored health insurance or is subject to an  
22 exclusion pursuant to Section 12693.71 or 12693.72, or is enrolled  
23 in the full scope of benefits under the Medi-Cal program at no  
24 share of cost. Except as otherwise specified in this section, this  
25 enrollment shall cover the first 12 months of the infant's life. At  
26 the end of the 12 months, as a condition of continued eligibility,  
27 the applicant shall provide income information. The infant shall  
28 be disenrolled if the gross annual household income exceeds the  
29 income eligibility standard that was in effect in the Access for  
30 Infants and Mothers Program at the time the infant's mother  
31 became eligible, or following the two-month period established  
32 in Section 12693.981 if the infant is eligible for Medi-Cal with no  
33 share of cost. At the end of the second year, infants shall again be  
34 screened for program eligibility pursuant to this section, with  
35 income eligibility evaluated pursuant to clause (i), subparagraphs  
36 (B) and (C), and paragraph (2) of subdivision (a).

37 (II) Effective on October 1, 2013, or when the State Department  
38 of Health Care Services has implemented Chapter 2 (commencing  
39 with Section 15850) of Part 3.3 of Division 9 of the Welfare and  
40 Institutions Code, whichever is later, eligibility for coverage in

1 the program pursuant to this clause shall terminate. The board shall  
2 coordinate with the State Department of Health Care Services to  
3 implement Chapter 2 (commencing with Section 15850) of Part  
4 3.3 of Division 9 of the Welfare and Institutions Code, including  
5 transition of subscribers to the AIM-Linked Infants Program. The  
6 State Department of Health Care Services shall administer the  
7 AIM-Linked Infants Program, pursuant to Chapter 2 (commencing  
8 with Section 15850) of Part 3.3 of Division 9 of the Welfare and  
9 Institutions Code, to address the health care needs of children  
10 formerly covered pursuant to this clause.

11 (B) All income over 200 percent of the federal poverty level  
12 but less than or equal to 250 percent of the federal poverty level  
13 shall be disregarded in calculating annual or monthly household  
14 income.

15 (C) In a family with an annual or monthly household income  
16 greater than 250 percent of the federal poverty level, any income  
17 deduction that is applicable to a child under Medi-Cal shall be  
18 applied in determining the annual or monthly household income.  
19 If the income deductions reduce the annual or monthly household  
20 income to 250 percent or less of the federal poverty level,  
21 subparagraph (B) shall be applied.

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

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

27 (d) In filing documentation to meet program eligibility  
28 requirements, if the applicant's income documentation cannot be  
29 provided, as defined in regulations promulgated by the board, the  
30 applicant's signed statement as to the value or amount of income  
31 shall be deemed to constitute verification.

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

35 (f) By January 2008, the board, in consultation with  
36 stakeholders, shall implement processes by which applicants for  
37 subscribers may certify income at the time of annual eligibility  
38 review, including rules concerning which applicants shall be  
39 permitted to certify income and the circumstances in which  
40 supplemental information or documentation may be required. The

1 board may terminate using these processes not sooner than 90 days  
2 after providing notification to the Chair of the Joint Legislative  
3 Budget Committee. This notification shall articulate the specific  
4 reasons for the termination and shall include all relevant data  
5 elements that are applicable to document the reasons for the  
6 termination. Upon the request of the Chair of the Joint Legislative  
7 Budget Committee, the board shall promptly provide any additional  
8 clarifying information regarding implementation of the processes  
9 required by this subdivision.

10 SEC. 24. Section 12698 of the Insurance Code is amended to  
11 read:

12 12698. To be eligible to participate in the program, a person  
13 shall meet all of the following requirements:

14 (a) Be a resident of the state. A person who is a member of a  
15 federally recognized California Indian tribe is a resident of the  
16 state for these purposes.

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

22 (2) Upon the first day of the second month following the  
23 effective date of the amendment made to this subdivision in 1994,  
24 have a household income that is above 200 percent of the official  
25 federal poverty level but does not exceed 250 percent of the official  
26 federal poverty level unless the board determines that the program  
27 funds are adequate to serve households above the 250 percent of  
28 the official federal poverty level.

29 (c) Pay an initial subscriber contribution of not more than fifty  
30 dollars (\$50), and agree to the payment of the complete subscriber  
31 contribution. A federally recognized California Indian tribal  
32 government may make the initial and complete subscriber  
33 contributions on behalf of a member of the tribe only if a  
34 contribution on behalf of members of federally recognized  
35 California Indian tribes does not limit or preclude federal financial  
36 participation under Title XXI of the Social Security Act. If a  
37 federally recognized California Indian tribal government makes a  
38 contribution on behalf of a member of the tribe, the tribal  
39 government shall ensure that the subscriber is made aware of all

1 the health plan options available in the county where the member  
2 resides.

3 (d) Effective January 1, 2014, when determining eligibility for  
4 benefits under the program, income shall be determined, counted,  
5 and valued in accordance with the requirements of Section  
6 1397bb(b)(1)(B) of Title 42 of the United States Code as added  
7 by the federal Patient Protection and Affordable Care Act (Public  
8 Law 111-148) and as amended by the federal Health Care and  
9 Education Reconciliation Act of 2010 (Public Law 111-152) and  
10 any subsequent amendments.

11 SEC. 25. Section 12737 of the Insurance Code is amended to  
12 read:

13 12737. (a) The board shall establish program contribution  
14 amounts for each category of risk for each participating health  
15 plan. The program contribution amounts shall be based on the  
16 average amount of subsidy funds required for the program as a  
17 whole. To determine the average amount of subsidy funds required,  
18 the board shall calculate a loss ratio, including all medical costs,  
19 administration fees, and risk payments, for the program in the prior  
20 calendar year. The loss ratio shall be calculated using 125 percent  
21 of the standard average individual rates for comparable coverage  
22 as the denominator, and all medical costs, administration fees, and  
23 risk payments as the numerator. The average amount of subsidy  
24 funds required is calculated by subtracting 100 percent from the  
25 program loss ratio. For purposes of calculating the program loss  
26 ratio, no participating health plan's loss ratio shall be less than 100  
27 percent and participating health plans with fewer than 1,000  
28 program members shall be excluded from the calculation.

29 Subscriber contributions shall be established to encourage  
30 members to select those health plans requiring subsidy funds at or  
31 below the program average subsidy. Subscriber contribution  
32 amounts shall be established so that no subscriber receives a  
33 subsidy greater than the program average subsidy, except that:

34 (1) In all areas of the state, at least one plan shall be available  
35 to program participants at an average subscriber contribution of  
36 125 percent of the standard average individual rates for comparable  
37 coverage.

38 (2) No subscriber contribution shall be increased by more than  
39 10 percent above 125 percent of the standard average individual  
40 rates for comparable coverage.



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

6 (b) The program shall pay program contribution amounts to  
7 participating health plans from the Major Risk Medical Insurance  
8 Fund.

9 (c) Commencing January 1, 2013, in addition to the amount of  
10 subsidy funds required pursuant to subdivision (a), the program  
11 may further subsidize subscriber contributions so that the amount  
12 paid by each subscriber is below 125 percent of the standard  
13 average individual risk rate for comparable coverage but no less  
14 than 100 percent of the standard average individual risk rate for  
15 comparable coverage. For purposes of calculating premiums for  
16 the following products, any reference to, or use of, subscriber  
17 contributions, premiums, average premiums, or amounts paid by  
18 subscribers in the program shall be construed to mean subscriber  
19 contributions as described in subdivision (a) without application  
20 of the additional subsidies permitted by this subdivision:

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

23 (2) Health benefit plans and health care service plan contracts  
24 for federally eligible defined individuals pursuant to Sections  
25 10901.3 and 10901.9 and Sections 1399.805 and 1399.811 of the  
26 Health and Safety Code.

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

29 SEC. 26. Section 12739.61 of the Insurance Code is amended  
30 to read:

31 12739.61. The board shall cease to provide coverage through  
32 the program on July 1, 2013, except as required by the contract  
33 between the board and the United States Department of Health  
34 and Human Services, and at that time shall cease to operate the  
35 program except as required to complete payments to, or payment  
36 reconciliations with, participating health plans or other contractors,  
37 process appeals, or conduct other necessary termination activities.

38 SEC. 27. Section 359 of the Welfare and Institutions Code is  
39 amended to read:

1 359. (a) Whenever a minor who appears to be a danger to  
2 himself or others as a result of the use of narcotics, as defined in  
3 Section 11019 of the Health and Safety Code, or a restricted  
4 dangerous drug (as defined in former Section 11901 of the Health  
5 and Safety Code), is brought before any judge of the juvenile court,  
6 the judge may continue the hearing and proceed pursuant to this  
7 section. The court may order the minor taken to a facility  
8 designated by the county and approved by the State Department  
9 of Health Care Services as a facility for 72-hour treatment and  
10 evaluation. Thereupon the provisions of Section 11922 of the  
11 Health and Safety Code shall apply, except that the professional  
12 person in charge of the facility shall make a written report to the  
13 court concerning the results of the evaluation of the minor.

14 (b) If the professional person in charge of the facility for 72-hour  
15 evaluation and treatment reports to the juvenile court that the minor  
16 is not a danger to himself or others as a result of the use of narcotics  
17 or restricted dangerous drugs or that the minor does not require  
18 14-day intensive treatment, or if the minor has been certified for  
19 not more than 14 days of intensive treatment and the certification  
20 is terminated, the minor shall be released if the juvenile court  
21 proceedings have been dismissed; referred for further care and  
22 treatment on a voluntary basis, subject to the disposition of the  
23 juvenile court proceedings; or returned to the juvenile court, in  
24 which event the court shall proceed with the case pursuant to this  
25 chapter.

26 (c) Any expenditure for the evaluation or intensive treatment  
27 of a minor under this section shall be considered an expenditure  
28 made under Part 2 (commencing with Section 5600) of Division  
29 5, and shall be reimbursed by the state as are other local  
30 expenditures pursuant to that part.

31 SEC. 28. Section 708 of the Welfare and Institutions Code is  
32 amended to read:

33 708. (a) Whenever a minor who appears to be a danger to  
34 himself or herself or others as a result of the use of controlled  
35 substances (as defined in Division 10 (commencing with Section  
36 11000) of the Health and Safety Code), is brought before any judge  
37 of the juvenile court, the judge may continue the hearing and  
38 proceed pursuant to this section. The court may order the minor  
39 taken to a facility designated by the county and approved by the  
40 State Department of Health Care Services as a facility for 72-hour

1 treatment and evaluation. Thereupon the provisions of Section  
2 5343 shall apply, except that the professional person in charge of  
3 the facility shall make a written report to the court concerning the  
4 results of the evaluation of the minor.

5 (b) If the professional person in charge of the facility for 72-hour  
6 evaluation and treatment reports to the juvenile court that the minor  
7 is not a danger to himself or herself or others as a result of the use  
8 of controlled substances or that the minor does not require 14-day  
9 intensive treatment, or if the minor has been certified for not more  
10 than 14 days of intensive treatment and the certification is  
11 terminated, the minor shall be released if the juvenile court  
12 proceedings have been dismissed; referred for further care and  
13 treatment on a voluntary basis, subject to the disposition of the  
14 juvenile court proceedings; or returned to the juvenile court, in  
15 which event the court shall proceed with the case pursuant to this  
16 chapter.

17 (c) Any expenditure for the evaluation or intensive treatment  
18 of a minor under this section shall be considered an expenditure  
19 made under Part 2 (commencing with Section 5600) of Division  
20 5, and shall be reimbursed by the state as are other local  
21 expenditures pursuant to that part.

22 SEC. 29. Section 4005.7 of the Welfare and Institutions Code  
23 is amended to read:

24 4005.7. All regulations heretofore adopted by the State  
25 Department of Mental Health, and its successor, pursuant to  
26 authority vested in the State Department of Health Care Services  
27 by Section 4005.1 and in effect immediately preceding the  
28 operative date of the act that amended this section in the first year  
29 of the 2013–14 Regular Session shall remain in effect and shall  
30 be fully enforceable unless and until readopted, amended, or  
31 repealed by the Director of Health Care Services.

32 SEC. 30. Section 4080 of the Welfare and Institutions Code is  
33 amended to read:

34 4080. (a) Psychiatric health facilities, as defined in Section  
35 1250.2 of the Health and Safety Code, shall only be licensed by  
36 the State Department of Health Care Services subsequent to  
37 application by counties, county contract providers, or other  
38 organizations pursuant to this part.

39 (b) (1) For counties or county contract providers that choose  
40 to apply, the local mental health director shall first present to the

1 local mental health advisory board for its review an explanation  
2 of the need for the facility and a description of the services to be  
3 provided. The local mental health director shall then submit to the  
4 governing body the explanation and description. The governing  
5 body, upon its approval, may submit the application to the State  
6 Department of Health Care Services.

7 (2) Other organizations that will be applying for licensure and  
8 do not intend to use any Bronzan-McCorquodale funds pursuant  
9 to Section 5707 shall submit to the local mental health director  
10 and the governing body in the county in which the facility is to be  
11 located a written and dated proposal of the services to be provided.  
12 The local mental health director and governing body shall have  
13 30 days during which to provide any advice and recommendations  
14 regarding licensure, as they deem appropriate. At any time after  
15 the 30-day period, the organizations may then submit their  
16 applications, along with the mental health director's and governing  
17 body's advice and recommendations, if any, to the State  
18 Department of Health Care Services.

19 (c) The State Fire Marshal and other appropriate state agencies,  
20 to the extent required by law, shall cooperate fully with the State  
21 Department of Health Care Services to ensure that the State  
22 Department of Health Care Services approves or disapproves the  
23 licensure applications not later than 90 days after the application  
24 submission by a county, county contract provider, or other  
25 organization.

26 (d) Every psychiatric health facility and program for which a  
27 license has been issued shall be periodically inspected by a  
28 multidisciplinary team appointed or designated by the State  
29 Department of Health Care Services. The inspection shall be  
30 conducted no less than once every two years and as often as  
31 necessary to ensure the quality of care provided. During the  
32 inspections the review team shall offer such advice and assistance  
33 to the psychiatric health facility as it deems appropriate.

34 (e) (1) The program aspects of a psychiatric health facility that  
35 shall be reviewed and may be approved by the State Department  
36 of Health Care Services shall include, but not be limited to:

- 37 (A) Activities programs.
- 38 (B) Administrative policies and procedures.
- 39 (C) Admissions, including provisions for a mental evaluation.
- 40 (D) Discharge planning.

