

AMENDED IN ASSEMBLY AUGUST 4, 2014

AMENDED IN ASSEMBLY JUNE 11, 2014

SENATE BILL

No. 1465

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

March 20, 2014

An act to amend Sections 8880.5, 14670.3, and 14670.5 of the Government Code, to amend Sections ~~1728.7 and 1797.98b~~ 1728.7, ~~1797.98b~~, 127665, and 128225.5 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, 308, 667.5,~~ 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,~~ 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~~ and 16541 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~~. *Public Health*. 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.

(2) Existing law ~~establishes the Maddy Emergency Medical Services (EMS) Fund, and~~ authorizes each county to establish an ~~emergency medical services fund~~ *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.

(3) *Existing law, until June 30, 2015, requests the University of California to establish the California Health Benefit Review Program to assess legislation proposing to mandate a benefit or service or to repeal a mandated benefit or service, and to prepare a written analysis with relevant data on specified areas, including public health impacts, medical impacts, and financial impacts.*

This bill would extend the repeal date of the above provisions to December 31, 2015.

(4) *Existing law requires, until January 1, 2018, and subject to the appropriation of funds in the Budget Act of 2014, the Director of Statewide Health Planning and Development to select and contract on behalf of the state with accredited primary care or family medicine residency programs for the purpose of providing grants to support newly created residency positions, and requires the California Healthcare Workforce Policy Commission to review and make recommendations to the director concerning the provision of those grants. Existing law requires the commission, in making these recommendations, to give priority to residency programs that demonstrate, among other things, that the new primary care physician*

residency positions have been, or will be, approved by the Accreditation Council for Graduate Medical Education prior to the first distribution of grant funds.

This bill would include primary care physician residency positions that have been, or will be, approved by the American Osteopathic Association in the above-described prioritization provision.

(3)

(5) 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.

(6) *Existing law, the Stop Tobacco Access to Kids Enforcement (STAKE) Act, prohibits a minor from purchasing, receiving, or possessing tobacco products or paraphernalia. Existing law prohibits a retailer from knowingly or under circumstances in which it has knowledge, or should otherwise have grounds for knowledge, selling, giving, or in any way furnishing a minor with tobacco products or paraphernalia. Existing law exempts a minor from prosecution for that purchase, receipt, or possession while the minor is participating in a random, onsite sting inspection conducted by the State Department of Public Health as part of its enforcement responsibilities.*

This bill would also exempt a minor from prosecution under that act while the minor is participating in an activity conducted by the State Department of Public Health, a local health department, or a law enforcement agency for the purpose of determining or evaluating youth tobacco purchase rates.

(4)

(7) 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. *Existing law requires the department to send a notice as to the status of an application to an applicant or provider within 60 days after receiving an application package that was noticed as incomplete, was resubmitted with all requested information and documentation, and was received by the department within 60 days of the date on the notice, notifying the applicant or provider if specified circumstances apply.*

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~~ provider, *in both above-described notices*, if the application package is withdrawn by request of the applicant or provider and the department's review is canceled.

(5)

(8) 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)~~

(9) 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.

~~(7)~~

(10) 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.

~~(8)~~

(11) 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.

(9)

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

Vote: 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.

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

5 (c) Payments shall also be made directly to the Board of Trustees
6 of the California State University on the basis of an amount for
7 each unit of equivalent full-time enrollment. Funds received by
8 the trustees shall be deposited in and expended from the California
9 State University Lottery Education Fund, which is hereby created
10 or, at the discretion of the trustees, deposited in local trust accounts
11 in accordance with subdivision (j) of Section 89721 of the
12 Education Code.

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

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

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

24 (g) Payments shall also be made directly to the two California
25 Schools for the Deaf, the California School for the Blind, and the
26 three Diagnostic Schools for Neurologically Handicapped Children,
27 on the basis of an amount for each unit of equivalent full-time
28 enrollment.

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

35 (i) No Budget Act or other statutory provision shall direct that
36 payments for public education made pursuant to this chapter be
37 used for purposes and programs (including workload adjustments
38 and maintenance of the level of service) authorized by Chapters
39 498, 565, and 1302 of the Statutes of 1983, Chapter 97 or 258 of

1 the Statutes of 1984, or Chapter 1 of the Statutes of the 1983–84
2 Second Extraordinary Session.

3 (j) School districts and other agencies receiving funds distributed
4 pursuant to this chapter may at their option utilize funds allocated
5 by this chapter to provide additional funds for those purposes and
6 programs prescribed by subdivision (i) for the purpose of
7 enrichment or expansion.

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

13 (l) Commencing with the 1998–99 fiscal year, and each year
14 thereafter, for purposes of subdivision (a), average daily attendance
15 shall be increased by the statewide average rate of excused
16 absences for the 1996–97 fiscal year as determined pursuant to the
17 provisions of Chapter 855 of the Statutes of 1997. The statewide
18 average excused absence rate, and the corresponding adjustment
19 factor required for the operation of this subdivision, shall be
20 certified to the Controller by the Superintendent of Public
21 Instruction.

22 (m) It is the intent of this chapter that all funds allocated from
23 the California State Lottery Education Fund shall be used
24 exclusively for the education of pupils and students and no funds
25 shall be spent for acquisition of real property, construction of
26 facilities, financing of research, or any other noninstructional
27 purpose.

28 SEC. 2. Section 14670.3 of the Government Code is amended
29 to read:

30 14670.3. Notwithstanding Section 14670, the Director of
31 General Services, with the consent of the State Department of
32 Developmental Services, may let to a nonprofit corporation, for
33 the purpose of conducting an educational and work program for
34 persons with intellectual disabilities, and for a period not to exceed
35 55 years, real property not exceeding five acres located within the
36 grounds of the Fairview State Hospital.

37 The lease authorized by this section shall be nonassignable and
38 shall be subject to periodic review every five years. The review
39 shall be made by the Director of General Services, who shall do
40 both of the following:

1 (a) Ensure the state that the original purposes of the lease are
2 being carried out.

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

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

9 SEC. 3. Section 14670.5 of the Government Code is amended
10 to read:

11 14670.5. Notwithstanding Section 14670, the Director of
12 General Services, with the consent of the State Department of
13 Developmental Services may let to a nonprofit corporation, for
14 the purpose of establishing and maintaining a rehabilitation center
15 for persons with intellectual disabilities, for a period not exceeding
16 20 years, real property, not exceeding five acres, located within
17 the grounds of the Fairview State Hospital in Orange County, and
18 that is retained by the state primarily to provide a peripheral buffer
19 area, or zone, between real property that the state hospital is located
20 on and adjacent real property, if the director deems the letting is
21 in the best interests of the state.

22 SEC. 4. Section 1728.7 of the Health and Safety Code is
23 amended to read:

24 1728.7. (a) Notwithstanding any other provision of this
25 chapter, the ~~state~~ department shall issue a license to a home health
26 agency that applies to the ~~state~~ department for a home health
27 agency license and meets all of the following requirements:

28 (1) Is accredited as a home health agency by an entity approved
29 by the federal Centers for Medicare and Medicaid Services as a
30 national accreditation organization, and the national accreditation
31 organization forwards to the ~~state~~ department copies of all initial
32 and subsequent survey and other accreditation reports or findings.

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

34 (3) Meets any other additional licensure requirements of, or
35 regulations adopted pursuant to, this chapter that the ~~state~~
36 department identifies, after consulting with the national
37 accreditation organizations, as more stringent than the accreditation
38 requirements of the national accreditation organizations.

39 (b) The ~~state~~ department may require a survey of an accredited
40 home health agency to ensure the accreditation requirements are

1 met. These surveys shall be conducted using a selective sample
2 basis.

3 (c) The ~~state~~ department may require a survey of an accredited
4 home health agency to investigate complaints against an accredited
5 home health agency for substantial noncompliance, as determined
6 by the ~~state~~ department, with these accreditation standards.

7 (d) Notwithstanding subdivisions (a), (b), and (c), the ~~state~~
8 department shall retain its full range of authority over accredited
9 home health agencies to ensure the licensure and accreditation
10 requirements are met. This authority shall include the entire scope
11 of enforcement sanctions and options available for unaccredited
12 home health agencies.

13 SEC. 5. Section 1797.98b of the Health and Safety Code is
14 amended to read:

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

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

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

37 (3) The fund balance and the amount of moneys disbursed under
38 the program to physicians and surgeons, for hospitals, and for other
39 emergency medical services purposes, and the amount of money
40 disbursed for actual administrative costs. If funds were disbursed

1 for other emergency medical services, the report shall provide a
2 description of each of those services.

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

6 (5) The amount of moneys available to be disbursed to
7 physicians and surgeons, descriptions of the physician and surgeon
8 claims payment methodologies, the dollar amount of the total
9 allowable claims submitted, and the percentage at which those
10 claims were reimbursed.

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

13 (7) The name of the physician and surgeon and hospital
14 administrator organization, or names of specific physicians and
15 surgeons and hospital administrators, contacted to review claims
16 payment methodologies.

17 (8) A description of the process used to solicit input from
18 physicians and surgeons and hospitals to review payment
19 distribution methodology as described in subdivision (a) of Section
20 1797.98e.

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

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

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

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

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

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

33 (B) Distribution of penalty assessments into the Emergency
34 Medical Services Fund.

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

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

39 (2) Each county, upon request, shall make available to any
40 member of the public a listing of physicians and surgeons and

1 hospitals that have received reimbursement from the Emergency
2 Medical Services Fund and the amount of the reimbursement they
3 have received. This listing shall be compiled on a semiannual basis.

4 *SEC. 6. Section 127665 of the Health and Safety Code is*
5 *amended to read:*

6 127665. This chapter shall remain in effect until ~~June 30,~~
7 *December 31, 2015*, and shall be repealed as of that date, unless
8 a later enacted statute that becomes operative on or before ~~June~~
9 ~~30, December 31, 2015~~, deletes or extends that date.

10 *SEC. 7. Section 128225.5 of the Health and Safety Code is*
11 *amended to read:*

12 128225.5. (a) The commission shall review and make
13 recommendations to the Director of the Office of Statewide Health
14 Planning and Development concerning the provision of grants
15 pursuant to this section. In making recommendations, the
16 commission shall give priority to residency programs that
17 demonstrate all of the following:

18 (1) That the grant will be used to support new primary care
19 physician slots.

20 (2) That priority in filling the position shall be given to
21 physicians who have graduated from a California-based medical
22 school.

23 (3) That the new primary care physician residency positions
24 have been, or will be, approved by the Accreditation Council for
25 Graduate Medical Education *or the American Osteopathic*
26 *Association* prior to the first distribution of grant funds.

27 (b) The director shall do both of the following:

28 (1) Determine whether the residency programs recommended
29 by the commission meet the standards established by this section.

30 (2) Select and contract on behalf of the state with accredited
31 primary care or family medicine residency programs for the
32 purpose of providing grants for the support of newly created
33 residency positions.

34 (c) This section does not apply to funding appropriated in the
35 annual Budget Act for the Song-Brown Health Care Workforce
36 Training Act (Article 1 (commencing with Section 128200)).

37 (d) This section shall be operative only if funds are appropriated
38 in the Budget Act of 2014 for the purposes described in this section.

1 (e) This section shall remain in effect only until January 1, 2018,
2 and as of that date is repealed, unless a later enacted statute, that
3 is enacted before January 1, 2018, deletes or extends that date.

4 ~~SEC. 6.~~

5 *SEC. 8.* Section 10961 of the Insurance Code is amended and
6 renumbered to read:

7 10965.18. (a) For purposes of this chapter, a bridge plan
8 product shall mean an individual health benefit plan that is offered
9 by a health insurer licensed under this part that contracts with the
10 Exchange pursuant to Title 22 (commencing with Section 100500)
11 of the Government Code.

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

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

27 (2) Notwithstanding subdivision (c) of Section 10965.3, a health
28 insurer selling a bridge plan product shall provide an initial open
29 enrollment period of six months, and an annual enrollment period
30 and a special enrollment period consistent with the annual
31 enrollment and special enrollment periods of the Exchange.

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

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

7 *SEC. 9. Section 308 of the Penal Code is amended to read:*

8 308. (a) (1) Every person, firm, or corporation that knowingly
 9 or under circumstances in which it has knowledge, or should
 10 otherwise have grounds for knowledge, sells, gives, or in any way
 11 furnishes to another person who is under the age of 18 years any
 12 tobacco, cigarette, or cigarette papers, or blunts wraps, or any other
 13 preparation of tobacco, or any other instrument or paraphernalia
 14 that is designed for the smoking or ingestion of tobacco, products
 15 prepared from tobacco, or any controlled substance, is subject to
 16 either a criminal action for a misdemeanor or to a civil action
 17 brought by a city attorney, a county counsel, or a district attorney,
 18 punishable by a fine of two hundred dollars (\$200) for the first
 19 offense, five hundred dollars (\$500) for the second offense, and
 20 one thousand dollars (\$1,000) for the third offense.

21 Notwithstanding Section 1464 or any other law, 25 percent of
 22 each civil and criminal penalty collected pursuant to this
 23 subdivision shall be paid to the office of the city attorney, county
 24 counsel, or district attorney, whoever is responsible for bringing
 25 the successful action, and 25 percent of each civil and criminal
 26 penalty collected pursuant to this subdivision shall be paid to the
 27 city or county for the administration and cost of the community
 28 service work component provided in subdivision (b).

29 Proof that a defendant, or his or her employee or agent,
 30 demanded, was shown, and reasonably relied upon evidence of
 31 majority shall be defense to any action brought pursuant to this
 32 subdivision. Evidence of majority of a person is a facsimile of or
 33 a reasonable likeness of a document issued by a federal, state,
 34 county, or municipal government, or subdivision or agency thereof,
 35 including, but not limited to, a motor vehicle operator's license, a
 36 registration certificate issued under the federal Selective Service
 37 Act, or an identification card issued to a member of the Armed
 38 Forces.

39 For purposes of this section, the person liable for selling or
 40 furnishing tobacco products to minors by a tobacco vending

1 machine shall be the person authorizing the installation or
2 placement of the tobacco vending machine upon premises he or
3 she manages or otherwise controls and under circumstances in
4 which he or she has knowledge, or should otherwise have grounds
5 for knowledge, that the tobacco vending machine will be utilized
6 by minors.

7 (2) For purposes of this section, “blunt wraps” means cigar
8 papers or cigar wrappers of all types that are designed for smoking
9 or ingestion of tobacco products and contain less than 50 percent
10 tobacco.

11 (b) Every person under the age of 18 years who purchases,
12 receives, or possesses any tobacco, cigarette, or cigarette papers,
13 or any other preparation of tobacco, or any other instrument or
14 paraphernalia that is designed for the smoking of tobacco, products
15 prepared from tobacco, or any controlled substance shall, upon
16 conviction, be punished by a fine of seventy-five dollars (\$75) or
17 30 hours of community service work.

18 (c) Every person, firm, or corporation that sells, or deals in
19 tobacco or any preparation thereof, shall post conspicuously and
20 keep so posted in his, her, or their place of business at each point
21 of purchase the notice required pursuant to subdivision (b) of
22 Section 22952 of the Business and Professions Code, and any
23 person failing to do so shall, upon conviction, be punished by a
24 fine of fifty dollars (\$50) for the first offense, one hundred dollars
25 (\$100) for the second offense, two hundred fifty dollars (\$250) for
26 the third offense, and five hundred dollars (\$500) for the fourth
27 offense and each subsequent violation of this provision, or by
28 imprisonment in a county jail not exceeding 30 days.

29 (d) For purposes of determining the liability of persons, firms,
30 or corporations controlling franchises or business operations in
31 multiple locations for the second and subsequent violations of this
32 section, each individual franchise or business location shall be
33 deemed a separate entity.

34 (e) Notwithstanding subdivision (b), any person under 18 years
35 of age who purchases, receives, or possesses any tobacco, cigarette,
36 or cigarette papers, or any other preparation of tobacco, any other
37 instrument or paraphernalia that is designed for the smoking of
38 tobacco, or products prepared from tobacco, ~~while participating~~
39 ~~in the enforcement activities that comply with the guidelines~~
40 ~~adopted pursuant to subdivisions (c) and (d) of Section 22952 of~~

1 ~~the Business and Professions Code~~ *tobacco* is immune from
2 prosecution for that purchase, receipt, or ~~possession~~: *possession*
3 *while participating in either of the following:*

4 (1) *An enforcement activity that complies with the guidelines*
5 *adopted pursuant to subdivisions (c) and (d) of Section 22952 of*
6 *the Business and Professions Code.*

7 (2) *An activity conducted by the State Department of Public*
8 *Health, a local health department, or a law enforcement agency*
9 *for the purpose of determining or evaluating youth tobacco*
10 *purchase rates.*

11 (f) It is the Legislature's intent to regulate the subject matter of
12 this section. As a result, a city, county, or city and county shall not
13 adopt any ordinance or regulation inconsistent with this section.

14 ~~SEC. 7.~~

15 *SEC. 10.* Section 667.5 of the Penal Code is amended to read:
16 667.5. Enhancement of prison terms for new offenses because
17 of prior prison terms shall be imposed as follows:

18 (a) Where one of the new offenses is one of the violent felonies
19 specified in subdivision (c), in addition to and consecutive to any
20 other prison terms therefor, the court shall impose a three-year
21 term for each prior separate prison term served by the defendant
22 where the prior offense was one of the violent felonies specified
23 in subdivision (c). However, no additional term shall be imposed
24 under this subdivision for any prison term served prior to a period
25 of 10 years in which the defendant remained free of both prison
26 custody and the commission of an offense which results in a felony
27 conviction.

28 (b) Except where subdivision (a) applies, where the new offense
29 is any felony for which a prison sentence or a sentence of
30 imprisonment in a county jail under subdivision (h) of Section
31 1170 is imposed or is not suspended, in addition and consecutive
32 to any other sentence therefor, the court shall impose a one-year
33 term for each prior separate prison term or county jail term imposed
34 under subdivision (h) of Section 1170 or when sentence is not
35 suspended for any felony; provided that no additional term shall
36 be imposed under this subdivision for any prison term or county
37 jail term imposed under subdivision (h) of Section 1170 or when
38 sentence is not suspended prior to a period of five years in which
39 the defendant remained free of both the commission of an offense
40 which results in a felony conviction, and prison custody or the

1 imposition of a term of jail custody imposed under subdivision (h)
2 of Section 1170 or any felony sentence that is not suspended. A
3 term imposed under the provisions of paragraph (5) of subdivision
4 (h) of Section 1170, wherein a portion of the term is suspended
5 by the court to allow mandatory supervision, shall qualify as a
6 prior county jail term for the purposes of the one-year enhancement.

