

AMENDED IN ASSEMBLY JUNE 11, 2014

**SENATE BILL**

**No. 1465**

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**Introduced by Committee on Health (Senators Hernandez (Chair),  
Anderson, Beall, De León, DeSaulnier, Evans, Monning, Morrell,  
Nielsen, and Wolk)**

March 20, 2014

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An act to amend Sections 8880.5, 14670.3, and 14670.5 of the Government Code, to amend ~~Section~~ Sections 1728.7 and 1797.98b of the Health and Safety Code, to amend and renumber Section 10961 of the Insurance Code, to amend Sections 667.5, 830.3, 830.5, and 3000 of the Penal Code, to amend Section 2356 of the Probate Code, and to amend Sections 736, 5328.15, 6000, 6002, 6600, 6601, 6608.7, 6609, 9717, 10600.1, 10725, 14043.26, 14087.36, 14105.192, 14124.5, 14169.51, 14169.52, 14169.53, 14169.55, 14169.56, 14169.58, 14169.59, 14169.61, 14169.63, 14169.65, 14169.66, 14169.72, 14312, 14451, 15657.8, 16541, and 17608.05 of the Welfare and Institutions Code, relating to health, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 1465, as amended, Committee on Health. Health.

*(1) Existing law prohibits any private or public organization, political subdivision of the state, or other government agency within the state from providing or arranging for skilled nursing services to patients in the home without first obtaining a home health agency license, as defined, from the State Department of Health Care Services. Existing law establishes the requirements for licensure as a home health agency. Existing law requires the department to license a home health agency that, among other things, is accredited by the Joint Commission on*

*Accreditation of Healthcare Organizations or the Community Health Accreditation Program and the accrediting organization forwards to the department certain information.*

*For purposes of licensure, the bill would instead require a home health agency to be accredited by an entity approved by the federal Centers for Medicare and Medicaid Services as a national accreditation organization.*

~~(1)~~

(2) Existing law establishes the Maddy Emergency Medical Services (EMS) Fund, and authorizes each county to establish an emergency medical services fund for reimbursement of costs related to emergency medical services. Existing law requires each county establishing a fund to, on January 1, 1989, and each April 15 thereafter, report to the Legislature on the implementation and status of the Emergency Medical Services Fund, as specified.

This bill would instead require each county to submit its reports to the Emergency Medical Services Authority. The bill would require the authority to compile and forward a summary of each county's report to the appropriate policy and fiscal committees of the Legislature.

~~(2)~~

(3) Existing law creates the California Health Benefit Exchange for the purpose of facilitating the enrollment of qualified individuals and small employers in qualified health plans. Existing law requires the Exchange to enter into contracts with and certify as a qualified health plan bridge plan products that meet specified requirements. Existing law provides for the regulation of health insurers by the Department of Insurance and defines a bridge plan product to include an individual health benefit plan offered by a health insurer. Existing law requires, until 5 years after federal approval of bridge plan products, a health insurer selling a bridge plan product to provide specified enrollment periods and to maintain a medical loss ratio of 85% for the product. Existing law specifies that the remaining provisions of the chapter of law to which these requirements regarding bridge plan products were added became inoperative on January 1, 2014.

This bill would relocate those requirements regarding bridge plan products to a different chapter of law and make other technical, nonsubstantive changes.

~~(3)~~

(4) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under

which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law requires an applicant or provider, as defined, to submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location. Existing law generally requires the department to give written notice as to the status of an application to an applicant or provider within 180 days after receiving an application package, or from the date of notifying an applicant or provider that he or she does not qualify as a preferred provider, notifying the applicant or provider if specified circumstances apply, *or, on the 181st day, to grant provisional provider status to the applicant or provider.*

This bill would, *except as specified, authorize an applicant or provider to request to withdraw an application package submitted pursuant to these provisions, and would require the department to notify the applicant or provider if the application package is withdrawn by request of the applicant or provider and the department's review is canceled.*

*(5) Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to various models of managed care. In this regard, existing law authorizes the City and County of San Francisco to establish a health authority to be the local initiative component of the managed care model in that city and county. Existing law requires that the governing board of the health authority consist of 18 voting members, 2 of which are required to be nominated by the beneficiary committee established by the health authority to advise the authority on issues of concern to the recipients of services. Existing law requires that at least one of the 2 persons nominated by the beneficiary committee be a Medi-Cal beneficiary.*

*This bill would instead require the health authority to establish a member advisory committee to advise the authority on issues of concern to the recipients of services and would delete the requirement that one of the 2 persons nominated by the committee be a Medi-Cal beneficiary. The bill would instead require the 2 persons nominated by the committee to be enrolled in a health care program operated by the health authority, as specified, or be the parent or legal guardian of an enrollee.*

*(6) Existing law authorizes the Director of Health Care Services to administer laws pertaining to the administration of health care services and medical assistance throughout the state by, among other things, adopting regulations pursuant to the provisions of the Administrative*

*Procedure Act to enable the department to carry out the purposes and intent of the Medi-Cal Act.*

*This bill would correct obsolete cross-references to the Administrative Procedure Act in these provisions, and would make other technical, nonsubstantive changes.*

~~(4)~~

(7) Existing law, subject to federal approval, imposes a hospital quality assurance fee, as specified, on certain general acute care hospitals, to be deposited into the Hospital Quality Assurance Revenue Fund. Existing law, subject to federal approval, requires that moneys in the Hospital Quality Assurance Revenue Fund be continuously appropriated during the first program period of January 1, 2014, to December 31, 2016, inclusive, and available only for certain purposes, including paying for health care coverage for children, as specified, and making supplemental payments for certain services to private hospitals and increased capitation payments to Medi-Cal managed care plans. Existing law also requires the payment of direct grants to designated and nondesignated public hospitals in support of health care expenditures funded by the quality assurance fee for the first program period. For subsequent program periods, existing law authorizes the payment of direct grants for designated and nondesignated public hospitals and requires that the moneys in the Hospital Quality Assurance Revenue Fund be used for the above-described purposes upon appropriation by the Legislature in the annual Budget Act.

This bill would define the term “fund” to mean the Hospital Quality Assurance Revenue Fund for the purposes of these provisions and would make other technical, conforming changes to these provisions.

~~(5)~~

(8) Existing law provides for state hospitals for the care, treatment, and education of mentally disordered persons, which are under the jurisdiction of the State Department of State Hospitals.

This bill would make technical, nonsubstantive changes to various provisions of law to, in part, delete obsolete references to the State Department of Mental Health. The bill would also make other technical, nonsubstantive changes.

~~(6)~~

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

Vote:  $\frac{2}{3}$ . Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

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

1 SECTION 1. Section 8880.5 of the Government Code is  
2 amended to read:

3 8880.5. Allocations for education:

4 The California State Lottery Education Fund is created within  
5 the State Treasury, and is continuously appropriated for carrying  
6 out the purposes of this chapter. The Controller shall draw warrants  
7 on this fund and distribute them quarterly in the following manner,  
8 provided that the payments specified in subdivisions (a) to (g),  
9 inclusive, shall be equal per capita amounts.

10 (a) (1) Payments shall be made directly to public school  
11 districts, including county superintendents of schools, serving  
12 kindergarten and grades 1 to 12, inclusive, or any part thereof, on  
13 the basis of an equal amount for each unit of average daily  
14 attendance, as defined by law and adjusted pursuant to subdivision  
15 (l).

16 (2) For purposes of this paragraph, in each of the 2008–09,  
17 2009–10, 2010–11, 2011–12, 2012–13, 2013–14, and 2014–15  
18 fiscal years, the number of units of average daily attendance in  
19 each of those fiscal years for programs for public school districts,  
20 including county superintendents of schools, serving kindergarten  
21 and grades 1 to 12, inclusive, shall include the same amount of  
22 average daily attendance for classes for adults and regional  
23 occupational centers and programs used in the calculation made  
24 pursuant to this subdivision for the 2007–08 fiscal year.

25 (b) Payments shall also be made directly to public school  
26 districts serving community colleges, on the basis of an equal  
27 amount for each unit of average daily attendance, as defined by  
28 law.

29 (c) Payments shall also be made directly to the Board of Trustees  
30 of the California State University on the basis of an amount for  
31 each unit of equivalent full-time enrollment. Funds received by  
32 the trustees shall be deposited in and expended from the California  
33 State University Lottery Education Fund, which is hereby created  
34 or, at the discretion of the trustees, deposited in local trust accounts  
35 in accordance with subdivision (j) of Section 89721 of the  
36 Education Code.

1 (d) Payments shall also be made directly to the Regents of the  
2 University of California on the basis of an amount for each unit  
3 of equivalent full-time enrollment.

4 (e) Payments shall also be made directly to the Board of  
5 Directors of the Hastings College of the Law on the basis of an  
6 amount for each unit of equivalent full-time enrollment.

7 (f) Payments shall also be made directly to the Department of  
8 the Youth Authority for educational programs serving kindergarten  
9 and grades 1 to 12, inclusive, or any part thereof, on the basis of  
10 an equal amount for each unit of average daily attendance, as  
11 defined by law.

12 (g) Payments shall also be made directly to the two California  
13 Schools for the Deaf, the California School for the Blind, and the  
14 three Diagnostic Schools for Neurologically Handicapped Children,  
15 on the basis of an amount for each unit of equivalent full-time  
16 enrollment.

17 (h) Payments shall also be made directly to the State Department  
18 of Developmental Services and the State Department of State  
19 Hospitals for clients with developmental or mental disabilities who  
20 are enrolled in state hospital education programs, including  
21 developmental centers, on the basis of an equal amount for each  
22 unit of average daily attendance, as defined by law.

23 (i) No Budget Act or other statutory provision shall direct that  
24 payments for public education made pursuant to this chapter be  
25 used for purposes and programs (including workload adjustments  
26 and maintenance of the level of service) authorized by Chapters  
27 498, 565, and 1302 of the Statutes of 1983, Chapter 97 or 258 of  
28 the Statutes of 1984, or Chapter 1 of the Statutes of the 1983–84  
29 Second Extraordinary Session.

30 (j) School districts and other agencies receiving funds distributed  
31 pursuant to this chapter may at their option utilize funds allocated  
32 by this chapter to provide additional funds for those purposes and  
33 programs prescribed by subdivision (i) for the purpose of  
34 enrichment or expansion.

35 (k) As a condition of receiving any moneys pursuant to  
36 subdivision (a) or (b), each school district and county  
37 superintendent of schools shall establish a separate account for the  
38 receipt and expenditure of those moneys, which account shall be  
39 clearly identified as a lottery education account.

1 (l) Commencing with the 1998–99 fiscal year, and each year  
2 thereafter, for purposes of subdivision (a), average daily attendance  
3 shall be increased by the statewide average rate of excused  
4 absences for the 1996–97 fiscal year as determined pursuant to the  
5 provisions of Chapter 855 of the Statutes of 1997. The statewide  
6 average excused absence rate, and the corresponding adjustment  
7 factor required for the operation of this subdivision, shall be  
8 certified to the ~~State~~ Controller by the Superintendent of Public  
9 Instruction.

10 (m) It is the intent of this chapter that all funds allocated from  
11 the California State Lottery Education Fund shall be used  
12 exclusively for the education of pupils and students and no funds  
13 shall be spent for acquisition of real property, construction of  
14 facilities, financing of research, or any other noninstructional  
15 purpose.

16 SEC. 2. Section 14670.3 of the Government Code is amended  
17 to read:

18 14670.3. Notwithstanding Section 14670, the Director of  
19 General Services, with the consent of the State Department of  
20 Developmental Services, may let to a nonprofit corporation, for  
21 the purpose of conducting an educational and work program for  
22 persons with intellectual disabilities, and for a period not to exceed  
23 55 years, real property not exceeding five acres located within the  
24 grounds of the Fairview State Hospital.

25 The lease authorized by this section shall be nonassignable and  
26 shall be subject to periodic review every five years. The review  
27 shall be made by the Director of General Services, who shall do  
28 both of the following:

29 (a) ~~Assure~~ *Ensure* the state that the original purposes of the  
30 lease are being carried out.

31 (b) Determine what, if any, adjustment should be made in the  
32 terms of the lease.

33 The lease shall also provide for an initial capital outlay by the  
34 lessee of thirty thousand dollars (\$30,000) prior to January 1, 1976.  
35 The capital outlay may be, or may have been, contributed before  
36 or after the effective date of the act adding this section.

37 SEC. 3. Section 14670.5 of the Government Code is amended  
38 to read:

39 14670.5. Notwithstanding Section 14670, the Director of  
40 General Services, with the consent of the State Department of

1 Developmental Services may let to a nonprofit corporation, for  
 2 the purpose of establishing and maintaining a rehabilitation center  
 3 for persons with intellectual disabilities, for a period not exceeding  
 4 20 years, real property, not exceeding five acres, located within  
 5 the grounds of the Fairview State Hospital in Orange County, and  
 6 that is retained by the state primarily to provide a peripheral buffer  
 7 area, or zone, between real property that the state hospital is located  
 8 on and adjacent real property, if the director deems the letting is  
 9 in the best interests of the state.

10 *SEC. 4. Section 1728.7 of the Health and Safety Code is*  
 11 *amended to read:*

12 1728.7. (a) Notwithstanding any other provision of this  
 13 chapter, the state department shall issue a license to a home health  
 14 agency that applies to the state department for a home health  
 15 agency license and meets all of the following requirements:

16 (1) Is accredited as a home health agency by ~~either the Joint~~  
 17 ~~Commission on Accreditation of Healthcare Organizations~~  
 18 ~~(JCAHO) or the Community Health Accreditation Program~~  
 19 ~~(CHAP) an entity approved by the federal Centers for Medicare~~  
 20 ~~and Medicaid Services as a national accreditation organization,~~  
 21 ~~and the accrediting organization national accreditation~~  
 22 ~~organization forwards to the state department copies of all initial~~  
 23 ~~and subsequent survey and other accreditation reports or findings.~~

24 (2) Files an application with fees pursuant to this chapter.

25 (3) Meets any other additional licensure requirements of, or  
 26 regulations adopted pursuant to, this chapter that the state  
 27 department identifies, after consulting with ~~either the JCAHO or~~  
 28 ~~the CHAP the national accreditation organizations,~~ as more  
 29 stringent than the accreditation requirements of ~~either JCAHO or~~  
 30 ~~CHAP the national accreditation organizations.~~

31 (b) The state department may require a survey of an accredited  
 32 home health agency to ensure the accreditation requirements are  
 33 met. These surveys shall be conducted using a selective sample  
 34 basis.

35 (c) The state department may require a survey of an accredited  
 36 home health agency to investigate complaints against an accredited  
 37 home health agency for substantial noncompliance, as determined  
 38 by the state department, with these accreditation standards.

39 (d) Notwithstanding subdivisions (a), (b), and (c), the state  
 40 department shall retain its full range of authority over accredited

1 home health agencies to ensure the licensure and accreditation  
2 requirements are met. This authority shall include the entire scope  
3 of enforcement sanctions and options available for unaccredited  
4 home health agencies.

5 ~~SEC. 4.~~

6 *SEC. 5.* Section 1797.98b of the Health and Safety Code is  
7 amended to read:

8 1797.98b. (a) Each county establishing a fund, on January 1,  
9 1989, and on each April 15 thereafter, shall report to the authority  
10 on the implementation and status of the Emergency Medical  
11 Services Fund. Notwithstanding Section 10231.5 of the  
12 Government Code, the authority shall compile and forward a  
13 summary of each county's report to the appropriate policy and  
14 fiscal committees of the Legislature. Each county report, and the  
15 summary compiled by the authority, shall cover the immediately  
16 preceding fiscal year, and shall include, but not be limited to, all  
17 of the following:

18 (1) The total amount of fines and forfeitures collected, the total  
19 amount of penalty assessments collected, and the total amount of  
20 penalty assessments deposited into the Emergency Medical  
21 Services Fund, or, if no moneys were deposited into the fund, the  
22 reason or reasons for the lack of deposits. The total amounts of  
23 penalty assessments shall be listed on the basis of each statute that  
24 provides the authority for the penalty assessment, including  
25 Sections 76000, 76000.5, and 76104 of the Government Code, and  
26 Section 42007 of the Vehicle Code.

27 (2) The amount of penalty assessment funds collected under  
28 Section 76000.5 of the Government Code that are used for the  
29 purposes of subdivision (e) of Section 1797.98a.

30 (3) The fund balance and the amount of moneys disbursed under  
31 the program to physicians and surgeons, for hospitals, and for other  
32 emergency medical services purposes, and the amount of money  
33 disbursed for actual administrative costs. If funds were disbursed  
34 for other emergency medical services, the report shall provide a  
35 description of each of those services.

36 (4) The number of claims paid to physicians and surgeons, and  
37 the percentage of claims paid, based on the uniform fee schedule,  
38 as adopted by the county.

39 (5) The amount of moneys available to be disbursed to  
40 physicians and surgeons, descriptions of the physician and surgeon

1 claims payment methodologies, the dollar amount of the total  
2 allowable claims submitted, and the percentage at which those  
3 claims were reimbursed.

4 (6) A statement of the policies, procedures, and regulatory action  
5 taken to implement and run the program under this chapter.

6 (7) The name of the physician and surgeon and hospital  
7 administrator organization, or names of specific physicians and  
8 surgeons and hospital administrators, contacted to review claims  
9 payment methodologies.

10 (8) A description of the process used to solicit input from  
11 physicians and surgeons and hospitals to review payment  
12 distribution methodology as described in subdivision (a) of Section  
13 1797.98e.

14 (9) An identification of the fee schedule used by the county  
15 pursuant to subdivision (e) of Section 1797.98c.

16 (10) (A) A description of the methodology used to disburse  
17 moneys to hospitals pursuant to subparagraph (B) of paragraph  
18 (5) of subdivision (b) of Section 1797.98a.

19 (B) The amount of moneys available to be disbursed to hospitals.

20 (C) If moneys are disbursed to hospitals on a claims basis, the  
21 dollar amount of the total allowable claims submitted and the  
22 percentage at which those claims were reimbursed to hospitals.

23 (11) The name and contact information of the entity responsible  
24 for each of the following:

25 (A) Collection of fines, forfeitures, and penalties.

26 (B) Distribution of penalty assessments into the Emergency  
27 Medical Services Fund.

28 (C) Distribution of moneys to physicians and surgeons.

29 (b) (1) Each county, upon request, shall make available to any  
30 member of the public the report provided to the authority under  
31 subdivision (a).

32 (2) Each county, upon request, shall make available to any  
33 member of the public a listing of physicians and surgeons and  
34 hospitals that have received reimbursement from the Emergency  
35 Medical Services Fund and the amount of the reimbursement they  
36 have received. This listing shall be compiled on a semiannual basis.

37 ~~SEC. 5.~~

38 *SEC. 6.* Section 10961 of the Insurance Code is amended and  
39 renumbered to read:

1 10965.18. (a) For purposes of this chapter, a bridge plan  
2 product shall mean an individual health benefit plan that is offered  
3 by a health insurer licensed under this part that contracts with the  
4 Exchange pursuant to Title 22 (commencing with Section 100500)  
5 of the Government Code.

6 (b) On and after September 30, 2013, if a health insurance policy  
7 has not been filed with the commissioner, a health insurer that  
8 contracts with the Exchange to offer a qualified bridge plan product  
9 pursuant to Section 100504.5 of the Government Code shall file  
10 the policy form with the commissioner pursuant to Section 10290.

11 (c) (1) Notwithstanding subdivision (a) of Section 10965.3, a  
12 health insurer selling a bridge plan product shall not be required  
13 to fairly and affirmatively offer, market, and sell the health  
14 insurer's bridge plan product except to individuals eligible for the  
15 bridge plan product pursuant to the State Department of Health  
16 Care Services and the Medi-Cal managed care plan's contract  
17 entered into pursuant to Section 14005.70 of the Welfare and  
18 Institutions Code, provided the health care service plan meets the  
19 requirements of subdivision (b) of Section 14005.70 of the Welfare  
20 and Institutions Code.

21 (2) Notwithstanding subdivision (c) of Section 10965.3, a health  
22 insurer selling a bridge plan product shall provide an initial open  
23 enrollment period of six months, and an annual enrollment period  
24 and a special enrollment period consistent with the annual  
25 enrollment and special enrollment periods of the Exchange.

26 (d) A health insurer that contracts with the Exchange to offer a  
27 qualified bridge plan product pursuant to Section 100504.5 of the  
28 Government Code shall maintain a medical loss ratio of 85 percent  
29 for the bridge plan product. A health insurer shall utilize, to the  
30 extent possible, the same methodology for calculating the medical  
31 loss ratio for the bridge plan product that is used for calculating  
32 the health insurer's medical loss ratio pursuant to Section 10112.25  
33 and shall report its medical loss ratio for the bridge plan product  
34 to the department as provided in Section 10112.25.

35 (e) This section shall become inoperative on the October 1 that  
36 is five years after the date that federal approval of the bridge plan  
37 option occurs, and, as of the second January 1 thereafter, is  
38 repealed, unless a later enacted statute that is enacted before that  
39 date deletes or extends the dates on which it becomes inoperative  
40 and is repealed.

1     ~~SEC. 6.~~

2     *SEC. 7.* Section 667.5 of the Penal Code is amended to read:

3     667.5. Enhancement of prison terms for new offenses because  
4 of prior prison terms shall be imposed as follows:

5     (a) Where one of the new offenses is one of the violent felonies  
6 specified in subdivision (c), in addition to and consecutive to any  
7 other prison terms therefor, the court shall impose a three-year  
8 term for each prior separate prison term served by the defendant  
9 where the prior offense was one of the violent felonies specified  
10 in subdivision (c). However, no additional term shall be imposed  
11 under this subdivision for any prison term served prior to a period  
12 of 10 years in which the defendant remained free of both prison  
13 custody and the commission of an offense which results in a felony  
14 conviction.

15     (b) Except where subdivision (a) applies, where the new offense  
16 is any felony for which a prison sentence or a sentence of  
17 imprisonment in a county jail under subdivision (h) of Section  
18 1170 is imposed or is not suspended, in addition and consecutive  
19 to any other sentence therefor, the court shall impose a one-year  
20 term for each prior separate prison term or county jail term imposed  
21 under subdivision (h) of Section 1170 or when sentence is not  
22 suspended for any felony; provided that no additional term shall  
23 be imposed under this subdivision for any prison term or county  
24 jail term imposed under subdivision (h) of Section 1170 or when  
25 sentence is not suspended prior to a period of five years in which  
26 the defendant remained free of both the commission of an offense  
27 which results in a felony conviction, and prison custody or the  
28 imposition of a term of jail custody imposed under subdivision (h)  
29 of Section 1170 or any felony sentence that is not suspended. A  
30 term imposed under the provisions of paragraph (5) of subdivision  
31 (h) of Section 1170, wherein a portion of the term is suspended  
32 by the court to allow mandatory supervision, shall qualify as a  
33 prior county jail term for the purposes of the one-year enhancement.

34     (c) For the purpose of this section, “violent felony” shall mean  
35 any of the following:

36     (1) Murder or voluntary manslaughter.

37     (2) Mayhem.

38     (3) Rape as defined in paragraph (2) or (6) of subdivision (a)  
39 of Section 261 or paragraph (1) or (4) of subdivision (a) of Section  
40 262.

- 1 (4) Sodomy as defined in subdivision (c) or (d) of Section 286.
- 2 (5) Oral copulation as defined in subdivision (c) or (d) of Section
- 3 288a.
- 4 (6) Lewd or lascivious act as defined in subdivision (a) or (b)
- 5 of Section 288.
- 6 (7) Any felony punishable by death or imprisonment in the state
- 7 prison for life.
- 8 (8) Any felony in which the defendant inflicts great bodily injury
- 9 on any person other than an accomplice which has been charged
- 10 and proved as provided for in Section 12022.7, 12022.8, or 12022.9
- 11 on or after July 1, 1977, or as specified prior to July 1, 1977, in
- 12 Sections 213, 264, and 461, or any felony in which the defendant
- 13 uses a firearm which use has been charged and proved as provided
- 14 in subdivision (a) of Section 12022.3, or Section 12022.5 or
- 15 12022.55.
- 16 (9) Any robbery.
- 17 (10) Arson, in violation of subdivision (a) or (b) of Section 451.
- 18 (11) Sexual penetration as defined in subdivision (a) or (j) of
- 19 Section 289.
- 20 (12) Attempted murder.
- 21 (13) A violation of Section 18745, 18750, or 18755.
- 22 (14) Kidnapping.
- 23 (15) Assault with the intent to commit a specified felony, in
- 24 violation of Section 220.
- 25 (16) Continuous sexual abuse of a child, in violation of Section
- 26 288.5.
- 27 (17) Carjacking, as defined in subdivision (a) of Section 215.
- 28 (18) Rape, spousal rape, or sexual penetration, in concert, in
- 29 violation of Section 264.1.
- 30 (19) Extortion, as defined in Section 518, which would constitute
- 31 a felony violation of Section 186.22 of the Penal Code.
- 32 (20) Threats to victims or witnesses, as defined in Section 136.1,
- 33 which would constitute a felony violation of Section ~~186.22 of the~~
- 34 ~~Penal Code.~~ 186.22.
- 35 (21) Any burglary of the first degree, as defined in subdivision
- 36 (a) of Section 460, wherein it is charged and proved that another
- 37 person, other than an accomplice, was present in the residence
- 38 during the commission of the burglary.
- 39 (22) Any violation of Section 12022.53.

1 (23) A violation of subdivision (b) or (c) of Section 11418. The  
2 Legislature finds and declares that these specified crimes merit  
3 special consideration when imposing a sentence to display society's  
4 condemnation for these extraordinary crimes of violence against  
5 the person.

6 (d) For the purposes of this section, the defendant shall be  
7 deemed to remain in prison custody for an offense until the official  
8 discharge from custody, including any period of mandatory  
9 supervision, or until release on parole or postrelease community  
10 supervision, whichever first occurs, including any time during  
11 which the defendant remains subject to reimprisonment or custody  
12 in county jail for escape from custody or is reimprisoned on  
13 revocation of parole or postrelease community supervision. The  
14 additional penalties provided for prior prison terms shall not be  
15 imposed unless they are charged and admitted or found true in the  
16 action for the new offense.

17 (e) The additional penalties provided for prior prison terms shall  
18 not be imposed for any felony for which the defendant did not  
19 serve a prior separate term in state prison or in county jail under  
20 subdivision (h) of Section 1170.

21 (f) A prior conviction of a felony shall include a conviction in  
22 another jurisdiction for an offense which, if committed in  
23 California, is punishable by imprisonment in the state prison or in  
24 county jail under subdivision (h) of Section 1170 if the defendant  
25 served one year or more in prison for the offense in the other  
26 jurisdiction. A prior conviction of a particular felony shall include  
27 a conviction in another jurisdiction for an offense which includes  
28 all of the elements of the particular felony as defined under  
29 California law if the defendant served one year or more in prison  
30 for the offense in the other jurisdiction.

31 (g) A prior separate prison term for the purposes of this section  
32 shall mean a continuous completed period of prison incarceration  
33 imposed for the particular offense alone or in combination with  
34 concurrent or consecutive sentences for other crimes, including  
35 any reimprisonment on revocation of parole which is not  
36 accompanied by a new commitment to prison, and including any  
37 reimprisonment after an escape from incarceration.

38 (h) Serving a prison term includes any confinement time in any  
39 state prison or federal penal institution as punishment for  
40 commission of an offense, including confinement in a hospital or

1 other institution or facility credited as service of prison time in the  
2 jurisdiction of the confinement.

3 (i) For the purposes of this section, a commitment to the State  
4 Department of Mental Health, or its successor the State Department  
5 of State Hospitals, as a mentally disordered sex offender following  
6 a conviction of a felony, which commitment exceeds one year in  
7 duration, shall be deemed a prior prison term.

8 (j) For the purposes of this section, when a person subject to  
9 the custody, control, and discipline of the Secretary of *the*  
10 *Department of Corrections and Rehabilitation* is incarcerated at a  
11 facility operated by the Division of Juvenile Justice, that  
12 incarceration shall be deemed to be a term served in state prison.

13 (k) (1) Notwithstanding subdivisions (d) and (g) or any other  
14 provision of law, where one of the new offenses is committed  
15 while the defendant is temporarily removed from prison pursuant  
16 to Section 2690 or while the defendant is transferred to a  
17 community facility pursuant to Section 3416, 6253, or 6263, or  
18 while the defendant is on furlough pursuant to Section 6254, the  
19 defendant shall be subject to the full enhancements provided for  
20 in this section.

21 (2) This subdivision shall not apply when a full, separate, and  
22 consecutive term is imposed pursuant to any other provision of  
23 law.