- 1 (E) Health records content.
- 2 (F) Health records services.
- 3 (G) Interdisciplinary treatment teams.
- 4 (H) Nursing services.
- 5 (I) Patient rights.
- 6 (J) Pharmaceutical services.
- 7 (K) Program space requirements.
- 8 (L) Psychiatrist and clinical psychological services.
- 9 (M) Rehabilitation services.
- 10 (N) Restraint and seclusion.
- 11 (O) Social work services.
- 12 (P) Space, supplies, and equipment.
- 13 (Q) Staffing standards.
- 14 (R) Unusual occurrences.
- 15 (S) Use of outside resources, including agreements with general
- 16 acute care hospitals.
- 17 (T) Linguistic access and cultural competence.
- 18 (U) Structured outpatient services to be provided under special
- 19 permit.
- 20 (2) The State Department of Health Care Services has the sole
- 21 authority to grant program flexibility.
- 22 (f) Commencing July 1, 2013, the State Department of Health
- 23 Care Services may adopt regulations regarding psychiatric health
- 24 facilities that shall include, but not be limited to, all of the
- 25 following:
- 26 (1) Procedures by which the State Department of Health Care
- 27 Services shall review and may approve the program and facility
- 28 requesting licensure as a psychiatric health facility as being in
- 29 compliance with program standards established by the department.
- 30 (2) Procedures by which the Director of Health Care Services
- 31 shall approve, or deny approval of, the program and facility
- 32 licensed as a psychiatric health facility pursuant to this section.
- 33 (3) Provisions for site visits by the State Department of Health
- 34 Care Services for the purpose of reviewing a facility's compliance
- 35 with program and facility standards.
- 36 (4) Provisions for the State Department of Health Care Services
- 37 for any administrative proceeding regarding denial, suspension,
- 38 or revocation of a psychiatric health facility license.

1 (5) Procedures for the appeal of an administrative finding or  
2 action pursuant to paragraph (4) of this subdivision and subdivision  
3 (j).

4 (g) Regulations may be adopted by the State Department of  
5 Health Care Services that establish standards for pharmaceutical  
6 services in psychiatric health facilities. Licensed psychiatric health  
7 facilities shall be exempt from requirements to obtain a separate  
8 pharmacy license or permit.

9 (h) (1) It is the intent of the Legislature that the State  
10 Department of Health Care Services shall license the facility in  
11 order to establish innovative and more competitive and specialized  
12 acute care services.

13 (2) The State Department of Health Care Services shall review  
14 and may approve the program aspects of public or private facilities,  
15 with the exception of those facilities that are federally certified or  
16 accredited by a nationally recognized commission that accredits  
17 health care facilities, only if the average per diem charges or costs  
18 of service provided in the facility is approximately 60 percent of  
19 the average per diem charges or costs of similar psychiatric services  
20 provided in a general hospital.

21 (3) (A) When a private facility is accredited by a nationally  
22 recognized commission that accredits health care facilities, the  
23 State Department of Health Care Services shall review and may  
24 approve the program aspects only if the average per diem charges  
25 or costs of service provided in the facility do not exceed  
26 approximately 75 percent of the average per diem charges or costs  
27 of similar psychiatric service provided in a psychiatric or general  
28 hospital.

29 (B) When a private facility serves county patients, the State  
30 Department of Health Care Services shall review and may approve  
31 the program aspects only if the facility is federally certified by the  
32 federal Centers for Medicare and Medicaid Services and serves a  
33 population mix that includes a proportion of Medi-Cal patients  
34 sufficient to project an overall cost savings to the county, and the  
35 average per diem charges or costs of service provided in the facility  
36 do not exceed approximately 75 percent of the average per diem  
37 charges or costs of similar psychiatric service provided in a  
38 psychiatric or general hospital.

39 (4) When a public facility is federally certified by the federal  
40 Centers for Medicare and Medicaid Services and serves a

1 population mix that includes a proportion of Medi-Cal patients  
2 sufficient to project an overall program cost savings with  
3 certification, the State Department of Health Care Services shall  
4 approve the program aspects only if the average per diem charges  
5 or costs of service provided in the facility do not exceed  
6 approximately 75 percent of the average per diem charges or costs  
7 of similar psychiatric service provided in a psychiatric or general  
8 hospital.

9 (5) (A) The State Department of Health Care Services may set  
10 a lower rate for private or public facilities than that required by  
11 paragraph (3) or (4), if so required by the federal Centers for  
12 Medicare and Medicaid Services as a condition for the receipt of  
13 federal matching funds.

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

18 (6) (A) In using the guidelines specified in this subdivision,  
19 the State Department of Health Care Services shall take into  
20 account local conditions affecting the costs or charges.

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

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

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

30 (i) The licensing fees charged for these facilities shall be credited  
31 to the State Department of Health Care Services for its costs  
32 incurred in the review of psychiatric health facility programs, in  
33 connection with the licensing of these facilities.

34 (j) (1) The State Department of Health Care Services shall  
35 establish a system for the imposition of prompt and effective civil  
36 sanctions against psychiatric health facilities in violation of the  
37 laws and regulations of this state pertaining to psychiatric health  
38 facilities. If the State Department of Health Care Services  
39 determines that there is or has been a failure, in a substantial  
40 manner, on the part of a psychiatric health facility to comply with

1 the laws and regulations, the Director of Health Care Services may  
2 impose the following sanctions:

3 (A) Cease and desist orders.

4 (B) Monetary sanctions, which may be imposed in addition to  
5 the penalties of suspension, revocation, or cease and desist orders.  
6 The amount of monetary sanctions permitted to be imposed  
7 pursuant to this subparagraph shall not be less than fifty dollars  
8 (\$50) nor more than one hundred dollars (\$100) multiplied by the  
9 licensed bed capacity, per day, for each violation. However, the  
10 monetary sanction shall not exceed three thousand dollars (\$3,000)  
11 per day. A facility that is assessed a monetary sanction under this  
12 subparagraph, and that repeats the deficiency, may, in accordance  
13 with the regulations adopted pursuant to this subdivision, be subject  
14 to immediate suspension of its license until the deficiency is  
15 corrected.

16 (2) The State Department of Health Care Services may adopt  
17 regulations necessary to implement this subdivision and paragraph  
18 (5) of subdivision (f) in accordance with the Administrative  
19 Procedure Act (Chapter 3.5 (commencing with Section 11340) of  
20 Part 1 of Division 3 of Title 2 of the Government Code).

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

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

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

32 5150. (a) When any person, as a result of mental disorder, is  
33 a danger to others, or to himself or herself, or gravely disabled, a  
34 peace officer, member of the attending staff, as defined by  
35 regulation, of an evaluation facility designated by the county, or  
36 other professional person designated by the county may, upon  
37 probable cause, take, or cause to be taken, the person into custody  
38 and place him or her in a facility designated by the county and  
39 approved by the State Department of Health Care Services as a  
40 facility for 72-hour treatment and evaluation.



1 (b) The facility shall require an application in writing stating  
2 the circumstances under which the person's condition was called  
3 to the attention of the officer, member of the attending staff, or  
4 professional person, and stating that the officer, member of the  
5 attending staff, or professional person has probable cause to believe  
6 that the person is, as a result of mental disorder, a danger to others,  
7 or to himself or herself, or gravely disabled. If the probable cause  
8 is based on the statement of a person other than the officer, member  
9 of the attending staff, or professional person, the person shall be  
10 liable in a civil action for intentionally giving a statement which  
11 he or she knows to be false.

12 SEC. 32. Section 5151 of the Welfare and Institutions Code is  
13 amended to read:

14 5151. (a) If the facility for 72-hour treatment and evaluation  
15 admits the person, it may detain him or her for evaluation and  
16 treatment for a period not to exceed 72 hours. Saturdays, Sundays,  
17 and holidays may be excluded from the 72-hour period if the State  
18 Department of Health Care Services certifies for each facility that  
19 evaluation and treatment services cannot reasonably be made  
20 available on those days. The certification by the department is  
21 subject to renewal every two years. The department may adopt  
22 regulations defining criteria for determining whether a facility can  
23 reasonably be expected to make evaluation and treatment services  
24 available on Saturdays, Sundays, and holidays.

25 (b) Prior to admitting a person to the facility for 72-hour  
26 treatment and evaluation pursuant to Section 5150, the professional  
27 person in charge of the facility or his or her designee shall assess  
28 the individual in person to determine the appropriateness of the  
29 involuntary detention.

30 (c) If in the judgment of the professional person in charge of  
31 the facility providing evaluation and treatment, or his or her  
32 designee, the person can be properly served without being detained,  
33 he or she shall be provided evaluation, crisis intervention, or other  
34 inpatient or outpatient services on a voluntary basis.

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

1 SEC. 33. Section 5157 of the Welfare and Institutions Code is  
2 amended to read:

3 5157. (a) Each person, at the time he or she is first taken into  
4 custody under provisions of Section 5150, shall be provided, by  
5 the person who takes such other person into custody, the following  
6 information orally. The information shall be in substantially the  
7 following form:

8  
9 My name is \_\_\_\_\_ .

10 I am a \_\_\_\_\_ .  
11 (peace officer, mental health professional)

12 with \_\_\_\_\_ .  
13 (name of agency)

14 You are not under criminal arrest, but I am taking you for examination by  
15 mental health professionals at \_\_\_\_\_ .

16 \_\_\_\_\_  
17 (name of facility)

18 You will be told your rights by the mental health staff.

19 If taken into custody at his or her residence, the person shall also be told the  
20 following information in substantially the following form:

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

24  
25 (b) The designated facility shall keep, for each patient evaluated,  
26 a record of the advisement given pursuant to subdivision (a) which  
27 shall include:

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

38 (c) Each person admitted to a designated facility for 72-hour  
39 evaluation and treatment shall be given the following information  
40 by admission staff at the evaluation unit. The information shall be

1 given orally and in writing and in a language or modality accessible  
2 to the person. The written information shall be available in the  
3 person's native language or the language which is the person's  
4 principal means of communication. The information shall be in  
5 substantially the following form:

6  
7 My name is \_\_\_\_\_.  
8 My position here is \_\_\_\_\_.

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

- 11 (check applicable)
- 12 harm yourself \_\_\_\_\_
- 13 harm someone else \_\_\_\_\_
- 14 be unable to take care of your own
- 15 food, clothing, and housing needs \_\_\_\_\_

16 We feel this is true because  
17 \_\_\_\_\_

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

21 You will be held on the ward for a period up to 72 hours.  
22 This does not include weekends or holidays.

23 Your 72-hour period will begin \_\_\_\_\_  
24 (day and time.)

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

32  
33 (d) For each patient admitted for 72-hour evaluation and  
34 treatment, the facility shall keep with the patient's medical record  
35 a record of the advisement given pursuant to subdivision (c) which  
36 shall include:

- 37 (1) Name of person performing advisement.
- 38 (2) Date.
- 39 (3) Whether advisement was completed.
- 40 (4) If not completed, a statement of good cause.

1 If the advisement was not completed at admission, the  
2 advisement process shall be continued on the ward until completed.  
3 A record of the matters prescribed by subdivisions (a), (b), and (c)  
4 shall be kept with the patient's medical record.

5 SEC. 34. Section 5202 of the Welfare and Institutions Code is  
6 amended to read:

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

27 If the petition is filed, it shall be accompanied by a report  
28 containing the findings of the person or agency designated by the  
29 county to provide prepetition screening. The prepetition screening  
30 report submitted to the superior court shall be confidential and  
31 shall be subject to the provisions of Section 5328.

32 SEC. 35. Section 5326.9 of the Welfare and Institutions Code  
33 is amended to read:

34 5326.9. (a) Any alleged or suspected violation of the rights  
35 described in Chapter 2 (commencing with Section 5150) shall be  
36 investigated by the local director of mental health, or his or her  
37 designee. Violations of Sections 5326.2 to 5326.8, inclusive,  
38 concerning patients involuntarily detained for evaluation or  
39 treatment under this part, or as a voluntary patient for psychiatric  
40 evaluation or treatment to a health facility, as defined in Section

1 1250 of the Health and Safety Code, in which psychiatric  
2 evaluation or treatment is offered, shall also be investigated by the  
3 Director of Health Care Services, or his or her designee. Violations  
4 of Sections 5326.2 to 5326.8, inclusive, concerning persons  
5 committed to a state hospital shall also be investigated by the  
6 Director of State Hospitals, or his or her designee. If it is  
7 determined by the local director of mental health, the Director of  
8 Health Care Services, or the Director of State Hospitals that a right  
9 has been violated, a formal notice of violation shall be issued.

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

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

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

19 (3) Revoke a facility's designation and authorization under  
20 Section 5404 to evaluate and treat persons detained involuntarily.

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

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

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

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

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

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

1 (e) Any person or facility found to have knowingly violated the  
2 provisions of the first paragraph of Section 5325.1 or to have  
3 denied without good cause any of the rights specified in Section  
4 5325 shall pay a civil penalty, as determined by the court, of fifty  
5 dollars (\$50) per day during the time in which the violation is not  
6 corrected, commencing on the day on which a notice of violation  
7 was issued, not to exceed one thousand dollars (\$1,000), for each  
8 and every violation, except that any liability under this provision  
9 shall be offset by an amount equal to a fine or penalty imposed for  
10 the same violation under the provisions of Sections 1423 to 1425,  
11 inclusive, or 1428 of the Health and Safety Code. These penalties  
12 shall be deposited in the general fund of the county in which the  
13 violation occurred. The local district attorney or the Attorney  
14 General shall enforce this section in any court with jurisdiction.  
15 Where the State Department of Public Health, under the provisions  
16 of Sections 1423 to 1425, inclusive, of the Health and Safety Code,  
17 determines that no violation has occurred, the provisions of  
18 paragraph (4) of subdivision (b) shall not apply.

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

22 SEC. 36. Section 5358 of the Welfare and Institutions Code is  
23 amended to read:

24 5358. (a) (1) When ordered by the court after the hearing  
25 required by this section, a conservator appointed pursuant to this  
26 chapter shall place his or her conservatee as follows:

27 (A) For a conservatee who is gravely disabled, as defined in  
28 subparagraph (A) of paragraph (1) of subdivision (h) of Section  
29 5008, in the least restrictive alternative placement, as designated  
30 by the court.