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

9 (1) Murder or voluntary manslaughter.

10 (2) Mayhem.

11 (3) Rape as defined in paragraph (2) or (6) of subdivision (a)
12 of Section 261 or paragraph (1) or (4) of subdivision (a) of Section
13 262.

14 (4) Sodomy as defined in subdivision (c) or (d) of Section 286.

15 (5) Oral copulation as defined in subdivision (c) or (d) of Section
16 288a.

17 (6) Lewd or lascivious act as defined in subdivision (a) or (b)
18 of Section 288.

19 (7) Any felony punishable by death or imprisonment in the state
20 prison for life.

21 (8) Any felony in which the defendant inflicts great bodily injury
22 on any person other than an accomplice which has been charged
23 and proved as provided for in Section 12022.7, 12022.8, or 12022.9
24 on or after July 1, 1977, or as specified prior to July 1, 1977, in
25 Sections 213, 264, and 461, or any felony in which the defendant
26 uses a firearm which use has been charged and proved as provided
27 in subdivision (a) of Section 12022.3, or Section 12022.5 or
28 12022.55.

29 (9) Any robbery.

30 (10) Arson, in violation of subdivision (a) or (b) of Section 451.

31 (11) Sexual penetration as defined in subdivision (a) or (j) of
32 Section 289.

33 (12) Attempted murder.

34 (13) A violation of Section 18745, 18750, or 18755.

35 (14) Kidnapping.

36 (15) Assault with the intent to commit a specified felony, in
37 violation of Section 220.

38 (16) Continuous sexual abuse of a child, in violation of Section
39 288.5.

40 (17) Carjacking, as defined in subdivision (a) of Section 215.

- 1 (18) Rape, spousal rape, or sexual penetration, in concert, in
2 violation of Section 264.1.
- 3 (19) Extortion, as defined in Section 518, which would constitute
4 a felony violation of Section 186.22.
- 5 (20) Threats to victims or witnesses, as defined in Section 136.1,
6 which would constitute a felony violation of Section 186.22.
- 7 (21) Any burglary of the first degree, as defined in subdivision
8 (a) of Section 460, wherein it is charged and proved that another
9 person, other than an accomplice, was present in the residence
10 during the commission of the burglary.
- 11 (22) Any violation of Section 12022.53.
- 12 (23) A violation of subdivision (b) or (c) of Section 11418. The
13 Legislature finds and declares that these specified crimes merit
14 special consideration when imposing a sentence to display society's
15 condemnation for these extraordinary crimes of violence against
16 the person.
- 17 (d) For the purposes of this section, the defendant shall be
18 deemed to remain in prison custody for an offense until the official
19 discharge from custody, including any period of mandatory
20 supervision, or until release on parole or postrelease community
21 supervision, whichever first occurs, including any time during
22 which the defendant remains subject to reimprisonment or custody
23 in county jail for escape from custody or is reimprisoned on
24 revocation of parole or postrelease community supervision. The
25 additional penalties provided for prior prison terms shall not be
26 imposed unless they are charged and admitted or found true in the
27 action for the new offense.
- 28 (e) The additional penalties provided for prior prison terms shall
29 not be imposed for any felony for which the defendant did not
30 serve a prior separate term in state prison or in county jail under
31 subdivision (h) of Section 1170.
- 32 (f) A prior conviction of a felony shall include a conviction in
33 another jurisdiction for an offense which, if committed in
34 California, is punishable by imprisonment in the state prison or in
35 county jail under subdivision (h) of Section 1170 if the defendant
36 served one year or more in prison for the offense in the other
37 jurisdiction. A prior conviction of a particular felony shall include
38 a conviction in another jurisdiction for an offense which includes
39 all of the elements of the particular felony as defined under

1 California law if the defendant served one year or more in prison
2 for the offense in the other jurisdiction.

3 (g) A prior separate prison term for the purposes of this section
4 shall mean a continuous completed period of prison incarceration
5 imposed for the particular offense alone or in combination with
6 concurrent or consecutive sentences for other crimes, including
7 any reimprisonment on revocation of parole which is not
8 accompanied by a new commitment to prison, and including any
9 reimprisonment after an escape from incarceration.

10 (h) Serving a prison term includes any confinement time in any
11 state prison or federal penal institution as punishment for
12 commission of an offense, including confinement in a hospital or
13 other institution or facility credited as service of prison time in the
14 jurisdiction of the confinement.

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

20 (j) For the purposes of this section, when a person subject to
21 the custody, control, and discipline of the Secretary of the
22 Department of Corrections and Rehabilitation is incarcerated at a
23 facility operated by the Division of Juvenile Justice, that
24 incarceration shall be deemed to be a term served in state prison.

25 (k) (1) Notwithstanding subdivisions (d) and (g) or any other
26 provision of law, where one of the new offenses is committed
27 while the defendant is temporarily removed from prison pursuant
28 to Section 2690 or while the defendant is transferred to a
29 community facility pursuant to Section 3416, 6253, or 6263, or
30 while the defendant is on furlough pursuant to Section 6254, the
31 defendant shall be subject to the full enhancements provided for
32 in this section.

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

36 ~~SEC. 8. Section 830.3 of the Penal Code, as amended by~~
37 ~~Section 37 of Chapter 515 of the Statutes of 2013, is amended to~~
38 ~~read:~~

39 ~~830.3. The following persons are peace officers whose authority~~
40 ~~extends to any place in the state for the purpose of performing~~

1 their primary duty or when making an arrest pursuant to Section
2 836 as to any public offense with respect to which there is
3 immediate danger to person or property, or of the escape of the
4 perpetrator of that offense, or pursuant to Section 8597 or 8598 of
5 the Government Code. These peace officers may carry firearms
6 only if authorized and under those terms and conditions as specified
7 by their employing agencies:

8 (a) ~~Persons employed by the Division of Investigation of the~~
9 ~~Department of Consumer Affairs and investigators of the Medical~~
10 ~~Board of California and the Board of Dental Examiners, who are~~
11 ~~designated by the Director of Consumer Affairs, provided that the~~
12 ~~primary duty of these peace officers shall be the enforcement of~~
13 ~~the law as that duty is set forth in Section 160 of the Business and~~
14 ~~Professions Code.~~

15 (b) ~~Voluntary fire wardens designated by the Director of~~
16 ~~Forestry and Fire Protection pursuant to Section 4156 of the Public~~
17 ~~Resources Code, provided that the primary duty of these peace~~
18 ~~officers shall be the enforcement of the law as that duty is set forth~~
19 ~~in Section 4156 of that code.~~

20 (c) ~~Employees of the Department of Motor Vehicles designated~~
21 ~~in Section 1655 of the Vehicle Code, provided that the primary~~
22 ~~duty of these peace officers shall be the enforcement of the law as~~
23 ~~that duty is set forth in Section 1655 of that code.~~

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

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

35 (f) ~~Inspectors of the food and drug section designated by the~~
36 ~~chief pursuant to subdivision (a) of Section 106500 of the Health~~
37 ~~and Safety Code, provided that the primary duty of these peace~~
38 ~~officers shall be the enforcement of the law as that duty is set forth~~
39 ~~in Section 106500 of that code.~~

1 ~~(g) All investigators of the Division of Labor Standards~~
2 ~~Enforcement designated by the Labor Commissioner, provided~~
3 ~~that the primary duty of these peace officers shall be the~~
4 ~~enforcement of the law as prescribed in Section 95 of the Labor~~
5 ~~Code.~~

6 ~~(h) All investigators of the State Departments of Health Care~~
7 ~~Services, Public Health, Social Services, State Hospitals, and~~
8 ~~Alcohol and Drug Programs, the Department of Toxic Substances~~
9 ~~Control, the Office of Statewide Health Planning and Development,~~
10 ~~and the Public Employees' Retirement System, provided that the~~
11 ~~primary duty of these peace officers shall be the enforcement of~~
12 ~~the law relating to the duties of his or her department or office.~~
13 ~~Notwithstanding any other provision of law, investigators of the~~
14 ~~Public Employees' Retirement System shall not carry firearms.~~

15 ~~(i) The Chief of the Bureau of Fraudulent Claims of the~~
16 ~~Department of Insurance and those investigators designated by the~~
17 ~~chief, provided that the primary duty of those investigators shall~~
18 ~~be the enforcement of Section 550.~~

19 ~~(j) Employees of the Department of Housing and Community~~
20 ~~Development designated under Section 18023 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 18023 of that code.~~

24 ~~(k) Investigators of the office of the Controller, provided that~~
25 ~~the primary duty of these investigators shall be the enforcement~~
26 ~~of the law relating to the duties of that office. Notwithstanding any~~
27 ~~other law, except as authorized by the Controller, the peace officers~~
28 ~~designated pursuant to this subdivision shall not carry firearms.~~

29 ~~(l) Investigators of the Department of Business Oversight~~
30 ~~designated by the Commissioner of Business Oversight, provided~~
31 ~~that the primary duty of these investigators shall be the enforcement~~
32 ~~of the provisions of law administered by the Department of~~
33 ~~Business Oversight. Notwithstanding any other provision of law,~~
34 ~~the peace officers designated pursuant to this subdivision shall not~~
35 ~~carry firearms.~~

36 ~~(m) Persons employed by the Contractors' State License Board~~
37 ~~designated by the Director of Consumer Affairs pursuant to Section~~
38 ~~7011.5 of the Business and Professions Code, provided that the~~
39 ~~primary duty of these persons shall be the enforcement of the law~~
40 ~~as that duty is set forth in Section 7011.5, and in Chapter 9~~

1 (commencing with Section 7000) of Division 3, of that code. The
2 Director of Consumer Affairs may designate as peace officers not
3 more than 12 persons who shall at the time of their designation be
4 assigned to the special investigations unit of the board.
5 Notwithstanding any other provision of law, the persons designated
6 pursuant to this subdivision shall not carry firearms.

7 (n) ~~The Chief and coordinators of the Law Enforcement Branch
8 of the Office of Emergency Services.~~

9 (o) ~~Investigators of the office of the Secretary of State designated
10 by the Secretary of State, provided that the primary duty of these
11 peace officers shall be the enforcement of the law as prescribed
12 in Chapter 3 (commencing with Section 8200) of Division 1 of
13 Title 2 of, and Section 12172.5 of, the Government Code.
14 Notwithstanding any other provision of law, the peace officers
15 designated pursuant to this subdivision shall not carry firearms.~~

16 (p) ~~The Deputy Director for Security designated by Section
17 8880.38 of the Government Code, and all lottery security personnel
18 assigned to the California State Lottery and designated by the
19 director, provided that the primary duty of any of those peace
20 officers shall be the enforcement of the laws related to ensuring
21 the integrity, honesty, and fairness of the operation and
22 administration of the California State Lottery.~~

23 (q) ~~(1) Investigators employed by the Investigation Division
24 of the Employment Development Department designated by the
25 director of the department, provided that the primary duty of those
26 peace officers shall be the enforcement of the law as that duty is
27 set forth in Section 317 of the Unemployment Insurance Code.~~

28 ~~(2) Notwithstanding any other provision of law, the peace
29 officers designated pursuant to this subdivision shall not carry
30 firearms.~~

31 (r) ~~The chief and assistant chief of museum security and safety
32 of the California Science Center, as designated by the executive
33 director pursuant to Section 4108 of the Food and Agricultural
34 Code, provided that the primary duty of those peace officers shall
35 be the enforcement of the law as that duty is set forth in Section
36 4108 of the Food and Agricultural Code.~~

37 (s) ~~Employees of the Franchise Tax Board designated by the
38 board, provided that the primary duty of these peace officers shall
39 be the enforcement of the law as set forth in Chapter 9~~

1 ~~(commencing with Section 19701) of Part 10.2 of Division 2 of~~
2 ~~the Revenue and Taxation Code.~~

3 ~~(t) (1) Notwithstanding any other provision of this section, a~~
4 ~~peace officer authorized by this section shall not be authorized to~~
5 ~~carry firearms by his or her employing agency until that agency~~
6 ~~has adopted a policy on the use of deadly force by those peace~~
7 ~~officers, and until those peace officers have been instructed in the~~
8 ~~employing agency's policy on the use of deadly force.~~

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

12 ~~(u) Investigators of the Department of Managed Health Care~~
13 ~~designated by the Director of the Department of Managed Health~~
14 ~~Care, provided that the primary duty of these investigators shall~~
15 ~~be the enforcement of the provisions of laws administered by the~~
16 ~~Director of the Department of Managed Health Care.~~
17 ~~Notwithstanding any other provision of law, the peace officers~~
18 ~~designated pursuant to this subdivision shall not carry firearms.~~

19 ~~(v) The Chief, Deputy Chief, supervising investigators, and~~
20 ~~investigators of the Office of Protective Services of the State~~
21 ~~Department of Developmental Services, provided that the primary~~
22 ~~duty of each of those persons shall be the enforcement of the law~~
23 ~~relating to the duties of his or her department or office.~~

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

28 ~~SEC. 9. Section 830.3 of the Penal Code, as added by Section~~
29 ~~38 of Chapter 515 of the Statutes of 2013, is amended to read:~~

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

39 ~~(a) Persons employed by the Division of Investigation of the~~
40 ~~Department of Consumer Affairs and investigators of the Board~~

1 of Dental Examiners, who are designated by the Director of
2 Consumer Affairs, provided that the primary duty of these peace
3 officers shall be the enforcement of the law as that duty is set forth
4 in Section 160 of the Business and Professions Code.

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

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

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

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

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

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

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

1 the law relating to the duties of his or her department or office.
2 Notwithstanding any other provision of law, investigators of the
3 Public Employees' Retirement System shall not carry firearms.

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

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

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

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

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

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

38 (o) ~~Investigators of the office of the Secretary of State designated~~
39 ~~by the Secretary of State, provided that the primary duty of these~~
40 ~~peace officers shall be the enforcement of the law as prescribed~~

1 in Chapter 3 (commencing with Section 8200) of Division 1 of
2 Title 2 of, and Section 12172.5 of, the Government Code.
3 Notwithstanding any other provision of law, the peace officers
4 designated pursuant to this subdivision shall not carry firearms.

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

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

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

20 (r) The chief and assistant chief of museum security and safety
21 of the California Science Center, as designated by the executive
22 director pursuant to Section 4108 of the Food and Agricultural
23 Code, provided that the primary duty of those peace officers shall
24 be the enforcement of the law as that duty is set forth in Section
25 4108 of the Food and Agricultural Code.

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

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

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

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

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

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

14 ~~SEC. 10. Section 830.5 of the Penal Code is amended to read:~~

15 ~~830.5. The following persons are peace officers whose authority~~
16 ~~extends to any place in the state while engaged in the performance~~
17 ~~of the duties of their respective employment and for the purpose~~
18 ~~of carrying out the primary function of their employment or as~~
19 ~~required under Sections 8597, 8598, and 8617 of the Government~~
20 ~~Code, as amended by Section 44 of Chapter 1124 of the Statutes~~
21 ~~of 2002. Except as specified in this section, these peace officers~~
22 ~~may carry firearms only if authorized and under those terms and~~
23 ~~conditions specified by their employing agency:~~

24 ~~(a) A parole officer of the Department of Corrections and~~
25 ~~Rehabilitation, or the Department of Corrections and~~
26 ~~Rehabilitation, Division of Juvenile Parole Operations, probation~~
27 ~~officer, deputy probation officer, or a board coordinating parole~~
28 ~~agent employed by the Juvenile Parole Board. Except as otherwise~~
29 ~~provided in this subdivision, the authority of these parole or~~
30 ~~probation officers shall extend only as follows:~~

31 ~~(1) To conditions of parole, probation, mandatory supervision,~~
32 ~~or postrelease community supervision by any person in this state~~
33 ~~on parole, probation, mandatory supervision, or postrelease~~
34 ~~community supervision.~~

35 ~~(2) To the escape of any inmate or ward from a state or local~~
36 ~~institution.~~

37 ~~(3) To the transportation of persons on parole, probation,~~
38 ~~mandatory supervision, or postrelease community supervision.~~

1 ~~(4) To violations of any penal provisions of law which are~~
2 ~~discovered while performing the usual or authorized duties of his~~
3 ~~or her employment.~~

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

6 ~~(B) For the purposes of this subdivision, “parole agent” shall~~
7 ~~have the same meaning as parole officer of the Department of~~
8 ~~Corrections and Rehabilitation or of the Department of Corrections~~
9 ~~and Rehabilitation, Division of Juvenile Justice.~~

10 ~~(C) Any parole officer of the Department of Corrections and~~
11 ~~Rehabilitation, or the Department of Corrections and~~
12 ~~Rehabilitation, Division of Juvenile Parole Operations, is~~
13 ~~authorized to carry firearms, but only as determined by the director~~
14 ~~on a case-by-case or unit-by-unit basis and only under those terms~~
15 ~~and conditions specified by the director or chairperson. The~~
16 ~~Department of Corrections and Rehabilitation, Division of Juvenile~~
17 ~~Justice, shall develop a policy for arming peace officers of the~~
18 ~~Department of Corrections and Rehabilitation, Division of Juvenile~~
19 ~~Justice, who comprise “high-risk transportation details” or~~
20 ~~“high-risk escape details” no later than June 30, 1995. This policy~~
21 ~~shall be implemented no later than December 31, 1995.~~

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

26 ~~(b) A correctional officer employed by the Department of~~
27 ~~Corrections and Rehabilitation, or of the Department of Corrections~~
28 ~~and Rehabilitation, Division of Juvenile Justice, having custody~~
29 ~~of wards or any employee of the Department of Corrections and~~
30 ~~Rehabilitation designated by the secretary or any correctional~~
31 ~~counselor series employee of the Department of Corrections and~~
32 ~~Rehabilitation or any medical technical assistant series employee~~
33 ~~designated by the secretary or designated by the secretary and~~
34 ~~employed by the State Department of State Hospitals or any~~
35 ~~employee of the Board of Parole Hearings designated by the~~
36 ~~secretary or employee of the Department of Corrections and~~
37 ~~Rehabilitation, Division of Juvenile Justice, designated by the~~
38 ~~secretary or any superintendent, supervisor, or employee having~~
39 ~~custodial responsibilities in an institution operated by a probation~~
40 ~~department, or any transportation officer of a probation department.~~