24 ~~SEC. 7.~~

25 *SEC. 8.* Section 830.3 of the Penal Code, as amended by  
26 Section 37 of Chapter 515 of the Statutes of 2013, is amended to  
27 read:

28 830.3. The following persons are peace officers whose authority  
29 extends to any place in the state for the purpose of performing  
30 their primary duty or when making an arrest pursuant to Section  
31 836 as to any public offense with respect to which there is  
32 immediate danger to person or property, or of the escape of the  
33 perpetrator of that offense, or pursuant to Section 8597 or 8598 of  
34 the Government Code. These peace officers may carry firearms  
35 only if authorized and under those terms and conditions as specified  
36 by their employing agencies:

37 (a) Persons employed by the Division of Investigation of the  
38 Department of Consumer Affairs and investigators of the Medical  
39 Board of California and the Board of Dental Examiners, who are  
40 designated by the Director of Consumer Affairs, provided that the

1 primary duty of these peace officers shall be the enforcement of  
2 the law as that duty is set forth in Section 160 of the Business and  
3 Professions Code.

4 (b) Voluntary fire wardens designated by the Director of  
5 Forestry and Fire Protection pursuant to Section 4156 of the Public  
6 Resources Code, provided that the primary duty of these peace  
7 officers shall be the enforcement of the law as that duty is set forth  
8 in Section 4156 of that code.

9 (c) Employees of the Department of Motor Vehicles designated  
10 in Section 1655 of the Vehicle Code, provided that the primary  
11 duty of these peace officers shall be the enforcement of the law as  
12 that duty is set forth in Section 1655 of that code.

13 (d) Investigators of the California Horse Racing Board  
14 designated by the board, provided that the primary duty of these  
15 peace officers shall be the enforcement of Chapter 4 (commencing  
16 with Section 19400) of Division 8 of the Business and Professions  
17 Code and Chapter 10 (commencing with Section 330) of Title 9  
18 of Part 1 of this code.

19 (e) The State Fire Marshal and assistant or deputy state fire  
20 marshals appointed pursuant to Section 13103 of the Health and  
21 Safety Code, provided that the primary duty of these peace officers  
22 shall be the enforcement of the law as that duty is set forth in  
23 Section 13104 of that code.

24 (f) Inspectors of the food and drug section designated by the  
25 chief pursuant to subdivision (a) of Section 106500 of the Health  
26 and Safety Code, provided that the primary duty of these peace  
27 officers shall be the enforcement of the law as that duty is set forth  
28 in Section 106500 of that code.

29 (g) All investigators of the Division of Labor Standards  
30 Enforcement designated by the Labor Commissioner, provided  
31 that the primary duty of these peace officers shall be the  
32 enforcement of the law as prescribed in Section 95 of the Labor  
33 Code.

34 (h) All investigators of the State Departments of Health Care  
35 Services, Public Health, Social Services, State Hospitals, and  
36 Alcohol and Drug Programs, the Department of Toxic Substances  
37 Control, the Office of Statewide Health Planning and Development,  
38 and the Public Employees' Retirement System, provided that the  
39 primary duty of these peace officers shall be the enforcement of  
40 the law relating to the duties of his or her department or office.

1 Notwithstanding any other provision of law, investigators of the  
2 Public Employees' Retirement System shall not carry firearms.

3 (i) The Chief of the Bureau of Fraudulent Claims of the  
4 Department of Insurance and those investigators designated by the  
5 chief, provided that the primary duty of those investigators shall  
6 be the enforcement of Section 550.

7 (j) Employees of the Department of Housing and Community  
8 Development designated under Section 18023 of the Health and  
9 Safety Code, provided that the primary duty of these peace officers  
10 shall be the enforcement of the law as that duty is set forth in  
11 Section 18023 of that code.

12 (k) Investigators of the office of the Controller, provided that  
13 the primary duty of these investigators shall be the enforcement  
14 of the law relating to the duties of that office. Notwithstanding any  
15 other law, except as authorized by the Controller, the peace officers  
16 designated pursuant to this subdivision shall not carry firearms.

17 (l) Investigators of the Department of Business Oversight  
18 designated by the Commissioner of Business Oversight, provided  
19 that the primary duty of these investigators shall be the enforcement  
20 of the provisions of law administered by the Department of  
21 Business Oversight. Notwithstanding any other provision of law,  
22 the peace officers designated pursuant to this subdivision shall not  
23 carry firearms.

24 (m) Persons employed by the ~~Contractors~~ *Contractors'* State  
25 License Board designated by the Director of Consumer Affairs  
26 pursuant to Section 7011.5 of the Business and Professions Code,  
27 provided that the primary duty of these persons shall be the  
28 enforcement of the law as that duty is set forth in Section 7011.5,  
29 and in Chapter 9 (commencing with Section 7000) of Division 3,  
30 of that code. The Director of Consumer Affairs may designate as  
31 peace officers not more than 12 persons who shall at the time of  
32 their designation be assigned to the special investigations unit of  
33 the board. Notwithstanding any other provision of law, the persons  
34 designated pursuant to this subdivision shall not carry firearms.

35 (n) The Chief and coordinators of the Law Enforcement Branch  
36 of the Office of Emergency Services.

37 (o) Investigators of the office of the Secretary of State designated  
38 by the Secretary of State, provided that the primary duty of these  
39 peace officers shall be the enforcement of the law as prescribed  
40 in Chapter 3 (commencing with Section 8200) of Division 1 of

1 Title 2 of, and Section 12172.5 of, the Government Code.  
2 Notwithstanding any other provision of law, the peace officers  
3 designated pursuant to this subdivision shall not carry firearms.

4 (p) The Deputy Director for Security designated by Section  
5 8880.38 of the Government Code, and all lottery security personnel  
6 assigned to the California State Lottery and designated by the  
7 director, provided that the primary duty of any of those peace  
8 officers shall be the enforcement of the laws related to ~~assuring~~  
9 *ensuring* the integrity, honesty, and fairness of the operation and  
10 administration of the California State Lottery.

11 (q) (1) Investigators employed by the Investigation Division  
12 of the Employment Development Department designated by the  
13 director of the department, provided that the primary duty of those  
14 peace officers shall be the enforcement of the law as that duty is  
15 set forth in Section 317 of the Unemployment Insurance Code.

16 (2) Notwithstanding any other provision of law, the peace  
17 officers designated pursuant to this subdivision shall not carry  
18 firearms.

19 (r) The chief and assistant chief of museum security and safety  
20 of the California Science Center, as designated by the executive  
21 director pursuant to Section 4108 of the Food and Agricultural  
22 Code, provided that the primary duty of those peace officers shall  
23 be the enforcement of the law as that duty is set forth in Section  
24 4108 of the Food and Agricultural Code.

25 (s) Employees of the Franchise Tax Board designated by the  
26 board, provided that the primary duty of these peace officers shall  
27 be the enforcement of the law as set forth in Chapter 9  
28 (commencing with Section 19701) of Part 10.2 of Division 2 of  
29 the Revenue and Taxation Code.

30 (t) (1) Notwithstanding any other provision of this section, a  
31 peace officer authorized by this section shall not be authorized to  
32 carry firearms by his or her employing agency until that agency  
33 has adopted a policy on the use of deadly force by those peace  
34 officers, and until those peace officers have been instructed in the  
35 employing agency's policy on the use of deadly force.

36 (2) Every peace officer authorized pursuant to this section to  
37 carry firearms by his or her employing agency shall qualify in the  
38 use of the firearms at least every six months.

39 (u) Investigators of the Department of Managed Health Care  
40 designated by the Director of the Department of Managed Health

1 Care, provided that the primary duty of these investigators shall  
2 be the enforcement of the provisions of laws administered by the  
3 Director of the Department of Managed Health Care.  
4 Notwithstanding any other provision of law, the peace officers  
5 designated pursuant to this subdivision shall not carry firearms.

6 (v) The Chief, Deputy Chief, supervising investigators, and  
7 investigators of the Office of Protective Services of the State  
8 Department of Developmental Services, provided that the primary  
9 duty of each of those persons shall be the enforcement of the law  
10 relating to the duties of his or her department or office.

11 (w) This section shall become inoperative on July 1, 2014, and,  
12 as of January 1, 2015, is repealed, unless a later enacted statute,  
13 that becomes operative on or before January 1, 2015, deletes or  
14 extends the dates on which it becomes inoperative and is repealed.

15 ~~SEC. 8.~~

16 *SEC. 9.* Section 830.3 of the Penal Code, as added by Section  
17 38 of Chapter 515 of the Statutes of 2013, is amended to read:

18 830.3. The following persons are peace officers whose authority  
19 extends to any place in the state for the purpose of performing  
20 their primary duty or when making an arrest pursuant to Section  
21 836 as to any public offense with respect to which there is  
22 immediate danger to person or property, or of the escape of the  
23 perpetrator of that offense, or pursuant to Section 8597 or 8598 of  
24 the Government Code. These peace officers may carry firearms  
25 only if authorized and under those terms and conditions as specified  
26 by their employing agencies:

27 (a) Persons employed by the Division of Investigation of the  
28 Department of Consumer Affairs and investigators of the Board  
29 of Dental Examiners, who are designated by the Director of  
30 Consumer Affairs, provided that the primary duty of these peace  
31 officers shall be the enforcement of the law as that duty is set forth  
32 in Section 160 of the Business and Professions Code.

33 (b) Voluntary fire wardens designated by the Director of  
34 Forestry and Fire Protection pursuant to Section 4156 of the Public  
35 Resources Code, provided that the primary duty of these peace  
36 officers shall be the enforcement of the law as that duty is set forth  
37 in Section 4156 of that code.

38 (c) Employees of the Department of Motor Vehicles designated  
39 in Section 1655 of the Vehicle Code, provided that the primary

1 duty of these peace officers shall be the enforcement of the law as  
2 that duty is set forth in Section 1655 of that code.

3 (d) Investigators of the California Horse Racing Board  
4 designated by the board, provided that the primary duty of these  
5 peace officers shall be the enforcement of Chapter 4 (commencing  
6 with Section 19400) of Division 8 of the Business and Professions  
7 Code and Chapter 10 (commencing with Section 330) of Title 9  
8 of Part 1 of this code.

9 (e) The State Fire Marshal and assistant or deputy state fire  
10 marshals appointed pursuant to Section 13103 of the Health and  
11 Safety Code, provided that the primary duty of these peace officers  
12 shall be the enforcement of the law as that duty is set forth in  
13 Section 13104 of that code.

14 (f) Inspectors of the food and drug section designated by the  
15 chief pursuant to subdivision (a) of Section 106500 of the Health  
16 and Safety Code, provided that the primary duty of these peace  
17 officers shall be the enforcement of the law as that duty is set forth  
18 in Section 106500 of that code.

19 (g) All investigators of the Division of Labor Standards  
20 Enforcement designated by the Labor Commissioner, provided  
21 that the primary duty of these peace officers shall be the  
22 enforcement of the law as prescribed in Section 95 of the Labor  
23 Code.

24 (h) All investigators of the State Departments of Health Care  
25 Services, Public Health, Social Services, State Hospitals, and  
26 Alcohol and Drug Programs, the Department of Toxic Substances  
27 Control, the Office of Statewide Health Planning and Development,  
28 and the Public Employees' Retirement System, provided that the  
29 primary duty of these peace officers shall be the enforcement of  
30 the law relating to the duties of his or her department or office.  
31 Notwithstanding any other provision of law, investigators of the  
32 Public Employees' Retirement System shall not carry firearms.

33 (i) The Chief of the Bureau of Fraudulent Claims of the  
34 Department of Insurance and those investigators designated by the  
35 chief, provided that the primary duty of those investigators shall  
36 be the enforcement of Section 550.

37 (j) Employees of the Department of Housing and Community  
38 Development designated under Section 18023 of the Health and  
39 Safety Code, provided that the primary duty of these peace officers

1 shall be the enforcement of the law as that duty is set forth in  
2 Section 18023 of that code.

3 (k) Investigators of the office of the Controller, provided that  
4 the primary duty of these investigators shall be the enforcement  
5 of the law relating to the duties of that office. Notwithstanding any  
6 other law, except as authorized by the Controller, the peace officers  
7 designated pursuant to this subdivision shall not carry firearms.

8 (l) Investigators of the Department of Business Oversight  
9 designated by the Commissioner of Business Oversight, provided  
10 that the primary duty of these investigators shall be the enforcement  
11 of the provisions of law administered by the Department of  
12 Business Oversight. Notwithstanding any other provision of law,  
13 the peace officers designated pursuant to this subdivision shall not  
14 carry firearms.

15 (m) Persons employed by the ~~Contractors~~ *Contractors'* State  
16 License Board designated by the Director of Consumer Affairs  
17 pursuant to Section 7011.5 of the Business and Professions Code,  
18 provided that the primary duty of these persons shall be the  
19 enforcement of the law as that duty is set forth in Section 7011.5,  
20 and in Chapter 9 (commencing with Section 7000) of Division 3,  
21 of that code. The Director of Consumer Affairs may designate as  
22 peace officers not more than 12 persons who shall at the time of  
23 their designation be assigned to the special investigations unit of  
24 the board. Notwithstanding any other provision of law, the persons  
25 designated pursuant to this subdivision shall not carry firearms.

26 (n) The Chief and coordinators of the Law Enforcement Branch  
27 of the Office of Emergency Services.

28 (o) Investigators of the office of the Secretary of State designated  
29 by the Secretary of State, provided that the primary duty of these  
30 peace officers shall be the enforcement of the law as prescribed  
31 in Chapter 3 (commencing with Section 8200) of Division 1 of  
32 Title 2 of, and Section 12172.5 of, the Government Code.  
33 Notwithstanding any other provision of law, the peace officers  
34 designated pursuant to this subdivision shall not carry firearms.

35 (p) The Deputy Director for Security designated by Section  
36 8880.38 of the Government Code, and all lottery security personnel  
37 assigned to the California State Lottery and designated by the  
38 director, provided that the primary duty of any of those peace  
39 officers shall be the enforcement of the laws related to ~~assuring~~

1 *ensuring* the integrity, honesty, and fairness of the operation and  
2 administration of the California State Lottery.

3 (q) (1) Investigators employed by the Investigation Division  
4 of the Employment Development Department designated by the  
5 director of the department, provided that the primary duty of those  
6 peace officers shall be the enforcement of the law as that duty is  
7 set forth in Section 317 of the Unemployment Insurance Code.

8 (2) Notwithstanding any other provision of law, the peace  
9 officers designated pursuant to this subdivision shall not carry  
10 firearms.

11 (r) The chief and assistant chief of museum security and safety  
12 of the California Science Center, as designated by the executive  
13 director pursuant to Section 4108 of the Food and Agricultural  
14 Code, provided that the primary duty of those peace officers shall  
15 be the enforcement of the law as that duty is set forth in Section  
16 4108 of the Food and Agricultural Code.

17 (s) Employees of the Franchise Tax Board designated by the  
18 board, provided that the primary duty of these peace officers shall  
19 be the enforcement of the law as set forth in Chapter 9  
20 (commencing with Section 19701) of Part 10.2 of Division 2 of  
21 the Revenue and Taxation Code.

22 (t) (1) Notwithstanding any other provision of this section, a  
23 peace officer authorized by this section shall not be authorized to  
24 carry firearms by his or her employing agency until that agency  
25 has adopted a policy on the use of deadly force by those peace  
26 officers, and until those peace officers have been instructed in the  
27 employing agency's policy on the use of deadly force.

28 (2) Every peace officer authorized pursuant to this section to  
29 carry firearms by his or her employing agency shall qualify in the  
30 use of the firearms at least every six months.

31 (u) Investigators of the Department of Managed Health Care  
32 designated by the Director of the Department of Managed Health  
33 Care, provided that the primary duty of these investigators shall  
34 be the enforcement of the provisions of laws administered by the  
35 Director of the Department of Managed Health Care.  
36 Notwithstanding any other provision of law, the peace officers  
37 designated pursuant to this subdivision shall not carry firearms.

38 (v) The Chief, Deputy Chief, supervising investigators, and  
39 investigators of the Office of Protective Services of the State  
40 Department of Developmental Services, provided that the primary

1 duty of each of those persons shall be the enforcement of the law  
2 relating to the duties of his or her department or office.

3 (w) This section shall become operative July 1, 2014.

4 ~~SEC. 9.~~

5 *SEC. 10.* Section 830.5 of the Penal Code is amended to read:

6 830.5. The following persons are peace officers whose authority  
7 extends to any place in the state while engaged in the performance  
8 of the duties of their respective employment and for the purpose  
9 of carrying out the primary function of their employment or as  
10 required under Sections 8597, 8598, and 8617 of the Government  
11 Code, as amended by Section 44 of Chapter 1124 of the Statutes  
12 of 2002. Except as specified in this section, these peace officers  
13 may carry firearms only if authorized and under those terms and  
14 conditions specified by their employing agency:

15 (a) A parole officer of the Department of Corrections and  
16 Rehabilitation, or the Department of Corrections and  
17 Rehabilitation, Division of Juvenile Parole Operations, probation  
18 officer, deputy probation officer, or a board coordinating parole  
19 agent employed by the Juvenile Parole Board. Except as otherwise  
20 provided in this subdivision, the authority of these parole or  
21 probation officers shall extend only as follows:

22 (1) To conditions of parole, probation, mandatory supervision,  
23 or postrelease community supervision by any person in this state  
24 on parole, probation, mandatory supervision, or postrelease  
25 community supervision.

26 (2) To the escape of any inmate or ward from a state or local  
27 institution.

28 (3) To the transportation of persons on parole, probation,  
29 mandatory supervision, or postrelease community supervision.

30 (4) To violations of any penal provisions of law which are  
31 discovered while performing the usual or authorized duties of his  
32 or her employment.

33 (5) (A) To the rendering of mutual aid to any other law  
34 enforcement agency.

35 (B) For the purposes of this subdivision, “parole agent” shall  
36 have the same meaning as parole officer of the Department of  
37 Corrections and Rehabilitation or of the Department of Corrections  
38 and Rehabilitation, Division of Juvenile Justice.

39 (C) Any parole officer of the Department of Corrections and  
40 Rehabilitation, or the Department of Corrections and

1 Rehabilitation, Division of Juvenile Parole Operations, is  
2 authorized to carry firearms, but only as determined by the director  
3 on a case-by-case or unit-by-unit basis and only under those terms  
4 and conditions specified by the director or chairperson. The  
5 Department of Corrections and Rehabilitation, Division of Juvenile  
6 Justice, shall develop a policy for arming peace officers of the  
7 Department of Corrections and Rehabilitation, Division of Juvenile  
8 Justice, who comprise “high-risk transportation details” or  
9 “high-risk escape details” no later than June 30, 1995. This policy  
10 shall be implemented no later than December 31, 1995.

11 (D) The Department of Corrections and Rehabilitation, Division  
12 of Juvenile Justice, shall train and arm those peace officers who  
13 comprise tactical teams at each facility for use during “high-risk  
14 escape details.”

15 (b) A correctional officer employed by the Department of  
16 Corrections and Rehabilitation, or of the Department of Corrections  
17 and Rehabilitation, Division of Juvenile Justice, having custody  
18 of wards or any employee of the Department of Corrections and  
19 Rehabilitation designated by the secretary or any correctional  
20 counselor series employee of the Department of Corrections and  
21 Rehabilitation or any medical technical assistant series employee  
22 designated by the secretary or designated by the secretary and  
23 employed by the State Department of State Hospitals or any  
24 employee of the Board of Parole Hearings designated by the  
25 secretary or employee of the Department of Corrections and  
26 Rehabilitation, Division of Juvenile Justice, designated by the  
27 secretary or any superintendent, supervisor, or employee having  
28 custodial responsibilities in an institution operated by a probation  
29 department, or any transportation officer of a probation department.

30 (c) The following persons may carry a firearm while not on  
31 duty: a parole officer of the Department of Corrections and  
32 Rehabilitation, or the Department of Corrections and  
33 Rehabilitation, Division of Juvenile Justice, a correctional officer  
34 or correctional counselor employed by the Department of  
35 Corrections and Rehabilitation, or an employee of the Department  
36 of Corrections and Rehabilitation, Division of Juvenile Justice,  
37 having custody of wards or any employee of the Department of  
38 Corrections and Rehabilitation designated by the secretary. A  
39 parole officer of the Juvenile Parole Board may carry a firearm  
40 while not on duty only when so authorized by the chairperson of

1 the board and only under the terms and conditions specified by  
2 the chairperson. Nothing in this section shall be interpreted to  
3 require licensure pursuant to Section 25400. The director or  
4 chairperson may deny, suspend, or revoke for good cause a  
5 person's right to carry a firearm under this subdivision. That person  
6 shall, upon request, receive a hearing, as provided for in the  
7 negotiated grievance procedure between the exclusive employee  
8 representative and the Department of Corrections and  
9 Rehabilitation, Division of Juvenile Justice, or the Juvenile Parole  
10 Board, to review the director's or the chairperson's decision.

11 (d) Persons permitted to carry firearms pursuant to this section,  
12 either on or off duty, shall meet the training requirements of Section  
13 832 and shall qualify with the firearm at least quarterly. It is the  
14 responsibility of the individual officer or designee to maintain his  
15 or her eligibility to carry concealable firearms off duty. Failure to  
16 maintain quarterly qualifications by an officer or designee with  
17 any concealable firearms carried off duty shall constitute good  
18 cause to suspend or revoke that person's right to carry firearms  
19 off duty.

20 (e) The Department of Corrections and Rehabilitation shall  
21 allow reasonable access to its ranges for officers and designees of  
22 either department to qualify to carry concealable firearms off duty.  
23 The time spent on the range for purposes of meeting the  
24 qualification requirements shall be the person's own time during  
25 the person's off-duty hours.

26 (f) The secretary shall promulgate regulations consistent with  
27 this section.

28 (g) "High-risk transportation details" and "high-risk escape  
29 details" as used in this section shall be determined by the secretary,  
30 or his or her designee. The secretary, or his or her designee, shall  
31 consider at least the following in determining "high-risk  
32 transportation details" and "high-risk escape details": protection  
33 of the public, protection of officers, flight risk, and violence  
34 potential of the wards.

35 (h) "Transportation detail" as used in this section shall include  
36 transportation of wards outside the facility, including, but not  
37 limited to, court appearances, medical trips, and interfacility  
38 transfers.

39 ~~SEC. 10.~~

40 *SEC. 11.* Section 3000 of the Penal Code is amended to read:

1 3000. (a) (1) The Legislature finds and declares that the period  
2 immediately following incarceration is critical to successful  
3 reintegration of the offender into society and to positive citizenship.  
4 It is in the interest of public safety for the state to provide for the  
5 effective supervision of and surveillance of parolees, including  
6 the judicious use of revocation actions, and to provide educational,  
7 vocational, family and personal counseling necessary to assist  
8 parolees in the transition between imprisonment and discharge. A  
9 sentence resulting in imprisonment in the state prison pursuant to  
10 Section 1168 or 1170 shall include a period of parole supervision  
11 or postrelease community supervision, unless waived, or as  
12 otherwise provided in this article.

13 (2) The Legislature finds and declares that it is not the intent of  
14 this section to diminish resources allocated to the Department of  
15 Corrections and Rehabilitation for parole functions for which the  
16 department is responsible. It is also not the intent of this section  
17 to diminish the resources allocated to the Board of Parole Hearings  
18 to execute its duties with respect to parole functions for which the  
19 board is responsible.

20 (3) The Legislature finds and declares that diligent effort must  
21 be made to ensure that parolees are held accountable for their  
22 criminal behavior, including, but not limited to, the satisfaction of  
23 restitution fines and orders.

24 (4) For any person subject to a sexually violent predator  
25 proceeding pursuant to Article 4 (commencing with Section 6600)  
26 of Chapter 2 of Part 2 of Division 6 of the Welfare and Institutions  
27 Code, an order issued by a judge pursuant to Section 6601.5 of the  
28 Welfare and Institutions Code, finding that the petition, on its face,  
29 supports a finding of probable cause to believe that the individual  
30 named in the petition is likely to engage in sexually violent  
31 predatory criminal behavior upon his or her release, shall toll the  
32 period of parole of that person, from the date that person is released  
33 by the Department of Corrections and Rehabilitation as follows:

34 (A) If the person is committed to the State Department of State  
35 Hospitals as a sexually violent predator and subsequently a court  
36 orders that the person be unconditionally discharged, the parole  
37 period shall be tolled until the date the judge enters the order  
38 unconditionally discharging that person.

39 (B) If the person is not committed to the State Department of  
40 State Hospitals as a sexually violent predator, the tolling of the

1 parole period shall be abrogated and the parole period shall be  
2 deemed to have commenced on the date of release from the  
3 Department of Corrections and Rehabilitation.

4 (5) Paragraph (4) applies to persons released by the Department  
5 of Corrections and Rehabilitation on or after January 1, 2012.  
6 Persons released by the Department of Corrections and  
7 Rehabilitation prior to January 1, 2012, shall continue to be subject  
8 to the law governing the tolling of parole in effect on December  
9 31, 2011.

10 (b) Notwithstanding any provision to the contrary in Article 3  
11 (commencing with Section 3040) of this chapter, the following  
12 shall apply to any inmate subject to Section 3000.08:

13 (1) In the case of any inmate sentenced under Section 1168 for  
14 a crime committed prior to July 1, 2013, the period of parole shall  
15 not exceed five years in the case of an inmate imprisoned for any  
16 offense other than first or second degree murder for which the  
17 inmate has received a life sentence, and shall not exceed three  
18 years in the case of any other inmate, unless in either case the  
19 Board of Parole Hearings for good cause waives parole and  
20 discharges the inmate from custody of the department. This  
21 subdivision shall also be applicable to inmates who committed  
22 crimes prior to July 1, 1977, to the extent specified in Section  
23 1170.2. In the case of any inmate sentenced under Section 1168  
24 for a crime committed on or after July 1, 2013, the period of parole  
25 shall not exceed five years in the case of an inmate imprisoned for  
26 any offense other than first or second degree murder for which the  
27 inmate has received a life sentence, and shall not exceed three  
28 years in the case of any other inmate, unless in either case the  
29 department for good cause waives parole and discharges the inmate  
30 from custody of the department.

31 (2) (A) For a crime committed prior to July 1, 2013, at the  
32 expiration of a term of imprisonment of one year and one day, or  
33 a term of imprisonment imposed pursuant to Section 1170 or at  
34 the expiration of a term reduced pursuant to Section 2931 or 2933,  
35 if applicable, the inmate shall be released on parole for a period  
36 not exceeding three years, except that any inmate sentenced for  
37 an offense specified in paragraph (3), (4), (5), (6), (11), or (18) of  
38 subdivision (c) of Section 667.5 shall be released on parole for a  
39 period not exceeding 10 years, unless a longer period of parole is  
40 specified in Section 3000.1.

1 (B) For a crime committed on or after July 1, 2013, at the  
2 expiration of a term of imprisonment of one year and one day, or  
3 a term of imprisonment imposed pursuant to Section 1170 or at  
4 the expiration of a term reduced pursuant to Section 2931 or 2933,  
5 if applicable, the inmate shall be released on parole for a period  
6 of three years, except that any inmate sentenced for an offense  
7 specified in paragraph (3), (4), (5), (6), (11), or (18) of subdivision  
8 (c) of Section 667.5 shall be released on parole for a period of 10  
9 years, unless a longer period of parole is specified in Section  
10 3000.1.

11 (3) Notwithstanding paragraphs (1) and (2), in the case of any  
12 offense for which the inmate has received a life sentence pursuant  
13 to subdivision (b) of Section 209, with the intent to commit a  
14 specified sex offense, or Section 667.51, 667.61, or 667.71, the  
15 period of parole shall be 10 years, unless a longer period of parole  
16 is specified in Section 3000.1.

17 (4) (A) Notwithstanding paragraphs (1) to (3), inclusive, in the  
18 case of a person convicted of and required to register as a sex  
19 offender for the commission of an offense specified in Section  
20 261, 262, 264.1, 286, 288a, paragraph (1) of subdivision (b) of  
21 Section 288, Section 288.5, or 289, in which one or more of the  
22 victims of the offense was a child under 14 years of age, the period  
23 of parole shall be 20 years and six months unless the board, for  
24 good cause, determines that the person will be retained on parole.  
25 The board shall make a written record of this determination and  
26 transmit a copy of it to the parolee.

27 (B) In the event of a retention on parole, the parolee shall be  
28 entitled to a review by the board each year thereafter.

29 (C) There shall be a board hearing consistent with the procedures  
30 set forth in Sections 3041.5 and 3041.7 within 12 months of the  
31 date of any revocation of parole to consider the release of the  
32 inmate on parole, and notwithstanding the provisions of paragraph  
33 (3) of subdivision (b) of Section 3041.5, there shall be annual  
34 parole consideration hearings thereafter, unless the person is  
35 released or otherwise ineligible for parole release. The panel or  
36 board shall release the person within one year of the date of the  
37 revocation unless it determines that the circumstances and gravity  
38 of the parole violation are such that consideration of the public  
39 safety requires a more lengthy period of incarceration or unless  
40 there is a new prison commitment following a conviction.

1 (D) The provisions of Section 3042 shall not apply to any  
2 hearing held pursuant to this subdivision.

3 (5) (A) The Board of Parole Hearings shall consider the request  
4 of any inmate whose commitment offense occurred prior to July  
5 1, 2013, regarding the length of his or her parole and the conditions  
6 thereof.