31 (B) For a conservatee who is gravely disabled, as defined in  
32 subparagraph (B) of paragraph (1) of subdivision (h) of Section  
33 5008, in a placement that achieves the purposes of treatment of  
34 the conservatee and protection of the public.

35 (2) The placement may include a medical, psychiatric, nursing,  
36 or other state-licensed facility, or a state hospital, county hospital,  
37 hospital operated by the Regents of the University of California,  
38 a United States government hospital, or other nonmedical facility  
39 approved by the State Department of Health Care Services or an  
40 agency accredited by the State Department of Health Care Services,

1 or in addition to any of the foregoing, in cases of chronic  
2 alcoholism, to a county alcoholic treatment center.

3 (b) A conservator shall also have the right, if specified in the  
4 court order, to require his or her conservatee to receive treatment  
5 related specifically to remedying or preventing the recurrence of  
6 the conservatee's being gravely disabled, or to require his or her  
7 conservatee to receive routine medical treatment unrelated to  
8 remedying or preventing the recurrence of the conservatee's being  
9 gravely disabled. Except in emergency cases in which the  
10 conservatee faces loss of life or serious bodily injury, no surgery  
11 shall be performed upon the conservatee without the conservatee's  
12 prior consent or a court order obtained pursuant to Section 5358.2  
13 specifically authorizing that surgery.

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

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

1 representing the originating county prior to any change of  
2 placement.

3 (3) For any conservatee, if requested, the local mental health  
4 director shall assist the conservator or the court in selecting a  
5 placement facility for the conservatee. When a conservatee who  
6 is receiving services from the local mental health program is  
7 placed, the conservator shall inform the local mental health director  
8 of the facility's location and any movement of the conservatee to  
9 another facility.

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

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

39 (3) At a hearing where the conservator is seeking placement to  
40 a less restrictive alternative placement pursuant to paragraph (2),



1 the placement shall not be approved where it is determined by a  
2 preponderance of the evidence that the placement poses a threat  
3 to the safety of the public, the conservatee, or any other individual.

4 (4) A hearing as to placement to a less restrictive alternative  
5 placement, whether requested pursuant to paragraph (2) or pursuant  
6 to Section 5358.3, shall be granted no more frequently than is  
7 provided for in Section 5358.3.

8 SEC. 37. Section 5366.1 of the Welfare and Institutions Code  
9 is amended to read:

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

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

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

1 of mental disorder, unless the person agrees voluntarily to remain  
2 in the institution in which he or she has been detained.

3 (d) If in the opinion of the professional person in charge of the  
4 facility or his or her designee, the person evaluated requires  
5 intensive treatment or recommendation for conservatorship, the  
6 professional person or his or her designee shall proceed under  
7 Article 4 (commencing with Section 5250) of Chapter 2, or under  
8 Chapter 3 (commencing with Section 5350), of Part 1 of Division  
9 5.

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

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

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

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

1 facilities for 72-hour treatment and evaluation and 14-day intensive  
2 treatment facilities.

3 SEC. 39. Section 5405 of the Welfare and Institutions Code is  
4 amended to read:

5 5405. (a) This section shall apply to each facility licensed by  
6 the State Department of Health Care Services, or its delegated  
7 agent, on or after January 1, 2003. For purposes of this section,  
8 “facility” means psychiatric health facilities, as defined in Section  
9 1250.2 of the Health and Safety Code, licensed pursuant to Chapter  
10 9 (commencing with Section 77001) of Division 5 of Title 22 of  
11 the California Code of Regulations and mental health rehabilitation  
12 centers licensed pursuant to Chapter 3.5 (commencing with Section  
13 781.00) of Division 1 of Title 9 of the California Code of  
14 Regulations.

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

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

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

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

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

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

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

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

37 (2) The application for licensure or renewal of any license shall  
38 be denied, and any employment or contract to provide direct  
39 services shall be disapproved or revoked, if the criminal record of  
40 the person includes a conviction in another jurisdiction for an

1 offense that, if committed or attempted in this state, would have  
2 been punishable as one or more of the offenses referred to in  
3 paragraph (1).

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

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

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

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

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

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

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

36 (F) Employment history and current employer recommendations.

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

39 (H) The granting by the Governor of a full and unconditional  
40 pardon.

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

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

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

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

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

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

35 (3) When an application is denied on the basis of a conviction  
36 pursuant to this section, the State Department of Health Care  
37 Services shall provide the individual whose application was denied  
38 with notice, in writing, of the specific grounds for the proposed  
39 denial.

1 SEC. 40. Section 5585.21 of the Welfare and Institutions Code  
2 is amended to read:

3 5585.21. The Director of Health Care Services may promulgate  
4 regulations as necessary to implement and clarify the provisions  
5 of this part as they relate to minors.

6 SEC. 41. Section 5585.50 of the Welfare and Institutions Code  
7 is amended to read:

8 5585.50. (a) When any minor, as a result of mental disorder,  
9 is a danger to others, or to himself or herself, or gravely disabled  
10 and authorization for voluntary treatment is not available, a peace  
11 officer, member of the attending staff, as defined by regulation,  
12 of an evaluation facility designated by the county, or other  
13 professional person designated by the county may, upon probable  
14 cause, take, or cause to be taken, the minor into custody and place  
15 him or her in a facility designated by the county and approved by  
16 the State Department of Health Care Services as a facility for  
17 72-hour treatment and evaluation of minors. The facility shall  
18 make every effort to notify the minor's parent or legal guardian  
19 as soon as possible after the minor is detained.

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

32 SEC. 42. Section 5585.55 of the Welfare and Institutions Code  
33 is amended to read:

34 5585.55. The minor committed for involuntary treatment under  
35 this part shall be placed in a mental health facility designated by  
36 the county and approved by the State Department of Health Care  
37 Services as a facility for 72-hour evaluation and treatment. Except  
38 as provided for in Section 5751.7, each county shall ensure that  
39 minors under 16 years of age are not held with adults receiving  
40 psychiatric treatment under the provisions of the



1 Lanterman-Petris-Short Act (Part 1 (commencing with Section  
2 5000)).

3 SEC. 43. Section 5675 of the Welfare and Institutions Code is  
4 amended to read:

5 5675. (a) Mental health rehabilitation centers shall only be  
6 licensed by the State Department of Health Care Services  
7 subsequent to application by counties, county contract providers,  
8 or other organizations. In the application for a mental health  
9 rehabilitation center, program evaluation measures shall include,  
10 but not be limited to:

11 (1) That the clients placed in the facilities show improved global  
12 assessment scores, as measured by preadmission and postadmission  
13 tests.

14 (2) That the clients placed in the facilities demonstrate improved  
15 functional behavior as measured by preadmission and  
16 postadmission tests.

17 (3) That the clients placed in the facilities have reduced  
18 medication levels as determined by comparison of preadmission  
19 and postadmission records.

20 (b) The State Department of Health Care Services shall conduct  
21 annual licensing inspections of mental health rehabilitation centers.

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

34 SEC. 44. Section 5675.1 of the Welfare and Institutions Code  
35 is amended to read:

36 5675.1. (a) In accordance with subdivision (b), the State  
37 Department of Health Care Services may establish a system for  
38 the imposition of prompt and effective civil sanctions for long-term  
39 care facilities licensed or certified by the department, including  
40 facilities licensed under the provisions of Sections 5675 and 5768,

1 and including facilities certified as providing a special treatment  
2 program under Sections 72443 to 72475, inclusive, of Title 22 of  
3 the California Code of Regulations.

4 (b) If the department determines that there is or has been a  
5 failure, in a substantial manner, on the part of any such facility to  
6 comply with the applicable laws and regulations, the director may  
7 impose the following sanctions:

8 (1) A plan of corrective action that addresses all failure identified  
9 by the department and includes timelines for correction.

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

15 (c) The department may also establish procedures for the appeal  
16 of an administrative action taken pursuant to this section, including  
17 a plan of corrective action or a suspension of license or  
18 certification.

19 SEC. 45. Section 5675.2 of the Welfare and Institutions Code  
20 is amended to read:

21 5675.2. (a) There is hereby created in the State Treasury the  
22 Mental Health Facility Licensing Fund, from which money, upon  
23 appropriation by the Legislature in the Budget Act, shall be  
24 expended by the State Department of Health Care Services to fund  
25 administrative and other activities in support of the mental health  
26 licensing and certification functions of the State Department of  
27 Health Care Services. The Mental Health Facility Licensing Fund  
28 is the successor to the Licensing and Certification Fund, Mental  
29 Health, which fund is hereby abolished. All references in any law  
30 to the Licensing and Certification Fund, Mental Health shall be  
31 deemed to refer to the Mental Health Facility Licensing Fund.

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

35 (c) The amount of the fees shall be determined and collected  
36 by the State Department of Health Care Services, but the total  
37 amount of the fees collected shall not exceed the actual costs of  
38 licensure and regulation of the centers, including, but not limited  
39 to, the costs of processing the application, inspection costs, and  
40 other related costs.

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

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

9 (f) Fees collected by the State Department of Health Care  
10 Services pursuant to this section shall be expended by the State  
11 Department of Health Care Services for the purpose of ensuring  
12 the health and safety of all individuals providing care and  
13 supervision by licensees and to support activities of the department,  
14 including, but not limited to, monitoring facilities for compliance  
15 with applicable laws and regulations.

16 (g) The State Department of Health Care Services may make  
17 additional charges to the facilities if additional visits are required  
18 to ensure that corrective action is taken by the licensee.

19 SEC. 46. Section 5751.7 of the Welfare and Institutions Code  
20 is amended to read:

21 5751.7. (a) For the purposes of this part and the  
22 Lanterman-Petris-Short Act (Part 1 (commencing with Section  
23 5000)), the State Department of Health Care Services and the State  
24 Department of State Hospitals shall ensure that, whenever feasible,  
25 minors shall not be admitted into psychiatric treatment with adults  
26 if the health facility has no specific separate housing arrangements,  
27 treatment staff, and treatment programs designed to serve children  
28 or adolescents. The Director of Health Care Services shall provide  
29 waivers to counties, upon their request, if this policy creates undue  
30 hardship in any county due to inadequate or unavailable alternative  
31 resources. In granting the waivers, the Director of Health Care  
32 Services shall require the county to establish specific treatment  
33 protocols and administrative procedures for identifying and  
34 providing appropriate treatment to minors admitted with adults.

35 (b) However, notwithstanding any other provision of law, no  
36 minor may be admitted for psychiatric treatment into the same  
37 treatment ward as any adult receiving treatment who is in the  
38 custody of any jailor for a violent crime, is a known registered sex  
39 offender, or has a known history of, or exhibits inappropriate,

1 sexual, or other violent behavior which would present a threat to  
2 the physical safety of minors.

3 SEC. 47. Section 5768 of the Welfare and Institutions Code is  
4 amended to read:

5 5768. (a) Notwithstanding any other provision of law, except  
6 as to requirements relating to fire and life safety of persons with  
7 mental illness, the State Department of Health Care Services, in  
8 its discretion, may permit new programs to be developed and  
9 implemented without complying with licensure requirements  
10 established pursuant to existing state law.

11 (b) Any program developed and implemented pursuant to  
12 subdivision (a) shall be reviewed at least once each six months,  
13 as determined by the State Department of Health Care Services.

14 (c) The State Department of Health Care Services may establish  
15 appropriate licensing requirements for these new programs upon  
16 a determination that the programs should be continued.

17 (d) Within six years, any program shall require a licensure  
18 category if it is to be continued. However, in the event that any  
19 agency other than the State Department of Health Care Services  
20 is responsible for developing a licensure category and fails to do  
21 so within the six years, the program may continue to be developed  
22 and implemented pursuant to subdivisions (a) and (b) until such  
23 time that the licensure category is established.

24 (e) (1) A nongovernmental entity proposing a program shall  
25 submit a program application and plan to the local mental health  
26 director that describes at least the following components: clinical  
27 treatment programs, activity programs, administrative policies and  
28 procedures, admissions, discharge planning, health records content,  
29 health records service, interdisciplinary treatment teams, client  
30 empowerment, patient rights, pharmaceutical services, program  
31 space requirements, psychiatric and psychological services,  
32 rehabilitation services, restraint and seclusion, space, supplies,  
33 equipment, and staffing standards. If the local mental health  
34 director determines that the application and plan are consistent  
35 with local needs and satisfactorily address the above components,  
36 he or she may approve the application and plan and forward them  
37 to the department.

38 (2) Upon the State Department of Health Care Services'  
39 approval, the local mental health director shall implement the  
40 program and shall be responsible for regular program oversight

1 and monitoring. The department shall be notified in writing of the  
2 outcome of each review of the program by the local mental health  
3 director, or his or her designee, for compliance with program  
4 requirements. The department shall retain ultimate responsibility  
5 for approving the method for review of each program, and the  
6 authority for determining the appropriateness of the local program's  
7 oversight and monitoring activities.

8 (f) Governmental entities proposing a program shall submit a  
9 program application and plan to the State Department of Health  
10 Care Services that describes at least the components described in  
11 subdivision (e). Upon approval, the department shall be responsible  
12 for program oversight and monitoring.

13 (g) Implementation of a program shall be contingent upon the  
14 State Department of Health Care Services' approval, and the  
15 department may reject applications or require modifications as it  
16 deems necessary. The department shall respond to each proposal  
17 within 90 days of receipt.

18 (h) The State Department of Health Care Services shall submit  
19 an evaluation to the Legislature of all pilot projects authorized  
20 pursuant to this section within five years of the commencement  
21 of operation of the pilot project, determining the effectiveness of  
22 that program or facility, or both, based on, but not limited to,  
23 changes in clinical indicators with respect to client functions.

24 SEC. 48. Section 5840 of the Welfare and Institutions Code is  
25 amended to read:

26 5840. (a) The State Department of Health Care Services, in  
27 coordination with counties, shall establish a program designed to  
28 prevent mental illnesses from becoming severe and disabling. The  
29 program shall emphasize improving timely access to services for  
30 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 (f) In consultation with mental health stakeholders, and  
26 consistent with regulations from the Mental Health Services  
27 Oversight and Accountability Commission, pursuant to Section  
28 5846, the department shall revise the program elements in Section  
29 5840 applicable to all county mental health programs in future  
30 years to reflect what is learned about the most effective prevention  
31 and intervention programs for children, adults, and seniors.