1 ~~(e) The following persons may carry a firearm while not on~~
2 ~~duty: a parole officer of the Department of Corrections and~~
3 ~~Rehabilitation, or the Department of Corrections and~~
4 ~~Rehabilitation, Division of Juvenile Justice, a correctional officer~~
5 ~~or correctional counselor employed by the Department of~~
6 ~~Corrections and Rehabilitation, or an employee of the Department~~
7 ~~of Corrections and Rehabilitation, Division of Juvenile Justice,~~
8 ~~having custody of wards or any employee of the Department of~~
9 ~~Corrections and Rehabilitation designated by the secretary. A~~
10 ~~parole officer of the Juvenile Parole Board may carry a firearm~~
11 ~~while not on duty only when so authorized by the chairperson of~~
12 ~~the board and only under the terms and conditions specified by~~
13 ~~the chairperson. Nothing in this section shall be interpreted to~~
14 ~~require licensure pursuant to Section 25400. The director or~~
15 ~~chairperson may deny, suspend, or revoke for good cause a~~
16 ~~person's right to carry a firearm under this subdivision. That person~~
17 ~~shall, upon request, receive a hearing, as provided for in the~~
18 ~~negotiated grievance procedure between the exclusive employee~~
19 ~~representative and the Department of Corrections and~~
20 ~~Rehabilitation, Division of Juvenile Justice, or the Juvenile Parole~~
21 ~~Board, to review the director's or the chairperson's decision.~~

22 ~~(d) Persons permitted to carry firearms pursuant to this section,~~
23 ~~either on or off duty, shall meet the training requirements of Section~~
24 ~~832 and shall qualify with the firearm at least quarterly. It is the~~
25 ~~responsibility of the individual officer or designee to maintain his~~
26 ~~or her eligibility to carry concealable firearms off duty. Failure to~~
27 ~~maintain quarterly qualifications by an officer or designee with~~
28 ~~any concealable firearms carried off duty shall constitute good~~
29 ~~cause to suspend or revoke that person's right to carry firearms~~
30 ~~off duty.~~

31 ~~(e) The Department of Corrections and Rehabilitation shall~~
32 ~~allow reasonable access to its ranges for officers and designees of~~
33 ~~either department to qualify to carry concealable firearms off duty.~~
34 ~~The time spent on the range for purposes of meeting the~~
35 ~~qualification requirements shall be the person's own time during~~
36 ~~the person's off-duty hours.~~

37 ~~(f) The secretary shall promulgate regulations consistent with~~
38 ~~this section.~~

39 ~~(g) "High-risk transportation details" and "high-risk escape~~
40 ~~details" as used in this section shall be determined by the secretary,~~

1 or his or her designee. The secretary, or his or her designee, shall
2 consider at least the following in determining “high-risk
3 transportation details” and “high-risk escape details”: protection
4 of the public, protection of officers, flight risk, and violence
5 potential of the wards.

6 (h) ~~“Transportation detail” as used in this section shall include~~
7 ~~transportation of wards outside the facility, including, but not~~
8 ~~limited to, court appearances, medical trips, and interfacility~~
9 ~~transfers.~~

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

11 3000. (a) (1) The Legislature finds and declares that the period
12 immediately following incarceration is critical to successful
13 reintegration of the offender into society and to positive citizenship.
14 It is in the interest of public safety for the state to provide for the
15 effective supervision of and surveillance of parolees, including
16 the judicious use of revocation actions, and to provide educational,
17 vocational, ~~family~~ *family*, and personal counseling necessary to
18 assist parolees in the transition between imprisonment and
19 discharge. A sentence resulting in imprisonment in the state prison
20 pursuant to Section 1168 or 1170 shall include a period of parole
21 supervision or postrelease community supervision, unless waived,
22 or as otherwise provided in this article.

23 (2) The Legislature finds and declares that it is not the intent of
24 this section to diminish resources allocated to the Department of
25 Corrections and Rehabilitation for parole functions for which the
26 department is responsible. It is also not the intent of this section
27 to diminish the resources allocated to the Board of Parole Hearings
28 to execute its duties with respect to parole functions for which the
29 board is responsible.

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

34 (4) For any person subject to a sexually violent predator
35 proceeding pursuant to Article 4 (commencing with Section 6600)
36 of Chapter 2 of Part 2 of Division 6 of the Welfare and Institutions
37 Code, an order issued by a judge pursuant to Section 6601.5 of the
38 Welfare and Institutions Code, finding that the petition, on its face,
39 supports a finding of probable cause to believe that the individual
40 named in the petition is likely to engage in sexually violent

1 predatory criminal behavior upon his or her release, shall toll the
2 period of parole of that person, from the date that person is released
3 by the Department of Corrections and Rehabilitation as follows:

4 (A) If the person is committed to the State Department of State
5 Hospitals as a sexually violent predator and subsequently a court
6 orders that the person be unconditionally discharged, the parole
7 period shall be tolled until the date the judge enters the order
8 unconditionally discharging that person.

9 (B) If the person is not committed to the State Department of
10 State Hospitals as a sexually violent predator, the tolling of the
11 parole period shall be abrogated and the parole period shall be
12 deemed to have commenced on the date of release from the
13 Department of Corrections and Rehabilitation.

14 (5) Paragraph (4) applies to persons released by the Department
15 of Corrections and Rehabilitation on or after January 1, 2012.
16 Persons released by the Department of Corrections and
17 Rehabilitation prior to January 1, 2012, shall continue to be subject
18 to the law governing the tolling of parole in effect on December
19 31, 2011.

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

23 (1) In the case of any inmate sentenced under Section 1168 for
24 a crime committed prior to July 1, 2013, the period of parole shall
25 not exceed five years in the case of an inmate imprisoned for any
26 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 Board of Parole Hearings for good cause waives parole and
30 discharges the inmate from custody of the department. This
31 subdivision shall also be applicable to inmates who committed
32 crimes prior to July 1, 1977, to the extent specified in Section
33 1170.2. In the case of any inmate sentenced under Section 1168
34 for a crime committed on or after July 1, 2013, the period of parole
35 shall not exceed five years in the case of an inmate imprisoned for
36 any offense other than first or second degree murder for which the
37 inmate has received a life sentence, and shall not exceed three
38 years in the case of any other inmate, unless in either case the
39 department for good cause waives parole and discharges the inmate
40 from custody of the department.

1 (2) (A) For a crime committed prior to 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 not exceeding three years, except that any inmate sentenced for
7 an offense specified in paragraph (3), (4), (5), (6), (11), or (18) of
8 subdivision (c) of Section 667.5 shall be released on parole for a
9 period not exceeding 10 years, unless a longer period of parole is
10 specified in Section 3000.1.

11 (B) For a crime committed on or after July 1, 2013, at the
12 expiration of a term of imprisonment of one year and one day, or
13 a term of imprisonment imposed pursuant to Section 1170 or at
14 the expiration of a term reduced pursuant to Section 2931 or 2933,
15 if applicable, the inmate shall be released on parole for a period
16 of three years, except that any inmate sentenced for an offense
17 specified in paragraph (3), (4), (5), (6), (11), or (18) of subdivision
18 (c) of Section 667.5 shall be released on parole for a period of 10
19 years, unless a longer period of parole is specified in Section
20 3000.1.

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

27 (4) (A) Notwithstanding paragraphs (1) to (3), inclusive, in the
28 case of a person convicted of and required to register as a sex
29 offender for the commission of an offense specified in Section
30 261, 262, 264.1, 286, 288a, paragraph (1) of subdivision (b) of
31 Section 288, Section 288.5, or 289, in which one or more of the
32 victims of the offense was a child under 14 years of age, the period
33 of parole shall be 20 years and six months unless the board, for
34 good cause, determines that the person will be retained on parole.
35 The board shall make a written record of this determination and
36 transmit a copy of it to the parolee.

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

39 (C) There shall be a board hearing consistent with the procedures
40 set forth in Sections 3041.5 and 3041.7 within 12 months of the

1 date of any revocation of parole to consider the release of the
2 inmate on parole, and notwithstanding the provisions of paragraph
3 (3) of subdivision (b) of Section 3041.5, there shall be annual
4 parole consideration hearings thereafter, unless the person is
5 released or otherwise ineligible for parole release. The panel or
6 board shall release the person within one year of the date of the
7 revocation unless it determines that the circumstances and gravity
8 of the parole violation are such that consideration of the public
9 safety requires a more lengthy period of incarceration or unless
10 there is a new prison commitment following a conviction.

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

13 (5) (A) The Board of Parole Hearings shall consider the request
14 of any inmate whose commitment offense occurred prior to July
15 1, 2013, regarding the length of his or her parole and the conditions
16 thereof.

17 (B) For an inmate whose commitment offense occurred on or
18 after July 1, 2013, except for those inmates described in Section
19 3000.1, the department shall consider the request of the inmate
20 regarding the length of his or her parole and the conditions thereof.
21 For those inmates described in Section 3000.1, the Board of Parole
22 Hearings shall consider the request of the inmate regarding the
23 length of his or her parole and the conditions thereof.

24 (6) Upon successful completion of parole, or at the end of the
25 maximum statutory period of parole specified for the inmate under
26 paragraph (1), (2), (3), or (4), as the case may be, whichever is
27 earlier, the inmate shall be discharged from custody. The date of
28 the maximum statutory period of parole under this subdivision and
29 paragraphs (1), (2), (3), and (4) shall be computed from the date
30 of initial parole and shall be a period chronologically determined.
31 Time during which parole is suspended because the prisoner has
32 absconded or has been returned to custody as a parole violator
33 shall not be credited toward any period of parole unless the prisoner
34 is found not guilty of the parole violation. However, the period of
35 parole is subject to the following:

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

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

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

9 (7) The Department of Corrections and Rehabilitation shall meet
10 with each inmate at least 30 days prior to his or her good time
11 release date and shall provide, under guidelines specified by the
12 parole authority or the department, whichever is applicable, the
13 conditions of parole and the length of parole up to the maximum
14 period of time provided by law. The inmate has the right to
15 reconsideration of the length of parole and conditions thereof by
16 the department or the parole authority, whichever is applicable.
17 The Department of Corrections and Rehabilitation or the board
18 may impose as a condition of parole that a prisoner make payments
19 on the prisoner's outstanding restitution fines or orders imposed
20 pursuant to subdivision (a) or (c) of Section 13967 of the
21 Government Code, as operative prior to September 28, 1994, or
22 subdivision (b) or (f) of Section 1202.4.

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

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

32 (B) Notwithstanding subparagraph (A), any warrant issued by
33 the Board of Parole Hearings prior to July 1, 2013, shall remain
34 in full force and effect until the warrant is served or it is recalled
35 by the board. All prisoners on parole arrested pursuant to a warrant
36 issued by the board shall be subject to a review by the board prior
37 to the department filing a petition with the court to revoke the
38 parole of the petitioner.

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

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

5 2356. (a) No ward or conservatee may be placed in a mental
6 health treatment facility under this division against the will of the
7 ward or conservatee. Involuntary civil placement of a ward or
8 conservatee in a mental health treatment facility may be obtained
9 only pursuant to Chapter 2 (commencing with Section 5150) or
10 Chapter 3 (commencing with Section 5350) of Part 1 of Division
11 5 of the Welfare and Institutions Code. Nothing in this subdivision
12 precludes the placing of a ward in a state hospital under Section
13 6000 of the Welfare and Institutions Code upon application of the
14 guardian as provided in that section. The Director of State Hospitals
15 shall adopt and issue regulations defining “mental health treatment
16 facility” for the purposes of this subdivision.

17 (b) No experimental drug as defined in Section 111515 of the
18 Health and Safety Code may be prescribed for or administered to
19 a ward or conservatee under this division. Such an experimental
20 drug may be prescribed for or administered to a ward or
21 conservatee only as provided in Article 4 (commencing with
22 Section 111515) of Chapter 6 of Part 5 of Division 104 of the
23 Health and Safety Code.

24 (c) No convulsive treatment as defined in Section 5325 of the
25 Welfare and Institutions Code may be performed on a ward or
26 conservatee under this division. Convulsive treatment may be
27 performed on a ward or conservatee only as provided in Article 7
28 (commencing with Section 5325) of Chapter 2 of Part 1 of Division
29 5 of the Welfare and Institutions Code.

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

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

34 SEC. 13. Section 736 of the Welfare and Institutions Code is
35 amended to read:

36 736. (a) Except as provided in Section 733, the Department
37 of Corrections and Rehabilitation, Division of Juvenile Facilities,
38 shall accept a ward committed to it pursuant to this article if the
39 Director of the Division of Juvenile Justice believes that the ward
40 can be materially benefited by the division’s reformatory and

1 educational discipline, and if the division has adequate facilities,
2 staff, and programs to provide that care. A ward subject to this
3 section shall not be transported to any facility under the jurisdiction
4 of the division until the superintendent of the facility has notified
5 the committing court of the place to which that ward is to be
6 transported and the time at which he or she can be received.

7 (b) To determine who is best served by the Division of Juvenile
8 Facilities, and who would be better served by the State Department
9 of State Hospitals, the Director of the Division of Juvenile Justice
10 and the Director of State Hospitals shall, at least annually, confer
11 and establish policy with respect to the types of cases that should
12 be the responsibility of each department.

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

15 5328.15. All information and records obtained in the course
16 of providing services under Division 5 (commencing with Section
17 5000), Division 6 (commencing with Section 6000), or Division
18 7 (commencing with Section 7000), to either voluntary or
19 involuntary recipients of services shall be confidential. Information
20 and records may be disclosed, however, notwithstanding any other
21 provision of law, as follows:

22 (a) To authorized licensing personnel who are employed by, or
23 who are authorized representatives of, the State Department of
24 Public Health, and who are licensed or registered health
25 professionals, and to authorized legal staff or special investigators
26 who are peace officers who are employed by, or who are authorized
27 representatives of the State Department of Social Services, as
28 necessary to the performance of their duties to inspect, license,
29 and investigate health facilities and community care facilities and
30 to ensure that the standards of care and services provided in such
31 facilities are adequate and appropriate and to ascertain compliance
32 with the rules and regulations to which the facility is subject. The
33 confidential information shall remain confidential except for
34 purposes of inspection, licensing, or investigation pursuant to
35 Chapter 2 (commencing with Section 1250) of, and Chapter 3
36 (commencing with Section 1500) of, Division 2 of the Health and
37 Safety Code, or a criminal, civil, or administrative proceeding in
38 relation thereto. The confidential information may be used by the
39 State Department of Public Health or the State Department of
40 Social Services in a criminal, civil, or administrative proceeding.

1 The confidential information shall be available only to the judge
2 or hearing officer and to the parties to the case. Names which are
3 confidential shall be listed in attachments separate to the general
4 pleadings. The confidential information shall be sealed after the
5 conclusion of the criminal, civil, or administrative hearings, and
6 shall not subsequently be released except in accordance with this
7 subdivision. If the confidential information does not result in a
8 criminal, civil, or administrative proceeding, it shall be sealed after
9 the State Department of Public Health or the State Department of
10 Social Services decides that no further action will be taken in the
11 matter of suspected licensing violations. Except as otherwise
12 provided in this subdivision, confidential information in the
13 possession of the State Department of Public Health or the State
14 Department of Social Services shall not contain the name of the
15 patient.

16 (b) To any board which licenses and certifies professionals in
17 the fields of mental health pursuant to state law, when the Director
18 of State Hospitals has reasonable cause to believe that there has
19 occurred a violation of any provision of law subject to the
20 jurisdiction of that board and the records are relevant to the
21 violation. This information shall be sealed after a decision is
22 reached in the matter of the suspected violation, and shall not
23 subsequently be released except in accordance with this
24 subdivision. Confidential information in the possession of the
25 board shall not contain the name of the patient.

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

29 (1) An unredacted facility evaluation report form or an
30 unredacted complaint investigation report form of the State
31 Department of Social Services. This information shall remain
32 confidential and subject to the confidentiality requirements of
33 subdivision (f) of Section 4903.

34 (2) An unredacted citation report, unredacted licensing report,
35 unredacted survey report, unredacted plan of correction, or
36 unredacted statement of deficiency of the State Department of
37 Public Health, prepared by authorized licensing personnel or
38 authorized representatives described in subdivision (n). This
39 information shall remain confidential and subject to the
40 confidentiality requirements of subdivision (f) of Section 4903.