7 (B) For an inmate whose commitment offense occurred on or  
8 after July 1, 2013, except for those inmates described in Section  
9 3000.1, the department shall consider the request of the inmate  
10 regarding the length of his or her parole and the conditions thereof.  
11 For those inmates described in Section 3000.1, the Board of Parole  
12 Hearings shall consider the request of the inmate regarding the  
13 length of his or her parole and the conditions thereof.

14 (6) Upon successful completion of parole, or at the end of the  
15 maximum statutory period of parole specified for the inmate under  
16 paragraph (1), (2), (3), or (4), as the case may be, whichever is  
17 earlier, the inmate shall be discharged from custody. The date of  
18 the maximum statutory period of parole under this subdivision and  
19 paragraphs (1), (2), (3), and (4) shall be computed from the date  
20 of initial parole and shall be a period chronologically determined.  
21 Time during which parole is suspended because the prisoner has  
22 absconded or has been returned to custody as a parole violator  
23 shall not be credited toward any period of parole unless the prisoner  
24 is found not guilty of the parole violation. However, the period of  
25 parole is subject to the following:

26 (A) Except as provided in Section 3064, in no case may a  
27 prisoner subject to three years on parole be retained under parole  
28 supervision or in custody for a period longer than four years from  
29 the date of his or her initial parole.

30 (B) Except as provided in Section 3064, in no case may a  
31 prisoner subject to five years on parole be retained under parole  
32 supervision or in custody for a period longer than seven years from  
33 the date of his or her initial parole.

34 (C) Except as provided in Section 3064, in no case may a  
35 prisoner subject to 10 years on parole be retained under parole  
36 supervision or in custody for a period longer than 15 years from  
37 the date of his or her initial parole.

38 (7) The Department of Corrections and Rehabilitation shall meet  
39 with each inmate at least 30 days prior to his or her good time  
40 release date and shall provide, under guidelines specified by the

1 parole authority or the department, whichever is applicable, the  
2 conditions of parole and the length of parole up to the maximum  
3 period of time provided by law. The inmate has the right to  
4 reconsideration of the length of parole and conditions thereof by  
5 the department or the parole authority, whichever is applicable.  
6 The Department of Corrections and Rehabilitation or the board  
7 may impose as a condition of parole that a prisoner make payments  
8 on the prisoner's outstanding restitution fines or orders imposed  
9 pursuant to subdivision (a) or (c) of Section 13967 of the  
10 Government Code, as operative prior to September 28, 1994, or  
11 subdivision (b) or (f) of Section 1202.4.

12 (8) For purposes of this chapter, and except as otherwise  
13 described in this section, the board shall be considered the parole  
14 authority.

15 (9) (A) On and after July 1, 2013, the sole authority to issue  
16 warrants for the return to actual custody of any state prisoner  
17 released on parole rests with the court pursuant to Section 1203.2,  
18 except for any escaped state prisoner or any state prisoner released  
19 prior to his or her scheduled release date who should be returned  
20 to custody, and Section 5054.1 shall apply.

21 (B) Notwithstanding subparagraph (A), any warrant issued by  
22 the Board of Parole Hearings prior to July 1, 2013, shall remain  
23 in full force and effect until the warrant is served or it is recalled  
24 by the board. All prisoners on parole arrested pursuant to a warrant  
25 issued by the board shall be subject to a review by the board prior  
26 to the department filing a petition with the court to revoke the  
27 parole of the petitioner.

28 (10) It is the intent of the Legislature that efforts be made with  
29 respect to persons who are subject to Section 290.011 who are on  
30 parole to engage them in treatment.

31 ~~SEC. 11.~~

32 *SEC. 12.* Section 2356 of the Probate Code is amended to read:

33 2356. (a) No ward or conservatee may be placed in a mental  
34 health treatment facility under this division against the will of the  
35 ward or conservatee. Involuntary civil placement of a ward or  
36 conservatee in a mental health treatment facility may be obtained  
37 only pursuant to Chapter 2 (commencing with Section 5150) or  
38 Chapter 3 (commencing with Section 5350) of Part 1 of Division  
39 5 of the Welfare and Institutions Code. Nothing in this subdivision  
40 precludes the placing of a ward in a state hospital under Section

1 6000 of the Welfare and Institutions Code upon application of the  
2 guardian as provided in that section. The Director of State Hospitals  
3 shall adopt and issue regulations defining “mental health treatment  
4 facility” for the purposes of this subdivision.

5 (b) No experimental drug as defined in Section 111515 of the  
6 Health and Safety Code may be prescribed for or administered to  
7 a ward or conservatee under this division. Such an experimental  
8 drug may be prescribed for or administered to a ward or  
9 conservatee only as provided in Article 4 (commencing with  
10 Section 111515) of Chapter 6 of Part 5 of Division 104 of the  
11 Health and Safety Code.

12 (c) No convulsive treatment as defined in Section 5325 of the  
13 Welfare and Institutions Code may be performed on a ward or  
14 conservatee under this division. Convulsive treatment may be  
15 performed on a ward or conservatee only as provided in Article 7  
16 (commencing with Section 5325) of Chapter 2 of Part 1 of Division  
17 5 of the Welfare and Institutions Code.

18 (d) No minor may be sterilized under this division.

19 (e) This chapter is subject to a valid and effective advance health  
20 care directive under the Health Care Decisions Law (Division 4.7  
21 (commencing with Section 4600)).

22 ~~SEC. 12.~~

23 *SEC. 13.* Section 736 of the Welfare and Institutions Code is  
24 amended to read:

25 736. (a) Except as provided in Section 733, the Department  
26 of Corrections and Rehabilitation, Division of Juvenile Facilities,  
27 shall accept a ward committed to it pursuant to this article if the  
28 Director of the Division of Juvenile Justice believes that the ward  
29 can be materially benefited by the division’s reformatory and  
30 educational discipline, and if the division has adequate facilities,  
31 staff, and programs to provide that care. A ward subject to this  
32 section shall not be transported to any facility under the jurisdiction  
33 of the division until the superintendent of the facility has notified  
34 the committing court of the place to which that ward is to be  
35 transported and the time at which he or she can be received.

36 (b) To determine who is best served by the Division of Juvenile  
37 Facilities, and who would be better served by the State Department  
38 of State Hospitals, the Director of the Division of Juvenile Justice  
39 and the Director of State Hospitals shall, at least annually, confer

1 and establish policy with respect to the types of cases that should  
2 be the responsibility of each department.

3 ~~SEC. 13.~~

4 *SEC. 14.* Section 5328.15 of the Welfare and Institutions Code  
5 is amended to read:

6 5328.15. All information and records obtained in the course  
7 of providing services under Division 5 (commencing with Section  
8 5000), Division 6 (commencing with Section 6000), or Division  
9 7 (commencing with Section 7000), to either voluntary or  
10 involuntary recipients of services shall be confidential. Information  
11 and records may be disclosed, however, notwithstanding any other  
12 provision of law, as follows:

13 (a) To authorized licensing personnel who are employed by, or  
14 who are authorized representatives of, the State Department of  
15 Public Health, and who are licensed or registered health  
16 professionals, and to authorized legal staff or special investigators  
17 who are peace officers who are employed by, or who are authorized  
18 representatives of the State Department of Social Services, as  
19 necessary to the performance of their duties to inspect, license,  
20 and investigate health facilities and community care facilities and  
21 to ensure that the standards of care and services provided in such  
22 facilities are adequate and appropriate and to ascertain compliance  
23 with the rules and regulations to which the facility is subject. The  
24 confidential information shall remain confidential except for  
25 purposes of inspection, licensing, or investigation pursuant to  
26 Chapter 2 (commencing with Section 1250) of, and Chapter 3  
27 (commencing with Section 1500) of, Division 2 of the Health and  
28 Safety Code, or a criminal, civil, or administrative proceeding in  
29 relation thereto. The confidential information may be used by the  
30 State Department of Public Health or the State Department of  
31 Social Services in a criminal, civil, or administrative proceeding.  
32 The confidential information shall be available only to the judge  
33 or hearing officer and to the parties to the case. Names which are  
34 confidential shall be listed in attachments separate to the general  
35 pleadings. The confidential information shall be sealed after the  
36 conclusion of the criminal, civil, or administrative hearings, and  
37 shall not subsequently be released except in accordance with this  
38 subdivision. If the confidential information does not result in a  
39 criminal, civil, or administrative proceeding, it shall be sealed after  
40 the State Department of Public Health or the State Department of

1 Social Services decides that no further action will be taken in the  
2 matter of suspected licensing violations. Except as otherwise  
3 provided in this subdivision, confidential information in the  
4 possession of the State Department of Public Health or the State  
5 Department of Social Services shall not contain the name of the  
6 patient.

7 (b) To any board which licenses and certifies professionals in  
8 the fields of mental health pursuant to state law, when the Director  
9 of State Hospitals has reasonable cause to believe that there has  
10 occurred a violation of any provision of law subject to the  
11 jurisdiction of that board and the records are relevant to the  
12 violation. This information shall be sealed after a decision is  
13 reached in the matter of the suspected violation, and shall not  
14 subsequently be released except in accordance with this  
15 subdivision. Confidential information in the possession of the  
16 board shall not contain the name of the patient.

17 (c) To a protection and advocacy agency established pursuant  
18 to Section 4901, to the extent that the information is incorporated  
19 within any of the following:

20 (1) An unredacted facility evaluation report form or an  
21 unredacted complaint investigation report form of the State  
22 Department of Social Services. This information shall remain  
23 confidential and subject to the confidentiality requirements of  
24 subdivision (f) of Section 4903.

25 (2) An unredacted citation report, unredacted licensing report,  
26 unredacted survey report, unredacted plan of correction, or  
27 unredacted statement of deficiency of the State Department of  
28 Public Health, prepared by authorized licensing personnel or  
29 authorized representatives described in subdivision (n). This  
30 information shall remain confidential and subject to the  
31 confidentiality requirements of subdivision (f) of Section 4903.

32 ~~SEC. 14.~~

33 *SEC. 15.* Section 6000 of the Welfare and Institutions Code is  
34 amended to read:

35 6000. (a) Pursuant to applicable rules and regulations  
36 established by the State Department of State Hospitals or the State  
37 Department of Developmental Services, the medical director of a  
38 state hospital for the mentally disordered or developmentally  
39 disabled may receive in such hospital, as a boarder and patient,  
40 any person who is a suitable person for care and treatment in such

1 hospital, upon receipt of a written application for the admission  
2 of the person into the hospital for care and treatment made in  
3 accordance with the following requirements:

4 (1) In the case of an adult person, the application shall be made  
5 voluntarily by the person, at a time when he *or she* is in such  
6 condition of mind as to render him *or her* competent to make it  
7 or, if he *or she* is a conservatee with a conservator of the person  
8 or person and estate who was appointed under Chapter 3  
9 (commencing with Section 5350) of Part 1 of Division 5 with the  
10 right as specified by court order under Section 5358 to place his  
11 *or her* conservatee in a state hospital, by his *or her* conservator.

12 (2) (A) In the case of a minor person, the application shall be  
13 made by his *or her* parents, or by the parent, guardian, conservator,  
14 or other person entitled to his *or her* custody to any of such mental  
15 hospitals as may be designated by the Director of State Hospitals  
16 or the Director of Developmental Services to admit minors on  
17 voluntary applications. If the minor has a conservator of the person,  
18 or the person and the estate, appointed under Chapter 3  
19 (commencing with Section 5350) of Part 1 of Division 5, with the  
20 right as specified by court order under Section 5358 to place the  
21 conservatee in a state hospital the application for the minor shall  
22 be made by his *or her* conservator.

23 (B) Any person received in a state hospital shall be deemed a  
24 voluntary patient.

25 (C) Upon the admission of a voluntary patient to a state hospital  
26 the medical director shall immediately forward to the office of the  
27 State Department of State Hospitals or the State Department of  
28 Developmental Services the record of such voluntary patient,  
29 showing the name, residence, age, sex, place of birth, occupation,  
30 civil condition, date of admission of such patient to such hospital,  
31 and such other information as is required by the rules and  
32 regulations of the department.

33 (D) The charges for the care and keeping of a mentally  
34 disordered person in a state hospital shall be governed by the  
35 provisions of Article 4 (commencing with Section 7275) of Chapter  
36 3 of Division 7 relating to the charges for the care and keeping of  
37 mentally disordered persons in state hospitals.

38 (E) A voluntary adult patient may leave the hospital or institution  
39 at any time by giving notice of his *or her* desire to leave to any  
40 member of the hospital staff and completing normal hospitalization

1 departure procedures. A conservatee may leave in a like manner  
2 if notice is given by his *or her* conservator.

3 (F) A minor person who is a voluntary patient may leave the  
4 hospital or institution after completing normal hospitalization  
5 departure procedures after notice is given to the superintendent or  
6 person in charge by the parents, or the parent, guardian,  
7 conservator, or other person entitled to the custody of the minor,  
8 of their desire to remove him *or her* from the hospital.

9 (G) No person received into a state hospital, private mental  
10 institution, or county psychiatric hospital as a voluntary patient  
11 during his *or her* minority shall be detained therein after he *or she*  
12 reaches the age of majority, but any such person, after attaining  
13 the age of majority, may apply for admission into the hospital or  
14 institution for care and treatment in the manner prescribed in this  
15 section for applications by adult persons.

16 (b) The State Department of State Hospitals or the State  
17 Department of Developmental Services shall establish such rules  
18 and regulations as are necessary to carry out properly the provisions  
19 of this section.

20 (c) Commencing July 1, 2012, the department shall not admit  
21 any person to a developmental center pursuant to this section.

22 ~~SEC. 15.~~

23 *SEC. 16.* Section 6002 of the Welfare and Institutions Code is  
24 amended to read:

25 6002. (a) The person in charge of any private institution,  
26 hospital, clinic, or sanitarium which is conducted for, or includes  
27 a department or ward conducted for, the care and treatment of  
28 persons who are mentally disordered may receive therein as a  
29 voluntary patient any person suffering from a mental disorder who  
30 is a suitable person for care and treatment in the institution,  
31 hospital, clinic, or sanitarium who voluntarily makes a written  
32 application to the person in charge for admission into the  
33 institution, hospital, clinic, or sanitarium, and who is at the time  
34 of making the application mentally competent to make the  
35 application. A conservatee, with a conservator of the person, or  
36 person and estate, appointed under Chapter 3 (commencing with  
37 Section 5350) of Part 1 of Division 5, with the right as specified  
38 by court order under Section 5358 to place his *or her* conservatee,  
39 may be admitted upon written application by his *or her* conservator.

1 (b) After the admission of a voluntary patient to a private  
2 institution, hospital, clinic, or sanitarium the person in charge shall  
3 forward to the office of the State Department of State Hospitals a  
4 record of the voluntary patient showing such information as may  
5 be required by rule by the department.

6 (c) A voluntary adult patient may leave the hospital, clinic, or  
7 institution at any time by giving notice of his *or her* desire to leave  
8 to any member of the hospital staff and completing normal  
9 hospitalization departure procedures. A conservatee may leave in  
10 a like manner if notice is given by his *or her* conservator.

11 ~~SEC. 16.~~

12 *SEC. 17.* Section 6600 of the Welfare and Institutions Code is  
13 amended to read:

14 6600. As used in this article, the following terms have the  
15 following meanings:

16 (a) (1) “Sexually violent predator” means a person who has  
17 been convicted of a sexually violent offense against one or more  
18 victims and who has a diagnosed mental disorder that makes the  
19 person a danger to the health and safety of others in that it is likely  
20 that he or she will engage in sexually violent criminal behavior.

21 (2) For purposes of this subdivision any of the following shall  
22 be considered a conviction for a sexually violent offense:

23 (A) A prior or current conviction that resulted in a determinate  
24 prison sentence for an offense described in subdivision (b).

25 (B) A conviction for an offense described in subdivision (b)  
26 that was committed prior to July 1, 1977, and that resulted in an  
27 indeterminate prison sentence.

28 (C) A prior conviction in another jurisdiction for an offense that  
29 includes all of the elements of an offense described in subdivision  
30 (b).

31 (D) A conviction for an offense under a predecessor statute that  
32 includes all of the elements of an offense described in subdivision  
33 (b).

34 (E) A prior conviction for which the inmate received a grant of  
35 probation for an offense described in subdivision (b).

36 (F) A prior finding of not guilty by reason of insanity for an  
37 offense described in subdivision (b).

38 (G) A conviction resulting in a finding that the person was a  
39 mentally disordered sex offender.

1 (H) A prior conviction for an offense described in subdivision  
2 (b) for which the person was committed to the Division of Juvenile  
3 Facilities, Department of Corrections and Rehabilitation pursuant  
4 to Section 1731.5.

5 (I) A prior conviction for an offense described in subdivision  
6 (b) that resulted in an indeterminate prison sentence.

7 (3) Conviction of one or more of the crimes enumerated in this  
8 section shall constitute evidence that may support a court or jury  
9 determination that a person is a sexually violent predator, but shall  
10 not be the sole basis for the determination. The existence of any  
11 prior convictions may be shown with documentary evidence. The  
12 details underlying the commission of an offense that led to a prior  
13 conviction, including a predatory relationship with the victim, may  
14 be shown by documentary evidence, including, but not limited to,  
15 preliminary hearing transcripts, trial transcripts, probation and  
16 sentencing reports, and evaluations by the State Department of  
17 State Hospitals. Jurors shall be admonished that they may not find  
18 a person a sexually violent predator based on prior offenses absent  
19 relevant evidence of a currently diagnosed mental disorder that  
20 makes the person a danger to the health and safety of others in that  
21 it is likely that he or she will engage in sexually violent criminal  
22 behavior.

23 (4) The provisions of this section shall apply to any person  
24 against whom proceedings were initiated for commitment as a  
25 sexually violent predator on or after January 1, 1996.

26 (b) “Sexually violent offense” means the following acts when  
27 committed by force, violence, duress, menace, fear of immediate  
28 and unlawful bodily injury on the victim or another person, or  
29 threatening to retaliate in the future against the victim or any other  
30 person, and that are committed on, before, or after the effective  
31 date of this article and result in a conviction or a finding of not  
32 guilty by reason of insanity, as defined in subdivision (a): a felony  
33 violation of Section 261, 262, 264.1, 269, 286, 288, 288a, 288.5,  
34 or 289 of the Penal Code, or any felony violation of Section 207,  
35 209, or 220 of the Penal Code, committed with the intent to commit  
36 a violation of Section 261, 262, 264.1, 286, 288, 288a, or 289 of  
37 the Penal Code.

38 (c) “Diagnosed mental disorder” includes a congenital or  
39 acquired condition affecting the emotional or volitional capacity  
40 that predisposes the person to the commission of criminal sexual

1 acts in a degree constituting the person a menace to the health and  
2 safety of others.

3 (d) “Danger to the health and safety of others” does not require  
4 proof of a recent overt act while the offender is in custody.

5 (e) “Predatory” means an act is directed toward a stranger, a  
6 person of casual acquaintance with whom no substantial  
7 relationship exists, or an individual with whom a relationship has  
8 been established or promoted for the primary purpose of  
9 victimization.

10 (f) “Recent overt act” means any criminal act that manifests a  
11 likelihood that the actor may engage in sexually violent predatory  
12 criminal behavior.

13 (g) Notwithstanding any other provision of law and for purposes  
14 of this section, a prior juvenile adjudication of a sexually violent  
15 offense may constitute a prior conviction for which the person  
16 received a determinate term if all of the following apply:

17 (1) The juvenile was 16 years of age or older at the time he or  
18 she committed the prior offense.

19 (2) The prior offense is a sexually violent offense as specified  
20 in subdivision (b).

21 (3) The juvenile was adjudged a ward of the juvenile court  
22 within the meaning of Section 602 because of the person’s  
23 commission of the offense giving rise to the juvenile court  
24 adjudication.

25 (4) The juvenile was committed to the Division of Juvenile  
26 Facilities, Department of Corrections and Rehabilitation for the  
27 sexually violent offense.

28 (h) A minor adjudged a ward of the court for commission of an  
29 offense that is defined as a sexually violent offense shall be entitled  
30 to specific treatment as a sexual offender. The failure of a minor  
31 to receive that treatment shall not constitute a defense or bar to a  
32 determination that any person is a sexually violent predator within  
33 the meaning of this article.

34 ~~SEC. 17.~~

35 *SEC. 18.* Section 6601 of the Welfare and Institutions Code is  
36 amended to read:

37 6601. (a) (1) Whenever the Secretary of the Department of  
38 Corrections and Rehabilitation determines that an individual who  
39 is in custody under the jurisdiction of the Department of  
40 Corrections and Rehabilitation, and who is either serving a

1 determinate prison sentence or whose parole has been revoked,  
2 may be a sexually violent predator, the secretary shall, at least six  
3 months prior to that individual's scheduled date for release from  
4 prison, refer the person for evaluation in accordance with this  
5 section. However, if the inmate was received by the department  
6 with less than nine months of his or her sentence to serve, or if the  
7 inmate's release date is modified by judicial or administrative  
8 action, the secretary may refer the person for evaluation in  
9 accordance with this section at a date that is less than six months  
10 prior to the inmate's scheduled release date.

11 (2) A petition may be filed under this section if the individual  
12 was in custody pursuant to his or her determinate prison term,  
13 parole revocation term, or a hold placed pursuant to Section 6601.3,  
14 at the time the petition is filed. A petition shall not be dismissed  
15 on the basis of a later judicial or administrative determination that  
16 the individual's custody was unlawful, if the unlawful custody was  
17 the result of a good faith mistake of fact or law. This paragraph  
18 shall apply to any petition filed on or after January 1, 1996.

19 (b) The person shall be screened by the Department of  
20 Corrections and Rehabilitation and the Board of Parole Hearings  
21 based on whether the person has committed a sexually violent  
22 predatory offense and on a review of the person's social, criminal,  
23 and institutional history. This screening shall be conducted in  
24 accordance with a structured screening instrument developed and  
25 updated by the State Department of State Hospitals in consultation  
26 with the Department of Corrections and Rehabilitation. If as a  
27 result of this screening it is determined that the person is likely to  
28 be a sexually violent predator, the Department of Corrections and  
29 Rehabilitation shall refer the person to the State Department of  
30 State Hospitals for a full evaluation of whether the person meets  
31 the criteria in Section 6600.

32 (c) The State Department of State Hospitals shall evaluate the  
33 person in accordance with a standardized assessment protocol,  
34 developed and updated by the State Department of State Hospitals,  
35 to determine whether the person is a sexually violent predator as  
36 defined in this article. The standardized assessment protocol shall  
37 require assessment of diagnosable mental disorders, as well as  
38 various factors known to be associated with the risk of reoffense  
39 among sex offenders. Risk factors to be considered shall include

1 criminal and psychosexual history, type, degree, and duration of  
2 sexual deviance, and severity of mental disorder.

3 (d) Pursuant to subdivision (c), the person shall be evaluated  
4 by two practicing psychiatrists or psychologists, or one practicing  
5 psychiatrist and one practicing psychologist, designated by the  
6 Director of State Hospitals. If both evaluators concur that the  
7 person has a diagnosed mental disorder so that he or she is likely  
8 to engage in acts of sexual violence without appropriate treatment  
9 and custody, the Director of State Hospitals shall forward a request  
10 for a petition for commitment under Section 6602 to the county  
11 designated in subdivision (i). Copies of the evaluation reports and  
12 any other supporting documents shall be made available to the  
13 attorney designated by the county pursuant to subdivision (i) who  
14 may file a petition for commitment.

15 (e) If one of the professionals performing the evaluation pursuant  
16 to subdivision (d) does not concur that the person meets the criteria  
17 specified in subdivision (d), but the other professional concludes  
18 that the person meets those criteria, the Director of State Hospitals  
19 shall arrange for further examination of the person by two  
20 independent professionals selected in accordance with subdivision  
21 (g).

22 (f) If an examination by independent professionals pursuant to  
23 subdivision (e) is conducted, a petition to request commitment  
24 under this article shall only be filed if both independent  
25 professionals who evaluate the person pursuant to subdivision (e)  
26 concur that the person meets the criteria for commitment specified  
27 in subdivision (d). The professionals selected to evaluate the person  
28 pursuant to subdivision (g) shall inform the person that the purpose  
29 of their examination is not treatment but to determine if the person  
30 meets certain criteria to be involuntarily committed pursuant to  
31 this article. It is not required that the person appreciate or  
32 understand that information.

33 (g) Any independent professional who is designated by the  
34 Secretary of the Department of Corrections and Rehabilitation or  
35 the Director of State Hospitals for purposes of this section shall  
36 not be a state government employee, shall have at least five years  
37 of experience in the diagnosis and treatment of mental disorders,  
38 and shall include psychiatrists and licensed psychologists who  
39 have a doctoral degree in psychology. The requirements set forth  
40 in this section also shall apply to any professionals appointed by

1 the court to evaluate the person for purposes of any other  
2 proceedings under this article.

3 (h) If the State Department of State Hospitals determines that  
4 the person is a sexually violent predator as defined in this article,  
5 the Director of State Hospitals shall forward a request for a petition  
6 to be filed for commitment under this article to the county  
7 designated in subdivision (i). Copies of the evaluation reports and  
8 any other supporting documents shall be made available to the  
9 attorney designated by the county pursuant to subdivision (i) who  
10 may file a petition for commitment in the superior court.

11 (i) If the county's designated counsel concurs with the  
12 recommendation, a petition for commitment shall be filed in the  
13 superior court of the county in which the person was convicted of  
14 the offense for which he or she was committed to the jurisdiction  
15 of the Department of Corrections and Rehabilitation. The petition  
16 shall be filed, and the proceedings shall be handled, by either the  
17 district attorney or the county counsel of that county. The county  
18 board of supervisors shall designate either the district attorney or  
19 the county counsel to assume responsibility for proceedings under  
20 this article.

21 (j) The time limits set forth in this section shall not apply during  
22 the first year that this article is operative.

23 (k) An order issued by a judge pursuant to Section 6601.5,  
24 finding that the petition, on its face, supports a finding of probable  
25 cause to believe that the individual named in the petition is likely  
26 to engage in sexually violent predatory criminal behavior upon his  
27 or her release, shall toll that person's parole pursuant to paragraph  
28 (4) of subdivision (a) of Section 3000 of the Penal Code, if that  
29 individual is determined to be a sexually violent predator.

30 (l) Pursuant to subdivision (d), the attorney designated by the  
31 county pursuant to subdivision (i) shall notify the State Department  
32 of State Hospitals of its decision regarding the filing of a petition  
33 for commitment within 15 days of making that decision.

34 (m) This section shall become operative on the date that the  
35 director executes a declaration, which shall be provided to the  
36 fiscal and policy committees of the Legislature, including the  
37 Chairperson of the Joint Legislative Budget Committee, and the  
38 Department of Finance, specifying that sufficient qualified state  
39 employees have been hired to conduct the evaluations required

1 pursuant to subdivision (d), or January 1, 2013, whichever occurs  
2 first.

3 ~~SEC. 18.~~

4 *SEC. 19.* Section 6608.7 of the Welfare and Institutions Code  
5 is amended to read:

6 6608.7. The State Department of State Hospitals may enter  
7 into an interagency agreement or contract with the Department of  
8 Corrections and Rehabilitation or with local law enforcement  
9 agencies for services related to supervision or monitoring of  
10 sexually violent predators who have been conditionally released  
11 into the community under the forensic conditional release program  
12 pursuant to this article.

13 ~~SEC. 19.~~

14 *SEC. 20.* Section 6609 of the Welfare and Institutions Code is  
15 amended to read:

16 6609. Within 10 days of a request made by the chief of police  
17 of a city or the sheriff of a county, the State Department of State  
18 Hospitals shall provide the following information concerning each  
19 person committed as a sexually violent predator who is receiving  
20 outpatient care in a conditional release program in that city or  
21 county: name, address, date of commitment, county from which  
22 committed, date of placement in the conditional release program,  
23 fingerprints, and a glossy photograph no smaller than  $3\frac{1}{8} \times 3\frac{1}{8}$   
24 inches in size, or clear copies of the fingerprints and photograph.

25 ~~SEC. 20.~~

26 *SEC. 21.* Section 9717 of the Welfare and Institutions Code is  
27 amended to read:

28 9717. (a) All advocacy programs and any programs similar in  
29 nature to the Long-Term Care Ombudsman Program that receive  
30 funding or official designation from the state shall cooperate with  
31 the office, where appropriate. These programs include, but are not  
32 limited to, the Office of Human Rights within the State Department  
33 of State Hospitals, the Office of Patients' Rights, Disability Rights  
34 California, and the Department of Rehabilitation's Client  
35 Assistance Program.

36 (b) The office shall maintain a close working relationship with  
37 the Legal Services Development Program for the Elderly within  
38 the department.

39 (c) In order to ensure the provision of counsel for patients and  
40 residents of long-term care facilities, the office shall seek to

1 establish effective coordination with programs that provide legal  
2 services for the elderly, including, but not limited to, programs  
3 that are funded by the federal Legal Services Corporation or under  
4 the federal Older Americans Act (42 U.S.C. Sec. 3001 et seq.), as  
5 amended.

6 (d) The department and other state departments and programs  
7 that have roles in funding, regulating, monitoring, or serving  
8 long-term care facility residents, including law enforcement  
9 agencies, shall cooperate with and meet with the office periodically  
10 and as needed to address concerns or questions involving the care,  
11 quality of life, safety, rights, health, and well-being of long-term  
12 care facility residents.