32 SEC. 49. Section 5845 of the Welfare and Institutions Code is  
33 amended to read:

34 5845. (a) The Mental Health Services Oversight and  
35 Accountability Commission is hereby established to oversee Part  
36 3 (commencing with Section 5800), the Adult and Older Adult  
37 Mental Health System of Care Act; Part 3.1 (commencing with  
38 Section 5820), Human Resources, Education, and Training  
39 Programs; Part 3.2 (commencing with Section 5830), Innovative  
40 Programs; Part 3.6 (commencing with Section 5840), Prevention

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

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

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

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

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

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

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

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

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

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

38 (2) Within the limit of funds allocated for these purposes,  
39 pursuant to the laws and regulations governing state civil service,  
40 employ staff, including any clerical, legal, and technical assistance

1 as may appear necessary. The commission shall administer its  
2 operations separate and apart from the State Department of Health  
3 Care Services and the California Health and Human Services  
4 Agency.

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 Health Care Services, the Office of Statewide Health Planning and  
15 Development, or other state or local entities that receive Mental  
16 Health Services Act funds, for the commission to utilize in its  
17 oversight, review, training and technical assistance, accountability,  
18 and evaluation capacity regarding projects and programs supported  
19 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 Health Care Services pursuant to  
34 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. 50. Section 5846 of the Welfare and Institutions Code is  
10 amended to read:

11 5846. (a) The commission shall adopt regulations for programs  
12 and expenditures pursuant to Part 3.2 (commencing with Section  
13 5830), for innovative programs, and Part 3.6 (commencing with  
14 Section 5840), for prevention and early intervention.

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

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

21 (d) The commission shall ensure that the perspective and  
22 participation of diverse community members reflective of  
23 California populations and others suffering from severe mental  
24 illness and their family members is a significant factor in all of its  
25 decisions and recommendations.

26 SEC. 51. Section 5909 of the Welfare and Institutions Code is  
27 amended to read:

28 5909. (a) The Director of Health Care Services shall retain the  
29 authority and responsibility to monitor and approve special  
30 treatment programs in skilled nursing facilities in accordance with  
31 Sections 72443 to 72475, inclusive, of Title 22 of the California  
32 Code of Regulations.

33 (b) The State Department of Health Care Services shall conduct  
34 annual certification inspections of special treatment programs for  
35 the mentally disordered for the purpose of approving the special  
36 treatment programs that are located in skilled nursing facilities  
37 licensed pursuant to Section 1265 of the Health and Safety Code.

38 SEC. 52. Section 6007 of the Welfare and Institutions Code is  
39 amended to read:

1 6007. (a) Any person detained pursuant to this section shall  
2 be evaluated by the facility designated by the county and approved  
3 by the State Department of Health Care Services pursuant to  
4 Section 5150 as a facility for 72-hour treatment and evaluation.  
5 The evaluation shall be made at the request of the person in charge  
6 of the private institution in which the person is detained or by one  
7 of the physicians who signed the certificate. If in the opinion of  
8 the professional person in charge of the evaluation and treatment  
9 facility or his or her designee, the evaluation of the person can be  
10 made by the professional person or his or her designee at the private  
11 institution in which the person is detained, the person shall not be  
12 required to be evaluated at the evaluation and treatment facility,  
13 but shall be evaluated at the private institution to determine if the  
14 person is a danger to others, himself or herself, or gravely disabled  
15 as a result of mental disorder.

16 (b) Any person evaluated under this section shall be released  
17 from the private institution immediately upon completion of the  
18 evaluation if in the opinion of the professional person in charge  
19 of the evaluation and treatment facility, or his or her designee, the  
20 person evaluated is not a danger to others, or to himself or herself,  
21 or gravely disabled as a result of mental disorder, unless the person  
22 agrees voluntarily to remain in the private institution.

23 (c) If in the opinion of the professional person in charge of the  
24 facility or his or her designee, the person evaluated requires  
25 intensive treatment or recommendation for conservatorship, the  
26 professional person or his or her designee shall proceed under  
27 Article 4 (commencing with Section 5250) of Chapter 2, or under  
28 Chapter 3 (commencing with Section 5350), of Part 1 of Division  
29 5.

30 SEC. 53. Section 6551 of the Welfare and Institutions Code is  
31 amended to read:

32 6551. (a) If the court is in doubt as to whether the person is  
33 mentally disordered or intellectually disabled, the court shall order  
34 the person to be taken to a facility designated by the county and  
35 approved by the State Department of Health Care Services as a  
36 facility for 72-hour treatment and evaluation. Thereupon, Article  
37 1 (commencing with Section 5150) of Chapter 2 of Part 1 of  
38 Division 5 applies, except that the professional person in charge  
39 of the facility shall make a written report to the court concerning  
40 the results of the evaluation of the person's mental condition. If

1 the professional person in charge of the facility finds the person  
2 is, as a result of mental disorder, in need of intensive treatment,  
3 the person may be certified for not more than 14 days of  
4 involuntary intensive treatment if the conditions set forth in  
5 subdivision (c) of Section 5250 and subdivision (b) of Section  
6 5260 are complied with. Thereupon, Article 4 (commencing with  
7 Section 5250) of Chapter 2 of Part 1 of Division 5 shall apply to  
8 the person. The person may be detained pursuant to Article 4.5  
9 (commencing with Section 5260), or Article 4.7 (commencing  
10 with Section 5270.10), or Article 6 (commencing with Section  
11 5300) of Part 1 of Division 5 if that article applies.

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

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

35 (d) Any expenditure for the evaluation or intensive treatment  
36 of a minor under this section shall be considered an expenditure  
37 made under Part 2 (commencing with Section 5600) of Division  
38 5 and shall be reimbursed by the state as are other local  
39 expenditures pursuant to that part.

1 (e) The jurisdiction of the juvenile court over the minor shall  
2 be suspended during the time that the minor is subject to the  
3 jurisdiction of the court in which the petition for postcertification  
4 treatment of an imminently dangerous person or the petition for  
5 commitment of an intellectually disabled person is filed or under  
6 remand for 90 days for intensive treatment or commitment ordered  
7 by the court.

8 SEC. 54. Section 7100 of the Welfare and Institutions Code is  
9 amended to read:

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

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

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

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

36 SEC. 54.5. Section 14005.275 is added to the Welfare and  
37 Institutions Code, to read:

38 14005.275. The department shall ensure coordination of  
39 covered services across all delivery systems of care in order to  
40 minimize disruption in services for children transitioning from the

1 *Healthy Families Program to Medi-Cal pursuant to Chapter 28*  
2 *of the Statutes of 2012.*

3 SEC. 55. Section 14005.281 is added to the Welfare and  
4 Institutions Code, immediately following Section 14005.28, to  
5 read:

6 14005.281. (a) The department shall maintain eligibility for  
7 all former independent foster care adolescents who were receiving  
8 services pursuant to Section 14005.28 on or after July 1, 2013, but  
9 no later than December 31, 2013, and lost Medi-Cal coverage as  
10 a result of attaining 21 years of age.

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

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

16 SEC. 56. Section 14100.3 is added to the Welfare and  
17 Institutions Code, to read:

18 14100.3. (a) The State Department of Health Care Services  
19 shall post on its Internet Web site all submitted state plan  
20 amendments and all federal waiver applications and requests for  
21 new waivers, waiver amendments, and waiver renewals and  
22 extensions, within 10 business days from the date the department  
23 submits these documents for approval to the federal Centers for  
24 Medicare and Medicaid Services (CMS).

25 (b) The department shall post on its Internet Web site final  
26 approval or denial letters and accompanying documents for all  
27 submitted state plan amendments and federal waiver applications  
28 and requests within 10 business days from the date the department  
29 receives notification of final approval or denial from CMS.

30 (c) If the department notifies CMS of the withdrawal of a  
31 submitted state plan amendment or federal waiver application or  
32 request, as described in subdivisions (a) and (b), the department  
33 shall post on its Internet Web site the withdrawal notification within  
34 10 business days from the date the department notifies CMS of  
35 the withdrawal.

36 (d) Unless already posted on the Internet Web site pursuant to  
37 subdivisions (a) to (c), inclusive, the department shall post on its  
38 Internet Web site all pending submitted state plan amendments  
39 and federal waiver applications and requests, that the department  
40 submitted to CMS in 2009 and every year thereafter.

1 SEC. 57. Section 14100.51 is added to the Welfare and  
2 Institutions Code, immediately following Section 14100.5, to read:

3 14100.51. (a) Each year, by no later than January 10 and  
4 concurrently with the release of the May Revision, the State  
5 Department of Health Care Services shall provide to the fiscal  
6 committees of the Legislature supplemental fiscal information for  
7 the Medi-Cal Specialty Mental Health Services Program. This  
8 supplemental fiscal information shall include service-type  
9 descriptions, children's and adults' caseload and fiscal forecast by  
10 service type, a detailed explanation of changes to these forecasts,  
11 fiscal charts containing children's and adults' claim costs and  
12 unduplicated client counts, and summary fiscal charts with  
13 current-year and budget-year proposals.

14 (b) For purposes of making the information described in  
15 subdivision (a) available to the public, the department shall post  
16 this information on its Internet Web site.

17 SEC. 58. Section 14100.52 is added to the Welfare and  
18 Institutions Code, immediately following Section 14100.51, to  
19 read:

20 14100.52. (a) Each year, by no later than January 10 and  
21 concurrently with the release of the May Revision, the State  
22 Department of Health Care Services shall provide to the fiscal  
23 committees of the Legislature supplemental fiscal information for  
24 the Drug Medi-Cal Program. This supplemental fiscal information  
25 shall include adult, minor-consent, child, and perinatal unique  
26 client counts and summary fiscal charts with current-year and  
27 budget-year proposals.

28 (b) For purposes of making the information described in  
29 subdivision (a) available to the public, the department shall post  
30 this information on its Internet Web site.

31 SEC. 59. Section 14105.22 of the Welfare and Institutions  
32 Code is amended to read:

33 14105.22. (a) (1) Reimbursement for clinical laboratory or  
34 laboratory services, as defined in Section 51137.2 of Title 22 of  
35 the California Code of Regulations, shall not exceed 80 percent  
36 of the lowest maximum allowance established by the federal  
37 Medicare Program for the same or similar services.

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

1 (b) (1) It is the intent of the Legislature that the department  
2 develop reimbursement rates for clinical laboratory or laboratory  
3 services that are comparable to the payment amounts received  
4 from other payers for clinical laboratory or laboratory services.  
5 Development of these rates will enable the department to reimburse  
6 clinical laboratory or laboratory service providers in compliance  
7 with state and federal law.

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

13 (B) In addition to subparagraph (A), laboratory providers  
14 reimbursed under any payment reductions implemented pursuant  
15 to this section shall not be subject to the provisions of Section  
16 51501(a) of Title 22 of the California Code of Regulations for 21  
17 months following the date of implementation of this reduction.

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

20 (A) The amount billed.

21 (B) The charge to the general public.

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

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

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

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

39 (5) (A) For purposes of establishing reimbursement rates for  
40 clinical laboratory or laboratory services based on the lowest

1 amounts other payers are paying providers for similar clinical  
2 laboratory or laboratory services, laboratory service providers shall  
3 submit data reports within 11 months of the date the act that added  
4 this paragraph becomes effective and annually thereafter. The data  
5 initially provided shall be for the 2011 calendar year, and for each  
6 subsequent year, shall be based on the previous calendar year and  
7 shall specify the provider's lowest amounts other payers are paying,  
8 including other state Medicaid programs and private insurance,  
9 minus discounts and rebates. The specific data required for  
10 submission under this subparagraph and the format for the data  
11 submission shall be determined and specified by the department  
12 after receiving stakeholder input pursuant to paragraph (7).

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

23 (C) For purposes of subparagraph (B), the department may  
24 contract with a vendor for the purposes of collecting payment data  
25 reports from clinical laboratories, analyzing payment information,  
26 and calculating a proposed rate.

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

31 (E) Data reports submitted to the department shall be certified  
32 by the provider's certified financial officer or an authorized  
33 individual.

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

38 (6) Data reports provided to the department pursuant to this  
39 section shall be confidential and shall be exempt from disclosure  
40 under the California Public Records Act (Chapter 3.5 (commencing



1 with Section 6250) of Division 7 of Title 1 of the Government  
2 Code).

3 (7) The department shall seek stakeholder input on the  
4 ratesetting methodology.

5 (8) (A) Notwithstanding Chapter 3.5 (commencing with Section  
6 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
7 the department shall, without taking any further regulatory action,  
8 implement, interpret, or make specific this section by means of  
9 provider bulletins or similar instructions until regulations are  
10 adopted. It is the intent of the Legislature that the department have  
11 temporary authority as necessary to implement program changes  
12 until completion of the regulatory process.

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

25 (C) The initial emergency regulations and the one readoption  
26 of emergency regulations authorized by this section shall be  
27 submitted to the Office of Administrative Law for filing with the  
28 Secretary of State and each shall remain in effect for no more than  
29 180 days, by which time final regulations may be adopted.

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

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

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

6 (C) To the extent that the director determines that the rates and  
7 payments do not comply with applicable federal Medicaid  
8 requirements or that federal financial participation is not available  
9 with respect to any reimbursement rate, the director retains the  
10 discretion not to implement that rate or payment and may revise  
11 the rate or payment as necessary to comply with federal Medicaid  
12 requirements. The department shall notify the Joint Legislative  
13 Budget Committee 10 days prior to revising the rate or payment  
14 to comply with federal Medicaid requirements.

15 SEC. 60. Section 14105.3 of the Welfare and Institutions Code  
16 is amended to read:

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

29 (b) The department may enter into exclusive or nonexclusive  
30 contracts on a bid or negotiated basis with manufacturers,  
31 distributors, dispensers, or suppliers of appliances, durable medical  
32 equipment, medical supplies, and other product-type health care  
33 services and with laboratories for clinical laboratory services for  
34 the purpose of obtaining the most favorable prices to the state and  
35 to assure adequate quality of the product or service. Except as  
36 provided in subdivision (f), this subdivision shall not apply to  
37 prescribed drugs dispensed by pharmacies licensed pursuant to  
38 Article 7 (commencing with Section 4110) of Chapter 9 of Division  
39 2 of the Business and Professions Code.