1 ~~SEC. 15. Section 6000 of the Welfare and Institutions Code is~~
2 ~~amended to read:~~

3 ~~6000. (a) Pursuant to applicable rules and regulations~~
4 ~~established by the State Department of State Hospitals or the State~~
5 ~~Department of Developmental Services, the medical director of a~~
6 ~~state hospital for the mentally disordered or developmentally~~
7 ~~disabled may receive in such hospital, as a boarder and patient,~~
8 ~~any person who is a suitable person for care and treatment in such~~
9 ~~hospital, upon receipt of a written application for the admission~~
10 ~~of the person into the hospital for care and treatment made in~~
11 ~~accordance with the following requirements:~~

12 ~~(1) In the case of an adult person, the application shall be made~~
13 ~~voluntarily by the person, at a time when he or she is in such~~
14 ~~condition of mind as to render him or her competent to make it or,~~
15 ~~if he or she is a conservatee with a conservator of the person or~~
16 ~~person and estate who was appointed under Chapter 3~~
17 ~~(commencing with Section 5350) of Part 1 of Division 5 with the~~
18 ~~right as specified by court order under Section 5358 to place his~~
19 ~~or her conservatee in a state hospital, by his or her conservator.~~

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

31 ~~(B) Any person received in a state hospital shall be deemed a~~
32 ~~voluntary patient.~~

33 ~~(C) Upon the admission of a voluntary patient to a state hospital~~
34 ~~the medical director shall immediately forward to the office of the~~
35 ~~State Department of State Hospitals or the State Department of~~
36 ~~Developmental Services the record of such voluntary patient,~~
37 ~~showing the name, residence, age, sex, place of birth, occupation,~~
38 ~~civil condition, date of admission of such patient to such hospital,~~
39 ~~and such other information as is required by the rules and~~
40 ~~regulations of the department.~~

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

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

11 ~~(F) A minor person who is a voluntary patient may leave the~~
12 ~~hospital or institution after completing normal hospitalization~~
13 ~~departure procedures after notice is given to the superintendent or~~
14 ~~person in charge by the parents, or the parent, guardian,~~
15 ~~conservator, or other person entitled to the custody of the minor,~~
16 ~~of their desire to remove him or her from the hospital.~~

17 ~~(G) No person received into a state hospital, private mental~~
18 ~~institution, or county psychiatric hospital as a voluntary patient~~
19 ~~during his or her minority shall be detained therein after he or she~~
20 ~~reaches the age of majority, but any such person, after attaining~~
21 ~~the age of majority, may apply for admission into the hospital or~~
22 ~~institution for care and treatment in the manner prescribed in this~~
23 ~~section for applications by adult persons.~~

24 ~~(b) The State Department of State Hospitals or the State~~
25 ~~Department of Developmental Services shall establish such rules~~
26 ~~and regulations as are necessary to carry out properly the provisions~~
27 ~~of this section.~~

28 ~~(e) Commencing July 1, 2012, the department shall not admit~~
29 ~~any person to a developmental center pursuant to this section.~~

30 ~~SEC. 16.— Section 6002 of the Welfare and Institutions Code is~~
31 ~~amended to read:~~

32 ~~6002.— (a) The person in charge of any private institution,~~
33 ~~hospital, clinic, or sanitarium which is conducted for, or includes~~
34 ~~a department or ward conducted for, the care and treatment of~~
35 ~~persons who are mentally disordered may receive therein as a~~
36 ~~voluntary patient any person suffering from a mental disorder who~~
37 ~~is a suitable person for care and treatment in the institution,~~
38 ~~hospital, clinic, or sanitarium who voluntarily makes a written~~
39 ~~application to the person in charge for admission into the~~
40 ~~institution, hospital, clinic, or sanitarium, and who is at the time~~

1 of making the application mentally competent to make the
2 application. A conservatee, with a conservator of the person, or
3 person and estate, appointed under Chapter 3 (commencing with
4 Section 5350) of Part 1 of Division 5, with the right as specified
5 by court order under Section 5358 to place his or her conservatee,
6 may be admitted upon written application by his or her conservator.

7 (b) After the admission of a voluntary patient to a private
8 institution, hospital, clinic, or sanitarium the person in charge shall
9 forward to the office of the State Department of State Hospitals a
10 record of the voluntary patient showing such information as may
11 be required by rule by the department.

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

17 ~~SEC. 17.~~

18 *SEC. 15.* Section 6600 of the Welfare and Institutions Code is
19 amended to read:

20 6600. As used in this article, the following terms have the
21 following meanings:

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

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

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

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

34 (C) A prior conviction in another jurisdiction for an offense that
35 includes all of the elements of an offense described in subdivision
36 (b).

37 (D) A conviction for an offense under a predecessor statute that
38 includes all of the elements of an offense described in subdivision
39 (b).

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

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

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

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

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

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

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

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

1 209, or 220 of the Penal Code, committed with the intent to commit
2 a violation of Section 261, 262, 264.1, 286, 288, 288a, or 289 of
3 the Penal Code.

4 (c) “Diagnosed mental disorder” includes a congenital or
5 acquired condition affecting the emotional or volitional capacity
6 that predisposes the person to the commission of criminal sexual
7 acts in a degree constituting the person a menace to the health and
8 safety of others.

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

11 (e) “Predatory” means an act is directed toward a stranger, a
12 person of casual acquaintance with whom no substantial
13 relationship exists, or an individual with whom a relationship has
14 been established or promoted for the primary purpose of
15 victimization.

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

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

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

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

27 (3) The juvenile was adjudged a ward of the juvenile court
28 within the meaning of Section 602 because of the person’s
29 commission of the offense giving rise to the juvenile court
30 adjudication.

31 (4) The juvenile was committed to the Division of Juvenile
32 Facilities, Department of Corrections and Rehabilitation for the
33 sexually violent offense.

34 (h) A minor adjudged a ward of the court for commission of an
35 offense that is defined as a sexually violent offense shall be entitled
36 to specific treatment as a sexual offender. The failure of a minor
37 to receive that treatment shall not constitute a defense or bar to a
38 determination that any person is a sexually violent predator within
39 the meaning of this article.

1 ~~SEC. 18.~~

2 *SEC. 16.* Section 6601 of the Welfare and Institutions Code is
3 amended to read:

4 6601. (a) (1) Whenever the Secretary of the Department of
5 Corrections and Rehabilitation determines that an individual who
6 is in custody under the jurisdiction of the Department of
7 Corrections and Rehabilitation, and who is either serving a
8 determinate prison sentence or whose parole has been revoked,
9 may be a sexually violent predator, the secretary shall, at least six
10 months prior to that individual's scheduled date for release from
11 prison, refer the person for evaluation in accordance with this
12 section. However, if the inmate was received by the department
13 with less than nine months of his or her sentence to serve, or if the
14 inmate's release date is modified by judicial or administrative
15 action, the secretary may refer the person for evaluation in
16 accordance with this section at a date that is less than six months
17 prior to the inmate's scheduled release date.

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

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

39 (c) The State Department of State Hospitals shall evaluate the
40 person in accordance with a standardized assessment protocol,

1 developed and updated by the State Department of State Hospitals,
2 to determine whether the person is a sexually violent predator as
3 defined in this article. The standardized assessment protocol shall
4 require assessment of diagnosable mental disorders, as well as
5 various factors known to be associated with the risk of reoffense
6 among sex offenders. Risk factors to be considered shall include
7 criminal and psychosexual history, type, degree, and duration of
8 sexual deviance, and severity of mental disorder.

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

21 (e) If one of the professionals performing the evaluation pursuant
22 to subdivision (d) does not concur that the person meets the criteria
23 specified in subdivision (d), but the other professional concludes
24 that the person meets those criteria, the Director of State Hospitals
25 shall arrange for further examination of the person by two
26 independent professionals selected in accordance with subdivision
27 (g).

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

39 (g) Any independent professional who is designated by the
40 Secretary of the Department of Corrections and Rehabilitation or

1 the Director of State Hospitals for purposes of this section shall
2 not be a state government employee, shall have at least five years
3 of experience in the diagnosis and treatment of mental disorders,
4 and shall include psychiatrists and licensed psychologists who
5 have a doctoral degree in psychology. The requirements set forth
6 in this section also shall apply to any professionals appointed by
7 the court to evaluate the person for purposes of any other
8 proceedings under this article.

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

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

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

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

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

1 (m) This section shall become operative on the date that the
2 director executes a declaration, which shall be provided to the
3 fiscal and policy committees of the Legislature, including the
4 Chairperson of the Joint Legislative Budget Committee, and the
5 Department of Finance, specifying that sufficient qualified state
6 employees have been hired to conduct the evaluations required
7 pursuant to subdivision (d), or January 1, 2013, whichever occurs
8 first.

9 ~~SEC. 19.~~

10 *SEC. 17.* Section 6608.7 of the Welfare and Institutions Code
11 is amended to read:

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

19 ~~SEC. 20.~~

20 *SEC. 18.* Section 6609 of the Welfare and Institutions Code is
21 amended to read:

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

31 ~~SEC. 21.~~

32 *SEC. 19.* Section 9717 of the Welfare and Institutions Code is
33 amended to read:

34 9717. (a) All advocacy programs and any programs similar in
35 nature to the Long-Term Care Ombudsman Program that receive
36 funding or official designation from the state shall cooperate with
37 the office, where appropriate. These programs include, but are not
38 limited to, the Office of Human Rights within the State Department
39 of State Hospitals, the Office of Patients' Rights, Disability Rights

1 California, and the Department of Rehabilitation’s Client
2 Assistance Program.

3 (b) The office shall maintain a close working relationship with
4 the Legal Services Development Program for the Elderly within
5 the department.

6 (c) In order to ensure the provision of counsel for patients and
7 residents of long-term care facilities, the office shall seek to
8 establish effective coordination with programs that provide legal
9 services for the elderly, including, but not limited to, programs
10 that are funded by the federal Legal Services Corporation or under
11 the federal Older Americans Act (42 U.S.C. Sec. 3001 et seq.), as
12 amended.

13 (d) The department and other state departments and programs
14 that have roles in funding, regulating, monitoring, or serving
15 long-term care facility residents, including law enforcement
16 agencies, shall cooperate with and meet with the office periodically
17 and as needed to address concerns or questions involving the care,
18 quality of life, safety, rights, health, and well-being of long-term
19 care facility residents.

20 ~~SEC. 22.~~

21 *SEC. 20.* Section 10600.1 of the Welfare and Institutions Code
22 is amended to read:

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

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

1 Department of State Hospitals or the State Department of
2 Developmental Services.

3 ~~SEC. 23.~~

4 *SEC. 21.* Section 10725 of the Welfare and Institutions Code
5 is amended to read:

6 10725. The director may adopt regulations, orders, or standards
7 of general application to implement, interpret, or make specific
8 the law enforced by the department, and those regulations, orders,
9 and standards shall be adopted, amended, or repealed by the
10 director only in accordance with Chapter 3.5 (commencing with
11 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
12 Code. Regulations relating to services need not be printed in the
13 California Code of Regulations or the California Regulatory Notice
14 Register if they are included in the publications of the department.
15 This authority also may be exercised by the director's designee.

16 In adopting regulations the director shall strive for clarity of
17 language that may be readily understood by those administering
18 services or subject to those regulations.

19 The rules of the department need not specify or include the detail
20 of forms, reports, or records, but shall include the essential
21 authority by which any person, agency, organization, association,
22 or institution subject to the supervision or investigation of the
23 department is required to use, submit, or maintain those forms,
24 reports, or records.

25 ~~SEC. 24.~~

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

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

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

5 (3) Health facilities licensed by the department pursuant to
6 Chapter 2 (commencing with Section 1250) of Division 2 of the
7 Health and Safety Code and certified by the department to
8 participate in the Medi-Cal program shall not be subject to this
9 section.

10 (4) Adult day health care providers licensed pursuant to Chapter
11 3.3 (commencing with Section 1570) of Division 2 of the Health
12 and Safety Code and certified by the department to participate in
13 the Medi-Cal program shall not be subject to this section.

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

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

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

35 (c) (1) Except as provided in paragraph (2), within 30 days
36 after receiving an application package submitted pursuant to
37 subdivision (a), the department shall provide written notice that
38 the application package has been received and, if applicable, that
39 there is a moratorium on the enrollment of providers in the specific
40 provider of service category or subgroup of the category to which

1 the applicant or provider belongs. This moratorium shall bar further
2 processing of the application package.

3 (2) Within 15 days after receiving an application package from
4 a physician, or a group of physicians, licensed by the Medical
5 Board of California or the Osteopathic Medical Board of California,
6 or a change of location form pursuant to subdivision (b), the
7 department shall provide written notice that the application package
8 or the change of location form has been received.

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

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

34 (A) Hold a current license as a physician and surgeon issued by
35 the Medical Board of California or the Osteopathic Medical Board
36 of California, which license shall not have been revoked, whether
37 stayed or not, suspended, placed on probation, or subject to other
38 limitation.

39 (B) Be a current faculty member of a teaching hospital or a
40 children's hospital, as defined in Section 10727, accredited by the

1 Joint Commission or the American Osteopathic Association, or
2 be credentialed by a health care service plan that is licensed under
3 the Knox-Keene Health Care Service Plan Act of 1975 (Chapter
4 2.2 (commencing with Section 1340) of Division 2 of the Health
5 and Safety Code) or county organized health system, or be a current
6 member in good standing of a group that is credentialed by a health
7 care service plan that is licensed under the Knox-Keene Act.

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

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

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

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

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

34 (A) The applicant's or provider's practice is based in one or
35 more of the following: a general acute care hospital, a rural general
36 acute care hospital, or an acute psychiatric hospital, as defined in
37 subdivisions (a) and (b) of Section 1250 of the Health and Safety
38 Code.

39 (B) The applicant or provider holds a current, unrevoked, or
40 unsuspended license as a physician and surgeon issued by the

1 Medical Board of California or the Osteopathic Medical Board of
2 California. An applicant or provider shall not be in compliance
3 with this subparagraph if a license revocation has been stayed, the
4 licensee has been placed on probation, or the license is subject to
5 any other limitation.

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

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

10 (f) Except as provided in subdivision (g), within 180 days after
11 receiving an application package submitted pursuant to subdivision
12 (a), or from the date of the notice to an applicant or provider that
13 the applicant or provider does not qualify as a preferred provider
14 under subdivision (d), the department shall give written notice to
15 the applicant or provider that any of the following applies, or shall
16 on the 181st day grant the applicant or provider provisional
17 provider status pursuant to this section for a period no longer than
18 12 months, effective from the 181st day:

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

22 (2) The application package is incomplete. The notice shall
23 identify additional information or documentation that is needed to
24 complete the application package.

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

28 (4) The application package is denied for any of the following
29 reasons:

30 (A) Pursuant to Section 14043.2 or 14043.36.

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

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

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

38 (E) For failing to submit fingerprints as required by federal
39 Medicaid regulations.

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

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

6 (g) Notwithstanding subdivision (f), within 90 days after
7 receiving an application package submitted pursuant to subdivision
8 (a) from a physician or physician group licensed by the Medical
9 Board of California or the Osteopathic Medical Board of California,
10 or from the date of the notice to that physician or physician group
11 that does not qualify as a preferred provider under subdivision (d),
12 or within 90 days after receiving a change of location form
13 submitted pursuant to subdivision (b), the department shall give
14 written notice to the applicant or provider that either paragraph
15 (1), (2), (3), (4), or (5) of subdivision (f) applies, or shall on the
16 91st day grant the applicant or provider provisional provider status
17 pursuant to this section for a period no longer than 12 months,
18 effective from the 91st day.

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

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

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

30 (C) The department is exercising its authority under Section
31 14043.37, 14043.4, or 14043.7 to conduct background checks,
32 preenrollment inspections, or unannounced visits.

33 (D) *The application package is withdrawn by request of the*
34 *applicant or provider and the department's review is canceled*
35 *pursuant to subdivision (n).*

36 (2) (A) If the application package that was noticed as
37 incomplete under paragraph (2) of subdivision (f) is not resubmitted
38 with all requested information and documentation and received
39 by the department within 60 days of the date on the notice, the
40 application package shall be denied by operation of law. The

1 applicant or provider may reapply by submitting a new application
2 package that shall be reviewed de novo.

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

9 (C) Notwithstanding subparagraph (A), if the notice of an
10 incomplete application package included a request for information
11 or documentation related to grounds for denial under Section
12 14043.2 or 14043.36, the applicant or provider shall not reapply
13 for enrollment or continued enrollment in the Medi-Cal program
14 or for participation in any health care program administered by
15 the department or its agents or contractors for a period of three
16 years.

17 (i) (1) If the department exercises its authority under Section
18 14043.37, 14043.4, or 14043.7 to conduct background checks,
19 preenrollment inspections, or unannounced visits, the applicant or
20 provider shall receive notice, from the department, after the
21 conclusion of the background check, preenrollment inspection, or
22 unannounced visit of either of the following:

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

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

29 (2) (A) The notice shall identify the discrepancies or failures,
30 and whether remediation can be made or not, and if so, the time
31 period within which remediation must be accomplished. Failure
32 to remediate discrepancies and failures as prescribed by the
33 department, or notification that remediation is not available, shall
34 result in denial of the application by operation of law. The applicant
35 or provider may reapply by submitting a new application package
36 that shall be reviewed de novo.

37 (B) If the failure to remediate is by a currently enrolled provider
38 as defined in Section 14043.1, including providers applying for
39 continued enrollment, the failure may make the provider also
40 subject to deactivation of the provider's number and all of the

1 business addresses used by the provider to provide services, goods,
2 supplies, or merchandise to Medi-Cal beneficiaries.

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

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

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

1 that location is received by the department, the department may
2 deny the claim.

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

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

10 (2) During the budget proceedings of the 2006–07 fiscal year,
11 and each fiscal year thereafter, the department shall provide data
12 to the Legislature specifying the timeframe under which it has
13 processed and approved the provider applications submitted by
14 individual nurse providers.

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

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

24 (2) The department’s review shall not be canceled if, at the time
25 the applicant or provider requests to withdraw ~~his or her~~ *the*
26 application package, the department has already initiated *its* review
27 under Section 14043.37, 14043.4, or 14043.7.

28 ~~SEC. 25.~~

29 *SEC. 23.* Section 14087.36 of the Welfare and Institutions
30 Code is amended to read:

31 14087.36. (a) The following definitions shall apply for
32 purposes of this section:

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

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

36 (3) “Department” means the State Department of Health Care
37 Services.

38 (4) “Governing body” means the governing body of the health
39 authority.

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

5 (b) The Legislature finds and declares that it is necessary that
6 a health authority be established in the county to arrange for the
7 provision of health care services in order to meet the problems of
8 the delivery of publicly assisted medical care in the county, to
9 enter into a contract with the department under Article 2.97
10 (commencing with Section 14093), or to contract with a health
11 care service plan on terms and conditions acceptable to the
12 department, and to demonstrate ways of promoting quality care
13 and cost efficiency.

14 (c) The county may, by resolution or ordinance, establish a
15 health authority to act as and be the local initiative component of
16 the Medi-Cal state plan pursuant to regulations adopted by the
17 department. If the board elects to establish a health authority, all
18 rights, powers, duties, privileges, and immunities vested in a county
19 under Article 2.8 (commencing with Section 14087.5) and Article
20 2.97 (commencing with Section 14093) shall be vested in the health
21 authority. The health authority shall have all power necessary and
22 appropriate to operate programs involving health care services,
23 including, but not limited to, the power to acquire, possess, and
24 dispose of real or personal property, to employ personnel and
25 contract for services required to meet its obligations, to sue or be
26 sued, to take all actions and engage in all public and private
27 business activities, subject to any applicable licensure, as permitted
28 a health care service plan pursuant to Chapter 2.2 (commencing
29 with Section 1340) of Division 2 of the Health and Safety Code,
30 and to enter into agreements under Chapter 5 (commencing with
31 Section 6500) of Division 7 of Title 1 of the Government Code.