13 ~~SEC. 21.~~

14 *SEC. 22.* Section 10600.1 of the Welfare and Institutions Code  
15 is amended to read:

16 10600.1. (a) The State Department of Social Services succeeds  
17 to and is vested with the duties, purposes, responsibilities, and  
18 jurisdiction exercised by the State Department of Health or the  
19 State Department of Benefit Payments pursuant to the provisions  
20 of this division, except those contained in Chapter 7 (commencing  
21 with Section 14000), Chapter 8 (commencing with Section 14200),  
22 Chapter 8.5 (commencing with Section 14500), and Chapter 8.7  
23 (commencing with Section 14520) of Part 3, on the date  
24 immediately prior to the date this section becomes operative.

25 (b) The State Department of Social Services also succeeds to  
26 and is vested with the duties, purposes, responsibilities, and  
27 jurisdiction heretofore exercised by the State Department of Health  
28 with respect to its disability determination function performed  
29 pursuant to Titles II and XVI of the federal Social Security Act;  
30 provided, however, that this paragraph shall not vest in the State  
31 Department of Social Services any power or authority over  
32 programs for aid or rehabilitation of mentally disordered or  
33 developmentally disabled persons administered by the State  
34 Department of State Hospitals or the State Department of  
35 Developmental Services.

36 *SEC. 23.* Section 10725 of the Welfare and Institutions Code  
37 is amended to read:

38 10725. The director may adopt regulations, orders, or standards  
39 of general application to implement, interpret, or make specific  
40 the law enforced by the department, and ~~such~~ those regulations,

1 orders, and standards shall be adopted, amended, or repealed by  
2 the director only in accordance with the provisions of Chapter 4.5  
3 3.5 (commencing with Section ~~11371~~, 11340) of Part 1; of  
4 Division 3; of Title 2 of the Government Code, provided that  
5 regulations Code. Regulations relating to services need not be  
6 printed in the ~~California Administrative Code~~ California Code of  
7 Regulations or ~~California Administrative Register~~ the California  
8 Regulatory Notice Register if they are included in the publications  
9 of the department. ~~Such~~ This authority also may be exercised by  
10 the director's designee.

11 In adopting regulations the director shall strive for clarity of  
12 language ~~which~~ that may be readily understood by those  
13 administering services or subject to ~~such~~ those regulations.

14 The rules of the department need not specify or include the detail  
15 of forms, reports, or records, but shall include the essential  
16 authority by which any person, agency, organization, association,  
17 or institution subject to the supervision or investigation of the  
18 department is required to use, submit, or maintain ~~such~~ those forms,  
19 reports, or records.

20 ~~SEC. 22.~~

21 *SEC. 24.* Section 14043.26 of the Welfare and Institutions  
22 Code is amended to read:

23 14043.26. (a) (1) On and after January 1, 2004, an applicant  
24 that currently is not enrolled in the Medi-Cal program, or a provider  
25 applying for continued enrollment, upon written notification from  
26 the department that enrollment for continued participation of all  
27 providers in a specific provider of service category or subgroup  
28 of that category to which the provider belongs will occur, or, except  
29 as provided in subdivisions (b) and (e), a provider not currently  
30 enrolled at a location where the provider intends to provide  
31 services, goods, supplies, or merchandise to a Medi-Cal  
32 beneficiary, shall submit a complete application package for  
33 enrollment, continuing enrollment, or enrollment at a new location  
34 or a change in location.

35 (2) Clinics licensed by the department pursuant to Chapter 1  
36 (commencing with Section 1200) of Division 2 of the Health and  
37 Safety Code and certified by the department to participate in the  
38 Medi-Cal program shall not be subject to this section.

39 (3) Health facilities licensed by the department pursuant to  
40 Chapter 2 (commencing with Section 1250) of Division 2 of the

1 Health and Safety Code and certified by the department to  
2 participate in the Medi-Cal program shall not be subject to this  
3 section.

4 (4) Adult day health care providers licensed pursuant to Chapter  
5 3.3 (commencing with Section 1570) of Division 2 of the Health  
6 and Safety Code and certified by the department to participate in  
7 the Medi-Cal program shall not be subject to this section.

8 (5) Home health agencies licensed pursuant to Chapter 8  
9 (commencing with Section 1725) of Division 2 of the Health and  
10 Safety Code and certified by the department to participate in the  
11 Medi-Cal program shall not be subject to this section.

12 (6) Hospices licensed pursuant to Chapter 8.5 (commencing  
13 with Section 1745) of Division 2 of the Health and Safety Code  
14 and certified by the department to participate in the Medi-Cal  
15 program shall not be subject to this section.

16 (b) A physician and surgeon licensed by the Medical Board of  
17 California or the Osteopathic Medical Board of California, or a  
18 dentist licensed by the Dental Board of California, practicing as  
19 an individual physician practice or as an individual dentist practice,  
20 as defined in Section 14043.1, who is enrolled and in good standing  
21 in the Medi-Cal program, and who is changing locations of that  
22 individual physician practice or individual dentist practice within  
23 the same county, shall be eligible to continue enrollment at the  
24 new location by filing a change of location form to be developed  
25 by the department. The form shall comply with all minimum  
26 federal requirements related to Medicaid provider enrollment.  
27 Filing this form shall be in lieu of submitting a complete  
28 application package pursuant to subdivision (a).

29 (c) (1) Except as provided in paragraph (2), within 30 days  
30 after receiving an application package submitted pursuant to  
31 subdivision (a), the department shall provide written notice that  
32 the application package has been received and, if applicable, that  
33 there is a moratorium on the enrollment of providers in the specific  
34 provider of service category or subgroup of the category to which  
35 the applicant or provider belongs. This moratorium shall bar further  
36 processing of the application package.

37 (2) Within 15 days after receiving an application package from  
38 a physician, or a group of physicians, licensed by the Medical  
39 Board of California or the Osteopathic Medical Board of California,  
40 or a change of location form pursuant to subdivision (b), the

1 department shall provide written notice that the application package  
2 or the change of location form has been received.

3 (d) (1) If the application package submitted pursuant to  
4 subdivision (a) is from an applicant or provider who meets the  
5 criteria listed in paragraph (2), the applicant or provider shall be  
6 considered a preferred provider and shall be granted preferred  
7 provisional provider status pursuant to this section and for a period  
8 of no longer than 18 months, effective from the date on the notice  
9 from the department. The ability to request consideration as a  
10 preferred provider and the criteria necessary for the consideration  
11 shall be publicized to all applicants and providers. An applicant  
12 or provider who desires consideration as a preferred provider  
13 pursuant to this subdivision shall request consideration from the  
14 department by making a notation to that effect on the application  
15 package, by cover letter, or by other means identified by the  
16 department in a provider bulletin. Request for consideration as a  
17 preferred provider shall be made with each application package  
18 submitted in order for the department to grant the consideration.  
19 An applicant or provider who requests consideration as a preferred  
20 provider shall be notified within 60 days whether the applicant or  
21 provider meets or does not meet the criteria listed in paragraph  
22 (2). If an applicant or provider is notified that the applicant or  
23 provider does not meet the criteria for a preferred provider, the  
24 application package submitted shall be processed in accordance  
25 with the remainder of this section.

26 (2) To be considered a preferred provider, the applicant or  
27 provider shall meet all of the following criteria:

28 (A) Hold a current license as a physician and surgeon issued by  
29 the Medical Board of California or the Osteopathic Medical Board  
30 of California, which license shall not have been revoked, whether  
31 stayed or not, suspended, placed on probation, or subject to other  
32 limitation.

33 (B) Be a current faculty member of a teaching hospital or a  
34 children's hospital, as defined in Section 10727, accredited by the  
35 Joint Commission or the American Osteopathic Association, or  
36 be credentialed by a health care service plan that is licensed under  
37 the Knox-Keene Health Care Service Plan Act of 1975 (Chapter  
38 2.2 (commencing with Section 1340) of Division 2 of the Health  
39 and Safety Code) or county organized health system, or be a current

1 member in good standing of a group that is credentialed by a health  
2 care service plan that is licensed under the Knox-Keene Act.

3 (C) Have full, current, unrevoked, and unsuspended privileges  
4 at a Joint Commission or American Osteopathic Association  
5 accredited general acute care hospital.

6 (D) Not have any adverse entries in the federal Healthcare  
7 Integrity and Protection Data Bank.

8 (3) The department may recognize other providers as qualifying  
9 as preferred providers if criteria similar to those set forth in  
10 paragraph (2) are identified for the other providers. The department  
11 shall consult with interested parties and appropriate stakeholders  
12 to identify similar criteria for other providers so that they may be  
13 considered as preferred providers.

14 (e) (1) If a Medi-Cal applicant meets the criteria listed in  
15 paragraph (2), the applicant shall be enrolled in the Medi-Cal  
16 program after submission and review of a short form application  
17 to be developed by the department. The form shall comply with  
18 all minimum federal requirements related to Medicaid provider  
19 enrollment. The department shall notify the applicant that the  
20 department has received the application within 15 days of receipt  
21 of the application. The department shall enroll the applicant or  
22 notify the applicant that the applicant does not meet the criteria  
23 listed in paragraph (2) within 90 days of receipt of the application.

24 (2) Notwithstanding any other provision of law, an applicant or  
25 provider who meets all of the following criteria shall be eligible  
26 for enrollment in the Medi-Cal program pursuant to this  
27 subdivision, after submission and review of a short form  
28 application:

29 (A) The applicant's or provider's practice is based in one or  
30 more of the following: a general acute care hospital, a rural general  
31 acute care hospital, or an acute psychiatric hospital, as defined in  
32 subdivisions (a) and (b) of Section 1250 of the Health and Safety  
33 Code.

34 (B) The applicant or provider holds a current, unrevoked, or  
35 unsuspended license as a physician and surgeon issued by the  
36 Medical Board of California or the Osteopathic Medical Board of  
37 California. An applicant or provider shall not be in compliance  
38 with this subparagraph if a license revocation has been stayed, the  
39 licensee has been placed on probation, or the license is subject to  
40 any other limitation.

1 (C) The applicant or provider does not have an adverse entry  
2 in the federal Healthcare Integrity and Protection Data Bank.

3 (3) An applicant shall be granted provisional provider status  
4 under this subdivision for a period of 12 months.

5 (f) Except as provided in subdivision (g), within 180 days after  
6 receiving an application package submitted pursuant to subdivision  
7 (a), or from the date of the notice to an applicant or provider that  
8 the applicant or provider does not qualify as a preferred provider  
9 under subdivision (d), the department shall give written notice to  
10 the applicant or provider that any of the following applies, or shall  
11 on the 181st day grant the applicant or provider provisional  
12 provider status pursuant to this section for a period no longer than  
13 12 months, effective from the 181st day:

14 (1) The applicant or provider is being granted provisional  
15 provider status for a period of 12 months, effective from the date  
16 on the notice.

17 (2) The application package is incomplete. The notice shall  
18 identify additional information or documentation that is needed to  
19 complete the application package.

20 (3) The department is exercising its authority under Section  
21 14043.37, 14043.4, or 14043.7, and is conducting background  
22 checks, preenrollment inspections, or unannounced visits.

23 (4) The application package is denied for any of the following  
24 reasons:

25 (A) Pursuant to Section 14043.2 or 14043.36.

26 (B) For lack of a license necessary to perform the health care  
27 services or to provide the goods, supplies, or merchandise directly  
28 or indirectly to a Medi-Cal beneficiary, within the applicable  
29 provider of service category or subgroup of that category.

30 (C) The period of time during which an applicant or provider  
31 has been barred from reapplying has not passed.

32 (D) For other stated reasons authorized by law.

33 (E) For failing to submit fingerprints as required by federal  
34 Medicaid regulations.

35 (F) For failing to pay an application fee as required by federal  
36 Medicaid regulations.

37 (5) The application package is withdrawn by request of the  
38 applicant or provider and the department's review is canceled  
39 pursuant to subdivision (n).

1 (g) Notwithstanding subdivision (f), within 90 days after  
2 receiving an application package submitted pursuant to subdivision  
3 (a) from a physician or physician group licensed by the Medical  
4 Board of California or the Osteopathic Medical Board of California,  
5 or from the date of the notice to that physician or physician group  
6 that does not qualify as a preferred provider under subdivision (d),  
7 or within 90 days after receiving a change of location form  
8 submitted pursuant to subdivision (b), the department shall give  
9 written notice to the applicant or provider that either paragraph  
10 (1), (2), (3), (4), or (5) of subdivision (f) applies, or shall on the  
11 91st day grant the applicant or provider provisional provider status  
12 pursuant to this section for a period no longer than 12 months,  
13 effective from the 91st day.

14 (h) (1) If the application package that was noticed as incomplete  
15 under paragraph (2) of subdivision (f) is resubmitted with all  
16 requested information and documentation, and received by the  
17 department within 60 days of the date on the notice, the department  
18 shall, within 60 days of the resubmission, send a notice that any  
19 of the following applies:

20 (A) The applicant or provider is being granted provisional  
21 provider status for a period of 12 months, effective from the date  
22 on the notice.

23 (B) The application package is denied for any other reasons  
24 provided for in paragraph (4) of subdivision (f).

25 (C) The department is exercising its authority under Section  
26 14043.37, 14043.4, or 14043.7 to conduct background checks,  
27 preenrollment inspections, or unannounced visits.

28 (2) (A) If the application package that was noticed as  
29 incomplete under paragraph (2) of subdivision (f) is not resubmitted  
30 with all requested information and documentation and received  
31 by the department within 60 days of the date on the notice, the  
32 application package shall be denied by operation of law. The  
33 applicant or provider may reapply by submitting a new application  
34 package that shall be reviewed de novo.

35 (B) If the failure to resubmit is by a currently enrolled provider  
36 as defined in Section 14043.1, including providers applying for  
37 continued enrollment, the failure may make the provider also  
38 subject to deactivation of the provider's number and all of the  
39 business addresses used by the provider to provide services, goods,  
40 supplies, or merchandise to Medi-Cal beneficiaries.

1 (C) Notwithstanding subparagraph (A), if the notice of an  
2 incomplete application package included a request for information  
3 or documentation related to grounds for denial under Section  
4 14043.2 or 14043.36, the applicant or provider shall not reapply  
5 for enrollment or continued enrollment in the Medi-Cal program  
6 or for participation in any health care program administered by  
7 the department or its agents or contractors for a period of three  
8 years.

9 (i) (1) If the department exercises its authority under Section  
10 14043.37, 14043.4, or 14043.7 to conduct background checks,  
11 preenrollment inspections, or unannounced visits, the applicant or  
12 provider shall receive notice, from the department, after the  
13 conclusion of the background check, preenrollment inspection, or  
14 unannounced visit of either of the following:

15 (A) The applicant or provider is granted provisional provider  
16 status for a period of 12 months, effective from the date on the  
17 notice.

18 (B) Discrepancies or failure to meet program requirements, as  
19 prescribed by the department, have been found to exist during the  
20 preenrollment period.

21 (2) (A) The notice shall identify the discrepancies or failures,  
22 and whether remediation can be made or not, and if so, the time  
23 period within which remediation must be accomplished. Failure  
24 to remediate discrepancies and failures as prescribed by the  
25 department, or notification that remediation is not available, shall  
26 result in denial of the application by operation of law. The applicant  
27 or provider may reapply by submitting a new application package  
28 that shall be reviewed de novo.

29 (B) If the failure to remediate is by a currently enrolled provider  
30 as defined in Section 14043.1, including providers applying for  
31 continued enrollment, the failure may make the provider also  
32 subject to deactivation of the provider's number and all of the  
33 business addresses used by the provider to provide services, goods,  
34 supplies, or merchandise to Medi-Cal beneficiaries.

35 (C) Notwithstanding subparagraph (A), if the discrepancies or  
36 failure to meet program requirements, as prescribed by the director,  
37 included in the notice were related to grounds for denial under  
38 Section 14043.2 or 14043.36, the applicant or provider shall not  
39 reapply for three years.

1 (j) If provisional provider status or preferred provisional provider  
2 status is granted pursuant to this section, a provider number shall  
3 be used by the provider for each business address for which an  
4 application package has been approved. This provider number  
5 shall be used exclusively for the locations for which it was  
6 approved, unless the practice of the provider's profession or  
7 delivery of services, goods, supplies, or merchandise is such that  
8 services, goods, supplies, or merchandise are rendered or delivered  
9 at locations other than the provider's business address and this  
10 practice or delivery of services, goods, supplies, or merchandise  
11 has been disclosed in the application package approved by the  
12 department when the provisional provider status or preferred  
13 provisional provider status was granted.

14 (k) Except for providers subject to subdivision (c) of Section  
15 14043.47, a provider currently enrolled in the Medi-Cal program  
16 at one or more locations who has submitted an application package  
17 for enrollment at a new location or a change in location pursuant  
18 to subdivision (a), or filed a change of location form pursuant to  
19 subdivision (b), may submit claims for services, goods, supplies,  
20 or merchandise rendered at the new location until the application  
21 package or change of location form is approved or denied under  
22 this section, and shall not be subject, during that period, to  
23 deactivation, or be subject to any delay or nonpayment of claims  
24 as a result of billing for services rendered at the new location as  
25 herein authorized. However, the provider shall be considered during  
26 that period to have been granted provisional provider status or  
27 preferred provisional provider status and be subject to termination  
28 of that status pursuant to Section 14043.27. A provider that is  
29 subject to subdivision (c) of Section 14043.47 may come within  
30 the scope of this subdivision upon submitting documentation in  
31 the application package that identifies the physician providing  
32 supervision for every three locations. If a provider submits claims  
33 for services rendered at a new location before the application for  
34 that location is received by the department, the department may  
35 deny the claim.

36 (l) An applicant or a provider whose application for enrollment,  
37 continued enrollment, or a new location or change in location has  
38 been denied pursuant to this section, may appeal the denial in  
39 accordance with Section 14043.65.

1 (m) (1) Upon receipt of a complete and accurate claim for an  
2 individual nurse provider, the department shall adjudicate the claim  
3 within an average of 30 days.

4 (2) During the budget proceedings of the 2006–07 fiscal year,  
5 and each fiscal year thereafter, the department shall provide data  
6 to the Legislature specifying the timeframe under which it has  
7 processed and approved the provider applications submitted by  
8 individual nurse providers.

9 (3) For purposes of this subdivision, “individual nurse providers”  
10 are providers authorized under certain home- and community-based  
11 waivers and under the state plan to provide nursing services to  
12 Medi-Cal recipients in the recipients’ own homes rather than in  
13 institutional settings.

14 ~~(n) The amendments to subdivision (b), which implement a~~  
15 ~~change of location form, and the addition of paragraph (2) to~~  
16 ~~subdivision (c), the amendments to subdivision (c), and the addition~~  
17 ~~of subdivision (g), which prescribe different processing timeframes~~  
18 ~~for physicians and physician groups, as contained in Chapter 693~~  
19 ~~of the Statutes of 2007, shall become operative on July 1, 2008.~~

20 ~~(o) (1) This section shall become operative on the effective~~  
21 ~~date of the state plan amendment necessary to implement this~~  
22 ~~section, as stated in the declaration executed by the director~~  
23 ~~pursuant to paragraph (2).~~

24 ~~(2) Upon approval of the state plan amendment necessary to~~  
25 ~~implement this section under Sections 455.434 and 455.450 of~~  
26 ~~Title 42 of the Code of Federal Regulations, the director shall~~  
27 ~~execute a declaration, to be retained by the director, that states that~~  
28 ~~this approval has been obtained and the effective date of the state~~  
29 ~~plan amendment. The department shall post the declaration on its~~  
30 ~~Internet Web site and transmit a copy of the declaration to the~~  
31 ~~Legislature.~~

32 *(n) (1) Except as provided in paragraph (2), an applicant or*  
33 *provider may request to withdraw an application package*  
34 *submitted pursuant to this section at any time, at which point the*  
35 *department’s review shall be canceled.*

36 *(2) The department’s review shall not be canceled if, at the time*  
37 *the applicant or provider requests to withdraw his or her*  
38 *application package, the department has already initiated review*  
39 *under Section 14043.37, 14043.4, or 14043.7.*

1     *SEC. 25. Section 14087.36 of the Welfare and Institutions Code*  
2     *is amended to read:*

3     14087.36. (a) The following definitions shall apply for  
4     purposes of this section:

5     (1) “County” means the City and County of San Francisco.

6     (2) “Board” means the Board of Supervisors of the City and  
7     County of San Francisco.

8     (3) “Department” means the State Department of Health *Care*  
9     Services.

10    (4) “Governing body” means the governing body of the health  
11    authority.

12    (5) “Health authority” means the separate public agency  
13    established by the board of supervisors to operate a health care  
14    system in the county and to engage in the other activities authorized  
15    by this section.

16    (b) The Legislature finds and declares that it is necessary that  
17    a health authority be established in the county to arrange for the  
18    provision of health care services in order to meet the problems of  
19    the delivery of publicly assisted medical care in the county, to  
20    enter into a contract with the department under Article 2.97  
21    (commencing with Section 14093), or to contract with a health  
22    care service plan on terms and conditions acceptable to the  
23    department, and to demonstrate ways of promoting quality care  
24    and cost efficiency.

25    (c) The county may, by resolution or ordinance, establish a  
26    health authority to act as and be the local initiative component of  
27    the Medi-Cal state plan pursuant to regulations adopted by the  
28    department. If the board elects to establish a health authority, all  
29    rights, powers, duties, privileges, and immunities vested in a county  
30    under Article 2.8 (commencing with Section 14087.5) and Article  
31    2.97 (commencing with Section 14093) shall be vested in the health  
32    authority. The health authority shall have all power necessary and  
33    appropriate to operate programs involving health care services,  
34    including, but not limited to, the power to acquire, possess, and  
35    dispose of real or personal property, to employ personnel and  
36    contract for services required to meet its obligations, to sue or be  
37    sued, to take all actions and engage in all public and private  
38    business activities, subject to any applicable licensure, as permitted  
39    a health care service plan pursuant to Chapter 2.2 (commencing  
40    with Section 1340) of Division 2 of the Health and Safety Code,

1 and to enter into agreements under Chapter 5 (commencing with  
2 Section 6500) of Division 7 of Title 1 of the Government Code.

3 (d) (1) (A) The health authority shall be considered a public  
4 entity for purposes of Division 3.6 (commencing with Section 810)  
5 of Title 1 of the Government Code, separate and distinct from the  
6 county, and shall file the statement required by Section 53051 of  
7 the Government Code. The health authority shall have primary  
8 responsibility to provide the defense and indemnification required  
9 under Division 3.6 (commencing with Section 810) of Title 1 of  
10 the Government Code for employees of the health authority who  
11 are employees of the county. The health authority shall provide  
12 insurance under terms and conditions required by the county in  
13 order to satisfy its obligations under this section.

14 (B) For purposes of this paragraph, “employee” shall have the  
15 same meaning as set forth in Section 810.2 of the Government  
16 Code.

17 (2) The health authority shall not be considered to be an agency,  
18 division, department, or instrumentality of the county and shall  
19 not be subject to the personnel, procurement, or other operational  
20 rules of the county.

21 (3) Notwithstanding any other provision of law, any obligations  
22 of the health authority, statutory, contractual, or otherwise, shall  
23 be the obligations solely of the health authority and shall not be  
24 the obligations of the county, unless expressly provided for in a  
25 contract between the authority and the county, nor of the state.

26 (4) Except as agreed to by contract with the county, no liability  
27 of the health authority shall become an obligation of the county  
28 upon either termination of the health authority or the liquidation  
29 or disposition of the health authority’s remaining assets.

30 (e) (1) To the full extent permitted by federal law, the  
31 department and the health authority may enter into contracts to  
32 provide or arrange for health care services for any or all persons  
33 who are eligible to receive benefits under the Medi-Cal program.  
34 The contracts may be on an exclusive or nonexclusive basis, and  
35 shall include payment provisions on any basis negotiated between  
36 the department and the health authority. The health authority may  
37 also enter into contracts for the provision of health care services  
38 to individuals including, but not limited to, those covered under  
39 Subchapter XVIII (commencing with Section 1395) of Chapter 7  
40 of Title 42 of the United States Code, individuals employed by

1 public agencies and private businesses, and uninsured or indigent  
2 individuals.

3 (2) Notwithstanding paragraph (1), or subdivision (f), the health  
4 authority may not operate health plans or programs for individuals  
5 covered under Subchapter XVIII (commencing with Section 1395)  
6 of Chapter 7 of Title 42 of the United States Code, or for private  
7 businesses, until the health authority is in full compliance with all  
8 of the requirements of the Knox-Keene Health Care Service Plan  
9 Act of 1975 under Chapter 2.2 (commencing with Section 1340)  
10 of Division 2 of the Health and Safety Code, including tangible  
11 net equity requirements applicable to a licensed health care service  
12 plan. This limitation shall not preclude the health authority from  
13 enrolling persons pursuant to the county's obligations under Section  
14 17000, or from enrolling county employees.

15 (f) The board of supervisors may transfer responsibility for  
16 administration of county-provided health care services to the health  
17 authority for the purpose of service of populations including  
18 uninsured and indigent persons, subject to the provisions of any  
19 ordinances or resolutions passed by the county board of  
20 supervisors. The transfer of administrative responsibility for those  
21 health care services shall not relieve the county of its responsibility  
22 for indigent care pursuant to Section 17000. The health authority  
23 may also enter into contracts for the provision of health care  
24 services to individuals including, but not limited to, those covered  
25 under Subchapter XVIII (commencing with Section 1395) of  
26 Chapter 7 of Title 42 of the United States Code, and individuals  
27 employed by public agencies and private businesses.

28 (g) Upon creation, the health authority may borrow from the  
29 county and the county may lend the authority funds, or issue  
30 revenue anticipation notes to obtain those funds necessary to  
31 commence operations or perform the activities of the health  
32 authority. Notwithstanding any other provision of law, both the  
33 county and the health authority shall be eligible to receive funding  
34 under subdivision (p) of Section 14163.

35 (h) The county may terminate the health authority, but only by  
36 an ordinance approved by a two-thirds affirmative vote of the full  
37 board.

38 (i) Prior to the termination of the health authority, the county  
39 shall notify the department of its intent to terminate the health  
40 authority. The department shall conduct an audit of the health

1 authority's records within 30 days of notification to determine the  
2 liabilities and assets of the health authority. The department shall  
3 report its findings to the county and to the Department of Managed  
4 Health Care within 10 days of completion of the audit. The county  
5 shall prepare a plan to liquidate or otherwise dispose of the assets  
6 of the health authority and to pay the liabilities of the health  
7 authority to the extent of the health authority's assets, and present  
8 the plan to the department and the Department of Managed Health  
9 Care within 30 days upon receipt of these findings.

10 (j) Any assets of the health authority derived from the contract  
11 entered into between the state and the authority pursuant to Article  
12 2.97 (commencing with Section 14093), after payment of the  
13 liabilities of the health authority, shall be disposed of pursuant to  
14 the contract.

15 (k) (1) The governing body shall consist of 18 voting members,  
16 14 of whom shall be appointed by resolution or ordinance of the  
17 board as follows:

18 (A) One member shall be a member of the board or any other  
19 person designated by the board.

20 (B) One member shall be a person who is employed in the senior  
21 management of a hospital not operated by the county or the  
22 University of California and who is nominated by the San Francisco  
23 Section of the Westbay Hospital Conference or any successor  
24 organization, or if there is no successor organization, a person who  
25 shall be nominated by the Hospital Council of Northern and Central  
26 California.

27 (C) Two members, one of whom shall be a person employed in  
28 the senior management of San Francisco General Hospital and one  
29 of whom shall be a person employed in the senior management of  
30 St. Luke's Hospital (San Francisco). If San Francisco General  
31 Hospital or St. Luke's Hospital, at the end of the term of the person  
32 appointed from its senior management, is not designated as a  
33 disproportionate share hospital, and if the governing body, after  
34 providing an opportunity for comment by the Westbay Hospital  
35 Conference, or any successor organization, determines that the  
36 hospital no longer serves an equivalent patient population, the  
37 governing body may, by a two-thirds vote of the full governing  
38 body, select an alternative hospital to nominate a person employed  
39 in its senior management to serve on the governing body.  
40 Alternatively, the governing body may approve a reduction in the

1 number of positions on the governing body as set forth in  
2 subdivision (p).

3 (D) Two members shall be employees in the senior management  
4 of either private nonprofit community clinics or a community clinic  
5 consortium, nominated by the San Francisco Community Clinic  
6 Consortium, or any successor organization.

7 (E) Two members shall be physicians, nominated by the San  
8 Francisco Medical Society, or any successor organization.

9 (F) One member shall be nominated by the San Francisco Labor  
10 Council, or any successor organization.