1 (c) Notwithstanding subdivision (b), the department may not  
2 enter into a contract with a clinical laboratory unless the clinical  
3 laboratory operates in conformity with Chapter 3 (commencing  
4 with Section 1200) of Division 2 of the Business and Professions  
5 Code and the regulations adopted thereunder, and Section 263a of  
6 Title 42 of the United States Code and the regulations adopted  
7 thereunder.

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

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

17 (f) In order to provide specialized care in the distribution of  
18 specialized drugs, as identified by the department and that include,  
19 but are not limited to, blood factors and immunizations, the  
20 department may enter into contracts with providers licensed to  
21 dispense dangerous drugs or devices pursuant to Chapter 9  
22 (commencing with Section 4000) of Division 2 of the Business  
23 and Professions Code, for programs that qualify for federal funding  
24 pursuant to the Medicaid state plan, or waivers, and the programs  
25 authorized by Article 5 (commencing with Section 123800) of  
26 Chapter 3 of Part 2 of, and Article 1 (commencing with Section  
27 125125) of Chapter 2 of Part 5 of, Division 106 of the Health and  
28 Safety Code, in accordance with this subdivision.

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

32 (2) The department shall, for purposes of ensuring quality of  
33 care to people with unique conditions requiring specialty drugs,  
34 contract with a nonexclusive number of providers that meet the  
35 needs of the affected population, covers all geographic regions in  
36 California, and reflects the distribution of the specialty drug in the  
37 community. The department may use a single provider in the event  
38 the product manufacturer designates a sole-source delivery  
39 mechanism. The department shall consult with interested parties

1 and appropriate stakeholders in implementing this section with  
2 respect to all of the following:

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

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

7 (C) Scheduling at least one public meeting regarding the  
8 potential inclusion or exclusion of drugs into the specialty  
9 pharmacy program.

10 (D) Obtaining a recommendation from the Medi-Cal Drug  
11 Utilization Review Advisory Committee, established pursuant to  
12 Section 1927 of the federal Social Security Act (42 U.S.C. Sec.  
13 1396r-8), on the inclusion or exclusion of drugs into the specialty  
14 pharmacy program distribution based on clinical best practices  
15 related to each drug considered.

16 (3) For purposes of this subdivision, the definition of “blood  
17 factors” has the same meaning as that term is defined in Section  
18 14105.86.

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

22 (g) The department may contract with an intermediary to  
23 establish provider contracts pursuant to this section for programs  
24 that qualify for federal funding pursuant to the Medicaid state plan,  
25 or waivers, and the programs authorized by Article 5 (commencing  
26 with Section 123800) of Chapter 3 of Part 2 of, and Article 1  
27 (commencing with Section 125125) of Chapter 2 of Part 5 of,  
28 Division 106 of the Health and Safety Code.

29 (h) In carrying out contracting activity for this or any section  
30 associated with the Medi-Cal list of contract drugs, notwithstanding  
31 Section 19130 of the Government Code, the department may  
32 contract, either directly or through the fiscal intermediary, for  
33 pharmacy consultant staff necessary to accomplish the contracting  
34 process or treatment authorization request reviews. The fiscal  
35 intermediary contract, including any contract amendment, system  
36 change pursuant to a change order, and project or systems  
37 development notice shall be exempt from Part 2 (commencing  
38 with Section 10100) of Division 2 of the Public Contract Code  
39 and any policies, procedures, or regulations authorized by these  
40 provisions.

1 (i) In order to achieve maximum cost savings, the Legislature  
2 hereby determines that an expedited contract process for contracts  
3 under this section is necessary. Therefore, contracts under this  
4 section shall be exempt from Chapter 2 (commencing with Section  
5 10290) of Part 2 of Division 2 of the Public Contract Code.

6 (j) For purposes of implementing the contracting provisions  
7 specified in this section, the department shall do all of the  
8 following:

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

12 (2) Consult with the statewide association of clinical laboratories  
13 and other appropriate stakeholders on the implementation of the  
14 contracting provisions specified in this section to ensure maximum  
15 access for Medi-Cal patients consistent with the savings targets  
16 projected by the 2002–03 budget conference committee for clinical  
17 laboratory services provided under the Medi-Cal program.

18 (3) Consider which types of laboratories are appropriate for  
19 implementing the contracting provisions specified in this section,  
20 including independent laboratories, outreach laboratory programs  
21 of hospital-based laboratories, clinic laboratories, physician office  
22 laboratories, and group practice laboratories.

23 SEC. 61. Section 14131.07 of the Welfare and Institutions  
24 Code is repealed.

25 SEC. 62. Section 14131.10 of the Welfare and Institutions  
26 Code is amended to read:

27 14131.10. (a) Notwithstanding any other provision of this  
28 chapter, Chapter 8 (commencing with Section 14200), or Chapter  
29 8.75 (commencing with Section 14591), in order to implement  
30 changes in the level of funding for health care services, specific  
31 optional benefits are excluded from coverage under the Medi-Cal  
32 program.

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

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

36 (B) Acupuncture services.

37 (C) Audiology services and speech therapy services.

38 (D) Chiropractic services.

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

1 (F) Podiatric services.

2 (G) Psychology services.

3 (H) Incontinence creams and washes.

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

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

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

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

19 (ii) Amalgam and composite restorations.

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

21 (iv) Anterior root canal therapy.

22 (v) Complete dentures, including immediate dentures.

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

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

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

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

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

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

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

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

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

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

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

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

16 SEC. 63. Section 14132.86 is added to the Welfare and  
17 Institutions Code, to read:

18 14132.86. (a) Notwithstanding subdivision (ab) of Section  
19 14132, effective May 1, 2014, purchase of prescribed enteral  
20 nutrition products is covered, subject to the Medi-Cal list of enteral  
21 nutrition products pursuant to Section 14105.8 and utilization  
22 controls pursuant to Section 14105.395.

23 (b) Notwithstanding Chapter 3.5 (commencing with Section  
24 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
25 the department shall implement this section by means of a provider  
26 bulletin or similar instruction, without taking regulatory action.

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

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

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

34 14132.89. (a) Notwithstanding subdivision (h) of Section  
35 14132, effective May 1, 2014, or the effective date of any necessary  
36 federal approvals as required by subdivision (d), all of the  
37 following are covered benefits for persons 21 years of age or older,  
38 subject to utilization controls and medically necessary services:

39 (1) Examinations, radiographs/photographic images,  
40 prophylaxis, and fluoride treatments.

- 1 (2) Amalgam and composite restorations.
- 2 (3) Stainless steel, resin, and resin window crowns.
- 3 (4) Anterior root canal therapy.
- 4 (5) Complete dentures, including immediate dentures.
- 5 (6) Complete denture adjustments, repairs, and relines.
- 6 (7) Emergency procedures are also covered in the above
- 7 categories of service.

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

10 (c) Notwithstanding Chapter 3.5 (commencing with Section  
11 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
12 the department shall implement this section by means of a provider  
13 bulletin or similar instruction, without taking regulatory action.

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

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

20 14134. (a) Except for any prescription, refill, visit, service,  
21 device, or item for which the program’s payment is ten dollars  
22 (\$10) or less, in which case no copayment shall be required, a  
23 recipient of services under this chapter shall be required to make  
24 copayments not to exceed the maximum permitted under federal  
25 regulations or federal waivers as follows:

26 (1) Copayment of five dollars (\$5) shall be made for  
27 nonemergency services received in an emergency department or  
28 emergency room when the services do not result in the treatment  
29 of an emergency medical condition or inpatient admittance. For  
30 the purposes of this section, “nonemergency services” means  
31 services not required to, as appropriate, medically screen, examine,  
32 evaluate, or stabilize an emergency medical condition that  
33 manifests itself by acute symptoms of sufficient severity, including  
34 severe pain, such that the absence of immediate medical attention  
35 could reasonably be expected to result in any of the following:

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

39 (B) Serious impairment to bodily functions.

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



1 (2) Copayment of one dollar (\$1) shall be made for each drug  
2 prescription or refill.

3 (3) Copayment of one dollar (\$1) shall be made for each visit  
4 for services under subdivisions (a) and (h) of Section 14132.

5 (4) The copayment amounts set forth in paragraphs (1), (2), and  
6 (3) may be collected and retained or waived by the provider.

7 (5) The department shall not reduce the reimbursement otherwise  
8 due to providers as a result of the copayment. The copayment  
9 amounts shall be in addition to any reimbursement otherwise due  
10 the provider for services rendered under this program.

11 (6) This section does not apply to emergency services, family  
12 planning services, or to any services received by:

13 (A) Any child in AFDC-Foster Care, as defined in Section  
14 11400.

15 (B) Any person who is an inpatient in a health facility, as defined  
16 in Section 1250 of the Health and Safety Code.

17 (C) Any person 18 years of age or under.

18 (D) Any woman receiving perinatal care.

19 (7) Paragraph (2) does not apply to any person 65 years of age  
20 or over.

21 (8) A provider of service shall not deny care or services to an  
22 individual solely because of that person's inability to copay under  
23 this section. An individual shall, however, remain liable to the  
24 provider for any copayment amount owed.

25 (9) This section shall not apply to any preventive services that  
26 are assigned a grade of A or B by the United States Preventive  
27 Services Task Force provided by a physician or other licensed  
28 practitioner of the healing arts, or any approved adult vaccines and  
29 their administration recommended by the Advisory Committee on  
30 Immunization Practices. Pursuant to Section 1905(b) of the federal  
31 Social Security Act (42 U.S.C. Sec. 1396d(b)), these services shall  
32 be provided without any cost sharing by the beneficiary in order  
33 for the state to receive an increased federal medical assistance  
34 percentage for these services.

35 (10) The department shall seek any federal waivers necessary  
36 to implement this section. The provisions for which appropriate  
37 federal waivers cannot be obtained shall not be implemented, but  
38 provisions for which waivers are either obtained or found to be  
39 unnecessary shall be unaffected by the inability to obtain federal  
40 waivers for the other provisions.

1 (11) The director shall adopt any regulations necessary to  
2 implement this section as emergency regulations in accordance  
3 with Chapter 3.5 (commencing with Section 11340) of Part 1 of  
4 Division 3 of Title 2 of the Government Code. The adoption of  
5 the regulations shall be deemed to be an emergency and necessary  
6 for the immediate preservation of the public peace, health and  
7 safety, or general welfare. The director shall transmit these  
8 emergency regulations directly to the Secretary of State for filing  
9 and the regulations shall become effective immediately upon filing.  
10 Upon completion of the formal regulation adoption process and  
11 prior to the expiration of the 120 day duration period of emergency  
12 regulations, the director shall transmit directly to the Secretary of  
13 State for filing the adopted regulations, the rulemaking file, and  
14 the certification of compliance as required by subdivision (e) of  
15 Section 11346.1 of the Government Code.

16 (b) This section, or subdivisions thereof, if applicable, shall  
17 become inoperative on the implementation date for copayments  
18 stated in the declaration executed by the director pursuant to  
19 Section 14134 as added by Section 101.5 of Chapter 3 of the  
20 Statutes of 2011.

21 SEC. 66. Section 14134 of the Welfare and Institutions Code,  
22 as amended by Section 85 of Chapter 23 of the Statutes of 2012,  
23 is amended to read:

24 14134. (a) The Legislature finds and declares all of the  
25 following:

26 (1) Costs within the Medi-Cal program continue to grow due  
27 to the rising cost of providing health care throughout the state and  
28 also due to increases in enrollment, which are more pronounced  
29 during difficult economic times.

30 (2) In order to minimize the need for drastically cutting  
31 enrollment standards or benefits or imposing further reductions  
32 on Medi-Cal providers during times of economic crisis, it is crucial  
33 to find areas within the program where beneficiaries can share  
34 responsibility for utilization of health care, whether they are  
35 participating in the fee-for-service or the managed care model of  
36 service delivery.

37 (3) The establishment of cost-sharing obligations within the  
38 Medi-Cal program is complex and is subject to close supervision  
39 by the United States Department of Health and Human Services.

1 (4) As the single state agency for Medicaid in California, the  
2 State Department of Health Care Services has unique expertise  
3 that can inform decisions that set or adjust cost-sharing  
4 responsibilities for Medi-Cal beneficiaries receiving health care  
5 services.

6 (b) Therefore, it is the intent of the Legislature for the  
7 department to obtain federal approval to implement cost-sharing  
8 for Medi-Cal beneficiaries and permit providers to require that  
9 individuals meet their cost-sharing obligation prior to receiving  
10 care or services.

11 (c) A Medi-Cal beneficiary shall be required to make  
12 copayments as described in this section. These copayments  
13 represent a contribution toward the rate of payment made to  
14 providers of Medi-Cal services and shall be as follows:

15 (1) Copayment of up to fifty dollars (\$50) shall be made for  
16 nonemergency services received in an emergency department or  
17 emergency room when the services do not result in the treatment  
18 of an emergency condition or inpatient admittance. For the  
19 purposes of this section, “nonemergency services” means services  
20 not required to, as appropriate, medically screen, examine, evaluate,  
21 or stabilize an emergency medical condition that manifests itself  
22 by acute symptoms of sufficient severity, including severe pain,  
23 such that the absence of immediate medical attention could  
24 reasonably be expected to result in any of the following:

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

28 (B) Serious impairment to bodily functions.

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

30 (2) Copayment of up to fifty dollars (\$50) shall be made for  
31 emergency services received in an emergency department or  
32 emergency room when the services result in the treatment of an  
33 emergency medical condition or inpatient admittance. For purposes  
34 of this section, “emergency services” means services required to,  
35 as appropriate, medically screen, examine, evaluate, or stabilize  
36 an emergency medical condition that manifests itself by acute  
37 symptoms of sufficient severity, including severe pain, such that  
38 the absence of immediate medical attention could reasonably be  
39 expected to result in any of the following:

1 (A) Placing the individual's health, or, with respect to a pregnant  
2 woman, the health of the woman or her unborn child, in serious  
3 jeopardy.

4 (B) Serious impairment to bodily functions.

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

6 (3) Copayment of up to one hundred dollars (\$100) shall be  
7 made for each hospital inpatient day, up to a maximum of two  
8 hundred dollars (\$200) per admission.