32 (d) (1) (A) The health authority shall be considered a public
33 entity for purposes of Division 3.6 (commencing with Section 810)
34 of Title 1 of the Government Code, separate and distinct from the
35 county, and shall file the statement required by Section 53051 of
36 the Government Code. The health authority shall have primary
37 responsibility to provide the defense and indemnification required
38 under Division 3.6 (commencing with Section 810) of Title 1 of
39 the Government Code for employees of the health authority who
40 are employees of the county. The health authority shall provide

1 insurance under terms and conditions required by the county in
2 order to satisfy its obligations under this section.

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

6 (2) The health authority shall not be considered to be an agency,
7 division, department, or instrumentality of the county and shall
8 not be subject to the personnel, procurement, or other operational
9 rules of the county.

10 (3) Notwithstanding any other provision of law, any obligations
11 of the health authority, statutory, contractual, or otherwise, shall
12 be the obligations solely of the health authority and shall not be
13 the obligations of the county, unless expressly provided for in a
14 contract between the authority and the county, nor of the state.

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

19 (e) (1) To the full extent permitted by federal law, the
20 department and the health authority may enter into contracts to
21 provide or arrange for health care services for any or all persons
22 who are eligible to receive benefits under the Medi-Cal program.
23 The contracts may be on an exclusive or nonexclusive basis, and
24 shall include payment provisions on any basis negotiated between
25 the department and the health authority. The health authority may
26 also enter into contracts for the provision of health care services
27 to individuals including, but not limited to, those covered under
28 Subchapter XVIII (commencing with Section 1395) of Chapter 7
29 of Title 42 of the United States Code, individuals employed by
30 public agencies and private businesses, and uninsured or indigent
31 individuals.

32 (2) Notwithstanding paragraph (1), or subdivision (f), the health
33 authority may not operate health plans or programs for individuals
34 covered under Subchapter XVIII (commencing with Section 1395)
35 of Chapter 7 of Title 42 of the United States Code, or for private
36 businesses, until the health authority is in full compliance with all
37 of the requirements of the Knox-Keene Health Care Service Plan
38 Act of 1975 under Chapter 2.2 (commencing with Section 1340)
39 of Division 2 of the Health and Safety Code, including tangible
40 net equity requirements applicable to a licensed health care service

1 plan. This limitation shall not preclude the health authority from
2 enrolling persons pursuant to the county's obligations under Section
3 17000, or from enrolling county employees.

4 (f) The board of supervisors may transfer responsibility for
5 administration of county-provided health care services to the health
6 authority for the purpose of service of populations including
7 uninsured and indigent persons, subject to the provisions of any
8 ordinances or resolutions passed by the county board of
9 supervisors. The transfer of administrative responsibility for those
10 health care services shall not relieve the county of its responsibility
11 for indigent care pursuant to Section 17000. The health authority
12 may also enter into contracts for the provision of health care
13 services to individuals including, but not limited to, those covered
14 under Subchapter XVIII (commencing with Section 1395) of
15 Chapter 7 of Title 42 of the United States Code, and individuals
16 employed by public agencies and private businesses.

17 (g) Upon creation, the health authority may borrow from the
18 county and the county may lend the authority funds, or issue
19 revenue anticipation notes to obtain those funds necessary to
20 commence operations or perform the activities of the health
21 authority. Notwithstanding any other provision of law, both the
22 county and the health authority shall be eligible to receive funding
23 under subdivision (p) of Section 14163.

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

27 (i) Prior to the termination of the health authority, the county
28 shall notify the department of its intent to terminate the health
29 authority. The department shall conduct an audit of the health
30 authority's records within 30 days of notification to determine the
31 liabilities and assets of the health authority. The department shall
32 report its findings to the county and to the Department of Managed
33 Health Care within 10 days of completion of the audit. The county
34 shall prepare a plan to liquidate or otherwise dispose of the assets
35 of the health authority and to pay the liabilities of the health
36 authority to the extent of the health authority's assets, and present
37 the plan to the department and the Department of Managed Health
38 Care within 30 days upon receipt of these findings.

39 (j) Any assets of the health authority derived from the contract
40 entered into between the state and the authority pursuant to Article

1 2.97 (commencing with Section 14093), after payment of the
2 liabilities of the health authority, shall be disposed of pursuant to
3 the contract.

4 (k) (1) The governing body shall consist of 18 voting members,
5 14 of whom shall be appointed by resolution or ordinance of the
6 board as follows:

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

9 (B) One member shall be a person who is employed in the senior
10 management of a hospital not operated by the county or the
11 University of California and who is nominated by the San Francisco
12 Section of the ~~Westbay West Bay~~ Hospital Conference or any
13 successor organization, or if there is no successor organization, a
14 person who shall be nominated by the Hospital Council of Northern
15 and Central California.

16 (C) Two members, one of whom shall be a person employed in
17 the senior management of San Francisco General Hospital and one
18 of whom shall be a person employed in the senior management of
19 St. Luke's Hospital (San Francisco). If San Francisco General
20 Hospital or St. Luke's Hospital, at the end of the term of the person
21 appointed from its senior management, is not designated as a
22 disproportionate share hospital, and if the governing body, after
23 providing an opportunity for comment by the ~~Westbay West Bay~~
24 Hospital Conference, or any successor organization, determines
25 that the hospital no longer serves an equivalent patient population,
26 the governing body may, by a two-thirds vote of the full governing
27 body, select an alternative hospital to nominate a person employed
28 in its senior management to serve on the governing body.
29 Alternatively, the governing body may approve a reduction in the
30 number of positions on the governing body as set forth in
31 subdivision (p).

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

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

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

1 (G) Two members shall be persons nominated by the member
2 advisory committee of the health authority. Nominees of the
3 member advisory committee shall be enrolled in any of the health
4 insurance or health care coverage programs operated by the health
5 authority or be the parent or legal guardian of an enrollee in any
6 of the health insurance or health care coverage programs operated
7 by the health authority.

8 (H) Two members shall be persons knowledgeable in matters
9 relating to either traditional safety net providers, health care
10 organizations, the Medi-Cal program, or the activities of the health
11 authority, nominated by the program committee of the health
12 authority.

13 (I) One member shall be a person nominated by the San
14 Francisco Pharmacy Leadership Group, or any successor
15 organization.

16 (2) One member, selected to fulfill the appointments specified
17 in subparagraph (A), (G), or (H) shall, in addition to representing
18 his or her specified organization or employer, represent the
19 discipline of nursing, and shall possess or be qualified to possess
20 a registered nursing license.

21 (3) The initial members appointed by the board under the
22 subdivision shall be, to the extent those individuals meet the
23 qualifications set forth in this subdivision and are willing to serve,
24 those persons who are members of the steering committee created
25 by the county to develop the local initiative component of the
26 Medi-Cal state plan in San Francisco. Following the initial
27 staggering of terms, each of those members shall be appointed to
28 a term of three years, except the member appointed pursuant to
29 subparagraph (A) of paragraph (1), who shall serve at the pleasure
30 of the board. At the first meeting of the governing body, the
31 members appointed pursuant to this subdivision shall draw lots to
32 determine seven members whose initial terms shall be for two
33 years. Each member shall remain in office at the conclusion of
34 that member's term until a successor member has been nominated
35 and appointed.

36 (l) In addition to the requirements of subdivision (k), one
37 member of the governing body shall be appointed by the Mayor
38 of the City of San Francisco to serve at the pleasure of the mayor,
39 one member shall be the county's director of public health or
40 designee, who shall serve at the pleasure of that director, one

1 member shall be the Chancellor of the University of California at
2 San Francisco or his or her designee, who shall serve at the pleasure
3 of the chancellor, and one member shall be the county director of
4 mental health or his or her designee, who shall serve at the pleasure
5 of that director.

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

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

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

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

20 (p) A majority of the members of the governing body shall
21 constitute a quorum for the transaction of business, and all official
22 acts of the governing body shall require the affirmative vote of a
23 majority of the members present and voting. However, no official
24 shall be approved with less than the affirmative vote of six
25 members of the governing body, unless the number of members
26 prohibited from voting because of conflicts of interest precludes
27 adequate participation in the vote. The governing body may, by a
28 two-thirds vote adopt, amend, or repeal rules and procedures for
29 the governing body. Those rules and procedures may require that
30 certain decisions be made by a vote that is greater than a majority
31 vote.

32 (q) For purposes of Section 87103 of the Government Code,
33 members appointed pursuant to subparagraphs (B) to (E), inclusive,
34 of paragraph (1) of subdivision (k) represent, and are appointed
35 to represent, respectively, the hospitals, private nonprofit
36 community clinics, and physicians that contract with the health
37 authority, or the health care service plan with which the health
38 authority contracts, to provide health care services to the enrollees
39 of the health authority or the health care service plan. Members
40 appointed pursuant to subparagraphs (F) and (G) of paragraph (1)

1 of subdivision (k) represent, and are appointed to represent,
2 respectively, the health care workers and enrollees served by the
3 health authority or its contracted health care service plan, and
4 traditional safety net and ancillary providers and other
5 organizations concerned with the activities of the health authority.

6 (r) A member of the governing body may be removed from
7 office by the board by resolution or ordinance, only upon the
8 recommendation of the health authority, and for any of the
9 following reasons:

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

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

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

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

17 (5) Substantial failure to perform the duties of office, including,
18 but not limited to, unreasonable absence from meetings. The failure
19 to attend three meetings in a row of the governing body, or a
20 majority of the meetings in the most recent calendar year, may be
21 deemed to be unreasonable absence.

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

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

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

30 (1) A member advisory committee to advise the health authority
31 on issues of concern to the recipients of services.

32 (2) A program committee to advise the health authority on
33 matters relating to traditional safety net providers, ancillary
34 providers, and other organizations concerned with the activities
35 of the health authority.

36 (3) Any other committees determined to be advisable by the
37 health authority.

38 (v) (1) Notwithstanding any provision of state or local law,
39 including, but not limited to, the county charter, a member of the
40 health authority shall not be deemed to be interested in a contract

1 entered into by the authority within the meaning of Article 4
2 (commencing with Section 1090) of Chapter 1 of Division 4 of
3 Title 1 of the Government Code, or within the meaning of
4 conflict-of-interest restrictions in the county charter, if all of the
5 following apply:

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

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

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

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

18 (E) The contract authorizes the member or the organization the
19 member has an interest in or represents to provide services to
20 beneficiaries under the authority's program or administrative
21 services to the authority.

22 (2) In addition, no person serving as a member of the governing
23 body shall, by virtue of that membership, be deemed to be engaged
24 in activities that are inconsistent, incompatible, or in conflict with
25 their duties as an officer or employee of the county or the
26 University of California, or as an officer or an employee of any
27 private hospital, clinic, or other health care organization. The
28 membership shall not be deemed to be in violation of Section 1126
29 of the Government Code.

30 (w) Notwithstanding any other provision of law, those records
31 of the health authority and of the county that reveal the authority's
32 rates of payment for health care services or the health authority's
33 deliberative processes, discussions, communications, or any other
34 portion of the negotiations with providers of health care services
35 for rates of payment, or the health authority's peer review
36 proceedings shall not be required to be disclosed pursuant to the
37 California Public Records Act (Chapter 3.5 (commencing with
38 Section 6250) of Division 7 of Title 1 of the Government Code),
39 or any similar local law requiring the disclosure of public records.
40 However, three years after a contract or amendment to a contract

1 is fully executed, the portion of the contract or amendment
2 containing the rates of payment shall be open to inspection.

3 (x) Notwithstanding any other provision of law, the health
4 authority may meet in closed session to consider and take action
5 on peer review proceedings and on matters pertaining to contracts
6 and contract negotiations by the health authority's staff with
7 providers of health care services concerning all matters relating
8 to rates of payment. However, a decision as to whether to enter
9 into, amend the services provisions of, or terminate, other than for
10 reasons based upon peer review, a contract with a provider of
11 health care services, shall be made in open session.

12 (y) (1) (A) Notwithstanding the Ralph M. Brown Act (Chapter
13 9 (commencing with Section 54950) of Part 1 of Division 2 of
14 Title 5 of the Government Code), the governing board of the health
15 authority may meet in closed session for the purpose of discussion
16 of, or taking action on matters involving, health authority trade
17 secrets.

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

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

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

30 (ii) Premature disclosure of the trade secret would create a
31 substantial probability of depriving the health authority of a
32 substantial economic benefit or opportunity.

33 (2) Those records of the health authority that reveal the health
34 authority's trade secrets are exempt from disclosure pursuant to
35 the California Public Records Act (Chapter 3.5 (commencing with
36 Section 6250) of Division 7 of Title 1 of the Government Code),
37 or any similar local law requiring the disclosure of public records.
38 This exemption shall apply for a period of two years after the
39 service, program, marketing strategy, business plan, technology,
40 benefit, or product that is the subject of the trade secret is formally

1 adopted by the governing body of the health authority, provided
2 that the service, program, marketing strategy, business plan,
3 technology, benefit, or product continues to be a trade secret. The
4 governing board may delete the portion or portions containing
5 trade secrets from any documents that were finally approved in
6 the closed session held pursuant to this subdivision that are
7 provided to persons who have made the timely or standing request.

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

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

15 (ab) (1) The county controller or his or her designee, at intervals
16 the county controller deems appropriate, shall conduct a review
17 of the fiscal condition of the health authority, shall report the
18 findings to the health authority and the board, and shall provide a
19 copy of the findings to any public agency upon request.

20 (2) Upon the written request of the county controller, the health
21 authority shall provide full access to the county controller all health
22 authority records and documents as necessary to allow the county
23 controller or *his or her* designee to perform the activities authorized
24 by this subdivision.

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

28 ~~SEC. 26.~~

29 *SEC. 24.* Section 14105.192 of the Welfare and Institutions
30 Code is amended to read:

31 14105.192. (a) The Legislature finds and declares the
32 following:

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

37 (2) In order to minimize the need for drastically cutting
38 enrollment standards or benefits during times of economic crisis,
39 it is crucial to find areas within the program where reimbursement
40 levels are higher than required under the standard provided in

1 Section 1902(a)(30)(A) of the federal Social Security Act and can
2 be reduced in accordance with federal law.

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

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

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

15 (b) Therefore, it is the intent of the Legislature for the
16 department to analyze and identify where reimbursement levels
17 can be reduced consistent with the standard provided in Section
18 1902(a)(30)(A) of the federal Social Security Act and consistent
19 with federal and state law and policies, including any exemptions
20 contained in the provisions of the act that added this section,
21 provided that the reductions in reimbursement shall not exceed 10
22 percent on an aggregate basis for all providers, services and
23 products.

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

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

29 (2) For managed health care plans that contract with the
30 department pursuant to this chapter or Chapter 8 (commencing
31 with Section 14200), except contracts with Senior Care Action
32 Network and AIDS Healthcare Foundation, payments shall be
33 reduced by the actuarial equivalent amount of the payment
34 reductions specified in this section pursuant to contract
35 amendments or change orders effective on July 1, 2011, or
36 thereafter.

37 (3) Payments shall be reduced by 10 percent for non-Medi-Cal
38 programs described in Article 6 (commencing with Section 124025)
39 of Chapter 3 of Part 2 of Division 106 of the Health and Safety
40 Code, and Section 14105.18, for dates of service on and after June

1 1, 2011. This paragraph shall not apply to inpatient hospital
2 services provided in a hospital that is paid under contract pursuant
3 to Article 2.6 (commencing with Section 14081).

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

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

15 (e) Notwithstanding any other provision of this section,
16 payments to hospitals that are not under contract with the State
17 Department of Health Care Services pursuant to Article 2.6
18 (commencing with Section 14081) for inpatient hospital services
19 provided to Medi-Cal beneficiaries and that are subject to Section
20 14166.245 shall be governed by that section.

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

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

25 (2) (A) Subject to subparagraph (B), for dates of service on and
26 after June 1, 2011, Medi-Cal reimbursement rates for intermediate
27 care facilities for the developmentally disabled licensed pursuant
28 to subdivision (e), (g), or (h) of Section 1250 of the Health and
29 Safety Code, and facilities providing continuous skilled nursing
30 care to developmentally disabled individuals pursuant to the pilot
31 project established by Section 14132.20, as determined by the
32 applicable methodology for setting reimbursement rates for these
33 facilities, shall not exceed the reimbursement rates that were
34 applicable to providers in the 2008–09 rate year.

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

38 (ii) If Section 14105.07 is added to the Welfare and Institutions
39 Code during the 2011–12 Regular Session of the Legislature, then
40 for dates of service on and after June 1, 2011, payments to

1 intermediate care facilities for the developmentally disabled
2 licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of
3 the Health and Safety Code, and facilities providing continuous
4 skilled nursing care to developmentally disabled individuals
5 pursuant to the pilot project established by Section 14132.20, shall
6 be governed by the applicable methodology for setting
7 reimbursement rates for these facilities and by Section 14105.07.

8 (g) The department may enter into contracts with a vendor for
9 the purposes of implementing this section on a bid or nonbid basis.
10 In order to achieve maximum cost savings, the Legislature declares
11 that an expedited process for contracts under this subdivision is
12 necessary. Therefore, contracts entered into to implement this
13 section and all contract amendments and change orders shall be
14 exempt from Chapter 2 (commencing with Section 10290) of Part
15 2 Division 2 of the Public Contract Code.

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

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

21 (2) Federally qualified health center services, including those
22 facilities deemed to have federally qualified health center status
23 pursuant to a waiver pursuant to subsection (a) of Section 1115 of
24 the federal Social Security Act (42 U.S.C. Sec. 1315(a)).

25 (3) Rural health clinic services.

26 (4) Payments to facilities owned or operated by the State
27 Department of State Hospitals or the State Department of
28 Developmental Services.

29 (5) Hospice services.

30 (6) Contract services, as designated by the director pursuant to
31 subdivision (k).

32 (7) Payments to providers to the extent that the payments are
33 funded by means of a certified public expenditure or an
34 intergovernmental transfer pursuant to Section 433.51 of Title 42
35 of the Code of Federal Regulations. This paragraph shall apply to
36 payments described in paragraph (3) of subdivision (d) only to the
37 extent that they are also exempt from reduction pursuant to
38 subdivision (l).