11 (G) Two members shall be persons nominated by the ~~beneficiary~~  
12 ~~member advisory~~ committee of the health ~~authority~~, ~~at least one~~  
13 ~~of whom shall, at the time of appointment and during the person's~~  
14 ~~term, be a Medi-Cal beneficiary authority.~~ *Nominees of the member*  
15 *advisory committee shall be enrolled in any of the health insurance*  
16 *or health care coverage programs operated by the health authority*  
17 *or be the parent or legal guardian of an enrollee in any of the*  
18 *health insurance or health care coverage programs operated by*  
19 *the health authority.*

20 (H) Two members shall be persons knowledgeable in matters  
21 relating to either traditional safety net providers, health care  
22 organizations, the Medi-Cal program, or the activities of the health  
23 authority, nominated by the program committee of the health  
24 authority.

25 (I) One member shall be a person nominated by the San  
26 Francisco Pharmacy Leadership Group, or any successor  
27 organization.

28 (2) One member, selected to fulfill the appointments specified  
29 in subparagraph (A), (G), or (H) shall, in addition to representing  
30 his or her specified organization or employer, represent the  
31 discipline of nursing, and shall possess or be qualified to possess  
32 a registered nursing license.

33 (3) The initial members appointed by the board under the  
34 subdivision shall be, to the extent those individuals meet the  
35 qualifications set forth in this subdivision and are willing to serve,  
36 those persons who are members of the steering committee created  
37 by the county to develop the local initiative component of the  
38 Medi-Cal state plan in San Francisco. Following the initial  
39 staggering of terms, each of those members shall be appointed to  
40 a term of three years, except the member appointed pursuant to

1 subparagraph (A) of paragraph (1), who shall serve at the pleasure  
2 of the board. At the first meeting of the governing body, the  
3 members appointed pursuant to this subdivision shall draw lots to  
4 determine seven members whose initial terms shall be for two  
5 years. Each member shall remain in office at the conclusion of  
6 that member's term until a successor member has been nominated  
7 and appointed.

8 (l) In addition to the requirements of subdivision (k), one  
9 member of the governing body shall be appointed by the Mayor  
10 of the City of San Francisco to serve at the pleasure of the mayor,  
11 one member shall be the county's director of public health or  
12 designee, who shall serve at the pleasure of that director, one  
13 member shall be the Chancellor of the University of California at  
14 San Francisco or his or her designee, who shall serve at the pleasure  
15 of the chancellor, and one member shall be the county director of  
16 mental health or his or her designee, who shall serve at the pleasure  
17 of that director.

18 (m) There shall be one nonvoting member of the governing  
19 body who shall be appointed by, and serve at the pleasure of, the  
20 health commission of the county.

21 (n) Each person appointed to the governing body shall,  
22 throughout the member's term, either be a resident of the county  
23 or be employed within the geographic boundaries of the county.

24 (o) (1) The composition of the governing body and nomination  
25 process for appointment of its members shall be subject to  
26 alteration upon a two-thirds vote of the full membership of the  
27 governing body. This action shall be concurred in by a resolution  
28 or ordinance of the county.

29 (2) Notwithstanding paragraph (1), no alteration described in  
30 that paragraph shall cause the removal of a member prior to the  
31 expiration of that member's term.

32 (p) A majority of the members of the governing body shall  
33 constitute a quorum for the transaction of business, and all official  
34 acts of the governing body shall require the affirmative vote of a  
35 majority of the members present and voting. However, no official  
36 shall be approved with less than the affirmative vote of six  
37 members of the governing body, unless the number of members  
38 prohibited from voting because of conflicts of interest precludes  
39 adequate participation in the vote. The governing body may, by a  
40 two-thirds vote adopt, amend, or repeal rules and procedures for

1 the governing body. Those rules and procedures may require that  
2 certain decisions be made by a vote that is greater than a majority  
3 vote.

4 (q) For purposes of Section 87103 of the Government Code,  
5 members appointed pursuant to subparagraphs (B) to (E), inclusive,  
6 of paragraph (1) of subdivision (k) represent, and are appointed  
7 to represent, respectively, the hospitals, private nonprofit  
8 community clinics, and physicians that contract with the health  
9 authority, or the health care service plan with which the health  
10 authority contracts, to provide health care services to the enrollees  
11 of the health authority or the health care service plan. Members  
12 appointed pursuant to subparagraphs (F) and (G) of paragraph (1)  
13 of subdivision (k) represent, and are appointed to represent,  
14 respectively, the health care workers and enrollees served by the  
15 health authority or its contracted health care service plan, and  
16 traditional safety net and ancillary providers and other  
17 organizations concerned with the activities of the health authority.

18 (r) A member of the governing body may be removed from  
19 office by the board by resolution or ordinance, only upon the  
20 recommendation of the health authority, and for any of the  
21 following reasons:

22 (1) Failure to retain the qualifications for appointment specified  
23 in subdivisions (k) and (n).

24 (2) Death or a disability that substantially interferes with the  
25 member's ability to carry out the duties of office.

26 (3) Conviction of any felony or a crime involving corruption.

27 (4) Failure of the member to discharge legal obligations as a  
28 member of a public agency.

29 (5) Substantial failure to perform the duties of office, including,  
30 but not limited to, unreasonable absence from meetings. The failure  
31 to attend three meetings in a row of the governing body, or a  
32 majority of the meetings in the most recent calendar year, may be  
33 deemed to be unreasonable absence.

34 (s) Any vacancy on the governing body, however created, shall  
35 be filled for the unexpired term by the board by resolution or  
36 ordinance. Each vacancy shall be filled by an individual having  
37 the qualifications of his or her predecessor, nominated as set forth  
38 in subdivision (k).

39 (t) The chair of the authority shall be selected by, and serve at  
40 the pleasure of, the governing body.

1 (u) The health authority shall establish all of the following:

2 (1) A ~~beneficiary~~ *member advisory* committee to advise the  
3 health authority on issues of concern to the recipients of services.

4 (2) A program committee to advise the health authority on  
5 matters relating to traditional safety net providers, ancillary  
6 providers, and other organizations concerned with the activities  
7 of the health authority.

8 (3) Any other committees determined to be advisable by the  
9 health authority.

10 (v) (1) Notwithstanding any provision of state or local law,  
11 including, but not limited to, the county charter, a member of the  
12 health authority shall not be deemed to be interested in a contract  
13 entered into by the authority within the meaning of Article 4  
14 (commencing with Section 1090) of Chapter 1 of Division 4 of  
15 Title 1 of the Government Code, or within the meaning of  
16 conflict-of-interest restrictions in the county charter, if all of the  
17 following apply:

18 (A) The member does not influence or attempt to influence the  
19 health authority or another member of the health authority to enter  
20 into the contract in which the member is interested.

21 (B) The member discloses the interest to the health authority  
22 and abstains from voting on the contract.

23 (C) The health authority notes the member's disclosure and  
24 abstention in its official records and authorizes the contract in good  
25 faith by a vote of its membership sufficient for the purpose without  
26 counting the vote of the interested member.

27 (D) The member has an interest in or was appointed to represent  
28 the interests of physicians, health care practitioners, hospitals,  
29 pharmacies, or other health care organizations.

30 (E) The contract authorizes the member or the organization the  
31 member has an interest in or represents to provide services to  
32 beneficiaries under the authority's program or administrative  
33 services to the authority.

34 (2) In addition, no person serving as a member of the governing  
35 body shall, by virtue of that membership, be deemed to be engaged  
36 in activities that are inconsistent, incompatible, or in conflict with  
37 their duties as an officer or employee of the county or the  
38 University of California, or as an officer or an employee of any  
39 private hospital, clinic, or other health care organization. The

1 membership shall not be deemed to be in violation of Section 1126  
2 of the Government Code.

3 (w) Notwithstanding any other provision of law, those records  
4 of the health authority and of the county that reveal the authority's  
5 rates of payment for health care services or the health authority's  
6 deliberative processes, discussions, communications, or any other  
7 portion of the negotiations with providers of health care services  
8 for rates of payment, or the health authority's peer review  
9 proceedings shall not be required to be disclosed pursuant to the  
10 California Public Records Act (Chapter 3.5 (commencing with  
11 Section 6250) of Division 7 of Title 1 of the Government Code),  
12 or any similar local law requiring the disclosure of public records.  
13 However, three years after a contract or amendment to a contract  
14 is fully executed, the portion of the contract or amendment  
15 containing the rates of payment shall be open to inspection.

16 (x) Notwithstanding any other provision of law, the health  
17 authority may meet in closed session to consider and take action  
18 on peer review proceedings and on matters pertaining to contracts  
19 and contract negotiations by the health authority's staff with  
20 providers of health care services concerning all matters relating  
21 to rates of payment. However, a decision as to whether to enter  
22 into, amend the services provisions of, or terminate, other than for  
23 reasons based upon peer review, a contract with a provider of  
24 health care services, shall be made in open session.

25 (y) (1) (A) Notwithstanding the Ralph M. Brown Act (Chapter  
26 9 (commencing with Section 54950) of Part 1 of Division 2 of  
27 Title 5 of the Government Code), the governing board of the health  
28 authority may meet in closed session for the purpose of discussion  
29 of, or taking action on matters involving, health authority trade  
30 secrets.

31 (B) The requirement that the authority make a public report of  
32 actions taken in closed session and the vote or abstention of every  
33 member present may be limited to a brief general description of  
34 the action taken and the vote so as to prevent the disclosure of a  
35 trade secret.

36 (C) For purposes of this subdivision, "health authority trade  
37 secret" means a trade secret, as defined in subdivision (d) of  
38 Section 3426.1 of the Civil Code, that also meets both of the  
39 following criteria:

1 (i) The secrecy of the information is necessary for the health  
2 authority to initiate a new service, program, marketing strategy,  
3 business plan, or technology, or to add a benefit or product.

4 (ii) Premature disclosure of the trade secret would create a  
5 substantial probability of depriving the health authority of a  
6 substantial economic benefit or opportunity.

7 (2) Those records of the health authority that reveal the health  
8 authority's trade secrets are exempt from disclosure pursuant to  
9 the California Public Records Act (Chapter 3.5 (commencing with  
10 Section 6250) of Division 7 of Title 1 of the Government Code),  
11 or any similar local law requiring the disclosure of public records.  
12 This exemption shall apply for a period of two years after the  
13 service, program, marketing strategy, business plan, technology,  
14 benefit, or product that is the subject of the trade secret is formally  
15 adopted by the governing body of the health authority, provided  
16 that the service, program, marketing strategy, business plan,  
17 technology, benefit, or product continues to be a trade secret. The  
18 governing board may delete the portion or portions containing  
19 trade secrets from any documents that were finally approved in  
20 the closed session held pursuant to this subdivision that are  
21 provided to persons who have made the timely or standing request.

22 (z) The health authority shall be deemed to be a public agency  
23 for purposes of all grant programs and other funding and loan  
24 guarantee programs.

25 (aa) Contracts under this article between the State Department  
26 of Health Services and the health authority shall be on a nonbid  
27 basis and shall be exempt from Chapter 2 (commencing with  
28 Section 10290) of Part 2 of Division 2 of the Public Contract Code.

29 (ab) (1) The county controller or his or her designee, at intervals  
30 the county controller deems appropriate, shall conduct a review  
31 of the fiscal condition of the health authority, shall report the  
32 findings to the health authority and the board, and shall provide a  
33 copy of the findings to any public agency upon request.

34 (2) Upon the written request of the county controller, the health  
35 authority shall provide full access to the county controller all health  
36 authority records and documents as necessary to allow the county  
37 controller or designee to perform the activities authorized by this  
38 subdivision.

1 (ac) A Medi-Cal recipient receiving services through the health  
2 authority shall be deemed to be a subscriber or enrollee for  
3 purposes of Section 1379 of the Health and Safety Code.

4 ~~SEC. 23.~~

5 *SEC. 26.* Section 14105.192 of the Welfare and Institutions  
6 Code is amended to read:

7 14105.192. (a) The Legislature finds and declares the  
8 following:

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

13 (2) In order to minimize the need for drastically cutting  
14 enrollment standards or benefits during times of economic crisis,  
15 it is crucial to find areas within the program where reimbursement  
16 levels are higher than required under the standard provided in  
17 Section 1902(a)(30)(A) of the federal Social Security Act and can  
18 be reduced in accordance with federal law.

19 (3) The Medi-Cal program delivers its services and benefits to  
20 Medi-Cal beneficiaries through a wide variety of health care  
21 providers, some of which deliver care via managed care or other  
22 contract models while others do so through fee-for-service  
23 arrangements.

24 (4) The setting of rates within the Medi-Cal program is complex  
25 and is subject to close supervision by the United States Department  
26 of Health and Human Services.

27 (5) As the single state agency for Medicaid in California, the  
28 department has unique expertise that can inform decisions that set  
29 or adjust reimbursement methodologies and levels consistent with  
30 the requirements of federal law.

31 (b) Therefore, it is the intent of the Legislature for the  
32 department to analyze and identify where reimbursement levels  
33 can be reduced consistent with the standard provided in Section  
34 1902(a)(30)(A) of the federal Social Security Act and consistent  
35 with federal and state law and policies, including any exemptions  
36 contained in the provisions of the act that added this section,  
37 provided that the reductions in reimbursement shall not exceed 10  
38 percent on an aggregate basis for all providers, services and  
39 products.

1 (c) Notwithstanding any other provision of law, the director  
2 shall adjust provider payments, as specified in this section.

3 (d) (1) Except as otherwise provided in this section, payments  
4 shall be reduced by 10 percent for Medi-Cal fee-for-service benefits  
5 for dates of service on and after June 1, 2011.

6 (2) For managed health care plans that contract with the  
7 department pursuant to this chapter or Chapter 8 (commencing  
8 with Section 14200), except contracts with Senior Care Action  
9 Network and AIDS Healthcare Foundation, payments shall be  
10 reduced by the actuarial equivalent amount of the payment  
11 reductions specified in this section pursuant to contract  
12 amendments or change orders effective on July 1, 2011, or  
13 thereafter.

14 (3) Payments shall be reduced by 10 percent for non-Medi-Cal  
15 programs described in Article 6 (commencing with Section 124025)  
16 of Chapter 3 of Part 2 of Division 106 of the Health and Safety  
17 Code, and Section 14105.18, for dates of service on and after June  
18 1, 2011. This paragraph shall not apply to inpatient hospital  
19 services provided in a hospital that is paid under contract pursuant  
20 to Article 2.6 (commencing with Section 14081).

21 (4) (A) Notwithstanding any other provision of law, the director  
22 may adjust the payments specified in paragraphs (1) and (3) of  
23 this subdivision with respect to one or more categories of Medi-Cal  
24 providers, or for one or more products or services rendered, or any  
25 combination thereof, so long as the resulting reductions to any  
26 category of Medi-Cal providers, in the aggregate, total no more  
27 than 10 percent.

28 (B) The adjustments authorized in subparagraph (A) shall be  
29 implemented only if the director determines that, for each affected  
30 product, service, or provider category, the payments resulting from  
31 the adjustment comply with subdivision (m).

32 (e) Notwithstanding any other provision of this section,  
33 payments to hospitals that are not under contract with the State  
34 Department of Health Care Services pursuant to Article 2.6  
35 (commencing with Section 14081) for inpatient hospital services  
36 provided to Medi-Cal beneficiaries and that are subject to Section  
37 14166.245 shall be governed by that section.

38 (f) Notwithstanding any other provision of this section, the  
39 following shall apply:

1 (1) Payments to providers that are paid pursuant to Article 3.8  
2 (commencing with Section 14126) shall be governed by that article.

3 (2) (A) Subject to subparagraph (B), for dates of service on and  
4 after June 1, 2011, Medi-Cal reimbursement rates for intermediate  
5 care facilities for the developmentally disabled licensed pursuant  
6 to subdivision (e), (g), or (h) of Section 1250 of the Health and  
7 Safety Code, and facilities providing continuous skilled nursing  
8 care to developmentally disabled individuals pursuant to the pilot  
9 project established by Section 14132.20, as determined by the  
10 applicable methodology for setting reimbursement rates for these  
11 facilities, shall not exceed the reimbursement rates that were  
12 applicable to providers in the 2008–09 rate year.

13 (B) (i) If Section 14105.07 is added to the Welfare and  
14 Institutions Code during the 2011–12 Regular Session of the  
15 Legislature, subparagraph (A) shall become inoperative.

16 (ii) If Section 14105.07 is added to the Welfare and Institutions  
17 Code during the 2011–12 Regular Session of the Legislature, then  
18 for dates of service on and after June 1, 2011, payments to  
19 intermediate care facilities for the developmentally disabled  
20 licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of  
21 the Health and Safety Code, and facilities providing continuous  
22 skilled nursing care to developmentally disabled individuals  
23 pursuant to the pilot project established by Section 14132.20, shall  
24 be governed by the applicable methodology for setting  
25 reimbursement rates for these facilities and by Section 14105.07.

26 (g) The department may enter into contracts with a vendor for  
27 the purposes of implementing this section on a bid or nonbid basis.  
28 In order to achieve maximum cost savings, the Legislature declares  
29 that an expedited process for contracts under this subdivision is  
30 necessary. Therefore, contracts entered into to implement this  
31 section and all contract amendments and change orders shall be  
32 exempt from Chapter 2 (commencing with Section 10290) of Part  
33 2 Division 2 of the Public Contract Code.

34 (h) To the extent applicable, the services, facilities, and  
35 payments listed in this subdivision shall be exempt from the  
36 payment reductions specified in subdivision (d) as follows:

37 (1) Acute hospital inpatient services that are paid under contracts  
38 pursuant to Article 2.6 (commencing with Section 14081).

39 (2) Federally qualified health center services, including those  
40 facilities deemed to have federally qualified health center status

- 1 pursuant to a waiver pursuant to subsection (a) of Section 1115 of  
2 the federal Social Security Act (42 U.S.C. Sec. 1315(a)).
- 3 (3) Rural health clinic services.
- 4 (4) Payments to facilities owned or operated by the State  
5 Department of State Hospitals or the State Department of  
6 Developmental Services.
- 7 (5) Hospice services.
- 8 (6) Contract services, as designated by the director pursuant to  
9 subdivision (k).
- 10 (7) Payments to providers to the extent that the payments are  
11 funded by means of a certified public expenditure or an  
12 intergovernmental transfer pursuant to Section 433.51 of Title 42  
13 of the Code of Federal Regulations. This paragraph shall apply to  
14 payments described in paragraph (3) of subdivision (d) only to the  
15 extent that they are also exempt from reduction pursuant to  
16 subdivision (l).
- 17 (8) Services pursuant to local assistance contracts and  
18 interagency agreements to the extent the funding is not included  
19 in the funds appropriated to the department in the annual Budget  
20 Act.
- 21 (9) Breast and cervical cancer treatment provided pursuant to  
22 Section 14007.71 and as described in paragraph (3) of subdivision  
23 (a) of Section 14105.18 or Article 1.5 (commencing with Section  
24 104160) of Chapter 2 of Part 1 of Division 103 of the Health and  
25 Safety Code.
- 26 (10) The Family Planning, Access, Care, and Treatment (Family  
27 PACT) Program pursuant to subdivision (aa) of Section 14132.
- 28 (i) Subject to the exception for services listed in subdivision  
29 (h), the payment reductions required by subdivision (d) shall apply  
30 to the benefits rendered by any provider who may be authorized  
31 to bill for the service, including, but not limited to, physicians,  
32 podiatrists, nurse practitioners, certified nurse-midwives, nurse  
33 anesthetists, and organized outpatient clinics.
- 34 (j) Notwithstanding any other provision of law, for dates of  
35 service on and after June 1, 2011, Medi-Cal reimbursement rates  
36 applicable to the following classes of providers shall not exceed  
37 the reimbursement rates that were applicable to those classes of  
38 providers in the 2008–09 rate year, as described in subdivision (f)  
39 of Section 14105.191, reduced by 10 percent:

1 (1) Intermediate care facilities, excluding those facilities  
2 identified in paragraph (2) of subdivision (f). For purposes of this  
3 section, “intermediate care facility” has the same meaning as  
4 defined in Section 51118 of Title 22 of the California Code of  
5 Regulations.

6 (2) Skilled nursing facilities that are distinct parts of general  
7 acute care hospitals. For purposes of this section, “distinct part”  
8 has the same meaning as defined in Section 72041 of Title 22 of  
9 the California Code of Regulations.

10 (3) Rural swing-bed facilities.

11 (4) Subacute care units that are, or are parts of, distinct parts of  
12 general acute care hospitals. For purposes of this subparagraph,  
13 “subacute care unit” has the same meaning as defined in Section  
14 51215.5 of Title 22 of the California Code of Regulations.

15 (5) Pediatric subacute care units that are, or are parts of, distinct  
16 parts of general acute care hospitals. For purposes of this  
17 subparagraph, “pediatric subacute care unit” has the same meaning  
18 as defined in Section 51215.8 of Title 22 of the California Code  
19 of Regulations.

20 (6) Adult day health care centers.

21 (7) Freestanding pediatric subacute care units, as defined in  
22 Section 51215.8 of Title 22 of the California Code of Regulations.

23 (k) 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 may implement and administer this section by  
26 means of provider bulletins or similar instructions, without taking  
27 regulatory action.

28 (l) The reductions described in this section shall apply only to  
29 payments for services when the General Fund share of the payment  
30 is paid with funds directly appropriated to the department in the  
31 annual Budget Act and shall not apply to payments for services  
32 paid with funds appropriated to other departments or agencies.

33 (m) Notwithstanding any other provision of this section, the  
34 payment reductions and adjustments provided for in subdivision  
35 (d) shall be implemented only if the director determines that the  
36 payments that result from the application of this section will  
37 comply with applicable federal Medicaid requirements and that  
38 federal financial participation will be available.

39 (1) In determining whether federal financial participation is  
40 available, the director shall determine whether the payments

1 comply with applicable federal Medicaid requirements, including  
2 those set forth in Section 1396a(a)(30)(A) of Title 42 of the United  
3 States Code.

4 (2) To the extent that the director determines that the payments  
5 do not comply with the federal Medicaid requirements or that  
6 federal financial participation is not available with respect to any  
7 payment that is reduced pursuant to this section, the director retains  
8 the discretion to not implement the particular payment reduction  
9 or adjustment and may adjust the payment as necessary to comply  
10 with federal Medicaid requirements.

11 (n) The department shall seek any necessary federal approvals  
12 for the implementation of this section.

13 (o) (1) The payment reductions and adjustments set forth in  
14 this section shall not be implemented until federal approval is  
15 obtained.

16 (2) To the extent that federal approval is obtained for one or  
17 more of the payment reductions and adjustments in this section  
18 and Section 14105.07, the payment reductions and adjustments  
19 set forth in Section 14105.191 shall cease to be implemented for  
20 the same services provided by the same class of providers. In the  
21 event of a conflict between this section and Section 14105.191,  
22 other than the provisions setting forth a payment reduction or  
23 adjustment, this section shall govern.

24 (3) When federal approval is obtained, the payments resulting  
25 from the application of this section shall be implemented  
26 retroactively to June 1, 2011, or on any other date or dates as may  
27 be applicable.

28 (4) The director may clarify the application of this subdivision  
29 by means of provider bulletins or similar instructions, pursuant to  
30 subdivision (k).

31 (p) Adjustments to pharmacy drug product payment pursuant  
32 to this section shall no longer apply when the department  
33 determines that the average acquisition cost methodology pursuant  
34 to Section 14105.45 has been fully implemented and the  
35 department’s pharmacy budget reduction targets, consistent with  
36 payment reduction levels pursuant to this section, have been met.

37 *SEC. 27. Section 14124.5 of the Welfare and Institutions Code*  
38 *is amended to read:*

39 14124.5. (a) The director may, in accordance with ~~the~~  
40 ~~provisions of~~ Section 10725, adopt, amend, or repeal, in accordance

1 with Chapter ~~4.5~~ 3.5 (commencing with Section ~~11371~~ 11340)  
2 of Part 1; of Division 3; of Title 2 of the Government Code, such  
3 reasonable rules and regulations as may be necessary or proper to  
4 carry out the purposes and intent of this chapter, and to enable ~~it~~  
5 *the department* to exercise the powers and perform the duties  
6 conferred upon it by this chapter, not inconsistent with any ~~of the~~  
7 ~~provisions of any~~ statute of this state.

8 (b) All regulations ~~heretofore~~ *previously* adopted by the State  
9 Department of Health *Care Services* or any predecessor department  
10 pursuant to this chapter and in effect immediately preceding the  
11 operative date of this section, shall remain in effect and shall be  
12 fully enforceable unless and until readopted, amended, or repealed  
13 by the director in accordance with ~~the provisions of~~ Section 10725.

14 ~~SEC. 24.~~

15 *SEC. 28.* Section 14169.51 of the Welfare and Institutions  
16 Code is amended to read:

17 14169.51. For purposes of this article, the following definitions  
18 shall apply:

19 (a) “Acute psychiatric days” means the total number of Medi-Cal  
20 specialty mental health service administrative days, Medi-Cal  
21 specialty mental health service acute care days, acute psychiatric  
22 administrative days, and acute psychiatric acute days identified in  
23 the Final Medi-Cal Utilization Statistics for the state fiscal year  
24 preceding the rebase calculation year as calculated by the  
25 department as of the retrieval date.

26 (b) “Acute psychiatric per diem supplemental rate” means a  
27 fixed per diem supplemental payment for acute psychiatric days.

28 (c) “Annual fee-for-service days” means the number of  
29 fee-for-service days of each hospital subject to the quality assurance  
30 fee, as reported on the days data source.

31 (d) “Annual managed care days” means the number of managed  
32 care days of each hospital subject to the quality assurance fee, as  
33 reported on the days data source.

34 (e) “Annual Medi-Cal days” means the number of Medi-Cal  
35 days of each hospital subject to the quality assurance fee, as  
36 reported on the days data source.

37 (f) “Base calendar year” means a calendar year that ends before  
38 a subject fiscal year begins, but no more than six years before a  
39 subject fiscal year begins. Beginning with the third program period,  
40 the department shall establish the base calendar year during the

1 rebase calculation year as the calendar year for which the most  
2 recent data is available that the department determines is reliable.

3 (g) “Converted hospital” means a private hospital that becomes  
4 a designated public hospital or a nondesignated public hospital on  
5 or after the first day of a program period.

6 (h) “Days data source” means either: (1) if a hospital’s Annual  
7 Financial Disclosure Report for its fiscal year ending in the base  
8 calendar year includes data for a full fiscal year of operation, the  
9 hospital’s Annual Financial Disclosure Report retrieved from the  
10 Office of Statewide Health Planning and Development as retrieved  
11 by the department on the retrieval date pursuant to Section  
12 14169.59, for its fiscal year ending in the base calendar year; or  
13 (2) if a hospital’s Annual Financial Disclosure Report for its fiscal  
14 year ending in the base calendar year includes data for more than  
15 one day, but less than a full year of operation, the department’s  
16 best and reasonable estimates of the hospital’s Annual Financial  
17 Disclosure Report if the hospital had operated for a full year.

18 (i) “Department” means the State Department of Health Care  
19 Services.

20 (j) “Designated public hospital” shall have the meaning given  
21 in subdivision (d) of Section 14166.1.

22 (k) “Director” means the Director of Health Care Services.

23 (l) “Exempt facility” means any of the following:

24 (1) A public hospital, which shall include either of the following:

25 (A) A hospital, as defined in paragraph (25) of subdivision (a)  
26 of Section 14105.98.

27 (B) A tax-exempt nonprofit hospital that is licensed under  
28 subdivision (a) of Section 1250 of the Health and Safety Code and  
29 operating a hospital owned by a local health care district, and is  
30 affiliated with the health care district hospital owner by means of  
31 the district’s status as the nonprofit corporation’s sole corporate  
32 member.

33 (2) With the exception of a hospital that is in the Charitable  
34 Research Hospital peer group, as set forth in the 1991 Hospital  
35 Peer Grouping Report published by the department, a hospital that  
36 is designated as a specialty hospital in the hospital’s most recently  
37 filed Office of Statewide Health Planning and Development  
38 Hospital Annual Financial Disclosure Report, as of the first day  
39 of a program period.

1 (3) A hospital that satisfies the Medicare criteria to be a  
2 long-term care hospital.

3 (4) A small and rural hospital as specified in Section 124840  
4 of the Health and Safety Code designated as that in the hospital's  
5 most recently filed Office of Statewide Health Planning and  
6 Development Hospital Annual Financial Disclosure Report, as of  
7 the first day of a program period.

8 (m) "Federal approval" means the approval by the federal  
9 government of both the quality assurance fee established pursuant  
10 to this article and the supplemental payments to private hospitals  
11 described pursuant to this article.

12 (n) "Fee-for-service per diem quality assurance fee rate" means  
13 a fixed fee on fee-for-service days.

14 (o) "Fee-for-service days" means inpatient hospital days as  
15 reported on the days data source where the service type is reported  
16 as "acute care," "psychiatric care," or "rehabilitation care," and  
17 the payer category is reported as "Medicare traditional," "county  
18 indigent programs-traditional," "other third parties-traditional,"  
19 "other indigent," or "other payers," for purposes of the Annual  
20 Financial Disclosure Report submitted by hospitals to the Office  
21 of Statewide Health Planning and Development.

22 (p) "Fund" means the Hospital Quality Assurance Revenue  
23 Fund established by Section 14167.35.