9 (4) Copayment of up to three dollars (\$3) shall be made for each  
10 preferred drug prescription or refill. A copayment of up to five  
11 dollars (\$5) shall be made for each nonpreferred drug prescription  
12 or refill. Except as provided in subdivision (g), "preferred drug"  
13 shall have the same meaning as in Section 1916A of the Social  
14 Security Act (42 U.S.C. Sec. 1396o-1).

15 (5) Copayment of up to five dollars (\$5) shall be made for each  
16 visit for services under subdivision (a) of Section 14132 and for  
17 dental services received on an outpatient basis provided as a  
18 Medi-Cal benefit pursuant to this chapter or Chapter 8  
19 (commencing with Section 14200), as applicable.

20 (6) This section does not apply to services provided pursuant  
21 to subdivision (aa) of Section 14132.

22 (d) The copayments established pursuant to subdivision (c) shall  
23 be set by the department, at the maximum amount provided for in  
24 the applicable paragraph, except that each copayment amount shall  
25 not exceed the maximum amount allowable pursuant to the state  
26 plan amendments or other federal approvals.

27 (e) The copayment amounts set forth in subdivision (c) may be  
28 collected and retained or waived by the provider. The department  
29 shall deduct the amount of the copayment from the payment the  
30 department makes to the provider whether retained, waived, or not  
31 collected by the provider.

32 (f) Notwithstanding any other provision of law, and only to the  
33 extent allowed pursuant to federal law, a provider of service has  
34 no obligation to provide services to a Medi-Cal beneficiary who  
35 does not, at the point of service, pay the copayment assessed  
36 pursuant to this section. If the provider provides services without  
37 collecting the copayment, and has not waived the copayment, the  
38 provider may hold the beneficiary liable for the copayment amount  
39 owed.

1 (g) (1) Notwithstanding any other provision of law, except as  
2 described in paragraph (2), this section shall apply to Medi-Cal  
3 beneficiaries enrolled in a health plan contracting with the  
4 department pursuant to this chapter or Chapter 8 (commencing  
5 with Section 14200), except for the Senior Care Action Network  
6 or AIDS Healthcare Foundation. To the extent permitted by federal  
7 law and pursuant to any federal waivers or state plan adjustments  
8 obtained, a managed care health plan may establish a lower  
9 copayment or no copayment.

10 (2) For the purpose of paragraph (4) of subdivision (c),  
11 copayments assessed against a beneficiary who receives Medi-Cal  
12 services through a health plan described in paragraph (1) shall be  
13 based on the plan's designation of a drug as preferred or  
14 nonpreferred.

15 (3) To the extent provided by federal law, capitation payments  
16 shall be calculated on an actuarial basis as if copayments described  
17 in this section were collected.

18 (h) This section shall not apply to any preventive services that  
19 are assigned a grade of A or B by the United States Preventive  
20 Services Task Force provided by a physician or other licensed  
21 practitioner of the healing arts, or any approved adult vaccines and  
22 their administration recommended by the Advisory Committee on  
23 Immunization Practices. Pursuant to Section 1905(b) of the federal  
24 Social Security Act (42 U.S.C. Sec. 1396d(b)), these services shall  
25 be provided without any cost sharing by the beneficiary in order  
26 for the state to receive an increased federal medical assistance  
27 percentage for these services.

28 (i) This section shall be implemented only to the extent that  
29 federal financial participation is available. The department shall  
30 seek and obtain any federal waivers or state plan amendments  
31 necessary to implement this section. The provisions for which  
32 appropriate federal waivers or state plan amendments cannot be  
33 obtained shall not be implemented, but provisions for which  
34 waivers or state plan amendments are either obtained or found to  
35 be unnecessary shall be unaffected by the inability to obtain federal  
36 waivers or state plan amendments for the other provisions.

37 (j) Notwithstanding Chapter 3.5 (commencing with Section  
38 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
39 the department may implement, interpret, or make specific this  
40 section by means of all-county letters, all-plan letters, provider

1 bulletins, or similar instructions, without taking further regulatory  
 2 actions.

3 (k) (1) This section shall become operative on the date that the  
 4 act adding this section is effective, but shall not be implemented  
 5 until the date in the declaration executed by the director pursuant  
 6 to paragraph (2). In no event shall the director set an  
 7 implementation date prior to the date federal approval is received.

8 (2) The director shall execute a declaration that states the date  
 9 that implementation of the copayments described in this section  
 10 or subdivisions thereof, if applicable, will commence and shall  
 11 post the declaration on the department’s Internet Web site and  
 12 provide a copy of the declaration to the Chair of the Joint  
 13 Legislative Budget Committee, the Chief Clerk of the Assembly,  
 14 the Secretary of the Senate, the Office of the Legislative Counsel,  
 15 and the Secretary of State.

16 SEC. 67. Section 14707.5 of the Welfare and Institutions Code  
 17 is amended to read:

18 14707.5. (a) It is the intent of the Legislature to develop a  
 19 performance outcome system for Early and Periodic Screening,  
 20 Diagnosis, and Treatment (EPSDT) mental health services that  
 21 will improve outcomes at the individual and system levels and will  
 22 inform fiscal decision making related to the purchase of services.

23 (b) The State Department of Health Care Services, in  
 24 collaboration with the California Health and Human Services  
 25 Agency, and in consultation with the Mental Health Services  
 26 Oversight and Accountability Commission, shall create a plan for  
 27 a performance outcome system for EPSDT mental health services  
 28 provided to eligible Medi-Cal beneficiaries under the age of 21  
 29 pursuant to 42 U.S.C. Section 1396d(a)(4)(B).

30 (1) Commencing no later than September 1, 2012, the  
 31 department shall convene a stakeholder advisory committee  
 32 comprised of representatives of child and youth clients, family  
 33 members, providers, counties, and the Legislature. This  
 34 consultation shall inform the creation of a plan for a performance  
 35 outcome system for EPSDT mental health services.

36 (2) In developing a plan for a performance outcomes system  
 37 for EPSDT mental health services, the department shall consider  
 38 the following objectives, among others:

39 (A) High quality and accessible EPSDT mental health services  
 40 for eligible children and youth, consistent with federal law.

1 (B) Information that improves practice at the individual,  
2 program, and system levels.

3 (C) Minimization of costs by building upon existing resources  
4 to the fullest extent possible.

5 (D) Reliable data that are collected and analyzed in a timely  
6 fashion.

7 (3) At a minimum, the plan for a performance outcome system  
8 for EPSDT mental health services shall consider evidence-based  
9 models for performance outcome systems, such as the Child and  
10 Adolescent Needs and Strengths (CANS), federal requirements,  
11 including the review by the External Quality Review Organization  
12 (EQRO), and, timelines for implementation at the provider, county,  
13 and state levels.

14 (c) The State Department of Health Care Services shall provide  
15 the performance outcomes system plan, including milestones and  
16 timelines, for EPSDT mental health services described in  
17 subdivision (a) to all fiscal committees and appropriate policy  
18 committees of the Legislature no later than October 1, 2013.

19 (d) The State Department of Health Care Services shall propose  
20 how to implement the performance outcomes system plan for  
21 EPSDT mental health services described in subdivision (a) no later  
22 than January 10, 2014.

23 (e) Commencing no later than February 1, 2014, the department  
24 shall convene a stakeholder advisory committee comprised of  
25 advocates for and representatives of, child and youth clients, family  
26 members, managed care health plans, providers, counties, and the  
27 Legislature. The committee shall develop methods to routinely  
28 measure, assess, and communicate program information regarding  
29 informing, identifying, screening, assessing, referring, and linking  
30 Medi-Cal eligible beneficiaries to mental health services and  
31 supports. The committee shall also review health plan screenings  
32 for mental health illness, health plan referrals to Medi-Cal  
33 fee-for-service providers, and health plan referrals to county mental  
34 health plans, among others. The committee shall make  
35 recommendations to the department regarding performance and  
36 outcome measures that will contribute to improving timely access  
37 to appropriate care for Medi-Cal eligible beneficiaries.

38 (1) The department shall incorporate into the performance  
39 outcomes system established pursuant to this section the screenings  
40 and referrals described in this subdivision, including milestones

1 and timelines, and shall provide an updated performance outcomes  
 2 system plan to all fiscal committees and the appropriate policy  
 3 committees of the Legislature no later than October 1, 2014.

4 (2) The department shall propose how to implement the updated  
 5 performance systems outcome plan described in paragraph (1) no  
 6 later than January 10, 2015.

7 SEC. 68. Part 3.3 (commencing with Section 15800) is added  
 8 to Division 9 of the Welfare and Institutions Code, to read:

9

10 PART 3.3. HEALTH CARE COVERAGE ASSISTANCE

11

12 CHAPTER 1. GENERAL PROVISIONS

13

14 15800. (a) (1) Commencing October 1, 2013, the State  
 15 Department of Health Care Services shall administer the  
 16 AIM-Linked Infants Program to address the health care needs of  
 17 children formerly covered pursuant to clause (ii) of subparagraph  
 18 (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the  
 19 Insurance Code. The department is vested with the same powers,  
 20 purposes, responsibilities, and jurisdiction exercised by the  
 21 Managed Risk Medical Insurance Board as they relate to those  
 22 children. Nothing in this paragraph shall be construed to alter,  
 23 diminish, or supersede the authority of the Managed Risk Medical  
 24 Insurance Board to exercise the same powers, purposes,  
 25 responsibilities, and jurisdiction within the Healthy Families  
 26 Program established under Part 6.2 (commencing with Section  
 27 12693) of Division 2 of the Insurance Code.

28 (2) The department may, before October 1, 2013, conduct  
 29 transition activities necessary to ensure the efficient transfer of the  
 30 program identified in subdivision (a) and populations served by  
 31 that program.

32 (b) The department shall seek any federal waivers, approvals,  
 33 and state plan amendments necessary to implement this part. This  
 34 part shall only be implemented to the extent that necessary federal  
 35 approvals are obtained and federal financial participation is  
 36 available for eligible programs and services.

37 15801. The terms of all regulations and orders adopted by the  
 38 Managed Risk Medical Insurance Board in effect immediately  
 39 preceding October 1, 2013, that relate to the operation of the  
 40 program and to the children transferred by the act that added this



1 section and are not rendered legally unenforceable by the act that  
2 added this section shall be fully enforceable by the State  
3 Department of Health Care Services within the AIM-Linked Infants  
4 Program unless and until the department adopts regulations for  
5 the AIM-Linked Infants Program. Nothing in this section shall be  
6 construed to alter, diminish, or supersede the authority of the  
7 Managed Risk Medical Insurance Board to interpret, enforce,  
8 maintain, or amend the same regulations for purposes of the  
9 Healthy Families Program established under Part 6.2 (commencing  
10 with Section 12693) of Division 2 of the Insurance Code.

11 15802. (a) The State Department of Health Care Services may  
12 issue rules and regulations to carry out the purposes of this part.

13 (b) Notwithstanding subdivision (a) or Chapter 3.5 (commencing  
14 with Section 11340) of Part 1 of Division 3 of Title 2 of the  
15 Government Code, the department, without taking any further  
16 regulatory actions, may implement, interpret, or make specific this  
17 part and amend or repeal regulations and orders adopted by the  
18 Managed Risk Medical Insurance Board as provided in Section  
19 15801 by means of all-county letters, plan letters, plan or provider  
20 bulletins, or similar instructions, without taking regulatory action  
21 during the transition of the programs to the department. Thereafter,  
22 the adoption and readoption of regulations to implement, interpret,  
23 or make specific this part shall be deemed to be an emergency that  
24 calls for immediate action to avoid serious harm to the public  
25 peace, health, safety, or general welfare for purposes of Sections  
26 11346.1 and 11349.6 of the Government Code, and the department  
27 is exempted from the requirement that it describe facts showing  
28 the need for immediate action. The regulations shall become  
29 effective immediately upon filing with the Secretary of State.

30 15803. (a) To implement this part and clause (ii) of  
31 subparagraph (A) of paragraph (6) of subdivision (a) of Section  
32 12693.70 of the Insurance Code, the State Department of Health  
33 Care Services may contract with public or private entities, including  
34 the Managed Risk Medical Insurance Board, which administers  
35 the Access for Infants and Mothers Program pursuant to Part 6.3  
36 (commencing with Section 12695) of Division 2 of the Insurance  
37 Code. Contracts entered into under this part may be on a  
38 noncompetitive bid basis and shall be exempt from the following:

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

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

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

8 (b) During the transition of the programs to the department, the  
9 department shall also be exempt from the review or approval of  
10 feasibility study reports and the requirements of Sections 4819.35  
11 to 4819.37, inclusive, and 4920 to 4928, inclusive, of the State  
12 Administrative Manual.

13 15804. On October 1, 2013, or when the State Department of  
14 Health Care Services has implemented Chapter 2 (commencing  
15 with Section 15850), whichever occurs later, the Managed Risk  
16 Medical Insurance Board shall cease to provide coverage to the  
17 children transferred to the AIM-Linked Infants Program, pursuant  
18 to Section 15800.

19 15805. (a) The Managed Risk Medical Insurance Board shall  
20 provide the State Department of Health Care Services any data,  
21 information, or record concerning the Healthy Families Program  
22 or the Access for Infants and Mothers Program as are necessary  
23 to implement this part and clause (ii) of subparagraph (A) of  
24 paragraph (6) of subdivision (a) of Section 12693.70 of the  
25 Insurance Code.

26 (b) Notwithstanding any other law, all of the following shall  
27 apply:

28 (1) The term “data, information, or record” shall include, but is  
29 not limited to, personal information as defined in Section 1798.3  
30 of the Civil Code.

31 (2) Any data, information, or record shall be exempt from  
32 disclosure under the California Public Records Act (Chapter 3.5  
33 (commencing with Section 6250) of Division 7 of the Government  
34 Code) and any other law, to the same extent that it was exempt  
35 from disclosure or privileged prior to the provision of the data,  
36 information, or record to the department.

37 (3) The provision of any data, information, or record to the  
38 department shall not constitute a waiver of any evidentiary  
39 privilege or exemption from disclosure.

1 (4) The department shall keep all data, information, or records  
2 provided by the Managed Risk Medical Insurance Board  
3 confidential to the full extent permitted by law, including, but not  
4 limited to, the California Public Records Act (Chapter 3.5  
5 (commencing with Section 6250) of Division 7 of the Government  
6 Code), and consistent with the Managed Risk Medical Insurance  
7 Board’s contractual obligations to keep data, information, or  
8 records confidential.  
9

10 CHAPTER 2. AIM-LINKED INFANTS PROGRAM  
11

12 15810. This chapter shall be known, and may be cited, as the  
13 AIM-Linked Infants Program.