39 (8) Services pursuant to local assistance contracts and
40 interagency agreements to the extent the funding is not included

1 in the funds appropriated to the department in the annual Budget
2 Act.

3 (9) Breast and cervical cancer treatment provided pursuant to
4 Section 14007.71 and as described in paragraph (3) of subdivision
5 (a) of Section 14105.18 or Article 1.5 (commencing with Section
6 104160) of Chapter 2 of Part 1 of Division 103 of the Health and
7 Safety Code.

8 (10) The Family Planning, Access, Care, and Treatment (Family
9 PACT) Program pursuant to subdivision (aa) of Section 14132.

10 (i) Subject to the exception for services listed in subdivision
11 (h), the payment reductions required by subdivision (d) shall apply
12 to the benefits rendered by any provider who may be authorized
13 to bill for the service, including, but not limited to, physicians,
14 podiatrists, nurse practitioners, certified nurse-midwives, nurse
15 anesthetists, and organized outpatient clinics.

16 (j) Notwithstanding any other provision of law, for dates of
17 service on and after June 1, 2011, Medi-Cal reimbursement rates
18 applicable to the following classes of providers shall not exceed
19 the reimbursement rates that were applicable to those classes of
20 providers in the 2008–09 rate year, as described in subdivision (f)
21 of Section 14105.191, reduced by 10 percent:

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

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

31 (3) Rural swing-bed facilities.

32 (4) Subacute care units that are, or are parts of, distinct parts of
33 general acute care hospitals. For purposes of this subparagraph,
34 “subacute care unit” has the same meaning as defined in Section
35 51215.5 of Title 22 of the California Code of Regulations.

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

1 (6) Adult day health care centers.

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

4 (k) Notwithstanding Chapter 3.5 (commencing with Section
5 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
6 the department may implement and administer this section by
7 means of provider bulletins or similar instructions, without taking
8 regulatory action.

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

14 (m) Notwithstanding any other provision of this section, the
15 payment reductions and adjustments provided for in subdivision
16 (d) shall be implemented only if the director determines that the
17 payments that result from the application of this section will
18 comply with applicable federal Medicaid requirements and that
19 federal financial participation will be available.

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

25 (2) To the extent that the director determines that the payments
26 do not comply with the federal Medicaid requirements or that
27 federal financial participation is not available with respect to any
28 payment that is reduced pursuant to this section, the director retains
29 the discretion to not implement the particular payment reduction
30 or adjustment and may adjust the payment as necessary to comply
31 with federal Medicaid requirements.

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

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

37 (2) To the extent that federal approval is obtained for one or
38 more of the payment reductions and adjustments in this section
39 and Section 14105.07, the payment reductions and adjustments
40 set forth in Section 14105.191 shall cease to be implemented for

1 the same services provided by the same class of providers. In the
2 event of a conflict between this section and Section 14105.191,
3 other than the provisions setting forth a payment reduction or
4 adjustment, this section shall govern.

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

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

12 (p) Adjustments to pharmacy drug product payment pursuant
13 to this section shall no longer apply when the department
14 determines that the average acquisition cost methodology pursuant
15 to Section 14105.45 has been fully implemented and the
16 department's pharmacy budget reduction targets, consistent with
17 payment reduction levels pursuant to this section, have been met.

18 ~~SEC. 27.~~

19 *SEC. 25.* Section 14124.5 of the Welfare and Institutions Code
20 is amended to read:

21 14124.5. (a) The director may, in accordance with Section
22 10725, adopt, amend, or repeal, in accordance with Chapter 3.5
23 (commencing with Section 11340) of Part 1 of Division 3 of Title
24 2 of the Government Code, reasonable rules and regulations as
25 may be necessary or proper to carry out the purposes and intent
26 of this chapter, and to enable the department to exercise the powers
27 and perform the duties conferred upon it by this chapter, not
28 inconsistent with any statute of this state.

29 (b) All regulations previously adopted by the State Department
30 of Health Care Services or any predecessor department pursuant
31 to this chapter and in effect immediately preceding the operative
32 date of this section, shall remain in effect and shall be fully
33 enforceable unless and until readopted, amended, or repealed by
34 the director in accordance with Section 10725.

35 ~~SEC. 28.~~

36 *SEC. 26.* Section 14169.51 of the Welfare and Institutions
37 Code is amended to read:

38 14169.51. For purposes of this article, the following definitions
39 shall apply:

- 1 (a) “Acute psychiatric days” means the total number of Medi-Cal
2 specialty mental health service administrative days, Medi-Cal
3 specialty mental health service acute care days, acute psychiatric
4 administrative days, and acute psychiatric acute days identified in
5 the Final Medi-Cal Utilization Statistics for the state fiscal year
6 preceding the rebase calculation year as calculated by the
7 department as of the retrieval date.
- 8 (b) “Acute psychiatric per diem supplemental rate” means a
9 fixed per diem supplemental payment for acute psychiatric days.
- 10 (c) “Annual fee-for-service days” means the number of
11 fee-for-service days of each hospital subject to the quality assurance
12 fee, as reported on the days data source.
- 13 (d) “Annual managed care days” means the number of managed
14 care days of each hospital subject to the quality assurance fee, as
15 reported on the days data source.
- 16 (e) “Annual Medi-Cal days” means the number of Medi-Cal
17 days of each hospital subject to the quality assurance fee, as
18 reported on the days data source.
- 19 (f) “Base calendar year” means a calendar year that ends before
20 a subject fiscal year begins, but no more than six years before a
21 subject fiscal year begins. Beginning with the third program period,
22 the department shall establish the base calendar year during the
23 rebase calculation year as the calendar year for which the most
24 recent data is available that the department determines is reliable.
- 25 (g) “Converted hospital” means a private hospital that becomes
26 a designated public hospital or a nondesignated public hospital on
27 or after the first day of a program period.
- 28 (h) “Days data source” means either: (1) if a hospital’s Annual
29 Financial Disclosure Report for its fiscal year ending in the base
30 calendar year includes data for a full fiscal year of operation, the
31 hospital’s Annual Financial Disclosure Report retrieved from the
32 Office of Statewide Health Planning and Development as retrieved
33 by the department on the retrieval date pursuant to Section
34 14169.59, for its fiscal year ending in the base calendar year; or
35 (2) if a hospital’s Annual Financial Disclosure Report for its fiscal
36 year ending in the base calendar year includes data for more than
37 one day, but less than a full year of operation, the department’s
38 best and reasonable estimates of the hospital’s Annual Financial
39 Disclosure Report if the hospital had operated for a full year.

- 1 (i) “Department” means the State Department of Health Care
2 Services.
- 3 (j) “Designated public hospital” shall have the meaning given
4 in subdivision (d) of Section 14166.1.
- 5 (k) “Director” means the Director of Health Care Services.
- 6 (l) “Exempt facility” means any of the following:
- 7 (1) A public hospital, which shall include either of the following:
- 8 (A) A hospital, as defined in paragraph (25) of subdivision (a)
9 of Section 14105.98.
- 10 (B) A tax-exempt nonprofit hospital that is licensed under
11 subdivision (a) of Section 1250 of the Health and Safety Code and
12 operating a hospital owned by a local health care district, and is
13 affiliated with the health care district hospital owner by means of
14 the district’s status as the nonprofit corporation’s sole corporate
15 member.
- 16 (2) With the exception of a hospital that is in the Charitable
17 Research Hospital peer group, as set forth in the 1991 Hospital
18 Peer Grouping Report published by the department, a hospital that
19 is designated as a specialty hospital in the hospital’s most recently
20 filed Office of Statewide Health Planning and Development
21 Hospital Annual Financial Disclosure Report, as of the first day
22 of a program period.
- 23 (3) A hospital that satisfies the Medicare criteria to be a
24 long-term care hospital.
- 25 (4) A small and rural hospital as specified in Section 124840
26 of the Health and Safety Code designated as that in the hospital’s
27 most recently filed Office of Statewide Health Planning and
28 Development Hospital Annual Financial Disclosure Report, as of
29 the first day of a program period.
- 30 (m) “Federal approval” means the approval by the federal
31 government of both the quality assurance fee established pursuant
32 to this article and the supplemental payments to private hospitals
33 described pursuant to this article.
- 34 (n) “Fee-for-service per diem quality assurance fee rate” means
35 a fixed fee on fee-for-service days.
- 36 (o) “Fee-for-service days” means inpatient hospital days as
37 reported on the days data source where the service type is reported
38 as “acute care,” “psychiatric care,” or “rehabilitation care,” and
39 the payer category is reported as “Medicare traditional,” “county
40 indigent programs-traditional,” “other third parties-traditional,”

1 “other indigent,” or “other payers,” for purposes of the Annual
2 Financial Disclosure Report submitted by hospitals to the Office
3 of Statewide Health Planning and Development.

4 (p) “Fund” means the Hospital Quality Assurance Revenue
5 Fund established by Section 14167.35.

6 (q) “General acute care days” means the total number of
7 Medi-Cal general acute care days, including well baby days, less
8 any acute psychiatric inpatient days, paid by the department to a
9 hospital for services in the base calendar year, as reflected in the
10 state paid claims file on the retrieval date.

11 (r) “General acute care hospital” means any hospital licensed
12 pursuant to subdivision (a) of Section 1250 of the Health and Safety
13 Code.

14 (s) “General acute care per diem supplemental rate” means a
15 fixed per diem supplemental payment for general acute care days.

16 (t) “High acuity days” means Medi-Cal coronary care unit days,
17 pediatric intensive care unit days, intensive care unit days, neonatal
18 intensive care unit days, and burn unit days paid by the department
19 to a hospital for services in the base calendar year, as reflected in
20 the state paid claims file prepared by the department on the retrieval
21 date.

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

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

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

32 (x) “Hospital inpatient services” means all services covered
33 under Medi-Cal and furnished by hospitals to patients who are
34 admitted as hospital inpatients and reimbursed on a fee-for-service
35 basis by the department directly or through its fiscal intermediary.
36 Hospital inpatient services include outpatient services furnished
37 by a hospital to a patient who is admitted to that hospital within
38 24 hours of the provision of the outpatient services that are related
39 to the condition for which the patient is admitted. Hospital inpatient

1 services do not include services for which a managed health care
2 plan is financially responsible.

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

11 (z) “Managed care days” means inpatient hospital days as
12 reported on the days data source where the service type is reported
13 as “acute care,” “psychiatric care,” or “rehabilitation care,” and
14 the payer category is reported as “Medicare managed care,”
15 “county indigent programs-managed care,” or “other third
16 parties-managed care,” for purposes of the Annual Financial
17 Disclosure Report submitted by hospitals to the Office of Statewide
18 Health Planning and Development.

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

21 (ab) (1) “Managed health care plan” means a health care
22 delivery system that manages the provision of health care and
23 receives prepaid capitated payments from the state in return for
24 providing services to Medi-Cal beneficiaries.

25 (2) (A) Managed health care plans include county organized
26 health systems and entities contracting with the department to
27 provide or arrange services for Medi-Cal beneficiaries pursuant
28 to the two-plan model, geographic managed care, or regional
29 managed care for the rural expansion. Entities providing these
30 services contract with the department pursuant to any of the
31 following:

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

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

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

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

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

37 (B) Managed health care plans do not include any of the
38 following:

- 1 (i) Mental health plans contracting to provide mental health care
2 for Medi-Cal beneficiaries pursuant to Chapter 8.9 (commencing
3 with Section 14700).
- 4 (ii) Health plans not covering inpatient services such as primary
5 care case management plans operating pursuant to Section
6 14088.85.
- 7 (iii) Program—~~for~~ *of* All-Inclusive Care for the Elderly
8 organizations operating pursuant to Chapter 8.75 (commencing
9 with Section 14591).
- 10 (ac) “Medi-Cal days” means inpatient hospital days as reported
11 on the days data source where the service type is reported as “acute
12 care,” “psychiatric care,” or “rehabilitation care,” and the payer
13 category is reported as “Medi-Cal traditional” or “Medi-Cal
14 managed care,” for purposes of the Annual Financial Disclosure
15 Report submitted by hospitals to the Office of Statewide Health
16 Planning and Development.
- 17 (ad) “Medi-Cal fee-for-service days” means inpatient hospital
18 days as reported on the days data source where the service type is
19 reported as “acute care,” “psychiatric care,” or “rehabilitation
20 care,” and the payer category is reported as “Medi-Cal traditional”
21 for purposes of the Annual Financial Disclosure Report submitted
22 by hospitals to the Office of Statewide Health Planning and
23 Development.
- 24 (ae) “Medi-Cal managed care days” means the total number of
25 general acute care days, including well baby days, listed for the
26 county organized health system and prepaid health plans identified
27 in the Final Medi-Cal Utilization Statistics for the state fiscal year
28 preceding the rebase calculation year, as calculated by the
29 department as of the retrieval date.
- 30 (af) “Medi-Cal managed care fee days” means inpatient hospital
31 days as reported on the days data source where the service type is
32 reported as “acute care,” “psychiatric care,” or “rehabilitation
33 care,” and the payer category is reported as “Medi-Cal managed
34 care” for purposes of the Annual Financial Disclosure Report
35 submitted by hospitals to the Office of Statewide Health Planning
36 and Development.
- 37 (ag) “Medi-Cal per diem quality assurance fee rate” means a
38 fixed fee on Medi-Cal days.
- 39 (ah) “Medicaid inpatient utilization rate” means Medicaid
40 inpatient utilization rate as defined in Section 1396r-4 of Title 42

1 of the United States Code and as set forth in the Final Medi-Cal
2 Utilization Statistics for the state fiscal year preceding the rebase
3 calculation year, as calculated by the department as of the retrieval
4 date.

5 (ai) “New hospital” means a hospital operation, business, or
6 facility functioning under current or prior ownership as a private
7 hospital that does not have a days data source or a hospital that
8 has a days data source in whole, or in part, from a previous operator
9 where there is an outstanding monetary obligation owed to the
10 state in connection with the Medi-Cal program and the hospital is
11 not, or does not agree to become, financially responsible to the
12 department for the outstanding monetary obligation in accordance
13 with subdivision (d) of Section 14169.61.

14 (aj) “Nondesignated public hospital” means either of the
15 following:

16 (1) A public hospital that is licensed under subdivision (a) of
17 Section 1250 of the Health and Safety Code, is not designated as
18 a specialty hospital in the hospital’s most recently filed Annual
19 Financial Disclosure Report, as of the first day of a program period,
20 and satisfies the definition in paragraph (25) of subdivision (a) of
21 Section 14105.98, excluding designated public hospitals.

22 (2) A tax-exempt nonprofit hospital that is licensed under
23 subdivision (a) of Section 1250 of the Health and Safety Code, is
24 not designated as a specialty hospital in the hospital’s most recently
25 filed Annual Financial Disclosure Report, as of the first day of a
26 program period, is operating a hospital owned by a local health
27 care district, and is affiliated with the health care district hospital
28 owner by means of the district’s status as the nonprofit
29 corporation’s sole corporate member.

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

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

36 (am) “Prepaid health plan hospital” means a hospital owned by
37 a nonprofit public benefit corporation that shares a common board
38 of directors with a nonprofit health care service plan, which
39 exclusively contracts with no more than two medical groups in the

1 state to provide or arrange for professional medical services for
2 the enrollees of the plan, as of the effective date of this article.

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

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

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

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

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

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

21 (4) Is a nonpublic hospital, nonpublic converted hospital, or
22 converted hospital as those terms are defined in paragraphs (26)
23 to (28), inclusive, respectively, of subdivision (a) of Section
24 14105.98.

25 (5) Is not a nondesignated public hospital or a designated public
26 hospital.

27 (aq) “Program period” means a period not to exceed three years
28 during which a fee model and a supplemental payment model
29 developed under this article shall be effective. The first program
30 period shall be the period beginning January 1, 2014, and ending
31 December 31, 2016, inclusive. The second program period shall
32 be the period beginning on January 1, 2017, and ending June 30,
33 2019. Each subsequent program period shall begin on the day
34 immediately following the last day of the immediately preceding
35 program period and shall end on the last day of a state fiscal year,
36 as determined by the department.

37 (ar) “Quality assurance fee” means the quality assurance fee
38 assessed pursuant to Section 14169.52 and collected on the basis
39 of the quarterly quality assurance fee.

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

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

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

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

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

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

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

22 (C) The annual Medi-Cal managed care fee days for an
23 individual hospital multiplied by the prepaid health plan hospital
24 Medi-Cal managed care per diem quality assurance fee rate, divided
25 by four.

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

29 (at) “Rebase calculation year” means a state fiscal year during
30 which the department shall rebase the data, including, but not
31 limited to, the days data source, used for the following: acute
32 psychiatric days, annual fee-for-service days, annual managed care
33 days, annual Medi-Cal days, fee-for-service days, general acute
34 care days, high acuity days, managed care days, Medi-Cal days,
35 Medi-Cal fee-for-service days, Medi-Cal managed care days,
36 Medi-Cal managed care fee days, outpatient base amount, and
37 transplant days, pursuant to Section 14169.59. Beginning with the
38 third program period, the rebase calculation year for a program
39 period shall be the last subject fiscal year of the immediately
40 preceding program period.

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

3 (av) “Retrieval date” means a day for each data element during
4 the last quarter of the rebase calculation year upon which the
5 department retrieves the data, including, but not limited to, the
6 days data source, used for the following: acute psychiatric days,
7 annual fee-for-service days, annual managed care days, annual
8 Medi-Cal days, fee-for-service days, general acute care days, high
9 acuity days, managed care days, Medi-Cal days, Medi-Cal
10 fee-for-service days, Medi-Cal managed care days, Medi-Cal
11 managed care fee days, outpatient base amount, and transplant
12 days, pursuant to Section 14169.59. The retrieval date for each
13 data element may be a different date within the quarter as
14 determined to be necessary and appropriate by the department.

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

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

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

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

27 (ba) “Transplant days” means the number of Medi-Cal days for
28 Medicare Severity-Diagnosis Related Groups (MS-DRGs) 1, 2, 5
29 to 10, inclusive, 14, 15, or 652, according to the Patient Discharge
30 ~~file~~ *Data File Documentation* from the Office of Statewide Health
31 Planning and Development for the base calendar year accessed on
32 the retrieval date.