24 (q) "General acute care days" means the total number of  
25 Medi-Cal general acute care days, including well baby days, less  
26 any acute psychiatric inpatient days, paid by the department to a  
27 hospital for services in the base calendar year, as reflected in the  
28 state paid claims file on the retrieval date.

29 (r) "General acute care hospital" means any hospital licensed  
30 pursuant to subdivision (a) of Section 1250 of the Health and Safety  
31 Code.

32 (s) "General acute care per diem supplemental rate" means a  
33 fixed per diem supplemental payment for general acute care days.

34 (t) "High acuity days" means Medi-Cal coronary care unit days,  
35 pediatric intensive care unit days, intensive care unit days, neonatal  
36 intensive care unit days, and burn unit days paid by the department  
37 to a hospital for services in the base calendar year, as reflected in  
38 the state paid claims file prepared by the department on the retrieval  
39 date.

1 (u) “High acuity per diem supplemental rate” means a fixed per  
2 diem supplemental payment for high acuity days for specified  
3 hospitals in Section 14169.55.

4 (v) “High acuity trauma per diem supplemental rate” means a  
5 fixed per diem supplemental payment for high acuity days for  
6 specified hospitals in Section 14169.55 that have been designated  
7 as specified types of trauma hospitals.

8 (w) “Hospital community” includes, but is not limited to, the  
9 statewide hospital industry organization and systems representing  
10 general acute care hospitals.

11 (x) “Hospital inpatient services” means all services covered  
12 under Medi-Cal and furnished by hospitals to patients who are  
13 admitted as hospital inpatients and reimbursed on a fee-for-service  
14 basis by the department directly or through its fiscal intermediary.  
15 Hospital inpatient services include outpatient services furnished  
16 by a hospital to a patient who is admitted to that hospital within  
17 24 hours of the provision of the outpatient services that are related  
18 to the condition for which the patient is admitted. Hospital inpatient  
19 services do not include services for which a managed health care  
20 plan is financially responsible.

21 (y) “Hospital outpatient services” means all services covered  
22 under Medi-Cal furnished by hospitals to patients who are  
23 registered as hospital outpatients and reimbursed by the department  
24 on a fee-for-service basis directly or through its fiscal intermediary.  
25 Hospital outpatient services do not include services for which a  
26 managed health care plan is financially responsible, or services  
27 rendered by a hospital-based federally qualified health center for  
28 which reimbursement is received pursuant to Section 14132.100.

29 (z) “Managed care days” means inpatient hospital days as  
30 reported on the days data source where the service type is reported  
31 as “acute care,” “psychiatric care,” or “rehabilitation care,” and  
32 the payer category is reported as “Medicare managed care,”  
33 “county indigent programs-managed care,” or “other third  
34 parties-managed care,” for purposes of the Annual Financial  
35 Disclosure Report submitted by hospitals to the Office of Statewide  
36 Health Planning and Development.

37 (aa) “Managed care per diem quality assurance fee rate” means  
38 a fixed fee on managed care days.

39 (ab) (1) “Managed health care plan” means a health care  
40 delivery system that manages the provision of health care and

1 receives prepaid capitated payments from the state in return for  
2 providing services to Medi-Cal beneficiaries.

3 (2) (A) Managed health care plans include county organized  
4 health systems and entities contracting with the department to  
5 provide or arrange services for Medi-Cal beneficiaries pursuant  
6 to the two-plan model, geographic managed care, or regional  
7 managed care for the rural expansion. Entities providing these  
8 services contract with the department pursuant to any of the  
9 following:

10 (i) Article 2.7 (commencing with Section 14087.3).

11 (ii) Article 2.8 (commencing with Section 14087.5).

12 (iii) Article 2.81 (commencing with Section 14087.96).

13 (iv) Article 2.82 (commencing with Section 14087.98).

14 (v) Article 2.91 (commencing with Section 14089).

15 (B) Managed health care plans do not include any of the  
16 following:

17 (i) Mental health plans contracting to provide mental health care  
18 for Medi-Cal beneficiaries pursuant to Chapter 8.9 (commencing  
19 with Section 14700).

20 (ii) Health plans not covering inpatient services such as primary  
21 care case management plans operating pursuant to Section  
22 14088.85.

23 (iii) Program for All-Inclusive Care for the Elderly organizations  
24 operating pursuant to Chapter 8.75 (commencing with Section  
25 14591).

26 (ac) “Medi-Cal days” means inpatient hospital days as reported  
27 on the days data source where the service type is reported as “acute  
28 care,” “psychiatric care,” or “rehabilitation care,” and the payer  
29 category is reported as “Medi-Cal traditional” or “Medi-Cal  
30 managed care,” for purposes of the Annual Financial Disclosure  
31 Report submitted by hospitals to the Office of Statewide Health  
32 Planning and Development.

33 (ad) “Medi-Cal fee-for-service days” means inpatient hospital  
34 days as reported on the days data source where the service type is  
35 reported as “acute care,” “psychiatric care,” or “rehabilitation  
36 care,” and the payer category is reported as “Medi-Cal traditional”  
37 for purposes of the Annual Financial Disclosure Report submitted  
38 by hospitals to the Office of Statewide Health Planning and  
39 Development.

1 (ae) “Medi-Cal managed care days” means the total number of  
2 general acute care days, including well baby days, listed for the  
3 county organized health system and prepaid health plans identified  
4 in the Final Medi-Cal Utilization Statistics for the state fiscal year  
5 preceding the rebase calculation year, as calculated by the  
6 department as of the retrieval date.

7 (af) “Medi-Cal managed care fee days” means inpatient hospital  
8 days as reported on the days data source where the service type is  
9 reported as “acute care,” “psychiatric care,” or “rehabilitation  
10 care,” and the payer category is reported as “Medi-Cal managed  
11 care” for purposes of the Annual Financial Disclosure Report  
12 submitted by hospitals to the Office of Statewide Health Planning  
13 and Development.

14 (ag) “Medi-Cal per diem quality assurance fee rate” means a  
15 fixed fee on Medi-Cal days.

16 (ah) “Medicaid inpatient utilization rate” means Medicaid  
17 inpatient utilization rate as defined in Section 1396r-4 of Title 42  
18 of the United States Code and as set forth in the Final Medi-Cal  
19 Utilization Statistics for the state fiscal year preceding the rebase  
20 calculation year, as calculated by the department as of the retrieval  
21 date.

22 (ai) “New hospital” means a hospital operation, business, or  
23 facility functioning under current or prior ownership as a private  
24 hospital that does not have a days data source or a hospital that  
25 has a days data source in whole, or in part, from a previous operator  
26 where there is an outstanding monetary obligation owed to the  
27 state in connection with the Medi-Cal program and the hospital is  
28 not, or does not agree to become, financially responsible to the  
29 department for the outstanding monetary obligation in accordance  
30 with subdivision (d) of Section 14169.61.

31 (aj) “Nondesignated public hospital” means either of the  
32 following:

33 (1) A public hospital that is licensed under subdivision (a) of  
34 Section 1250 of the Health and Safety Code, is not designated as  
35 a specialty hospital in the hospital’s most recently filed Annual  
36 Financial Disclosure Report, as of the first day of a program period,  
37 and satisfies the definition in paragraph (25) of subdivision (a) of  
38 Section 14105.98, excluding designated public hospitals.

39 (2) A tax-exempt nonprofit hospital that is licensed under  
40 subdivision (a) of Section 1250 of the Health and Safety Code, is

1 not designated as a specialty hospital in the hospital’s most recently  
2 filed Annual Financial Disclosure Report, as of the first day of a  
3 program period, is operating a hospital owned by a local health  
4 care district, and is affiliated with the health care district hospital  
5 owner by means of the district’s status as the nonprofit  
6 corporation’s sole corporate member.

7 (ak) “Outpatient base amount” means the total amount of  
8 payments for hospital outpatient services made to a hospital in the  
9 base calendar year, as reflected in the state paid claims files  
10 prepared by the department as of the retrieval date.

11 (al) “Outpatient supplemental rate” means a fixed proportional  
12 supplemental payment for Medi-Cal outpatient services.

13 (am) “Prepaid health plan hospital” means a hospital owned by  
14 a nonprofit public benefit corporation that shares a common board  
15 of directors with a nonprofit health care service plan, which  
16 exclusively contracts with no more than two medical groups in the  
17 state to provide or arrange for professional medical services for  
18 the enrollees of the plan, as of the effective date of this article.

19 (an) “Prepaid health plan hospital managed care per diem quality  
20 assurance fee rate” means a fixed fee on non-Medi-Cal managed  
21 care fee days for prepaid health plan hospitals.

22 (ao) “Prepaid health plan hospital Medi-Cal managed care per  
23 diem quality assurance fee rate” means a fixed fee on Medi-Cal  
24 managed care fee days for prepaid health plan hospitals.

25 (ap) “Private hospital” means a hospital that meets all of the  
26 following conditions:

27 (1) Is licensed pursuant to subdivision (a) of Section 1250 of  
28 the Health and Safety Code.

29 (2) Is in the Charitable Research Hospital peer group, as set  
30 forth in the 1991 Hospital Peer Grouping Report published by the  
31 department, or is not designated as a specialty hospital in the  
32 hospital’s most recently filed Office of Statewide Health Planning  
33 and Development Annual Financial Disclosure Report, as of the  
34 first day of a program period.

35 (3) Does not satisfy the Medicare criteria to be classified as a  
36 long-term care hospital.

37 (4) Is a nonpublic hospital, nonpublic converted hospital, or  
38 converted hospital as those terms are defined in paragraphs (26)  
39 to (28), inclusive, respectively, of subdivision (a) of Section  
40 14105.98.

1 (5) Is not a nondesignated public hospital or a designated public  
2 hospital.

3 (aq) “Program period” means a period not to exceed three years  
4 during which a fee model and a supplemental payment model  
5 developed under this article shall be effective. The first program  
6 period shall be the period beginning January 1, 2014, and ending  
7 December 31, 2016, inclusive. The second program period shall  
8 be the period beginning on January 1, 2017, and ending June 30,  
9 2019. Each subsequent program period shall begin on the day  
10 immediately following the last day of the immediately preceding  
11 program period and shall end on the last day of a state fiscal year,  
12 as determined by the department.

13 (ar) “Quality assurance fee” means the quality assurance fee  
14 assessed pursuant to Section 14169.52 and collected on the basis  
15 of the quarterly quality assurance fee.

16 (as) (1) “Quarterly quality assurance fee” means, with respect  
17 to a hospital that is not a prepaid health plan hospital, the sum of  
18 all of the following:

19 (A) The annual fee-for-service days for an individual hospital  
20 multiplied by the fee-for-service per diem quality assurance fee  
21 rate, divided by four.

22 (B) The annual managed care days for an individual hospital  
23 multiplied by the managed care per diem quality assurance fee  
24 rate, divided by four.

25 (C) The annual Medi-Cal days for an individual hospital  
26 multiplied by the Medi-Cal per diem quality assurance fee rate,  
27 divided by four.

28 (2) “Quarterly quality assurance fee” means, with respect to a  
29 hospital that is a prepaid health plan hospital, the sum of all of the  
30 following:

31 (A) The annual fee-for-service days for an individual hospital  
32 multiplied by the fee-for-service per diem quality assurance fee  
33 rate, divided by four.

34 (B) The annual managed care days for an individual hospital  
35 multiplied by the prepaid health plan hospital managed care per  
36 diem quality assurance fee rate, divided by four.

37 (C) The annual Medi-Cal managed care fee days for an  
38 individual hospital multiplied by the prepaid health plan hospital  
39 Medi-Cal managed care per diem quality assurance fee rate, divided  
40 by four.

1 (D) The annual Medi-Cal fee-for-service days for an individual  
2 hospital multiplied by the Medi-Cal per diem quality assurance  
3 fee rate, divided by four.

4 (at) “Rebase calculation year” means a state fiscal year during  
5 which the department shall rebase the data, including, but not  
6 limited to, the days data source, used for the following: acute  
7 psychiatric days, annual fee-for-service days, annual managed care  
8 days, annual Medi-Cal days, fee-for-service days, general acute  
9 care days, high acuity days, managed care days, Medi-Cal days,  
10 Medi-Cal fee-for-service days, Medi-Cal managed care days,  
11 Medi-Cal managed care fee days, outpatient base amount, and  
12 transplant days, pursuant to Section 14169.59. Beginning with the  
13 third program period, the rebase calculation year for a program  
14 period shall be the last subject fiscal year of the immediately  
15 preceding program period.

16 (au) “Rebase year” means the first state fiscal year of a program  
17 period and shall immediately follow a rebase calculation year.

18 (av) “Retrieval date” means a day for each data element during  
19 the last quarter of the rebase calculation year upon which the  
20 department retrieves the data, including, but not limited to, the  
21 days data source, used for the following: acute psychiatric days,  
22 annual fee-for-service days, annual managed care days, annual  
23 Medi-Cal days, fee-for-service days, general acute care days, high  
24 acuity days, managed care days, Medi-Cal days, Medi-Cal  
25 fee-for-service days, Medi-Cal managed care days, Medi-Cal  
26 managed care fee days, outpatient base amount, and transplant  
27 days, pursuant to Section 14169.59. The retrieval date for each  
28 data element may be a different date within the quarter as  
29 determined to be necessary and appropriate by the department.

30 (aw) “Subacute supplemental rate” means a fixed proportional  
31 supplemental payment for acute inpatient services based on a  
32 hospital’s prior provision of Medi-Cal subacute services.

33 (ax) “Subject fiscal quarter” means a state fiscal quarter  
34 beginning on or after the first day of a program period and ending  
35 on or before the last day of a program period.

36 (ay) “Subject fiscal year” means a state fiscal year beginning  
37 on or after the first day of a program period and ending on or before  
38 the last day of a program period.

1 (az) “Subject month” means a calendar month beginning on or  
2 after the first day of a program period and ending on or before the  
3 last day of a program period.

4 (ba) “Transplant days” means the number of Medi-Cal days for  
5 Medicare Severity-Diagnosis Related Groups (MS-DRGs) 1, 2, 5  
6 to 10, inclusive, 14, 15, or 652, according to the Patient Discharge  
7 file from the Office of Statewide Health Planning and Development  
8 for the base calendar year accessed on the retrieval date.

9 (bb) “Transplant per diem supplemental rate” means a fixed per  
10 diem supplemental payment for transplant days.

11 (bc) “Upper payment limit” means a federal upper payment  
12 limit on the amount of the Medicaid payment for which federal  
13 financial participation is available for a class of service and a class  
14 of health care providers, as specified in Part 447 of Title 42 of the  
15 Code of Federal Regulations. The applicable upper payment limit  
16 shall be separately calculated for inpatient and outpatient hospital  
17 services.

18 ~~SEC. 25.~~

19 SEC. 29. Section 14169.52 of the Welfare and Institutions  
20 Code is amended to read:

21 14169.52. (a) There shall be imposed on each general acute  
22 care hospital that is not an exempt facility a quality assurance fee,  
23 except that a quality assurance fee under this article shall not be  
24 imposed on a converted hospital for the periods when the hospital  
25 is a public hospital or a new hospital with respect to a program  
26 period.

27 (b) The department shall compute the quarterly quality assurance  
28 fee for each subject fiscal year during a program period pursuant  
29 to Section 14169.59.

30 (c) Subject to Section 14169.63, on the later of the date of the  
31 department’s receipt of federal approval or the first day of each  
32 program period, the following shall commence:

33 (1) Within 10 business days following receipt of the notice of  
34 federal approval, the department shall send notice to each hospital  
35 subject to the quality assurance fee, which shall contain the  
36 following information:

37 (A) The date that the state received notice of federal approval.

38 (B) The quarterly quality assurance fee for each subject fiscal  
39 year.

40 (C) The date on which each payment is due.

1 (2) The hospitals shall pay the quarterly quality assurance fee,  
2 based on a schedule developed by the department. The department  
3 shall establish the date that each payment is due, provided that the  
4 first payment shall be due no earlier than 20 days following the  
5 department sending the notice pursuant to paragraph (1), and the  
6 payments shall be paid at least one month apart, but if possible,  
7 the payments shall be paid on a quarterly basis.

8 (3) Notwithstanding any other provision of this section, the  
9 amount of each hospital's quarterly quality assurance fee for a  
10 program period that has not been paid by the hospital before 15  
11 days prior to the end of a program period shall be paid by the  
12 hospital no later than 15 days prior to the end of a program period.

13 (4) Each hospital described in subdivision (a) shall pay the  
14 quarterly quality assurance fees that are due, if any, in the amounts  
15 and at the times set forth in the notice unless superseded by a  
16 subsequent notice from the department.

17 (d) The quality assurance fee, as assessed pursuant to this  
18 section, shall be paid by each hospital subject to the fee to the  
19 department for deposit in the fund. Deposits may be accepted at  
20 any time and shall be credited toward the program period for which  
21 the fees were assessed. This article shall not affect the ability of a  
22 hospital to pay fees assessed for a program period after the end of  
23 that program period.

24 (e) This section shall become inoperative if the federal Centers  
25 for Medicare and Medicaid Services denies approval for, or does  
26 not approve before December 1, 2016, the implementation of the  
27 quality assurance fee pursuant to this article or the supplemental  
28 payments to private hospitals pursuant to this article for the first  
29 program period.

30 (f) In no case shall the aggregate fees collected in a federal fiscal  
31 year pursuant to this section, former Section 14167.32, Section  
32 14168.32, and Section 14169.32 exceed the maximum percentage  
33 of the annual aggregate net patient revenue for hospitals subject  
34 to the fee that is prescribed pursuant to federal law and regulations  
35 as necessary to preclude a finding that an indirect guarantee has  
36 been created.

37 (g) (1) Interest shall be assessed on quality assurance fees not  
38 paid on the date due at the greater of 10 percent per annum or the  
39 rate at which the department assesses interest on Medi-Cal program  
40 overpayments to hospitals that are not repaid when due. Interest

1 shall begin to accrue the day after the date the payment was due  
2 and shall be deposited in the fund.

3 (2) In the event that any fee payment is more than 60 days  
4 overdue, a penalty equal to the interest charge described in  
5 paragraph (1) shall be assessed and due for each month for which  
6 the payment is not received after 60 days.

7 (h) When a hospital fails to pay all or part of the quality  
8 assurance fee on or before the date that payment is due, the  
9 department may immediately begin to deduct the unpaid assessment  
10 and interest from any Medi-Cal payments owed to the hospital,  
11 or, in accordance with Section 12419.5 of the Government Code,  
12 from any other state payments owed to the hospital until the full  
13 amount is recovered. All amounts, except penalties, deducted by  
14 the department under this subdivision shall be deposited in the  
15 fund. The remedy provided to the department by this section is in  
16 addition to other remedies available under law.

17 (i) The payment of the quality assurance fee shall not be  
18 considered as an allowable cost for Medi-Cal cost reporting and  
19 reimbursement purposes.

20 (j) The department shall work in consultation with the hospital  
21 community to implement this article.

22 (k) This subdivision creates a contractually enforceable promise  
23 on behalf of the state to use the proceeds of the quality assurance  
24 fee, including any federal matching funds, solely and exclusively  
25 for the purposes set forth in this article, to limit the amount of the  
26 proceeds of the quality assurance fee to be used to pay for the  
27 health care coverage of children as provided in Section 14169.53,  
28 to limit any payments for the department's costs of administration  
29 to the amounts set forth in this article, to maintain and continue  
30 prior reimbursement levels as set forth in Section 14169.68 on the  
31 effective date of that section, and to otherwise comply with all its  
32 obligations set forth in this article, provided that amendments that  
33 arise from, or have as a basis for, a decision, advice, or  
34 determination by the federal Centers for Medicare and Medicaid  
35 Services relating to federal approval of the quality assurance fee  
36 or the payments set forth in this article shall control for the  
37 purposes of this subdivision.

38 (l) (1) Subject to paragraph (2), the director may waive any or  
39 all interest and penalties assessed under this article in the event  
40 that the director determines, in his or her sole discretion, that the

1 hospital has demonstrated that imposition of the full quality  
2 assurance fee on the timelines applicable under this article has a  
3 high likelihood of creating a financial hardship for the hospital or  
4 a significant danger of reducing the provision of needed health  
5 care services.

6 (2) Waiver of some or all of the interest or penalties under this  
7 subdivision shall be conditioned on the hospital's agreement to  
8 make fee payments, or to have the payments withheld from  
9 payments otherwise due from the Medi-Cal program to the hospital,  
10 on a schedule developed by the department that takes into account  
11 the financial situation of the hospital and the potential impact on  
12 services.

13 (3) A decision by the director under this subdivision shall not  
14 be subject to judicial review.

15 (4) If fee payments are remitted to the department after the date  
16 determined by the department to be the final date for calculating  
17 the final supplemental payments for a program period under this  
18 article, the fee payments shall be refunded to general acute care  
19 hospitals, pro rata with the amount of quality assurance fee paid  
20 by the hospital in the program period, subject to the limitations of  
21 federal law. If federal rules prohibit the refund described in this  
22 paragraph, the excess funds shall be used as quality assurance fees  
23 for the next program period for general acute care hospitals, pro  
24 rata with the quality assurance fees paid by the hospital for the  
25 program period.

26 (5) If during the implementation of this article, fee payments  
27 that were due under former Article 5.21 (commencing with Section  
28 14167.1) and former Article 5.22 (commencing with Section  
29 14167.31), or former Article 5.226 (commencing with Section  
30 14168.1) and Article 5.227 (commencing with Section 14168.31),  
31 or Article 5.228 (commencing with Section 14169.1) and Article  
32 5.229 (commencing with Section 14169.31) are remitted to the  
33 department under a payment plan or for any other reason, and the  
34 final date for calculating the final supplemental payments under  
35 those articles has passed, then those fee payments shall be  
36 deposited in the fund to support the uses established by this article.

37 ~~SEC. 26.~~

38 *SEC. 30.* Section 14169.53 of the Welfare and Institutions  
39 Code is amended to read:

1 14169.53. (a) (1) All fees required to be paid to the state  
2 pursuant to this article shall be paid in the form of remittances  
3 payable to the department.

4 (2) The department shall directly transmit the fee payments to  
5 the Treasurer to be deposited in the fund. Notwithstanding Section  
6 16305.7 of the Government Code, any interest and dividends  
7 earned on deposits in the fund from the proceeds of the fee assessed  
8 pursuant to this article shall be retained in the fund for purposes  
9 specified in subdivision (b).

10 (b) (1) Notwithstanding subdivision (c) of Section 14167.35,  
11 subdivision (b) of Section 14168.33, and subdivision (b) of Section  
12 14169.33, all funds from the proceeds of the fee assessed pursuant  
13 to this article in the fund, together with any interest and dividends  
14 earned on money in the fund, shall continue to be used exclusively  
15 to enhance federal financial participation for hospital services  
16 under the Medi-Cal program, to provide additional reimbursement  
17 to, and to support quality improvement efforts of, hospitals, and  
18 to minimize uncompensated care provided by hospitals to uninsured  
19 patients, as well as to pay for the state's administrative costs and  
20 to provide funding for children's health coverage, in the following  
21 order of priority:

22 (A) To pay for the department's staffing and administrative  
23 costs directly attributable to implementing this article, not to exceed  
24 two hundred fifty thousand dollars (\$250,000) for each subject  
25 fiscal quarter, exclusive of any federal matching funds.

26 (B) To pay for the health care coverage, as described in  
27 subdivision (g), except that for the two subject fiscal quarters in  
28 the 2013–14 fiscal year, the amount for children's health care  
29 coverage shall be one hundred fifty-five million dollars  
30 (\$155,000,000) for each subject fiscal quarter, exclusive of any  
31 federal matching funds.

32 (C) To make increased capitation payments to managed health  
33 care plans pursuant to this article and Section 14169.82, including  
34 the nonfederal share of capitation payments to managed health  
35 care plans pursuant to this article and Section 14169.82 for services  
36 provided to individuals who meet the eligibility requirements in  
37 Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social  
38 Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who  
39 meet the conditions described in Section 1905(y) of the federal  
40 Social Security Act (42 U.S.C. Sec. 1396d(y)).

1 (D) To make increased payments and direct grants to hospitals  
2 pursuant to this article and Section 14169.83, including the  
3 nonfederal share of payments to hospitals under this article and  
4 Section 14169.83 for services provided to individuals who meet  
5 the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of  
6 Title XIX of the federal Social Security Act (42 U.S.C. Sec.  
7 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described  
8 in Section 1905(y) of the federal Social Security Act (42 U.S.C.  
9 Sec. 1396d(y)).

10 (2) Notwithstanding subdivision (c) of Section 14167.35,  
11 subdivision (b) of Section 14168.33, and subdivision (b) of Section  
12 14169.33, and notwithstanding Section 13340 of the Government  
13 Code, the moneys in the fund shall be continuously appropriated  
14 during the first program period only, without regard to fiscal year,  
15 for the purposes of this article, Article 5.229 (commencing with  
16 Section 14169.31), Article 5.228 (commencing with Section  
17 14169.1), Article 5.227 (commencing with Section 14168.31),  
18 former Article 5.226 (commencing with Section 14168.1), former  
19 Article 5.22 (commencing with Section 14167.31), and former  
20 Article 5.21 (commencing with Section 14167.1).

21 (3) For subsequent program periods, the moneys in the fund  
22 shall be used, upon appropriation by the Legislature in the annual  
23 Budget Act, for the purposes of this article and Sections 14169.82  
24 and 14169.83.

25 (c) Any amounts of the quality assurance fee collected in excess  
26 of the funds required to implement subdivision (b), including any  
27 funds recovered under subdivision (d) of Section 14169.61, shall  
28 be refunded to general acute care hospitals, pro rata with the  
29 amount of quality assurance fee paid by the hospital, subject to  
30 the limitations of federal law. If federal rules prohibit the refund  
31 described in this subdivision, the excess funds shall be used as  
32 quality assurance fees for the next program period for general acute  
33 care hospitals, pro rata with the amount of quality assurance fees  
34 paid by the hospital for the program period.

35 (d) Any methodology or other provision specified in this article  
36 may be modified by the department, in consultation with the  
37 hospital community, to the extent necessary to meet the  
38 requirements of federal law or regulations to obtain federal  
39 approval or to enhance the probability that federal approval can  
40 be obtained, provided the modifications do not violate the spirit,

1 purposes, and intent of this article and are not inconsistent with  
2 the conditions of implementation set forth in Section 14169.72.  
3 The department shall notify the Joint Legislative Budget Committee  
4 and the fiscal and appropriate policy committees of the Legislature  
5 30 days prior to implementation of a modification pursuant to this  
6 subdivision.

7 (e) The department, in consultation with the hospital community,  
8 shall make adjustments, as necessary, to the amounts calculated  
9 pursuant to Section 14169.52 in order to ensure compliance with  
10 the federal requirements set forth in Section 433.68 of Title 42 of  
11 the Code of Federal Regulations or elsewhere in federal law.

12 (f) The department shall request approval from the federal  
13 Centers for Medicare and Medicaid Services for the implementation  
14 of this article. In making this request, the department shall seek  
15 specific approval from the federal Centers for Medicare and  
16 Medicaid Services to exempt providers identified in this article as  
17 exempt from the fees specified, including the submission, as may  
18 be necessary, of a request for waiver of the broad-based  
19 requirement, waiver of the uniform fee requirement, or both,  
20 pursuant to paragraphs (1) and (2) of subdivision (e) of Section  
21 433.68 of Title 42 of the Code of Federal Regulations.

22 (g) (1) For purposes of this subdivision, the following  
23 definitions shall apply:

24 (A) “Actual net benefit” means the net benefit determined by  
25 the department for a net benefit period after the conclusion of the  
26 net benefit period using payments and grants actually made, and  
27 fees actually collected, for the net benefit period.

28 (B) “Aggregate fees” means the aggregate fees collected from  
29 hospitals under this article.

30 (C) “Aggregate payments” means the aggregate payments and  
31 grants made directly or indirectly to hospitals under this article,  
32 including payments and grants described in Sections 14169.54,  
33 14169.55, 14169.57, and 14169.58, and subdivision (b) of Section  
34 14169.82.

35 (D) “Net benefit” means the aggregate payments for a net benefit  
36 period minus the aggregate fees for the net benefit period.

37 (E) “Net benefit period” means a subject fiscal year or portion  
38 thereof that is in a program period and begins on or after July 1,  
39 2014.

1 (F) “Preliminary net benefit” means the net benefit determined  
2 by the department for a net benefit period prior to the beginning  
3 of that net benefit period using estimated or projected data.

4 (2) The amount of funding provided for children’s health care  
5 coverage under subdivision (b) for a net benefit period shall be  
6 equal to 24 percent of the net benefit for that net benefit period.

7 (3) The department shall determine the preliminary net benefit  
8 for all net benefit periods in the first program period before July  
9 1, 2014. The department shall determine the preliminary net benefit  
10 for all net benefit periods in a subsequent program period before  
11 the beginning of the program period.

12 (4) The department shall determine the actual net benefit and  
13 make the reconciliation described in paragraph (5) for each net  
14 benefit period within six months after the date determined by the  
15 department pursuant to subdivision (h).