14 15811. The definitions contained in this section govern the  
15 construction of this chapter, unless the context requires otherwise.

16 (a) “AIM-linked infant” means any infant born to a woman  
17 whose enrollment in the Access for Infants and Mothers Program  
18 under Part 6.3 (commencing with Section 12695) of Division 2 of  
19 the Insurance Code begins after June 30, 2004.

20 (b) “Department” means the State Department of Health Care  
21 Services.

22 (c) “Program” means the AIM-Linked Infants Program.

23 (d) “Subscriber” means an individual who is eligible for and  
24 enrolled in the program.

25 (e) “Subscriber contribution” means the cost to the subscriber  
26 to participate in the program.

27 15822. Health care services under the program shall include,  
28 but are not limited to, all of the following:

29 (a) Preventive, screening, diagnostic, and treatment services  
30 furnished directly by a licensed clinic, either onsite or by formal  
31 written contract, on a case-managed basis, to patients who remain  
32 less than 24 hours at the clinic for an illness or injury, advice,  
33 counseling, outreach, and translation as needed.

34 (b) Physician services.

35 (c) Emergency first aid, perinatal, obstetric, radiology,  
36 laboratory, and nutrition services.

37 (d) Services of advanced practice nurses or mid-level  
38 practitioners who are authorized to perform any of the services  
39 listed in this section within the scope of their licensure.

- 1 (e) All services and benefits set forth in Chapter 7 (commencing  
2 with Section 14000) of Part 3.  
3 15824. To the extent permitted by federal law, services for  
4 individuals eligible under this chapter shall be provided, at the  
5 department's discretion and to the extent the department determines  
6 the selected delivery system is cost effective, through the Medi-Cal  
7 fee-for-service or managed care delivery system, or both.  
8 15826. The department shall administer the program and may  
9 do all of the following:
- 10 (a) Determine eligibility criteria for the program. These criteria  
11 shall include the requirements set forth in Section 15832.  
12 (b) Determine the eligibility of AIM-linked infants.  
13 (c) Determine when subscribers are covered and the extent and  
14 scope of coverage.  
15 (d) Determine subscriber contribution amounts schedules.  
16 Subscriber contributions shall not be greater than those applicable  
17 on March 23, 2010, for infants enrolled pursuant to clause (ii) of  
18 subparagraph (A) of paragraph (6) of subdivision (a) of Section  
19 12693.70 of the Insurance Code.  
20 (e) Provide coverage through Medi-Cal delivery systems and  
21 contract for the administration of the program and the enrollment  
22 of subscribers. Any contract entered into pursuant to this chapter  
23 shall be exempt from any provision of law relating to competitive  
24 bidding, and shall be exempt from the review or approval of any  
25 division of the Department of General Services. The department  
26 shall not be required to specify the amounts encumbered for each  
27 contract, but may allocate funds to each contract based on projected  
28 and actual subscriber enrollments in a total amount not to exceed  
29 the amount appropriated for the program.  
30 (f) Authorize expenditures to pay program expenses that exceed  
31 subscriber contributions, and to administer the program as  
32 necessary.  
33 (g) Develop a promotional component of the program to make  
34 Californians aware of the program and the opportunity that it  
35 presents.  
36 (h) (1) Issue rules and regulations as necessary to administer  
37 the program.  
38 (2) During the 2011–12 to 2014–15 fiscal years, inclusive, the  
39 adoption and re-adoption of regulations pursuant to this chapter  
40 shall be deemed to be an emergency that calls for immediate action

1 to avoid serious harm to the public peace, health, safety, or general  
2 welfare for purposes of Sections 11346.1 and 11349.6 of the  
3 Government Code, and the department is hereby exempted from  
4 the requirement that the department describe facts showing the  
5 need for immediate action.

6 (i) Exercise all powers reasonably necessary to carry out the  
7 powers and responsibilities expressly granted or imposed by this  
8 chapter.

9 15828. The department shall coordinate with other state  
10 agencies, as appropriate, to help ensure continuity of health care  
11 services.

12 15830. (a) The department may contract with a variety of  
13 health plans and types of health care service delivery systems in  
14 order to offer subscribers a choice of plans, providers, and types  
15 of service delivery.

16 (b) Participating health plans contracting with the department  
17 pursuant to this chapter shall provide benefits or coverage to  
18 subscribers only as determined by the department pursuant to  
19 subdivision (b) of Section 15826.

20 15832. To be eligible to participate in the program, a person  
21 shall meet all of the following requirements:

22 (a) (1) Be a child under two years of age who is delivered by  
23 a mother enrolled in the program under Part 6.3 (commencing with  
24 Section 12695) of Division 2 of the Insurance Code. Except as  
25 stated in this section, these infants shall be automatically enrolled  
26 in the program.

27 (2) For the applicable month, not be enrolled in  
28 employer-sponsored health care coverage, or have been enrolled  
29 in that health care coverage in the prior three months or enrolled  
30 in full-scope Medi-Cal without a share of cost. Exceptions may  
31 be identified in regulations or other guidance and shall, at  
32 minimum, include all exceptions applicable to the Healthy Families  
33 Program on and after March 23, 2010.

34 (3) Be subject to subscriber contributions as determined by the  
35 department. The subscriber contributions shall not be greater than  
36 those applicable on March 23, 2010, for infants enrolled in the  
37 Healthy Families Program pursuant to clause (ii) of subparagraph  
38 (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the  
39 Insurance Code.

1 (b) For AIM-linked infants identified in subdivision (a), all of  
2 the following shall apply:

3 (1) Enrollment shall cover the first 12 months of the infant's  
4 life unless he or she is eligible for Medi-Cal benefits under Section  
5 14005.26. If the infant is eligible under Section 14005.26, he or  
6 she shall be automatically enrolled in the Medi-Cal program on  
7 that basis.

8 (2) (A) At the end of the 12 months, as a condition of continued  
9 eligibility, the subscriber shall provide income information. The  
10 infant shall be disenrolled from the program if the annual household  
11 income exceeds 300 percent of the federal poverty level, or if the  
12 infant is eligible for full-scope Medi-Cal with no share of cost.

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

21 (3) At the end of their first and second year in the program,  
22 infants shall be screened for eligibility for the Medi-Cal program.

23 (c) If at any time the director determines that the eligibility  
24 criteria established under this chapter for the program may  
25 jeopardize the state's ability to receive federal financial  
26 participation under the federal Patient Protection and Affordable  
27 Care Act (Public Law 111-148), or any amendment or extension  
28 of that act, the director may alter the eligibility criteria to the extent  
29 necessary for the state to receive that federal financial participation.

30 15834. A person shall not be eligible for covered services under  
31 the program if those services are covered through private health  
32 care coverage arrangements at the time of eligibility.

33 15836. (a) If a subscriber is dissatisfied with any action, or  
34 failure to act, that has occurred in connection with eligibility or  
35 covered services under this chapter, the subscriber may appeal to  
36 the department and shall be accorded an opportunity for a fair  
37 hearing. Hearings may be conducted pursuant to the provisions of  
38 Chapter 5 (commencing with Section 11500) of Part 1 of Division  
39 3 of Title 2 of the Government Code.

1 (b) The department may place a lien on compensation or benefits  
2 that are recovered or recoverable by a subscriber for whom benefits  
3 have been provided under a policy or plan issued under this chapter  
4 from any party or parties responsible for the compensation or  
5 benefits.

6 15838. (a) A provider who is furnished documentation of a  
7 subscriber's enrollment in the program shall not seek  
8 reimbursement or attempt to obtain payment for any covered  
9 services provided to that subscriber other than from the  
10 participating health plan or insurer covering the subscriber or from  
11 the department.

12 (b) Subdivision (a) shall not apply to any copayment required  
13 by the department under this chapter for the covered services  
14 provided to the subscriber.

15 (c) For purposes of this chapter, "provider" means any  
16 professional person, organization, health facility, or other person  
17 or institution licensed by the state to deliver or furnish health care  
18 services and includes as that term is defined in subdivision (o) of  
19 Section 14043.1.

20 15840. (a) At a minimum, coverage provided pursuant to this  
21 chapter shall be provided to eligible AIM-linked infants less than  
22 two years of age.

23 (b) Coverage provided pursuant to this chapter shall include, at  
24 a minimum, those services required to be provided by health care  
25 service plans approved by the Secretary of Health and Human  
26 Services as a federally qualified health care service plan pursuant  
27 to Section 417.101 of Title 42 of the Code of Federal Regulations.

28 (c) Medically necessary prescription drugs shall be a required  
29 benefit in the coverage provided pursuant to this chapter.

30 15842. Notwithstanding any other law, for a subscriber who  
31 is determined by the California Children's Services Program to be  
32 eligible for benefits under the program pursuant to Article 5  
33 (commencing with Section 123800) of Chapter 3 of Part 2 of  
34 Division 106 of the Health and Safety Code, a provider shall not  
35 be responsible for the provision of, or payment for, the particular  
36 services authorized by the California Children's Services Program  
37 for the particular subscriber for the treatment of a California  
38 Children's Services Program eligible medical condition. Providers  
39 shall refer a child whom they reasonably suspect of having a  
40 medical condition that is eligible for services under the California

1 Children's Services Program to the California Children's Services  
2 Program. The California Children's Services Program shall provide  
3 case management and authorization of services if the child is found  
4 to be medically eligible for the California Children's Services  
5 Program. Diagnosis and treatment services that are authorized by  
6 the California Children's Services Program shall be performed by  
7 paneled providers for that program and approved special care  
8 centers of that program in accordance with treatment plans  
9 approved by the California Children's Services Program. All other  
10 services provided under this chapter shall be available to the  
11 subscriber.

12 15844. A child enrolled in the program under this chapter who  
13 has a medical condition that is eligible for services pursuant to the  
14 California Children's Services Program, and whose family is not  
15 financially eligible for the California Children's Services Program,  
16 shall have the medically necessary treatment services for his or  
17 her California Children's Services Program eligible medical  
18 condition authorized and paid for by the California Children's  
19 Services Program. County expenditures for the payment of services  
20 for the child shall be waived and these expenditures shall be paid  
21 for by the state from Title XXI of the federal Social Security Act  
22 (42 U.S.C. Sec. 1397aa et seq.) funds and state general funds.

23 15846. The department shall encourage all providers who  
24 provide services under the program to have viable protocols for  
25 screening and referring children needing supplemental services  
26 outside of the scope of the screening, preventive, and medically  
27 necessary and therapeutic services covered by the contract to public  
28 programs providing such supplemental services for which they  
29 may be eligible, as well as for coordination of care between the  
30 provider and the public programs. The public programs for which  
31 providers may be required to develop screening, referral, and care  
32 coordination protocols may include the California Children's  
33 Services Program, the regional centers, county mental health  
34 programs, programs administered by the Department of Alcohol  
35 and Drug Programs or its successor agency or agencies, and  
36 programs administered by local education agencies.

37 SEC. 69. Section 15911 of the Welfare and Institutions Code  
38 is amended to read:

39 15911. (a) Funding for each LIHP shall be based on all of the  
40 following:



1 (1) The amount of funding that the participating entity  
2 voluntarily provides for the nonfederal share of LIHP expenditures.

3 (2) For a LIHP that had in operation a Health Care Coverage  
4 Initiative program under Part 3.5 (commencing with Section 15900)  
5 as of November 1, 2010, and elects to continue funding the  
6 program, the amount of funds requested to ensure that eligible  
7 enrollees continue to receive health care services for persons  
8 enrolled in the Health Care Coverage Initiative program as of  
9 November 1, 2010.

10 (3) Any limitations imposed by the Special Terms and  
11 Conditions of the demonstration project.

12 (4) The total allocations requested by participating entities for  
13 Health Care Coverage Initiative eligible individuals.

14 (5) Whether funding under this part would result in the reduction  
15 of other payments under the demonstration project.

16 (b) Nothing in this part shall be construed to require a political  
17 subdivision of the state to participate in a LIHP as set forth in this  
18 part, and those local funds expended or transferred for the  
19 nonfederal share of LIHP expenditures under this part shall be  
20 considered voluntary contributions for purposes of the federal  
21 Patient Protection and Affordable Care Act (Public Law 111-148),  
22 as amended by the federal Health Care and Education  
23 Reconciliation Act of 2010 (Public Law 111-152), and the federal  
24 American Recovery and Reinvestment Act of 2009 (Public Law  
25 111-5), as amended by the federal Patient Protection and  
26 Affordable Care Act.

27 (c) No state General Fund moneys shall be used to fund LIHP  
28 services, nor to fund any related administrative costs incurred by  
29 counties or any other political subdivision of the state.

30 (d) Subject to the Special Terms and Conditions of the  
31 demonstration project, if a participating entity elects to fund the  
32 nonfederal share of a LIHP, the nonfederal funding and payments  
33 to the LIHP shall be provided through one of the following  
34 mechanisms, at the options of the participating entity:

35 (1) On a quarterly basis, the participating entity shall transfer  
36 to the department for deposit in the LIHP Fund established for the  
37 participating counties and pursuant to subparagraph (A), the  
38 amount necessary to meet the nonfederal share of estimated  
39 payments to the LIHP for the next quarter under subdivision (g)  
40 Section 15910.3.

1 (A) The LIHP Fund is hereby created in the State Treasury.  
2 Notwithstanding Section 13340 of the Government Code, all  
3 moneys in the fund shall be continuously appropriated to the  
4 department for the purposes specified in this part. The fund shall  
5 contain all moneys deposited into the fund in accordance with this  
6 paragraph.

7 (B) The department shall obtain the related federal financial  
8 participation and pay the rates established under Section 15910.3,  
9 provided that the intergovernmental transfer is transferred in  
10 accordance with the deadlines imposed under the Medi-Cal  
11 Checkwrite Schedule, no later than the next available warrant  
12 release date. This payment shall be a nondiscretionary obligation  
13 of the department, enforceable under a writ of mandate pursuant  
14 to Section 1085 of the Code of Civil Procedure. Participating  
15 entities may request expedited processing within seven business  
16 days of the transfer as made available by the Controller's office,  
17 provided that the participating entity prepay the department for  
18 the additional administrative costs associated with the expedited  
19 processing.