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

35 (bc) “Upper payment limit” means a federal upper payment
36 limit on the amount of the Medicaid payment for which federal
37 financial participation is available for a class of service and a class
38 of health care providers, as specified in Part 447 of Title 42 of the
39 Code of Federal Regulations. The applicable upper payment limit

1 shall be separately calculated for inpatient and outpatient hospital
2 services.

3 ~~SEC. 29.~~

4 *SEC. 27.* Section 14169.52 of the Welfare and Institutions
5 Code is amended to read:

6 14169.52. (a) There shall be imposed on each general acute
7 care hospital that is not an exempt facility a quality assurance fee,
8 except that a quality assurance fee under this article shall not be
9 imposed on a converted hospital for the periods when the hospital
10 is a public hospital or a new hospital with respect to a program
11 period.

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

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

18 (1) Within 10 business days following receipt of the notice of
19 federal approval, the department shall send notice to each hospital
20 subject to the quality assurance fee, which shall contain the
21 following information:

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

23 (B) The quarterly quality assurance fee for each subject fiscal
24 year.

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

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

33 (3) Notwithstanding any other provision of this section, the
34 amount of each hospital’s quarterly quality assurance fee for a
35 program period that has not been paid by the hospital before 15
36 days prior to the end of a program period shall be paid by the
37 hospital no later than 15 days prior to the end of a program period.

38 (4) Each hospital described in subdivision (a) shall pay the
39 quarterly quality assurance fees that are due, if any, in the amounts

1 and at the times set forth in the notice unless superseded by a
2 subsequent notice from the department.

3 (d) The quality assurance fee, as assessed pursuant to this
4 section, shall be paid by each hospital subject to the fee to the
5 department for deposit in the fund. Deposits may be accepted at
6 any time and shall be credited toward the program period for which
7 the fees were assessed. This article shall not affect the ability of a
8 hospital to pay fees assessed for a program period after the end of
9 that program period.

10 (e) This section shall become inoperative if the federal Centers
11 for Medicare and Medicaid Services denies approval for, or does
12 not approve before December 1, 2016, the implementation of the
13 quality assurance fee pursuant to this article or the supplemental
14 payments to private hospitals pursuant to this article for the first
15 program period.

16 (f) In no case shall the aggregate fees collected in a federal fiscal
17 year pursuant to this section, former Section 14167.32, Section
18 14168.32, and Section 14169.32 exceed the maximum percentage
19 of the annual aggregate net patient revenue for hospitals subject
20 to the fee that is prescribed pursuant to federal law and regulations
21 as necessary to preclude a finding that an indirect guarantee has
22 been created.

23 (g) (1) Interest shall be assessed on quality assurance fees not
24 paid on the date due at the greater of 10 percent per annum or the
25 rate at which the department assesses interest on Medi-Cal program
26 overpayments to hospitals that are not repaid when due. Interest
27 shall begin to accrue the day after the date the payment was due
28 and shall be deposited in the fund.

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

33 (h) When a hospital fails to pay all or part of the quality
34 assurance fee on or before the date that payment is due, the
35 department may immediately begin to deduct the unpaid assessment
36 and interest from any Medi-Cal payments owed to the hospital,
37 or, in accordance with Section 12419.5 of the Government Code,
38 from any other state payments owed to the hospital until the full
39 amount is recovered. All amounts, except penalties, deducted by
40 the department under this subdivision shall be deposited in the

1 fund. The remedy provided to the department by this section is in
2 addition to other remedies available under law.

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

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

8 (k) This subdivision creates a contractually enforceable promise
9 on behalf of the state to use the proceeds of the quality assurance
10 fee, including any federal matching funds, solely and exclusively
11 for the purposes set forth in this article, to limit the amount of the
12 proceeds of the quality assurance fee to be used to pay for the
13 health care coverage of children as provided in Section 14169.53,
14 to limit any payments for the department's costs of administration
15 to the amounts set forth in this article, to maintain and continue
16 prior reimbursement levels as set forth in Section 14169.68 on the
17 effective date of that section, and to otherwise comply with all its
18 obligations set forth in this article, provided that amendments that
19 arise from, or have as a basis for, a decision, advice, or
20 determination by the federal Centers for Medicare and Medicaid
21 Services relating to federal approval of the quality assurance fee
22 or the payments set forth in this article shall control for the
23 purposes of this subdivision.

24 (l) (1) Subject to paragraph (2), the director may waive any or
25 all interest and penalties assessed under this article in the event
26 that the director determines, in his or her sole discretion, that the
27 hospital has demonstrated that imposition of the full quality
28 assurance fee on the timelines applicable under this article has a
29 high likelihood of creating a financial hardship for the hospital or
30 a significant danger of reducing the provision of needed health
31 care services.

32 (2) Waiver of some or all of the interest or penalties under this
33 subdivision shall be conditioned on the hospital's agreement to
34 make fee payments, or to have the payments withheld from
35 payments otherwise due from the Medi-Cal program to the hospital,
36 on a schedule developed by the department that takes into account
37 the financial situation of the hospital and the potential impact on
38 services.

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

1 (4) If fee payments are remitted to the department after the date
2 determined by the department to be the final date for calculating
3 the final supplemental payments for a program period under this
4 article, the fee payments shall be refunded to general acute care
5 hospitals, pro rata with the amount of quality assurance fee paid
6 by the hospital in the program period, subject to the limitations of
7 federal law. If federal rules prohibit the refund described in this
8 paragraph, the excess funds shall be used as quality assurance fees
9 for the next program period for general acute care hospitals, pro
10 rata with the quality assurance fees paid by the hospital for the
11 program period.

12 (5) If during the implementation of this article, fee payments
13 that were due under former Article 5.21 (commencing with Section
14 14167.1) and former Article 5.22 (commencing with Section
15 14167.31), or former Article 5.226 (commencing with Section
16 14168.1) and Article 5.227 (commencing with Section 14168.31),
17 or Article 5.228 (commencing with Section 14169.1) and Article
18 5.229 (commencing with Section 14169.31) are remitted to the
19 department under a payment plan or for any other reason, and the
20 final date for calculating the final supplemental payments under
21 those articles has passed, then those fee payments shall be
22 deposited in the fund to support the uses established by this article.

23 ~~SEC. 30.~~

24 *SEC. 28.* Section 14169.53 of the Welfare and Institutions
25 Code is amended to read:

26 14169.53. (a) (1) All fees required to be paid to the state
27 pursuant to this article shall be paid in the form of remittances
28 payable to the department.

29 (2) The department shall directly transmit the fee payments to
30 the Treasurer to be deposited in the fund. Notwithstanding Section
31 16305.7 of the Government Code, any interest and dividends
32 earned on deposits in the fund from the proceeds of the fee assessed
33 pursuant to this article shall be retained in the fund for purposes
34 specified in subdivision (b).

35 (b) (1) Notwithstanding subdivision (c) of Section 14167.35,
36 subdivision (b) of Section 14168.33, and subdivision (b) of Section
37 14169.33, all funds from the proceeds of the fee assessed pursuant
38 to this article in the fund, together with any interest and dividends
39 earned on money in the fund, shall continue to be used exclusively
40 to enhance federal financial participation for hospital services

1 under the Medi-Cal program, to provide additional reimbursement
2 to, and to support quality improvement efforts of, hospitals, and
3 to minimize uncompensated care provided by hospitals to uninsured
4 patients, as well as to pay for the state's administrative costs and
5 to provide funding for children's health coverage, in the following
6 order of priority:

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

11 (B) To pay for the health care coverage, as described in
12 subdivision (g), except that for the two subject fiscal quarters in
13 the 2013–14 fiscal year, the amount for children's health care
14 coverage shall be one hundred fifty-five million dollars
15 (\$155,000,000) for each subject fiscal quarter, exclusive of any
16 federal matching funds.

17 (C) To make increased capitation payments to managed health
18 care plans pursuant to this article and Section 14169.82, including
19 the nonfederal share of capitation payments to managed health
20 care plans pursuant to this article and Section 14169.82 for services
21 provided to individuals who meet the eligibility requirements in
22 Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social
23 Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who
24 meet the conditions described in Section 1905(y) of the federal
25 Social Security Act (42 U.S.C. Sec. 1396d(y)).

26 (D) To make increased payments and direct grants to hospitals
27 pursuant to this article and Section 14169.83, including the
28 nonfederal share of payments to hospitals under this article and
29 Section 14169.83 for services provided to individuals who meet
30 the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII) of
31 Title XIX of the federal Social Security Act (42 U.S.C. Sec.
32 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described
33 in Section 1905(y) of the federal Social Security Act (42 U.S.C.
34 Sec. 1396d(y)).

35 (2) Notwithstanding subdivision (c) of Section 14167.35,
36 subdivision (b) of Section 14168.33, and subdivision (b) of Section
37 14169.33, and notwithstanding Section 13340 of the Government
38 Code, the moneys in the fund shall be continuously appropriated
39 during the first program period only, without regard to fiscal year,
40 for the purposes of this article, Article 5.229 (commencing with

1 Section 14169.31), Article 5.228 (commencing with Section
2 14169.1), Article 5.227 (commencing with Section 14168.31),
3 former Article 5.226 (commencing with Section 14168.1), former
4 Article 5.22 (commencing with Section 14167.31), and former
5 Article 5.21 (commencing with Section 14167.1).

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

10 (c) Any amounts of the quality assurance fee collected in excess
11 of the funds required to implement subdivision (b), including any
12 funds recovered under subdivision (d) of Section 14169.61, shall
13 be refunded to general acute care hospitals, pro rata with the
14 amount of quality assurance fee paid by the hospital, subject to
15 the limitations of federal law. If federal rules prohibit the refund
16 described in this subdivision, the excess funds shall be used as
17 quality assurance fees for the next program period for general acute
18 care hospitals, pro rata with the amount of quality assurance fees
19 paid by the hospital for the program period.

20 (d) Any methodology or other provision specified in this article
21 may be modified by the department, in consultation with the
22 hospital community, to the extent necessary to meet the
23 requirements of federal law or regulations to obtain federal
24 approval or to enhance the probability that federal approval can
25 be obtained, provided the modifications do not violate the spirit,
26 purposes, and intent of this article and are not inconsistent with
27 the conditions of implementation set forth in Section 14169.72.
28 The department shall notify the Joint Legislative Budget Committee
29 and the fiscal and appropriate policy committees of the Legislature
30 30 days prior to implementation of a modification pursuant to this
31 subdivision.

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

37 (f) The department shall request approval from the federal
38 Centers for Medicare and Medicaid Services for the implementation
39 of this article. In making this request, the department shall seek
40 specific approval from the federal Centers for Medicare and

1 Medicaid Services to exempt providers identified in this article as
2 exempt from the fees specified, including the submission, as may
3 be necessary, of a request for waiver of the broad-based
4 requirement, waiver of the uniform fee requirement, or both,
5 pursuant to paragraphs (1) and (2) of subdivision (e) of Section
6 433.68 of Title 42 of the Code of Federal Regulations.

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

9 (A) “Actual net benefit” means the net benefit determined by
10 the department for a net benefit period after the conclusion of the
11 net benefit period using payments and grants actually made, and
12 fees actually collected, for the net benefit period.

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

15 (C) “Aggregate payments” means the aggregate payments and
16 grants made directly or indirectly to hospitals under this article,
17 including payments and grants described in Sections 14169.54,
18 14169.55, 14169.57, and 14169.58, and subdivision (b) of Section
19 14169.82.

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

22 (E) “Net benefit period” means a subject fiscal year or portion
23 thereof that is in a program period and begins on or after July 1,
24 2014.

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

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

31 (3) The department shall determine the preliminary net benefit
32 for all net benefit periods in the first program period before July
33 1, 2014. The department shall determine the preliminary net benefit
34 for all net benefit periods in a subsequent program period before
35 the beginning of the program period.

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

1 (5) For each net benefit period, the department shall reconcile
2 the amount of moneys in the fund used for children’s health
3 coverage based on the preliminary net benefit with the amount of
4 the fund that may be used for children’s health coverage under
5 this subdivision based on the actual net benefit. For each net benefit
6 period, any amounts that were in the fund and used for children’s
7 health coverage in excess of the 24 percent of the actual net benefit
8 shall be returned to the fund, and the amount, if any, by which 24
9 percent of the actual net benefit exceeds 24 percent of the
10 preliminary net benefit shall be available from the fund to the
11 department for children’s health coverage. The department shall
12 notify the Joint Legislative Budget Committee and the fiscal and
13 appropriate policy committees of the Legislature of the results of
14 the reconciliation for each net benefit period pursuant to this
15 paragraph within five working days of performing the
16 reconciliation.

17 (6) The department shall make all calculations and
18 reconciliations required by this subdivision in consultation with
19 the hospital community using data that the department determines
20 is the best data reasonably available.

21 (h) After consultation with the hospital community, the
22 department shall determine a date upon which substantially all
23 fees have been paid and substantially all supplemental payments,
24 grants, and rate range increases have been made for a program
25 period, which date shall be no later than two years after the end
26 of a program period. After the date determined by the department
27 pursuant to this subdivision, no further supplemental payments
28 shall be made under the program period, and any fees collected
29 with respect to the program period shall be used for a subsequent
30 program period consistent with this section. Nothing in this
31 subdivision shall affect the department’s authority to collect quality
32 assurance fees for a program period after the end of the program
33 period or after the date determined by the department pursuant to
34 this subdivision. The department shall notify the Joint Legislative
35 Budget Committee and fiscal and appropriate policy committees
36 of that date within five working days of the determination.

37 (i) Use of the fee proceeds to enhance federal financial
38 participation pursuant to subdivision (b) shall include use of the
39 proceeds to supply the nonfederal share, if any, of payments to
40 hospitals under this article for services provided to individuals

1 who meet the eligibility requirements in Section
2 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security
3 Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and who meet the
4 conditions described in Section 1905(y) of the federal Social
5 Security Act (42 U.S.C. Sec. 1396d(y)) such that expenditures for
6 services provided to the individual are eligible for the enhanced
7 federal medical assistance percentage described in that section.

8 ~~SEC. 31:~~

9 *SEC. 29.* Section 14169.55 of the Welfare and Institutions
10 Code is amended to read:

11 14169.55. (a) Private hospitals shall be paid supplemental
12 amounts for the provision of hospital inpatient services for each
13 subject fiscal quarter in a program period as set forth in this section.
14 The supplemental amounts shall be in addition to any other
15 amounts payable to hospitals with respect to those services and
16 shall not affect any other payments to hospitals. The inpatient
17 supplemental amounts shall result in payments to hospitals that
18 equal the applicable federal upper payment limit for the subject
19 fiscal year, except that with respect to a subject fiscal year that
20 begins before the start of a program period or that ends after the
21 end of the program period for which the payments are made, the
22 inpatient supplemental amounts shall result in payments to hospitals
23 that equal a percentage of the applicable upper payment limit where
24 the percentage equals the percentage of the subject fiscal year that
25 occurs during the program period.

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

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

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

34 (3) A high acuity per diem supplemental rate multiplied by the
35 number of the hospital's high acuity days if the hospital's Medicaid
36 inpatient utilization rate is less than the percent required to be
37 eligible to receive disproportionate share replacement funds for
38 the state fiscal year ending in the base calendar year and greater
39 than 5 percent and at least 5 percent of the hospital's general acute
40 care days are high acuity days.

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

8 (5) A transplant per diem supplemental rate multiplied by the
9 number of the hospital's transplant days if the hospital's Medicaid
10 inpatient utilization rate is less than the percent required to be
11 eligible to receive disproportionate share replacement funds for
12 the state fiscal year ending in the base calendar year and greater
13 than 5 percent.

14 (6) A payment for hospital inpatient services equal to the
15 subacute supplemental rate multiplied by the Medi-Cal subacute
16 payments as reflected in the state paid claims file prepared by the
17 department as of the retrieval date for the base calendar year if the
18 private hospital provided Medi-Cal subacute services during the
19 base calendar year.

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

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

28 (2) The amount payable under subdivision (b) to each private
29 hospital for the subject fiscal year shall be equal to the amount
30 computed under subdivision (b) multiplied by the ratio of the total
31 amount for which federal financial participation is available to the
32 total amount computed under subdivision (b).

33 (d) If the amount otherwise payable to a hospital under this
34 section for a subject fiscal year exceeds the amount for which
35 federal financial participation is available for that hospital, the
36 amount due to the hospital for that subject fiscal year shall be
37 reduced to the amount for which federal financial participation is
38 available.

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

1 (f) Payments shall be made to a converted hospital that converts
2 during a subject fiscal quarter by multiplying the hospital's
3 supplemental payment as calculated in subdivision (b) by the
4 number of days that the hospital was a private hospital in the
5 subject fiscal quarter, divided by the number of days in the subject
6 fiscal quarter. Payments shall not be made to a converted hospital
7 in any subsequent subject fiscal quarter.

8 ~~SEC. 32.~~

9 *SEC. 30.* Section 14169.56 of the Welfare and Institutions
10 Code is amended to read:

11 14169.56. (a) The department shall increase capitation
12 payments to Medi-Cal managed health care plans for each subject
13 fiscal year as set forth in this section.

14 (b) (1) Subject to the limitation in paragraph (2), the increased
15 capitation payments shall be made as part of the monthly capitated
16 payments made by the department to managed health care plans.
17 The aggregate amount of increased capitation payments to all
18 Medi-Cal managed health care plans for each subject fiscal year,
19 or portion thereof, shall be the maximum amount for which federal
20 financial participation is available on an aggregate statewide basis
21 for the applicable subject fiscal year within a program period, or
22 portion thereof.

23 (2) (A) The limitation in subparagraph (B) shall be applied with
24 respect to a subject fiscal year or portion thereof for which the
25 federal matching assistance percentage is less than 90-~~percentage~~
26 *percent* for expenditures for services furnished to individuals who
27 meet the eligibility requirements in Section 1902(a)(10)(A)(i)(VIII)
28 of Title XIX of the federal Social Security Act (42 U.S.C. Sec.
29 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described
30 in Section 1905(y) of the federal Social Security Act (42 U.S.C.
31 Sec. 1396d(y)).