16 (5) For each net benefit period, the department shall reconcile  
17 the amount of moneys in the fund used for children’s health  
18 coverage based on the preliminary net benefit with the amount of  
19 the fund that may be used for children’s health coverage under  
20 this subdivision based on the actual net benefit. For each net benefit  
21 period, any amounts that were in the fund and used for children’s  
22 health coverage in excess of the 24 percent of the actual net benefit  
23 shall be returned to the fund, and the amount, if any, by which 24  
24 percent of the actual net benefit exceeds 24 percent of the  
25 preliminary net benefit shall be available from the fund to the  
26 department for children’s health coverage. The department shall  
27 notify the Joint Legislative Budget Committee and the fiscal and  
28 appropriate policy committees of the Legislature of the results of  
29 the reconciliation for each net benefit period pursuant to this  
30 paragraph within five working days of performing the  
31 reconciliation.

32 (6) The department shall make all calculations and  
33 reconciliations required by this subdivision in consultation with  
34 the hospital community using data that the department determines  
35 is the best data reasonably available.

36 (h) After consultation with the hospital community, the  
37 department shall determine a date upon which substantially all  
38 fees have been paid and substantially all supplemental payments,  
39 grants, and rate range increases have been made for a program  
40 period, which date shall be no later than two years after the end

1 of a program period. After the date determined by the department  
2 pursuant to this subdivision, no further supplemental payments  
3 shall be made under the program period, and any fees collected  
4 with respect to the program period shall be used for a subsequent  
5 program period consistent with this section. Nothing in this  
6 subdivision shall affect the department's authority to collect quality  
7 assurance fees for a program period after the end of the program  
8 period or after the date determined by the department pursuant to  
9 this subdivision. The department shall notify the Joint Legislative  
10 Budget Committee and fiscal and appropriate policy committees  
11 of that date within five working days of the determination.

12 (i) Use of the fee proceeds to enhance federal financial  
13 participation pursuant to subdivision (b) shall include use of the  
14 proceeds to supply the nonfederal share, if any, of payments to  
15 hospitals under this article for services provided to individuals  
16 who meet the eligibility requirements in Section  
17 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security  
18 Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the  
19 conditions described in Section 1905(y) of the federal Social  
20 Security Act (42 U.S.C. Sec. 1396d(y)) such that expenditures for  
21 services provided to the individual are eligible for the enhanced  
22 federal medical assistance percentage described in that section.

23 ~~SEC. 27.~~

24 *SEC. 31.* Section 14169.55 of the Welfare and Institutions  
25 Code is amended to read:

26 14169.55. (a) Private hospitals shall be paid supplemental  
27 amounts for the provision of hospital inpatient services for each  
28 subject fiscal quarter in a program period as set forth in this section.  
29 The supplemental amounts shall be in addition to any other  
30 amounts payable to hospitals with respect to those services and  
31 shall not affect any other payments to hospitals. The inpatient  
32 supplemental amounts shall result in payments to hospitals that  
33 equal the applicable federal upper payment limit for the subject  
34 fiscal year, except that with respect to a subject fiscal year that  
35 begins before the start of a program period or that ends after the  
36 end of the program period for which the payments are made, the  
37 inpatient supplemental amounts shall result in payments to hospitals  
38 that equal a percentage of the applicable upper payment limit where  
39 the percentage equals the percentage of the subject fiscal year that  
40 occurs during the program period.

1 (b) Except as set forth in subdivisions (e) and (f), each private  
2 hospital shall be paid the sum of the following amounts as  
3 applicable for the provision of hospital inpatient services for each  
4 subject fiscal quarter:

5 (1) A general acute care per diem supplemental rate multiplied  
6 by the hospital's general acute care days.

7 (2) An acute psychiatric per diem supplemental rate multiplied  
8 by the hospital's acute psychiatric days.

9 (3) A high acuity per diem supplemental rate multiplied by the  
10 number of the hospital's high acuity days if the hospital's Medicaid  
11 inpatient utilization rate is less than the percent required to be  
12 eligible to receive disproportionate share replacement funds for  
13 the state fiscal year ending in the base calendar year and greater  
14 than 5 percent and at least 5 percent of the hospital's general acute  
15 care days are high acuity days.

16 (4) A high acuity trauma per diem supplemental rate multiplied  
17 by the number of the hospital's high acuity days if the hospital  
18 qualifies to receive the amount set forth in paragraph (3) and has  
19 been designated as a Level I, Level II, Adult/Ped Level I, or  
20 Adult/Ped Level II trauma center by the Emergency Medical  
21 Services Authority established pursuant to Section 1797.1 of the  
22 Health and Safety Code.

23 (5) A transplant per diem supplemental rate multiplied by the  
24 number of the hospital's transplant days if the hospital's Medicaid  
25 inpatient utilization rate is less than the percent required to be  
26 eligible to receive disproportionate share replacement funds for  
27 the state fiscal year ending in the base calendar year and greater  
28 than 5 percent.

29 (6) A payment for hospital inpatient services equal to the  
30 subacute supplemental rate multiplied by the Medi-Cal subacute  
31 payments as reflected in the state paid claims file prepared by the  
32 department as of the retrieval date for the base calendar year if the  
33 private hospital provided Medi-Cal subacute services during the  
34 base calendar year.

35 (c) In the event federal financial participation for a subject fiscal  
36 year is not available for all of the supplemental amounts payable  
37 to private hospitals under subdivision (b) due to the application of  
38 an upper payment limit or for any other reason, both of the  
39 following shall apply:

1 (1) The total amount payable to private hospitals under  
2 subdivision (b) for the subject fiscal year shall be reduced to reflect  
3 the amount for which federal financial participation is available.

4 (2) The amount payable under subdivision (b) to each private  
5 hospital for the subject fiscal year shall be equal to the amount  
6 computed under subdivision (b) multiplied by the ratio of the total  
7 amount for which federal financial participation is available to the  
8 total amount computed under subdivision (b).

9 (d) If the amount otherwise payable to a hospital under this  
10 section for a subject fiscal year exceeds the amount for which  
11 federal financial participation is available for that hospital, the  
12 amount due to the hospital for that subject fiscal year shall be  
13 reduced to the amount for which federal financial participation is  
14 available.

15 (e) Payments shall not be made under this section for the periods  
16 when a hospital is a new hospital during a program period.

17 (f) Payments shall be made to a converted hospital that converts  
18 during a subject fiscal quarter by multiplying the hospital's  
19 supplemental payment as calculated in subdivision (b) by the  
20 number of days that the hospital was a private hospital in the  
21 subject fiscal quarter, divided by the number of days in the subject  
22 fiscal quarter. Payments shall not be made to a converted hospital  
23 in any subsequent subject fiscal quarter.

24 ~~SEC. 28.~~

25 *SEC. 32.* Section 14169.56 of the Welfare and Institutions  
26 Code is amended to read:

27 14169.56. (a) The department shall increase capitation  
28 payments to Medi-Cal managed health care plans for each subject  
29 fiscal year as set forth in this section.

30 (b) (1) Subject to the limitation in paragraph (2), the increased  
31 capitation payments shall be made as part of the monthly capitated  
32 payments made by the department to managed health care plans.  
33 The aggregate amount of increased capitation payments to all  
34 Medi-Cal managed health care plans for each subject fiscal year,  
35 or portion thereof, shall be the maximum amount for which federal  
36 financial participation is available on an aggregate statewide basis  
37 for the applicable subject fiscal year within a program period, or  
38 portion thereof.

39 (2) (A) The limitation in subparagraph (B) shall be applied with  
40 respect to a subject fiscal year or portion thereof for which the

1 federal matching assistance percentage is less than 90 percentage  
2 for expenditures for services furnished to individuals who meet  
3 the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of  
4 Title XIX of the federal Social Security Act (42 U.S.C. Sec.  
5 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described  
6 in Section 1905(y) of the federal Social Security Act (42 U.S.C.  
7 Sec. 1396d(y)).

8 (B) During a subject fiscal year or portion thereof described in  
9 subparagraph (A), the aggregate amount of the increased capitation  
10 payments under this section shall not exceed the aggregate amount  
11 of the increased capitation payments that would be made if the  
12 nonfederal share of the increased capitation payments were the  
13 amount that the nonfederal share would have been if the federal  
14 matching assistance percentage were 90 percent for expenditures  
15 for services furnished to individuals who meet the eligibility  
16 requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of  
17 the federal Social Security Act (42 U.S.C. Sec.  
18 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described  
19 in Section 1905(y) of the federal Social Security Act (42 U.S.C.  
20 Sec. 1396d(y)).

21 (c) The department shall determine the amount of the increased  
22 capitation payments for each managed health care plan for each  
23 subject fiscal year or portion thereof during a program period. The  
24 department shall consider the composition of Medi-Cal enrollees  
25 in the plan, the anticipated utilization of hospital services by the  
26 plan's Medi-Cal enrollees, and other factors that the department  
27 determines are reasonable and appropriate to ensure access to  
28 high-quality hospital services by the plan's enrollees.

29 (d) The amount of increased capitation payments to each  
30 Medi-Cal managed health care plan shall not exceed an amount  
31 that results in capitation payments that are certified by the state's  
32 actuary as meeting federal requirements, taking into account the  
33 requirement that all of the increased capitation payments under  
34 this section shall be paid by the Medi-Cal managed health care  
35 plans to hospitals for hospital services to Medi-Cal enrollees of  
36 the plan.

37 (e) (1) The increased capitation payments to managed health  
38 care plans under this section shall be made to support the  
39 availability of hospital services and ensure access to hospital  
40 services for Medi-Cal beneficiaries. The increased capitation

1 payments to managed health care plans shall commence within 90  
2 days after the date on which all necessary federal approvals have  
3 been received, and shall include, but not be limited to, the sum of  
4 the increased payments for all prior months for which payments  
5 are due.

6 (2) To secure the necessary funding for the payment or payments  
7 made pursuant to paragraph (1), the department may accumulate  
8 funds in the fund, for the purpose of funding managed health care  
9 capitation payments under this article regardless of the date on  
10 which capitation payments are scheduled to be paid in order to  
11 secure the necessary total funding for managed health care  
12 payments by the end of a program period.

13 (f) Payments to managed health care plans that would be paid  
14 consistent with actuarial certification and enrollment in the absence  
15 of the payments made pursuant to this section, including, but not  
16 limited to, payments described in Section 14182.15, shall not be  
17 reduced as a consequence of payments under this section.

18 (g) (1) Each managed health care plan shall expend 100 percent  
19 of any increased capitation payments it receives under this section  
20 on hospital services as provided in Section 14169.57.

21 (2) The department may issue change orders to amend contracts  
22 with managed health care plans as needed to adjust monthly  
23 capitation payments in order to implement this section.

24 (3) For entities contracting with the department pursuant to  
25 Article 2.91 (commencing with Section 14089), any incremental  
26 increase in capitation rates pursuant to this section shall not be  
27 subject to negotiation and approval by the department.

28 (h) (1) In the event federal financial participation is not  
29 available for all of the increased capitation payments determined  
30 for a month pursuant to this section for any reason, the increased  
31 capitation payments mandated by this section for that month shall  
32 be reduced proportionately to the amount for which federal  
33 financial participation is available.

34 (2) The determination under this subdivision for any month in  
35 a program period shall be made after accounting for all federal  
36 financial participation necessary for full implementation of Section  
37 14182.15 for that month.

38 ~~SEC. 29:~~

39 *SEC. 33.* Section 14169.58 of the Welfare and Institutions  
40 Code is amended to read:

1 14169.58. (a) (1) For the first program period, designated  
2 public hospitals shall be paid direct grants in support of health care  
3 expenditures, which shall not constitute Medi-Cal payments, and  
4 which shall be funded by the quality assurance fee set forth in this  
5 article. For the first program period, the aggregate amount of the  
6 grants to designated public hospitals funded by the quality  
7 assurance fee set forth in this article shall be forty-five million  
8 dollars (\$45,000,000) in the aggregate for the two subject fiscal  
9 quarters in the 2013–14 subject fiscal year, ninety-three million  
10 dollars (\$93,000,000) for the 2014–15 subject fiscal year, one  
11 hundred ten million five hundred thousand dollars (\$110,500,000)  
12 for the 2015–16 subject fiscal year, and sixty-two million five  
13 hundred thousand dollars (\$62,500,000) in the aggregate for the  
14 two subject fiscal quarters in the 2016–17 subject fiscal year.

15 (2) (A) Of the direct grant amounts set forth in paragraph (1),  
16 the director shall allocate twenty-four million five hundred  
17 thousand dollars (\$24,500,000) in the aggregate for the two subject  
18 fiscal quarters in the 2013–14 subject fiscal year, fifty million five  
19 hundred thousand dollars (\$50,500,000) for the 2014–15 subject  
20 fiscal year, sixty million five hundred thousand dollars  
21 (\$60,500,000) for the 2015–16 subject fiscal year, and thirty-four  
22 million five hundred thousand dollars (\$34,500,000) in the  
23 aggregate for the two subject fiscal quarters in the 2016–17 subject  
24 fiscal year among the designated public hospitals pursuant to a  
25 methodology developed in consultation with the designated public  
26 hospitals.

27 (B) Of the direct grant amounts set forth in subparagraph (A),  
28 the director shall distribute six million one hundred twenty-five  
29 thousand dollars (\$6,125,000) for each subject fiscal quarter in the  
30 2013–14 subject fiscal year, six million three hundred twelve  
31 thousand five hundred dollars (\$6,312,500) for each subject fiscal  
32 quarter in the 2014–15 subject fiscal year, seven million five  
33 hundred sixty-two thousand five hundred dollars (\$7,562,500) for  
34 each subject fiscal quarter in the 2015–16 subject fiscal year, and  
35 eight million six hundred twenty-five thousand dollars (\$8,625,000)  
36 for each subject fiscal quarter in the 2016–17 subject fiscal year  
37 in accordance with the timeframes specified in subdivision (a) of  
38 Section 14169.66.

39 (C) Of the direct grant amounts set forth in subparagraph (A),  
40 the director shall distribute six million one hundred twenty-five

1 thousand dollars (\$6,125,000) for each subject fiscal quarter in the  
2 2013–14 subject fiscal year, six million three hundred twelve  
3 thousand five hundred dollars (\$6,312,500) for each subject fiscal  
4 quarter in the 2014–15 subject fiscal year, seven million five  
5 hundred sixty-two thousand five hundred dollars (\$7,562,500) for  
6 each subject fiscal quarter in the 2015–16 subject fiscal year, and  
7 eight million six hundred twenty-five thousand dollars (\$8,625,000)  
8 for each subject fiscal quarter in the 2016–17 subject fiscal year  
9 only upon 100 percent of the rate range increases being distributed  
10 to managed health care plans pursuant to subparagraph (D) for the  
11 respective subject fiscal quarter. If the rate range increases pursuant  
12 to subparagraph (D) are distributed to managed health care plans,  
13 the direct grant amounts described in this subparagraph shall be  
14 distributed to designated public hospitals no later than 30 days  
15 after the rate range increases have been distributed to managed  
16 health care plans pursuant to subparagraph (D).

17 (D) Of the direct grant amounts set forth in paragraph (1), twenty  
18 million five hundred thousand dollars (\$20,500,000) in the  
19 aggregate for the two subject fiscal quarters in the 2013–14 subject  
20 fiscal year, forty-two million five hundred thousand dollars  
21 (\$42,500,000) for the 2014–15 subject fiscal year, fifty million  
22 dollars (\$50,000,000) for the 2015–16 subject fiscal year, and  
23 twenty-eight million dollars (\$28,000,000) in the aggregate for the  
24 two subject fiscal quarters in the 2016–17 subject fiscal year shall  
25 be withheld from payment to the designated public hospitals by  
26 the director, and shall be used as the nonfederal share for rate range  
27 increases, as defined in paragraph (4) of subdivision (b) of Section  
28 14301.4, to risk-based payments to managed care health plans that  
29 contract with the department to serve counties where a designated  
30 public hospital is located. The rate range increases shall apply to  
31 managed care rates for beneficiaries other than newly eligible  
32 beneficiaries, as defined in subdivision (s) of Section 17612.2, and  
33 shall enable plans to compensate hospitals for Medi-Cal health  
34 services and to support the Medi-Cal program. Each managed  
35 health care plan shall expend 100 percent of the rate range increases  
36 on hospital services within 30 days of receiving the increased  
37 payments. Rate range increases funded under this subparagraph  
38 shall be allocated among plans pursuant to a methodology  
39 developed in consultation with the hospital community.

1 (3) Notwithstanding any other provision of law, any amounts  
2 withheld from payment to the designated public hospitals by the  
3 director as the nonfederal share for rate range increases, including  
4 those described in subparagraph (D) of paragraph (2), shall not be  
5 considered hospital fee direct grants as defined under subdivision  
6 (k) of Section 17612.2 and shall not be included in the  
7 determination under paragraph (1) of subdivision (a) of Section  
8 17612.3.

9 (b) (1) For the first program period, nondesignated public  
10 hospitals shall be paid direct grants in support of health care  
11 expenditures, which shall not constitute Medi-Cal payments, and  
12 which shall be funded by the quality assurance fee set forth in this  
13 article. For the first program period, the aggregate amount of the  
14 grants funded by the quality assurance fee set forth in this article  
15 to nondesignated public hospitals shall be twelve million five  
16 hundred thousand dollars (\$12,500,000) in the aggregate for two  
17 subject fiscal quarters in the 2013–14 subject fiscal year,  
18 twenty-five million dollars (\$25,000,000) for the 2014–15 subject  
19 fiscal year, thirty million dollars (\$30,000,000) for the 2015–16  
20 subject fiscal year, and seventeen million five hundred thousand  
21 dollars (\$17,500,000) in the aggregate for the two subject fiscal  
22 quarters in the 2016–17 subject fiscal year.

23 (2) (A) Of the direct grant amounts set forth in paragraph (1),  
24 the director shall allocate two million five hundred thousand dollars  
25 (\$2,500,000) in the aggregate for the two subject fiscal quarters  
26 in the 2013–14 subject fiscal year, five million dollars (\$5,000,000)  
27 for the 2014–15 subject fiscal year, six million dollars (\$6,000,000)  
28 for the 2015–16 subject fiscal year, and three million five hundred  
29 thousand dollars (\$3,500,000) in the aggregate for the two subject  
30 fiscal quarters in the 2016–17 subject fiscal year among the  
31 nondesignated public hospitals pursuant to a methodology  
32 developed in consultation with the nondesignated public hospitals.

33 (B) Of the direct grant amounts set forth in paragraph (1), ten  
34 million dollars (\$10,000,000) in the aggregate for the two subject  
35 fiscal quarters in the 2013–14 subject fiscal year, twenty million  
36 dollars (\$20,000,000) for the 2014–15 subject fiscal year,  
37 twenty-four million dollars (\$24,000,000) for the 2015–16 subject  
38 fiscal year, and fourteen million dollars (\$14,000,000) in the  
39 aggregate for the two subject fiscal quarters in the 2016–17 subject  
40 fiscal year shall be withheld from payment to the nondesignated

1 public hospitals by the director, and shall be used as the nonfederal  
2 share for rate range increases, as defined in paragraph (4) of  
3 subdivision (b) of Section 14301.4, to risk-based payments to  
4 managed care health plans that contract with the department. The  
5 rate range increases shall enable plans to compensate hospitals for  
6 Medi-Cal health services and to support the Medi-Cal program.  
7 Each managed health care plan shall expend 100 percent of the  
8 rate range increases on hospital services within 30 days of receiving  
9 the increased payments. Rate range increases funded under this  
10 subparagraph shall be allocated among plans pursuant to a  
11 methodology developed in consultation with the hospital  
12 community.

13 (c) If the amounts set forth in this section for rate range increases  
14 are not actually used for rate range increases as described in this  
15 section, the direct grant amounts set forth in this section that are  
16 withheld pursuant to subparagraph (D) of paragraph (2) of  
17 subdivision (a) and subparagraph (B) of paragraph (2) of  
18 subdivision (b) shall be returned *to* the fund subject to paragraph  
19 (4) of subdivision (l) of Section 14169.52.

20 (d) For subsequent program periods, designated public hospitals  
21 and nondesignated public hospitals may be paid direct grants  
22 pursuant to subdivision (e) of Section 14169.59 upon appropriation  
23 in the annual Budget Act.

24 ~~SEC. 30.~~

25 *SEC. 34.* Section 14169.59 of the Welfare and Institutions  
26 Code is amended to read:

27 14169.59. (a) The department shall determine during each  
28 rebase calculation year the number of subject fiscal years in the  
29 next program period.

30 (b) During each rebase calculation year, the department shall  
31 retrieve the data, including, but not limited to, the days data source,  
32 used to determine the following for the subsequent program period:  
33 acute psychiatric days, annual fee-for-service days, annual managed  
34 care days, annual Medi-Cal days, fee-for-service days, general  
35 acute care days, high acuity days, managed care days, Medi-Cal  
36 days, Medi-Cal fee-for-service days, Medi-Cal managed care days,  
37 Medi-Cal managed care fee days, outpatient base amount, and  
38 transplant days. The department shall pull data from the most  
39 recent base calendar year for which the department determines  
40 reliable data is available for all hospitals.

1 (c) (1) During each rebase calculation year, the department  
2 shall determine all of the following supplemental payment rates  
3 for the subsequent program period, which supplemental payment  
4 rates shall be specified in provisional language in the annual Budget  
5 Act:

6 (A) The acute psychiatric per diem supplemental rate for each  
7 subject fiscal year during the program period.

8 (B) The general acute care per diem supplemental rate for each  
9 subject fiscal year during the program period.

10 (C) The high acuity per diem supplemental rate for each subject  
11 fiscal year during the program period.

12 (D) The high acuity trauma per diem supplemental rate for each  
13 subject fiscal year during the program period.

14 (E) The outpatient supplemental rate for each subject fiscal year  
15 during the program period.

16 (F) The subacute supplemental rate for each subject fiscal year  
17 during the program period.

18 (G) The transplant per diem supplemental rate for each subject  
19 fiscal year during the program period.

20 (2) During each rebase calculation year, the department shall  
21 determine all of the following fee rates for the subsequent program  
22 period, which fee rates shall be specified in provisional language  
23 in the annual Budget Act:

24 (A) The fee-for-service per diem quality assurance fee rate for  
25 each subject fiscal year during the program period.

26 (B) The managed care per diem quality assurance fee rate for  
27 each subject fiscal year during the program period.

28 (C) The Medi-Cal per diem quality assurance fee rate for each  
29 subject fiscal year during the program period.

30 (D) The prepaid health plan hospital managed care per diem  
31 quality assurance fee rate for each subject fiscal year during the  
32 program period.

33 (E) The prepaid health plan hospital Medi-Cal managed care  
34 per diem quality assurance fee rate for each subject fiscal year  
35 during the program period.

36 (d) The department shall determine the rates set forth in  
37 subdivision (c) based on the data retrieved pursuant to subdivision  
38 (b). Each rate determined by the department shall be the same for  
39 all hospitals to which the rate applies. These rates shall be specified

1 in provisional language in the annual Budget Act. The department  
2 shall determine the rates in accordance with all of the following:

3 (1) The rates shall meet the requirements of federal law and be  
4 established in a manner to obtain federal approval.

5 (2) The department shall consult with the hospital community  
6 in determining the rates.

7 (3) The supplemental payments and other Medi-Cal payments  
8 for hospital outpatient services furnished by private hospitals for  
9 each fiscal year shall equal as close as possible the applicable  
10 federal upper payment limit.

11 (4) The supplemental payments and other Medi-Cal payments  
12 for hospital inpatient services furnished by private hospitals for  
13 each fiscal year shall equal as close as possible the applicable  
14 federal upper payment limit.

15 (5) The increased capitation payments to managed health care  
16 plans shall result in the maximum payments to the plans permitted  
17 by federal law.

18 (6) The quality assurance fee proceeds shall be adequate to make  
19 the expenditures described in this article, but shall not be more  
20 than necessary to make the expenditures.

21 (7) The relative values of per diem supplemental payment rates  
22 to one another for the various categories of patient days shall be  
23 generally consistent with the relative values during the first  
24 program period under this article.

25 (8) The relative values of per diem fee rates to one another for  
26 the various categories of patient days shall be generally consistent  
27 with the relative values during the first program period under this  
28 article.

29 (9) The rates shall result in supplemental payments and quality  
30 assurance fees that are consistent with the purposes of this article.

31 (e) During each rebase calculation year, the director shall  
32 determine the amounts and allocation methodology, if any, of  
33 direct grants to designated public hospitals and nondesignated  
34 public hospitals for each subject fiscal year in a program period,  
35 in consultation with the hospital community. The amounts and  
36 allocation methodology may include a withhold of direct grants  
37 to be used as the nonfederal share for rate range increases. These  
38 amounts shall be specified in provisional language in the annual  
39 Budget Act.

1 (f) (1) Notwithstanding any other provision in this article, the  
2 following shall apply to the first program period under this article:

3 (A) The first program period under this article shall be the period  
4 from January 1, 2014, to December 31, 2016, inclusive.

5 (B) The acute psychiatric days shall be those identified in the  
6 Final Medi-Cal Utilization Statistics for the 2012–13 state fiscal  
7 year as calculated by the department as of December 17, 2012.

8 (C) The days data source shall be the hospital’s Annual Financial  
9 Disclosure Report filed with the Office of Statewide Health  
10 Planning and Development as of June 6, 2013, for its fiscal year  
11 ending during the 2010 calendar year.

12 (D) The general acute care days shall be those identified in the  
13 2010 calendar year, as reflected in the state paid claims file on  
14 April 26, 2013.

15 (E) The high acuity days shall be those paid during the 2010  
16 calendar year, as reflected in the state paid claims file prepared by  
17 the department on April 26, 2013.

18 (F) The Medi-Cal managed care days shall be those identified  
19 in the Final Medi-Cal Utilization Statistics for the 2012–13 fiscal  
20 year, as calculated by the department as of December 17, 2012.

21 (G) The outpatient base amount shall be those payments for  
22 outpatient services made to a hospital in the 2010 calendar year,  
23 as reflected in the state paid claims files prepared by the department  
24 on April 26, 2013.

25 (H) The transplant days shall be those identified in the 2010  
26 Patient Discharge file from the Office of Statewide Health Planning  
27 and Development accessed on June 28, 2011.

28 (I) With respect to a hospital described in subdivision (f) of  
29 Section 14165.50, both of the following shall apply:

30 (i) The hospital shall not be considered a new hospital as defined  
31 in Section 14169.51 for the purposes of this article.

32 (ii) To the extent permitted by federal law and other federal  
33 requirements, the department shall use the best available and  
34 reasonable current estimates or projections made with respect to  
35 the hospital for an annual period as the data, including, but not  
36 limited to, the days data source and data described as being derived  
37 from a state paid claims file, used for all purposes, including, but  
38 not limited to, the calculation of supplemental payments and the  
39 quality assurance fee. The estimates and projections shall be  
40 deemed to reflect paid claims and shall be used for each data

1 element regardless of the time period otherwise applicable to the  
2 data element. The data elements include, but are not limited to,  
3 acute psychiatric days, annual fee-for-service days, annual managed  
4 care days, annual Medi-Cal days, fee-for-service days, general  
5 acute care days, high acuity days, managed care days, Medi-Cal  
6 days, Medi-Cal fee-for-service days, Medi-Cal managed care days,  
7 Medi-Cal managed care fee days, outpatient base amount, and  
8 transplant days.

9 (2) Notwithstanding any other provision in this article, the  
10 following shall apply to determine the supplemental payment rates  
11 for the first program period:

12 (A) The acute psychiatric per diem supplemental rate shall be  
13 nine hundred sixty-five dollars (\$965) for the two remaining subject  
14 fiscal quarters in the 2013–14 subject fiscal year, nine hundred  
15 seventy dollars (\$970) for the subject fiscal quarters in the 2014–15  
16 subject fiscal year, nine hundred seventy-five dollars (\$975) for  
17 the subject fiscal quarters in the 2015–16 subject fiscal year and  
18 nine hundred seventy-five dollars (\$975) for the first two subject  
19 fiscal quarters in the 2016–17 subject fiscal year.

20 (B) The general acute care per diem supplemental rate shall be  
21 eight hundred twenty-four dollars and forty cents (\$824.40) for  
22 the two remaining subject fiscal quarters in the 2013–14 subject  
23 fiscal year, one thousand one hundred ten dollars and sixty-seven  
24 cents (\$1,110.67) for the subject fiscal quarters in the 2014–15  
25 subject fiscal year, one thousand three hundred thirty-five dollars  
26 and forty-two cents (\$1,335.42) for the subject fiscal quarters in  
27 the 2015–16 subject fiscal year, and one thousand four hundred  
28 forty-one dollars and twenty cents (\$1,441.20) for the first two  
29 subject fiscal quarters in the 2016–17 subject fiscal year.

30 (C) The high acuity per diem supplemental rate shall be two  
31 thousand five hundred dollars (\$2,500) for the two remaining  
32 subject fiscal quarters in the 2013–14 subject fiscal year, two  
33 thousand five hundred dollars (\$2,500) for the subject fiscal  
34 quarters in the 2014–15 subject fiscal year, two thousand five  
35 hundred dollars (\$2,500) for the subject fiscal quarters in the  
36 2015–16 subject fiscal year, and two thousand five hundred dollars  
37 (\$2,500) for the first two subject fiscal quarters in the 2016–17  
38 subject fiscal year.