20 (C) Total quarterly payment amounts shall be determined in  
21 accordance with estimates of the number of enrollees in each rate  
22 category, subject to annual reconciliation to final enrollment data.

23 (2) If a participating entity operates its LIHP through a contract  
24 with another entity, the participating entity may pay the operating  
25 entity based on the per enrollee rates established under Section  
26 15910.3 on a quarterly basis in accordance with estimates of the  
27 number of enrollees in each rate category, subject to annual  
28 reconciliation to final enrollment data.

29 (A) (i) On a quarterly basis, the participating entity shall certify  
30 the expenditures made under this paragraph and submit the report  
31 of certified public expenditures to the department.

32 (ii) The department shall report the certified public expenditures  
33 of a participating entity under this paragraph on the next available  
34 quarterly report as necessary to obtain federal financial  
35 participation for the expenditures. The total amount of federal  
36 financial participation associated with the participating entity's  
37 expenditures under this paragraph shall be reimbursed to the  
38 participating entity.

39 (B) At the option of the participating entity, the LIHP may be  
40 reimbursed on a cost basis in accordance with the methodology

1 applied to Health Care Coverage Initiative programs established  
2 under Part 3.5 (commencing with Section 15900) including interim  
3 quarterly payments.

4 (e) Notwithstanding Section 15910.3 and subdivision (d) of this  
5 section, if the participating entity cannot reach an agreement with  
6 the department as to the appropriate rate to be paid under Section  
7 15910.3, at the option of the participating entity, the LIHP shall  
8 be reimbursed on a cost basis in accordance with the methodology  
9 applied to Health Care Coverage Initiative programs established  
10 under Part 3.5 (commencing with Section 15900), including interim  
11 quarterly payments. If the participating entity and the department  
12 reach an agreement as to the appropriate rate, the rate shall be  
13 applied no earlier than the first day of the LIHP year in which the  
14 parties agree to the rate.

15 (f) If authorized under the Special Terms and Conditions of the  
16 demonstration project, pending the department's development of  
17 rates in accordance with Section 15910.3, the department shall  
18 make interim quarterly payments to approved LIHPs for  
19 expenditures based on estimated costs submitted for rate setting.

20 (g) Participating entities that operate a LIHP directly or through  
21 contract with another entity shall be entitled to any federal financial  
22 participation available for administrative expenditures incurred in  
23 the operation of the Medi-Cal program or the demonstration  
24 project, including, but not limited to, outreach, screening and  
25 enrollment, program development, data collection, reporting and  
26 quality monitoring, and contract administration, but only to the  
27 extent that the expenditures are allowable under federal law and  
28 only to the extent the expenditures are not taken into account in  
29 the determination of the per enrollee rates under Section 15910.3.

30 (h) On and after January 1, 2014, the state shall implement  
31 comprehensive health care reform for the populations targeted by  
32 the LIHP in compliance with federal health care reform law,  
33 regulation, and policy, including the federal Patient Protection and  
34 Affordable Care Act (Public Law 111-148), as amended by the  
35 federal Health Care and Education Reconciliation Act of 2010  
36 (Public Law 111-152), and subsequent amendments.

37 (i) Subject to the Special Terms and Conditions of the  
38 demonstration project, a participating entity may elect to include,  
39 in collaboration with the department, as the nonfederal share of  
40 LIHP expenditures, voluntary intergovernmental transfers or

1 certified public expenditures of another governmental entity, as  
2 long as the intergovernmental transfer or certified public  
3 expenditure is consistent with federal law.

4 (j) Participation in the LIHP under this part is voluntary on the  
5 part of the eligible entity for purposes of all applicable federal  
6 laws. As part of its voluntary participation under this article, the  
7 participating entity shall agree to reimburse the state for the  
8 nonfederal share of state staffing and administrative costs directly  
9 attributable to the cost of administering that LIHP, including, but  
10 not limited to, the state administrative costs related to certified  
11 public expenditures and intergovernmental transfers. This section  
12 shall be implemented only to the extent federal financial  
13 participation is not jeopardized.

14 SEC. 70. (a) The State Department of Health Care Services  
15 shall accept contributions by private foundations in the amount of  
16 at least fourteen million dollars (\$14,000,000) for the purpose of  
17 this section and shall immediately seek an equal amount of federal  
18 matching funds.

19 (b) Entities and persons that are eligible for Medi-Cal in-person  
20 enrollment assistance payments of fifty-eight dollars (\$58) per  
21 approved Medi-Cal application and payment processing costs shall  
22 be those trained and eligible for in-person enrollment assistance  
23 payments by the California Health Benefit Exchange. The  
24 payments may be made by the State Department of Health Care  
25 Services or through the California Health Benefit Exchange  
26 in-person assistance payment system.

27 (c) Enrollment assistance payments shall be made only for  
28 Medi-Cal applicants newly eligible for coverage pursuant to the  
29 federal Patient Protection and Affordable Care Act (Public Law  
30 111-148), as amended by the Health Care and Education  
31 Reconciliation Act of 2010 (Public Law 111-152), or those who  
32 have not been enrolled in the Medi-Cal program during the  
33 previous 12 months prior to making the application.

34 (d) The commencement of enrollment assistance payments shall  
35 be consistent with those of the California Health Benefit Exchange.

36 (e) The State Department of Health Care Services or the  
37 California Health Benefit Exchange shall provide monthly and  
38 cumulative payment updates and number of persons enrolled  
39 through in-person assistance payments on its Internet Web site.

1 SEC. 71. (a) (1) The State Department of Health Care Services  
2 shall accept funding from private foundations in the amount of at  
3 least \$12.5 million to provide allocations for the management and  
4 funding of Medi-Cal outreach and enrollment plans specific to the  
5 provisions contained in this section.

6 (2) The department shall seek necessary federal approval for  
7 purposes of obtaining federal funding for activities conducted  
8 under this section.

9 (3) Notwithstanding any other law, and in a manner that the  
10 Director of Health Care Services shall provide, the department  
11 may make allocations to fund Medi-Cal outreach and enrollment  
12 activities as described in this section.

13 (b) (1) Funds appropriated by the Legislature to the department  
14 for the purposes of this section shall be made available to selected  
15 counties, counties acting jointly, and the County Medical Services  
16 Program Governing Board pursuant to Section 16809 of the  
17 Welfare and Institutions Code.

18 (2) Selected counties, counties acting jointly, and the County  
19 Medical Services Program Governing Board may partner with  
20 community-based organizations as applicable to conduct outreach  
21 and enrollment to the target population as contained in subdivision  
22 (d).

23 (3) The director may, at his or her discretion, also give  
24 consideration to community-based organizations in an area or  
25 region of the state if a county, or counties acting jointly do not  
26 seek an allocation or funds are made available.

27 (4) For purposes of this section only, “county” shall be defined  
28 as county, city and county, a consortium of counties serving a  
29 region consisting of more than one county, the County Medical  
30 Services Program Governing Board, or a health authority.

31 (c) (1) The allocations shall be apportioned geographically, by  
32 the entities identified in subdivision (b), according to the estimated  
33 number of persons who are eligible but not enrolled in Medi-Cal  
34 and who will be newly Medi-Cal eligible as of January 1, 2014.

35 (2) The department may determine the number of allocations  
36 and the application process. The director may consult or obtain  
37 technical assistance from private foundations in implementation  
38 of the application and allocation process.

39 (3) The department shall coordinate and partner with the  
40 California Health Benefit Exchange on certified application assister

1 and outreach, enrollment, and marketing activities related to the  
2 federal Patient Protection and Affordable Care Act.

3 (d) Notwithstanding any other law, the department shall develop  
4 selection criteria to allocate funds for the Medi-Cal outreach and  
5 enrollment activities with special emphasis targeting all of the  
6 following populations:

7 (1) Persons with mental health disorder needs.

8 (2) Persons with substance use disorder needs.

9 (3) Persons who are homeless.

10 (4) Young men of color.

11 (5) Persons who are in county jail, in state prison, on state  
12 parole, on county probation, or under postrelease community  
13 supervision.

14 (6) Families of mixed-immigration status.

15 (7) Persons with limited English proficiency.

16 (e) (1) The funds allocated under this section shall be used only  
17 for the Medi-Cal outreach and enrollment activities and may  
18 supplement, but shall not supplant, existing local, state, and  
19 foundation funding of county outreach and enrollment activities.

20 (2) Notwithstanding Section 10744 of the Welfare and  
21 Institutions Code, the department may recoup or withhold all or  
22 part of an allocation for failure to comply with any requirements  
23 or standards set forth by the department for the purposes of this  
24 section.

25 (f) The department shall begin the payment for the outreach and  
26 enrollment allocation program no later than February 1, 2014.

27 (g) Under the terms of the approved allocation for the outreach  
28 and enrollment program, funded entities under this section shall  
29 not receive payment for in-person assister payments for assisting  
30 potential Medi-Cal enrollees.

31 (h) The department shall require progress reports, in a manner  
32 as determined by the department, from those receiving allocations  
33 under this section.

34 (i) To the extent federal funding is received for the services  
35 specified in this section, reimbursements for costs incurred under  
36 the approved allocations shall be made in compliance with federal  
37 law.

38 (j) Notwithstanding Chapter 3.5 (commencing with Section  
39 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
40 the department may implement, interpret, or make specific this

1 section by means of all-county letters, provider bulletins, or similar  
2 instructions.

3 (k) The department may use a portion of the private foundation  
4 funding pursuant to paragraph (a) to carry out the activities under  
5 this section.

6 SEC. 72. Commencing no later than August 1, 2013, the State  
7 Department of Health Care Services shall convene a series of  
8 stakeholder meetings to receive input from clients, family members,  
9 providers, counties, and representatives of the Legislature  
10 concerning the development of the Behavioral Health Services  
11 Plan, as required by paragraph 25.d of the Special Terms and  
12 Conditions of California’s Bridge to Reform Section 1115(a)  
13 Medicaid Demonstration.

14 SEC. 73. Given the uncertainty within which persons diagnosed  
15 with HIV/AIDS from federal Ryan White HIV/AIDS Treatment  
16 Extension Act of 2009 funded programs may transition to Medi-Cal  
17 or other health insurance coverage, the State Department of Public  
18 Health shall report to the Joint Legislative Budget Committee by  
19 October 1, 2013, on whether any of the projections or assumptions  
20 used to develop the AIDS Drug Assistance Program (ADAP)  
21 estimated budget for the Budget Act of 2013 may result in an  
22 inability of ADAP to provide services to ADAP eligible clients.  
23 If the State Department of Public Health determines, before  
24 October 1, 2013, that ADAP is unable to provide services to ADAP  
25 eligible clients, the State Department of Public Health shall provide  
26 notification to the Joint Legislative Budget Committee within 15  
27 calendar days of making this determination.

28 SEC. 74. By October 1, 2013, the State Department of Public  
29 Health shall submit to the fiscal and appropriate policy committees  
30 of the Legislature a report describing how it plans to address the  
31 findings and recommendations described in its “Zero-Based  
32 Budgeting Review” report dated May 14, 2013, regarding the  
33 Infant Botulism Treatment and Prevention Program (BabyBIG  
34 program).

35 SEC. 75. As part of the Governor’s annual budget release to  
36 the Legislature in January and May, the State Department of Health  
37 Care Services shall identify as a separate policy change within the  
38 Medi-Cal Local Assistance Estimate, the projected General Fund  
39 savings attributable to the receipt of enhanced federal funding for  
40 Medi-Cal eligibles, subject to the use of Modified Adjusted Gross

1 Income as the basis for their income eligibility, who were  
2 previously calculated as being currently eligible and for whom the  
3 state received only a 50 percent federal matching assistant payment.  
4 The identified savings shall be attributed to the receipt of enhanced  
5 federal funding under Title XIX of the federal Social Security Act.  
6 The State Department of Health Care Services shall confer with  
7 applicable fiscal and policy staff of the Legislature by no later than  
8 October 1, 2013, regarding the potential content and attributes of  
9 the information provided in this policy change. This separate policy  
10 change format shall be provided through 2019–20.

11 SEC. 76. Notwithstanding any other law, the balance of Item  
12 4150-001-0890 of the Budget Act of 2012 is reappropriated to the  
13 Department of Managed Health Care for the purposes of continuing  
14 operation of consumer assistance programs to help uninsured  
15 individuals obtain health care coverage pursuant to the terms of  
16 the federal Consumer Assistance Program Grant. These funds shall  
17 be available for encumbrance and expenditure until June 30, 2014.

18 SEC. 77. The adoption and readoption of regulations  
19 implementing portions of this act by the Managed Risk Medical  
20 Insurance Board shall be deemed an emergency and necessary to  
21 avoid serious harm to the public peace, health, safety, or general  
22 welfare for purposes of Sections 11346.1 and 11349.6 of the  
23 Government Code, and the board is hereby exempted from the  
24 requirement that it describe facts showing the need for immediate  
25 action and from review by the Office of Administrative Law.

26 SEC. 78. The Legislature finds and declares that Section 2 of  
27 this act, which amends Section 6254 to the Government Code, and  
28 Section 68 of this act, which adds Part 3.3 (commencing with  
29 Section 15800) to Division 9 of the Welfare and Institution Code,  
30 impose a limitation on the public's right of access to the meetings  
31 of public bodies or the writings of public officials and agencies  
32 within the meaning of Section 3 of Article I of the California  
33 Constitution. Pursuant to that constitutional provision, the  
34 Legislature makes the following findings to demonstrate the interest  
35 protected by this limitation and the need for protecting that interest:

36 (a) In order to ensure that the State Department of Health Care  
37 Services is not constrained in exercising its fiduciary powers and  
38 obligations to negotiate on behalf of the public as it implements  
39 the provisions of Part 3.3 (commencing with Section 15800) of  
40 Division 9 of the Welfare and Institutions Code, the limitations



1 on the public's right of access imposed by Section 2 of this act are  
2 necessary.

3 (b) To ensure the continued confidentiality of otherwise  
4 privileged or confidential information, the limitations on the  
5 public's right of access imposed by Section 68 of this act are  
6 necessary.

7 SEC. 79. This act is a bill providing for appropriations related  
8 to the Budget Bill within the meaning of subdivision (e) of Section  
9 12 of Article IV of the California Constitution, has been identified  
10 as related to the budget in the Budget Bill, and shall take effect  
11 immediately.

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