39 (D) The high acuity trauma per diem supplemental rate shall be  
40 two thousand five hundred dollars (\$2,500) for the two remaining

1 subject fiscal quarters in the 2013–14 subject fiscal year, two  
2 thousand five hundred dollars (\$2,500) for the subject fiscal  
3 quarters in the 2014–15 subject fiscal year, two thousand five  
4 hundred dollars (\$2,500) for the subject fiscal quarters in the  
5 2015–16 subject fiscal year, and two thousand five hundred dollars  
6 (\$2,500) for the first two subject fiscal quarters in the 2016–17  
7 subject fiscal year.

8 (E) The outpatient supplemental rate shall be 119 percent of the  
9 outpatient base amount for the two remaining subject fiscal quarters  
10 in the 2013–14 subject fiscal year, 268 percent of the outpatient  
11 base amount for the subject fiscal quarters in the 2014–15 subject  
12 fiscal year, 292 percent of the outpatient base amount for the  
13 subject fiscal quarters in the 2015–16 subject fiscal year, and 151  
14 percent of the outpatient base amount for the first two subject fiscal  
15 quarters in the 2016–17 subject fiscal year.

16 (F) The subacute supplemental rate shall be 50 percent for the  
17 two remaining subject fiscal quarters in the 2013–14 subject fiscal  
18 year, 55 percent for the subject fiscal quarters in the 2014–15  
19 subject fiscal year, 60 percent for the subject fiscal quarters in the  
20 2015–16 subject fiscal year, and 60 percent for the first two subject  
21 fiscal quarters in the 2016–17 subject fiscal year of the Medi-Cal  
22 subacute payments paid by the department to the hospital during  
23 the 2010 calendar year, as reflected in the state paid claims file  
24 prepared by the department on April 26, 2013.

25 (G) The transplant per diem supplemental rate shall be two  
26 thousand five hundred dollars (\$2,500) for the two remaining  
27 subject fiscal quarters in the 2013–14 subject fiscal year, two  
28 thousand five hundred dollars (\$2,500) for the subject fiscal  
29 quarters in the 2014–15 subject fiscal year, two thousand five  
30 hundred dollars (\$2,500) for the subject fiscal quarters in the  
31 2015–16 subject fiscal year, and two thousand five hundred dollars  
32 (\$2,500) for the first two subject fiscal quarters in the 2016–17  
33 subject fiscal year.

34 (3) Notwithstanding any other provision in this article, the  
35 following shall apply to determine the fee rates for the first program  
36 period:

37 (A) The fee-for-service per diem quality assurance fee rate shall  
38 be three hundred seventy-four dollars and ninety-one cents  
39 (\$374.91) for the two remaining subject fiscal quarters in the  
40 2013–14 subject fiscal year, four hundred twenty-five dollars and

1 twenty-two cents (\$425.22) for the subject fiscal quarters in the  
2 2014–15 subject fiscal year, four hundred eighty dollars and eleven  
3 cents (\$480.11) for the subject fiscal quarters in the 2015–16  
4 subject fiscal year, and five hundred forty-two dollars and ten cents  
5 (\$542.10) for the first two subject fiscal quarters in the 2016–17  
6 subject fiscal year.

7 (B) The managed care per diem quality assurance fee rate shall  
8 be one hundred forty-five dollars (\$145) for the two remaining  
9 subject fiscal quarters in the 2013–14 subject fiscal year, one  
10 hundred forty-five dollars (\$145) for the subject fiscal quarters in  
11 the 2014–15 subject fiscal year, one hundred seventy dollars (\$170)  
12 for the subject fiscal quarters in the 2015–16 subject fiscal year,  
13 and one hundred seventy dollars (\$170) for the first two subject  
14 fiscal quarters in the 2016–17 subject fiscal year.

15 (C) The Medi-Cal per diem quality assurance fee rate shall be  
16 four hundred fifty-seven dollars and ten cents (\$457.10) for the  
17 two remaining subject fiscal quarters in the 2013–14 subject fiscal  
18 year, four hundred ninety-seven dollars and eight cents (\$497.08)  
19 for the subject fiscal quarters in the 2014–15 subject fiscal year,  
20 five hundred sixty-eight dollars and fifteen cents (\$568.15) for the  
21 subject fiscal quarters in the 2015–16 subject fiscal year, and six  
22 hundred eighteen dollars and fourteen cents (\$618.14) for the first  
23 two subject fiscal quarters in the 2016–17 subject fiscal year.

24 (D) The prepaid health plan hospital managed care per diem  
25 quality assurance fee rate shall be eighty-one dollars and twenty  
26 cents (\$81.20) for the two remaining subject fiscal quarters in the  
27 2013–14 subject fiscal year, eighty-one dollars and twenty cents  
28 (\$81.20) for the subject fiscal quarters in the 2014–15 subject fiscal  
29 year, ninety-five dollars and twenty cents (\$95.20) for the subject  
30 fiscal quarters in the 2015–16 subject fiscal year, and ninety-five  
31 dollars and twenty cents (\$95.20) for the first two subject fiscal  
32 quarters in the 2016–17 subject fiscal year.

33 (E) The prepaid health plan hospital Medi-Cal managed care  
34 per diem quality assurance fee rate shall be two hundred fifty-five  
35 dollars and ninety-seven cents (\$255.97) for the two remaining  
36 subject fiscal quarters in the 2013–14 subject fiscal year, two  
37 hundred seventy-eight dollars and thirty-seven cents (\$278.37) for  
38 the subject fiscal quarters in the 2014–15 subject fiscal year, three  
39 hundred eighteen dollars and sixteen cents (\$318.16) for the subject  
40 fiscal quarters in the 2015–16 subject fiscal year, and three hundred

1 forty-six dollars and sixteen cents (\$346.16) for the first two subject  
2 fiscal quarters in the 2016–17 subject fiscal year.

3 (F) Upon federal approval or conditional federal approval  
4 described in Section 14169.63, the director shall have the discretion  
5 to revise the fee-for-service per diem quality assurance fee rate,  
6 the managed care per diem quality assurance fee rate, the Medi-Cal  
7 per diem quality assurance fee rate, the prepaid health plan hospital  
8 managed care per diem quality assurance fee rate, or the prepaid  
9 health plan hospital Medi-Cal managed care per diem quality  
10 assurance fee rate, based on the funds required to make the  
11 payments specified in this article, in consultation with the hospital  
12 community.

13 (g) Notwithstanding any other provision in this article, the  
14 following shall apply to the second program period under this  
15 article:

16 (1) The second program period under this article shall begin on  
17 January 1, 2017, and shall end on June 30, 2019.

18 (2) The retrieval date shall occur between October 1, 2016, and  
19 December 31, 2016.

20 (3) The base calendar year shall be the 2013 calendar year, or  
21 a more recent calendar year for which the department determines  
22 reliable data is available.

23 (4) The rebase calculation year shall be the 2015–16 state fiscal  
24 year.

25 (5) With respect to a hospital described in subdivision (f) of  
26 Section 14165.50, both of the following shall apply:

27 (A) The hospital shall not be considered a new hospital as  
28 defined in subdivision (ai) of Section 14169.51 for the purposes  
29 of this article.

30 (B) To the extent permitted by federal law or other federal  
31 requirements, the department shall use the best available and  
32 reasonable current estimates or projections made with respect to  
33 the hospital for an annual period as to the data, including, but not  
34 limited to, the days data source and data described as being derived  
35 from a state paid claims file, used for all purposes, including, but  
36 not limited to, the calculation of supplemental payments and the  
37 quality assurance fee. The estimates and projections shall be  
38 deemed to reflect paid claims and shall be used for each data  
39 element regardless of the time period otherwise applicable to the  
40 data element. The data elements include, but are not limited to,

1 acute psychiatric days, annual fee-for-service days, annual managed  
2 care days, annual Medi-Cal days, fee-for-service days, general  
3 acute care days, high acuity days, managed care days, Medi-Cal  
4 days, Medi-Cal fee-for-service days, Medi-Cal managed care days,  
5 Medi-Cal managed care fee days, outpatient base amount, and  
6 transplant days.

7 ~~(i)~~

8 (h) Commencing January 2016, the department shall provide a  
9 clear narrative description along with fiscal detail in the Medi-Cal  
10 estimate package, submitted to the Legislature in January and May  
11 of each year, of all of the calculations made by the department  
12 pursuant to this section for the second program period and every  
13 program period thereafter.

14 ~~SEC. 31.~~

15 *SEC. 35.* Section 14169.61 of the Welfare and Institutions  
16 Code is amended to read:

17 14169.61. (a) (1) Except as provided in this section, all data  
18 and other information relating to a hospital that are used for the  
19 purposes of this article, including, without limitation, the days data  
20 source, shall continue to be used to determine the payments to that  
21 hospital, regardless of whether the hospital has undergone one or  
22 more changes of ownership.

23 (2) All supplemental payments to a hospital under this article  
24 shall be made to the licensee of a hospital on the date the  
25 supplemental payment is made. All quality assurance fee payments  
26 under this article shall be paid by the licensee of a hospital on the  
27 date the quarterly quality assurance fee payment is due.

28 (b) The data of separate facilities prior to a consolidation shall  
29 be aggregated for the purposes of this article if: (1) a private  
30 hospital consolidates with another private hospital, (2) the facilities  
31 operate under a consolidated hospital license, (3) data for a period  
32 prior to the consolidation is used for purposes of this article, and  
33 (4) neither hospital has had a change of ownership on or after the  
34 effective date of this article unless paragraph (2) of subdivision

35 (d) has been satisfied by the new owner. Data of a facility that was  
36 a separately licensed hospital prior to the consolidation shall not  
37 be included in the data, including the days data source, for the  
38 purpose of determining payments to the facility or the quality  
39 assurance fees due from the facility under the article for any time  
40 period during which the facility is closed. A facility shall be

1 deemed to be closed for purposes of this subdivision on the first  
2 day of any period during which the facility has no general acute,  
3 psychiatric, or rehabilitation inpatients for at least 30 consecutive  
4 days. A facility that has been deemed to be closed under this  
5 subdivision shall no longer be deemed to be closed on the first  
6 subsequent day on which it has general acute, psychiatric, or  
7 rehabilitation inpatients.

8 (c) The payments to a hospital under this article shall not be  
9 made, and the quality assurance fees shall not be due, for any  
10 period during which the hospital is closed. A hospital shall be  
11 deemed to be closed on the first day of any period during which  
12 the hospital has no general acute, psychiatric, or rehabilitation  
13 inpatients for at least 30 consecutive days. A hospital that has been  
14 deemed to be closed under this subdivision shall no longer be  
15 deemed to be closed on the first subsequent day on which it has  
16 general acute, psychiatric, or rehabilitation inpatients. Payments  
17 under this article to a hospital and installment payments of the  
18 aggregate quality assurance fee due from a hospital that is closed  
19 during any portion of a subject fiscal quarter shall be reduced by  
20 applying a fraction, expressed as a percentage, the numerator of  
21 which shall be the number of days during the applicable subject  
22 fiscal quarter that the hospital is closed during the subject fiscal  
23 year and the denominator of which shall be the number of days in  
24 the subject fiscal quarter.

25 (d) The following provisions shall apply only for purposes of  
26 this article, and shall have no application outside of this article nor  
27 shall they affect the assumption of any outstanding monetary  
28 obligation to the Medi-Cal program:

29 (1) The director shall develop and describe in provider bulletins  
30 and on the department's Internet Web site a process by which the  
31 new operator of a hospital that has a days data source in whole or  
32 in part from a previous operator may enter into an agreement with  
33 the department to confirm that it is financially responsible or to  
34 become financially responsible to the department for the  
35 outstanding monetary obligation to the Medi-Cal program of the  
36 previous operator in order to avoid being classified as a new  
37 hospital for purposes of this article. This process shall be available  
38 for changes of ownership that occur before, on, or after January  
39 1, 2014, but only in regard to payments under this article and  
40 otherwise shall have no retroactive effect.

1 (2) The outstanding monetary obligation referred to in  
2 subdivision (ai) of Section 14169.51 shall include responsibility  
3 for all of the following:

4 (A) Payment of the quality assurance fee established pursuant  
5 to this article.

6 (B) Known overpayments that have been asserted by the  
7 department or its fiscal intermediary by sending a written  
8 communication that is received by the hospital prior to the date  
9 that the new operator becomes the licensee of the hospital.

10 (C) Overpayments that are asserted after such date and arise  
11 from customary reconciliations of payments, such as cost report  
12 settlements, and, with the exception of overpayments described in  
13 subparagraph (B), shall exclude liabilities arising from the  
14 fraudulent or intentionally criminal act of a prior operator if the  
15 new operator did not knowingly participate in or continue the  
16 fraudulent or criminal act after becoming the licensee.

17 (3) The department shall have the discretion to determine  
18 whether the new owner properly and fully agreed to be financially  
19 responsible for the outstanding monetary obligation in connection  
20 with the Medi-Cal program and seek additional assurances as the  
21 department deems necessary, except that a new owner that executes  
22 an agreement with the department to be financially responsible for  
23 the monetary obligations as described in paragraph (1) shall be  
24 conclusively deemed to have agreed to be financially responsible  
25 for the outstanding monetary obligation in connection with the  
26 Medi-Cal program. The department shall have the discretion to  
27 establish the terms for satisfying the outstanding monetary  
28 obligation in connection with the Medi-Cal program, including,  
29 but not limited to, recoupment from amounts payable to the hospital  
30 under this section.

31 ~~SEC. 32.~~

32 *SEC. 36.* Section 14169.63 of the Welfare and Institutions  
33 Code is amended to read:

34 14169.63. (a) Notwithstanding any other provision of this  
35 article requiring federal approvals, the department may impose  
36 and collect the quality assurance fee and may make payments  
37 under this article, including increased capitation payments, based  
38 upon receiving a letter from the federal Centers for Medicare and  
39 Medicaid Services or the United States Department of Health and  
40 Human Services that indicates likely federal approval, but only if

1 and to the extent that the letter is sufficient as set forth in  
2 subdivision (b).

3 (b) In order for the letter to be sufficient under this section, the  
4 director shall find that the letter meets both of the following  
5 requirements:

6 (1) The letter is in writing and signed by an official of the federal  
7 Centers for Medicare and Medicaid Services or an official of the  
8 United States Department of Health and Human Services.

9 (2) The director, after consultation with the hospital community,  
10 has determined, in the exercise of his or her sole discretion, that  
11 the letter provides a sufficient level of assurance to justify advanced  
12 implementation of the fee and payment provisions.

13 (c) Nothing in this section shall be construed as modifying the  
14 requirement under Section 14169.69 that payments shall be made  
15 only to the extent a sufficient amount of funds collected as the  
16 quality assurance fee are available to cover the nonfederal share  
17 of those payments.

18 (d) Upon notice from the federal government that final federal  
19 approval for the fee model under this article or for the supplemental  
20 payments to private hospitals under Section 14169.54 or 14169.55  
21 has been denied, any fees collected pursuant to this section shall  
22 be refunded and any payments made pursuant to this article shall  
23 be recouped, including, but not limited to, supplemental payments  
24 and grants, increased capitation payments, payments to hospitals  
25 by health care plans resulting from the increased capitation  
26 payments, and payments for the health care coverage of children.  
27 To the extent fees were paid by a hospital that also received  
28 payments under this section, the payments may first be recouped  
29 from fees that would otherwise be refunded to the hospital prior  
30 to the use of any other recoupment method allowed under law.

31 (e) Any payment made pursuant to this section shall be a  
32 conditional payment until final federal approval has been received.

33 (f) The director shall have broad authority under this section to  
34 collect the quality assurance fee for an interim period after receipt  
35 of the letter described in subdivision (a) pending receipt of all  
36 necessary federal approvals. This authority shall include discretion  
37 to determine both of the following:

38 (1) Whether the quality assurance fee should be collected on a  
39 full or pro rata basis during the interim period.

1 (2) The dates on which payments of the quality assurance fee  
2 are due.

3 (g) The department may draw against the fund for all  
4 administrative costs associated with implementation under this  
5 article, consistent with subdivision (b) of Section 14169.53.

6 (h) This section shall be implemented only to the extent federal  
7 financial participation is not jeopardized by implementation prior  
8 to the receipt of all necessary final federal approvals.

9 ~~SEC. 33.~~

10 *SEC. 37.* Section 14169.65 of the Welfare and Institutions  
11 Code is amended to read:

12 14169.65. (a) Upon receipt of a letter that indicates likely  
13 federal approval that the director determines is sufficient for  
14 implementation under Section 14169.63, or upon the receipt of  
15 federal approval, the following shall occur:

16 (1) To the maximum extent possible, and consistent with the  
17 availability of funds in the fund, the department shall make all of  
18 the payments under Sections 14169.54, 14169.55, and 14169.56,  
19 including, but not limited to, supplemental payments and increased  
20 capitation payments, prior to the end of a program period, except  
21 that the increased capitation payments under Section 14169.56  
22 shall not be made until federal approval is obtained for these  
23 payments.

24 (2) The department shall make supplemental payments to  
25 hospitals under this article consistent with the timeframe described  
26 in Section 14169.66 or a modified timeline developed pursuant to  
27 Section 14169.64.

28 (b) If any payment or payments made pursuant to this section  
29 are found to be inconsistent with federal law, the department shall  
30 recoup the payments by means of withholding or any other  
31 available remedy.

32 (c) This section shall not affect the department’s ongoing  
33 authority to continue, after the end of a program period, to collect  
34 quality assurance fees imposed on or before the end of the program  
35 period.

36 ~~SEC. 34.~~

37 *SEC. 38.* Section 14169.66 of the Welfare and Institutions  
38 Code is amended to read:

39 14169.66. The department shall make disbursements from the  
40 fund consistent with the following:

1 (a) Fund disbursements shall be made periodically within 15  
2 days of each date on which quality assurance fees are due from  
3 hospitals.

4 (b) The funds shall be disbursed in accordance with the order  
5 of priority set forth in subdivision (b) of Section 14169.53, except  
6 that funds may be set aside for increased capitation payments to  
7 managed care health plans pursuant to subdivision (e) of Section  
8 14169.56.

9 (c) The funds shall be disbursed in each payment cycle in  
10 accordance with the order of priority set forth in subdivision (b)  
11 of Section 14169.53 as modified by subdivision (b), and so that  
12 the supplemental payments and direct grants to hospitals and the  
13 increased capitation payments to managed health care plans are  
14 made to the maximum extent for which funds are available.

15 (d) To the maximum extent possible, consistent with the  
16 availability of funds in the fund and the timing of federal approvals,  
17 the supplemental payments and direct grants to hospitals and  
18 increased capitation payments to managed health care plans under  
19 this article shall be made before the last day of a program period.

20 (e) The aggregate amount of funds to be disbursed to private  
21 hospitals shall be determined under Sections 14169.54 and  
22 14169.55. The aggregate amount of funds to be disbursed to  
23 managed health care plans shall be determined under Section  
24 14169.56. The aggregate amount of direct grants to designated  
25 and nondesignated public hospitals shall be determined under  
26 Section 14169.58.

27 ~~SEC. 35.~~

28 *SEC. 39.* Section 14169.72 of the Welfare and Institutions  
29 Code is amended to read:

30 14169.72. This article shall become inoperative if any of the  
31 following occurs:

32 (a) The effective date of a final judicial determination made by  
33 any court of appellate jurisdiction or a final determination by the  
34 United States Department of Health and Human Services or the  
35 federal Centers for Medicare and Medicaid Services that the quality  
36 assurance fee established pursuant to this article, or Section  
37 14169.54 or 14169.55, cannot be implemented. This subdivision  
38 shall not apply to any final judicial determination made by any  
39 court of appellate jurisdiction in a case brought by hospitals located  
40 outside the state.

1 (b) The federal Centers for Medicare and Medicaid Services  
2 denies approval for, or does not approve on or before the last day  
3 of a program period, the implementation of Sections 14169.52,  
4 14169.53, 14169.54, and 14169.55, and the department fails to  
5 modify Section 14169.52, 14169.53, 14169.54, or 14169.55  
6 pursuant to subdivision (d) of Section 14169.53 in order to meet  
7 the requirements of federal law or to obtain federal approval.

8 (c) A final judicial determination by the California Supreme  
9 Court or any California Court of Appeal that the revenues collected  
10 pursuant to this article that are deposited in the fund are either of  
11 the following:

12 (1) “General Fund proceeds of taxes appropriated pursuant to  
13 Article XIII B of the California Constitution,” as used in  
14 subdivision (b) of Section 8 of Article XVI of the California  
15 Constitution.

16 (2) “Allocated local proceeds of taxes,” as used in subdivision  
17 (b) of Section 8 of Article XVI of the California Constitution.

18 (d) The department has sought but has not received federal  
19 financial participation for the supplemental payments and other  
20 costs required by this article for which federal financial  
21 participation has been sought.

22 (e) A lawsuit related to this article is filed against the state and  
23 a preliminary injunction or other order has been issued that results  
24 in a financial disadvantage to the state. For purposes of this  
25 subdivision, “financial disadvantage to the state” means either of  
26 the following:

27 (1) A loss of federal financial participation.

28 (2) A cost to the General Fund that is equal to or greater than  
29 one-quarter of 1 percent of the General Fund expenditures  
30 authorized in the most recent annual Budget Act.

31 (f) The proceeds of the fee and any interest and dividends earned  
32 on deposits are not deposited into the fund or are not used as  
33 provided in Section 14169.53.

34 (g) The proceeds of the fee, the matching amount provided by  
35 the federal government, and interest and dividends earned on  
36 deposits in the fund are not used as provided in Section 14169.68.

37 ~~SEC. 36.~~

38 *SEC. 40.* Section 14312 of the Welfare and Institutions Code  
39 is amended to read:

1 14312. The director shall adopt all necessary rules and  
2 regulations to carry out the provisions of this chapter. In adopting  
3 such rules and regulations, the director shall be guided by the needs  
4 of eligible persons as well as prevailing practices in the delivery  
5 of health care on a prepaid basis. Except where otherwise required  
6 by federal law or by this part, the rules and regulations shall be  
7 consistent with the requirements of the Knox-Keene Health Care  
8 Service Plan Act of 1975.

9 ~~SEC. 37.~~

10 *SEC. 41.* Section 14451 of the Welfare and Institutions Code  
11 is amended to read:

12 14451. Services under a prepaid health plan contract shall be  
13 provided in accordance with the requirements of the Knox-Keene  
14 Health Care Service Plan Act of 1975.

15 ~~SEC. 38.~~

16 *SEC. 42.* Section 15657.8 of the Welfare and Institutions Code  
17 is amended to read:

18 15657.8. (a) An agreement to settle a civil action for physical  
19 abuse, as defined in Section 15610.63, neglect, as defined in  
20 Section 15610.57, or financial abuse, as defined in Section  
21 15610.30, of an elder or dependent adult shall not include any of  
22 the following provisions, whether the agreement is made before  
23 or after filing the action:

24 (1) A provision that prohibits any party to the dispute from  
25 contacting or cooperating with the county adult protective services  
26 agency, the local law enforcement agency, the long-term care  
27 ombudsman, the California Department of Aging, the Department  
28 of Justice, the Licensing and Certification Division of the State  
29 Department of Public Health, the State Department of  
30 Developmental Services, the State Department of State Hospitals,  
31 a licensing or regulatory agency that has jurisdiction over the  
32 license or certification of the defendant, any other governmental  
33 entity, a protection and advocacy agency, as defined in Section  
34 4900, or the defendant's current employer if the defendant's job  
35 responsibilities include contact with elders, dependent adults, or  
36 children, provided that the party contacting or cooperating with  
37 one of these entities had a good faith belief that the information  
38 he or she provided is relevant to the concerns, duties, or obligations  
39 of that entity.

1 (2) A provision that prohibits any party to the dispute from filing  
2 a complaint with, or reporting any violation of law to, the county  
3 adult protective services agency, the local law enforcement agency,  
4 the long-term care ombudsman, the California Department of  
5 Aging, the Department of Justice, the Licensing and Certification  
6 Division of the State Department of Public Health, the State  
7 Department of Developmental Services, the State Department of  
8 State Hospitals, a licensing or regulatory agency that has  
9 jurisdiction over the license or certification of the defendant, any  
10 other governmental entity, a protection and advocacy agency, as  
11 defined in Section 4900, or the defendant's current employer if  
12 the defendant's job responsibilities include contact with elders,  
13 dependent adults, or children.

14 (3) A provision that requires any party to the dispute to withdraw  
15 a complaint he or she has filed with, or a violation he or she has  
16 reported to, the county adult protective services agency, the local  
17 law enforcement agency, the long-term care ombudsman, the  
18 California Department of Aging, the Department of Justice, the  
19 Licensing and Certification Division of the State Department of  
20 Public Health, the State Department of Developmental Services,  
21 the State Department of State Hospitals, a licensing or regulatory  
22 agency that has jurisdiction over the license or certification of the  
23 defendant, any other governmental entity, a protection and  
24 advocacy agency, as defined in Section 4900, or the defendant's  
25 current employer if the defendant's job responsibilities include  
26 contact with elders, dependent adults, or children.

27 (b) A provision described in subdivision (a) is void as against  
28 public policy.

29 (c) This section shall apply only to an agreement entered on or  
30 after January 1, 2013.

31 ~~SEC. 39.~~

32 *SEC. 43.* Section 16541 of the Welfare and Institutions Code  
33 is amended to read:

34 16541. The council shall be comprised of the following  
35 members:

36 (a) The Secretary of California Health and Human Services,  
37 who shall serve as cochair.

38 (b) The Chief Justice of the California Supreme Court, or his  
39 or her designee, who shall serve as cochair.

- 1 (c) The Superintendent of Public Instruction, or his or her
- 2 designee.
- 3 (d) The Chancellor of the California Community Colleges, or
- 4 his or her designee.
- 5 (e) The executive director of the State Board of Education.
- 6 (f) The Director of Social Services.
- 7 (g) The Director of Health Services.
- 8 (h) The Director of State Hospitals.
- 9 (i) The Director of Alcohol and Drug Programs.
- 10 (j) The Director of Developmental Services.
- 11 (k) The Director of the Youth Authority.
- 12 (l) The Administrative Director of the Courts.
- 13 (m) The State Foster Care Ombudsperson.
- 14 (n) Four foster youth or former foster youth.
- 15 (o) The chairpersons of the Assembly Human Services
- 16 Committee and the Assembly Judiciary Committee, or two other
- 17 Members of the Assembly as appointed by the Speaker of the
- 18 Assembly.
- 19 (p) The chairpersons of the Senate Human Services Committee
- 20 and the Senate Judiciary Committee, or two other members
- 21 appointed by the President pro Tempore of the Senate.
- 22 (q) Leaders and representatives of county child welfare, foster
- 23 care, health, education, probation, and mental health agencies and
- 24 departments, child advocacy organizations; labor organizations,
- 25 recognized professional associations that represent child welfare
- 26 and foster care social workers, tribal representatives, and other
- 27 groups and stakeholders that provide benefits, services, and
- 28 advocacy to families and children in the child welfare and foster
- 29 care systems, as recommended by representatives of these groups
- 30 and as designated by the cochairs.

31 ~~SEC. 40.~~

32 *SEC. 44.* Section 17608.05 of the Welfare and Institutions  
33 Code is amended to read:

34 17608.05. (a) As a condition of deposit of funds from the Sales  
35 Tax Account of the Local Revenue Fund into a county's local  
36 health and welfare trust fund mental health account, the county or  
37 city shall deposit each month local matching funds in accordance  
38 with a schedule developed by the State Department of Mental  
39 Health, or its successor the State Department of State Hospitals,

1 based on county or city standard matching obligations for the  
2 1990–91 fiscal year for mental health programs.

3 (b) A county, city, or city and county may limit its deposit of  
4 matching funds to the amount necessary to meet minimum federal  
5 maintenance of effort requirements, as calculated by the State  
6 Department of State Hospitals, subject to the approval of the  
7 Department of Finance. However, the amount of the reduction  
8 permitted by the limitation provided for by this subdivision shall  
9 not exceed twenty-five million dollars (\$25,000,000) per fiscal  
10 year on a statewide basis.

11 (c) Any county, city, or city and county that elects not to apply  
12 maintenance of effort funds for community mental health programs  
13 shall not use the loss of these expenditures from local mental health  
14 programs for realignment purposes, including any calculation for  
15 poverty-population shortfall for clause (iv) of subparagraph (B)  
16 of paragraph (2) of subdivision (c) of Section 17606.05.

17 ~~SEC. 41.~~

18 *SEC. 45.* This act is an urgency statute necessary for the  
19 immediate preservation of the public peace, health, or safety within  
20 the meaning of Article IV of the Constitution and shall go into  
21 immediate effect. The facts constituting the necessity are:

22 In order to ensure the health and safety of Californians by  
23 updating existing law consistent with current practices at the  
24 earliest possible time, it is necessary that this act take effect  
25 immediately.