32 (B) During a subject fiscal year or portion thereof described in
33 subparagraph (A), the aggregate amount of the increased capitation
34 payments under this section shall not exceed the aggregate amount
35 of the increased capitation payments that would be made if the
36 nonfederal share of the increased capitation payments were the
37 amount that the nonfederal share would have been if the federal
38 matching assistance percentage were 90 percent for expenditures
39 for services furnished to individuals who meet the eligibility
40 requirements in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of

1 the federal Social Security Act (42 U.S.C. Sec.
2 1396a(a)(10)(A)(i)(VIII)), and who meet the conditions described
3 in Section 1905(y) of the federal Social Security Act (42 U.S.C.
4 Sec. 1396d(y)).

5 (c) The department shall determine the amount of the increased
6 capitation payments for each managed health care plan for each
7 subject fiscal year or portion thereof during a program period. The
8 department shall consider the composition of Medi-Cal enrollees
9 in the plan, the anticipated utilization of hospital services by the
10 plan's Medi-Cal enrollees, and other factors that the department
11 determines are reasonable and appropriate to ensure access to
12 high-quality hospital services by the plan's enrollees.

13 (d) The amount of increased capitation payments to each
14 Medi-Cal managed health care plan shall not exceed an amount
15 that results in capitation payments that are certified by the state's
16 actuary as meeting federal requirements, taking into account the
17 requirement that all of the increased capitation payments under
18 this section shall be paid by the Medi-Cal managed health care
19 plans to hospitals for hospital services to Medi-Cal enrollees of
20 the plan.

21 (e) (1) The increased capitation payments to managed health
22 care plans under this section shall be made to support the
23 availability of hospital services and ensure access to hospital
24 services for Medi-Cal beneficiaries. The increased capitation
25 payments to managed health care plans shall commence within 90
26 days after the date on which all necessary federal approvals have
27 been received, and shall include, but not be limited to, the sum of
28 the increased payments for all prior months for which payments
29 are due.

30 (2) To secure the necessary funding for the payment or payments
31 made pursuant to paragraph (1), the department may accumulate
32 funds in the fund, for the purpose of funding managed health care
33 capitation payments under this article regardless of the date on
34 which capitation payments are scheduled to be paid in order to
35 secure the necessary total funding for managed health care
36 payments by the end of a program period.

37 (f) Payments to managed health care plans that would be paid
38 consistent with actuarial certification and enrollment in the absence
39 of the payments made pursuant to this section, including, but not

1 limited to, payments described in Section 14182.15, shall not be
2 reduced as a consequence of payments under this section.

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

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

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

13 (h) (1) In the event federal financial participation is not
14 available for all of the increased capitation payments determined
15 for a month pursuant to this section for any reason, the increased
16 capitation payments mandated by this section for that month shall
17 be reduced proportionately to the amount for which federal
18 financial participation is available.

19 (2) The determination under this subdivision for any month in
20 a program period shall be made after accounting for all federal
21 financial participation necessary for full implementation of Section
22 14182.15 for that month.

23 ~~SEC. 33.~~

24 *SEC. 31.* Section 14169.58 of the Welfare and Institutions
25 Code is amended to read:

26 14169.58. (a) (1) For the first program period, designated
27 public hospitals shall be paid direct grants in support of health care
28 expenditures, which shall not constitute Medi-Cal payments, and
29 which shall be funded by the quality assurance fee set forth in this
30 article. For the first program period, the aggregate amount of the
31 grants to designated public hospitals funded by the quality
32 assurance fee set forth in this article shall be forty-five million
33 dollars (\$45,000,000) in the aggregate for the two subject fiscal
34 quarters in the 2013–14 subject fiscal year, ninety-three million
35 dollars (\$93,000,000) for the 2014–15 subject fiscal year, one
36 hundred ten million five hundred thousand dollars (\$110,500,000)
37 for the 2015–16 subject fiscal year, and sixty-two million five
38 hundred thousand dollars (\$62,500,000) in the aggregate for the
39 two subject fiscal quarters in the 2016–17 subject fiscal year.

1 (2) (A) Of the direct grant amounts set forth in paragraph (1),
2 the director shall allocate twenty-four million five hundred
3 thousand dollars (\$24,500,000) in the aggregate for the two subject
4 fiscal quarters in the 2013–14 subject fiscal year, fifty million five
5 hundred thousand dollars (\$50,500,000) for the 2014–15 subject
6 fiscal year, sixty million five hundred thousand dollars
7 (\$60,500,000) for the 2015–16 subject fiscal year, and thirty-four
8 million five hundred thousand dollars (\$34,500,000) in the
9 aggregate for the two subject fiscal quarters in the 2016–17 subject
10 fiscal year among the designated public hospitals pursuant to a
11 methodology developed in consultation with the designated public
12 hospitals.

13 (B) Of the direct grant amounts set forth in subparagraph (A),
14 the director shall distribute six million one hundred twenty-five
15 thousand dollars (\$6,125,000) for each subject fiscal quarter in the
16 2013–14 subject fiscal year, six million three hundred twelve
17 thousand five hundred dollars (\$6,312,500) for each subject fiscal
18 quarter in the 2014–15 subject fiscal year, seven million five
19 hundred sixty-two thousand five hundred dollars (\$7,562,500) for
20 each subject fiscal quarter in the 2015–16 subject fiscal year, and
21 eight million six hundred twenty-five thousand dollars (\$8,625,000)
22 for each subject fiscal quarter in the 2016–17 subject fiscal year
23 in accordance with the timeframes specified in subdivision (a) of
24 Section 14169.66.

25 (C) Of the direct grant amounts set forth in subparagraph (A),
26 the director shall distribute six million one hundred twenty-five
27 thousand dollars (\$6,125,000) for each subject fiscal quarter in the
28 2013–14 subject fiscal year, six million three hundred twelve
29 thousand five hundred dollars (\$6,312,500) for each subject fiscal
30 quarter in the 2014–15 subject fiscal year, seven million five
31 hundred sixty-two thousand five hundred dollars (\$7,562,500) for
32 each subject fiscal quarter in the 2015–16 subject fiscal year, and
33 eight million six hundred twenty-five thousand dollars (\$8,625,000)
34 for each subject fiscal quarter in the 2016–17 subject fiscal year
35 only upon 100 percent of the rate range increases being distributed
36 to managed health care plans pursuant to subparagraph (D) for the
37 respective subject fiscal quarter. If the rate range increases pursuant
38 to subparagraph (D) are distributed to managed health care plans,
39 the direct grant amounts described in this subparagraph shall be
40 distributed to designated public hospitals no later than 30 days

1 after the rate range increases have been distributed to managed
2 health care plans pursuant to subparagraph (D).

3 (D) Of the direct grant amounts set forth in paragraph (1), twenty
4 million five hundred thousand dollars (\$20,500,000) in the
5 aggregate for the two subject fiscal quarters in the 2013–14 subject
6 fiscal year, forty-two million five hundred thousand dollars
7 (\$42,500,000) for the 2014–15 subject fiscal year, fifty million
8 dollars (\$50,000,000) for the 2015–16 subject fiscal year, and
9 twenty-eight million dollars (\$28,000,000) in the aggregate for the
10 two subject fiscal quarters in the 2016–17 subject fiscal year shall
11 be withheld from payment to the designated public hospitals by
12 the director, and shall be used as the nonfederal share for rate range
13 increases, as defined in paragraph (4) of subdivision (b) of Section
14 14301.4, to risk-based payments to managed care health plans that
15 contract with the department to serve counties where a designated
16 public hospital is located. The rate range increases shall apply to
17 managed care rates for beneficiaries other than newly eligible
18 beneficiaries, as defined in subdivision (s) of Section 17612.2, and
19 shall enable plans to compensate hospitals for Medi-Cal health
20 services and to support the Medi-Cal program. Each managed
21 health care plan shall expend 100 percent of the rate range increases
22 on hospital services within 30 days of receiving the increased
23 payments. Rate range increases funded under this subparagraph
24 shall be allocated among plans pursuant to a methodology
25 developed in consultation with the hospital community.

26 (3) Notwithstanding any other provision of law, any amounts
27 withheld from payment to the designated public hospitals by the
28 director as the nonfederal share for rate range increases, including
29 those described in subparagraph (D) of paragraph (2), shall not be
30 considered hospital fee direct grants as defined under subdivision
31 (k) of Section 17612.2 and shall not be included in the
32 determination under paragraph (1) of subdivision (a) of Section
33 17612.3.

34 (b) (1) For the first program period, nondesignated public
35 hospitals shall be paid direct grants in support of health care
36 expenditures, which shall not constitute Medi-Cal payments, and
37 which shall be funded by the quality assurance fee set forth in this
38 article. For the first program period, the aggregate amount of the
39 grants funded by the quality assurance fee set forth in this article
40 to nondesignated public hospitals shall be twelve million five

1 hundred thousand dollars (\$12,500,000) in the aggregate for two
2 subject fiscal quarters in the 2013–14 subject fiscal year,
3 twenty-five million dollars (\$25,000,000) for the 2014–15 subject
4 fiscal year, thirty million dollars (\$30,000,000) for the 2015–16
5 subject fiscal year, and seventeen million five hundred thousand
6 dollars (\$17,500,000) in the aggregate for the two subject fiscal
7 quarters in the 2016–17 subject fiscal year.

8 (2) (A) Of the direct grant amounts set forth in paragraph (1),
9 the director shall allocate two million five hundred thousand dollars
10 (\$2,500,000) in the aggregate for the two subject fiscal quarters
11 in the 2013–14 subject fiscal year, five million dollars (\$5,000,000)
12 for the 2014–15 subject fiscal year, six million dollars (\$6,000,000)
13 for the 2015–16 subject fiscal year, and three million five hundred
14 thousand dollars (\$3,500,000) in the aggregate for the two subject
15 fiscal quarters in the 2016–17 subject fiscal year among the
16 nondesignated public hospitals pursuant to a methodology
17 developed in consultation with the nondesignated public hospitals.

18 (B) Of the direct grant amounts set forth in paragraph (1), ten
19 million dollars (\$10,000,000) in the aggregate for the two subject
20 fiscal quarters in the 2013–14 subject fiscal year, twenty million
21 dollars (\$20,000,000) for the 2014–15 subject fiscal year,
22 twenty-four million dollars (\$24,000,000) for the 2015–16 subject
23 fiscal year, and fourteen million dollars (\$14,000,000) in the
24 aggregate for the two subject fiscal quarters in the 2016–17 subject
25 fiscal year shall be withheld from payment to the nondesignated
26 public hospitals by the director, and shall be used as the nonfederal
27 share for rate range increases, as defined in paragraph (4) of
28 subdivision (b) of Section 14301.4, to risk-based payments to
29 managed care health plans that contract with the department. The
30 rate range increases shall enable plans to compensate hospitals for
31 Medi-Cal health services and to support the Medi-Cal program.
32 Each managed health care plan shall expend 100 percent of the
33 rate range increases on hospital services within 30 days of receiving
34 the increased payments. Rate range increases funded under this
35 subparagraph shall be allocated among plans pursuant to a
36 methodology developed in consultation with the hospital
37 community.

38 (c) If the amounts set forth in this section for rate range increases
39 are not actually used for rate range increases as described in this
40 section, the direct grant amounts set forth in this section that are

1 withheld pursuant to subparagraph (D) of paragraph (2) of
2 subdivision (a) and subparagraph (B) of paragraph (2) of
3 subdivision (b) shall be returned to the fund subject to paragraph
4 (4) of subdivision (l) of Section 14169.52.

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

9 ~~SEC. 34.~~

10 *SEC. 32.* Section 14169.59 of the Welfare and Institutions
11 Code is amended to read:

12 14169.59. (a) The department shall determine during each
13 rebase calculation year the number of subject fiscal years in the
14 next program period.

15 (b) During each rebase calculation year, the department shall
16 retrieve the data, including, but not limited to, the days data source,
17 used to determine the following for the subsequent program period:
18 acute psychiatric days, annual fee-for-service days, annual managed
19 care days, annual Medi-Cal days, fee-for-service days, general
20 acute care days, high acuity days, managed care days, Medi-Cal
21 days, Medi-Cal fee-for-service days, Medi-Cal managed care days,
22 Medi-Cal managed care fee days, outpatient base amount, and
23 transplant days. The department shall pull data from the most
24 recent base calendar year for which the department determines
25 reliable data is available for all hospitals.

26 (c) (1) During each rebase calculation year, the department
27 shall determine all of the following supplemental payment rates
28 for the subsequent program period, which supplemental payment
29 rates shall be specified in provisional language in the annual Budget
30 Act:

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (d) The department shall determine the rates set forth in
22 subdivision (c) based on the data retrieved pursuant to subdivision
23 (b). Each rate determined by the department shall be the same for
24 all hospitals to which the rate applies. These rates shall be specified
25 in provisional language in the annual Budget Act. The department
26 shall determine the rates in accordance with all of the following:

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

29 (2) The department shall consult with the hospital community
30 in determining the rates.

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

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

1 (5) The increased capitation payments to managed health care
2 plans shall result in the maximum payments to the plans permitted
3 by federal law.

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

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

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

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

17 (e) During each rebase calculation year, the director shall
18 determine the amounts and allocation methodology, if any, of
19 direct grants to designated public hospitals and nondesignated
20 public hospitals for each subject fiscal year in a program period,
21 in consultation with the hospital community. The amounts and
22 allocation methodology may include a ~~withhold~~ *withholding* of
23 direct grants to be used as the nonfederal share for rate range
24 increases. These amounts shall be specified in provisional language
25 in the annual Budget Act.

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

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

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

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

37 (D) The general acute care days shall be those identified in the
38 2010 calendar year, as reflected in the state paid claims file on
39 April 26, 2013.

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

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

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

11 (H) The transplant days shall be those identified in the 2010
12 Patient Discharge ~~file~~ *Data File Documentation* from the Office
13 of Statewide Health Planning and Development accessed on June
14 28, 2011.

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

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

19 (ii) To the extent permitted by federal law and other federal
20 requirements, the department shall use the best available and
21 reasonable current estimates or projections made with respect to
22 the hospital for an annual period as the data, including, but not
23 limited to, the days data source and data described as being derived
24 from a state paid claims file, used for all purposes, including, but
25 not limited to, the calculation of supplemental payments and the
26 quality assurance fee. The estimates and projections shall be
27 deemed to reflect paid claims and shall be used for each data
28 element regardless of the time period otherwise applicable to the
29 data element. The data elements include, but are not limited to,
30 acute psychiatric days, annual fee-for-service days, annual managed
31 care days, annual Medi-Cal days, fee-for-service days, general
32 acute care days, high acuity days, managed care days, Medi-Cal
33 days, Medi-Cal fee-for-service days, Medi-Cal managed care days,
34 Medi-Cal managed care fee days, outpatient base amount, and
35 transplant days.

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

39 (A) The acute psychiatric per diem supplemental rate shall be
40 nine hundred sixty-five dollars (\$965) for the two remaining subject

1 fiscal quarters in the 2013–14 subject fiscal year, nine hundred
2 seventy dollars (\$970) for the subject fiscal quarters in the 2014–15
3 subject fiscal year, nine hundred seventy-five dollars (\$975) for
4 the subject fiscal quarters in the 2015–16 subject fiscal year and
5 nine hundred seventy-five dollars (\$975) for the first two subject
6 fiscal quarters in the 2016–17 subject fiscal year.

7 (B) The general acute care per diem supplemental rate shall be
8 eight hundred twenty-four dollars and forty cents (\$824.40) for
9 the two remaining subject fiscal quarters in the 2013–14 subject
10 fiscal year, one thousand one hundred ten dollars and sixty-seven
11 cents (\$1,110.67) for the subject fiscal quarters in the 2014–15
12 subject fiscal year, one thousand three hundred thirty-five dollars
13 and forty-two cents (\$1,335.42) for the subject fiscal quarters in
14 the 2015–16 subject fiscal year, and one thousand four hundred
15 forty-one dollars and twenty cents (\$1,441.20) for the first two
16 subject fiscal quarters in the 2016–17 subject fiscal year.

17 (C) The high acuity per diem supplemental rate shall be two
18 thousand five hundred dollars (\$2,500) for the two remaining
19 subject fiscal quarters in the 2013–14 subject fiscal year, two
20 thousand five hundred dollars (\$2,500) for the subject fiscal
21 quarters in the 2014–15 subject fiscal year, two thousand five
22 hundred dollars (\$2,500) for the subject fiscal quarters in the
23 2015–16 subject fiscal year, and two thousand five hundred dollars
24 (\$2,500) for the first two subject fiscal quarters in the 2016–17
25 subject fiscal year.

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

35 (E) The outpatient supplemental rate shall be 119 percent of the
36 outpatient base amount for the two remaining subject fiscal quarters
37 in the 2013–14 subject fiscal year, 268 percent of the outpatient
38 base amount for the subject fiscal quarters in the 2014–15 subject
39 fiscal year, 292 percent of the outpatient base amount for the
40 subject fiscal quarters in the 2015–16 subject fiscal year, and 151

1 percent of the outpatient base amount for the first two subject fiscal
2 quarters in the 2016–17 subject fiscal year.

3 (F) The subacute supplemental rate shall be 50 percent for the
4 two remaining subject fiscal quarters in the 2013–14 subject fiscal
5 year, 55 percent for the subject fiscal quarters in the 2014–15
6 subject fiscal year, 60 percent for the subject fiscal quarters in the
7 2015–16 subject fiscal year, and 60 percent for the first two subject
8 fiscal quarters in the 2016–17 subject fiscal year of the Medi-Cal
9 subacute payments paid by the department to the hospital during
10 the 2010 calendar year, as reflected in the state paid claims file
11 prepared by the department on April 26, 2013.

12 (G) The transplant per diem supplemental rate shall be two
13 thousand five hundred dollars (\$2,500) for the two remaining
14 subject fiscal quarters in the 2013–14 subject fiscal year, two
15 thousand five hundred dollars (\$2,500) for the subject fiscal
16 quarters in the 2014–15 subject fiscal year, two thousand five
17 hundred dollars (\$2,500) for the subject fiscal quarters in the
18 2015–16 subject fiscal year, and two thousand five hundred dollars
19 (\$2,500) for the first two subject fiscal quarters in the 2016–17
20 subject fiscal year.

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

24 (A) The fee-for-service per diem quality assurance fee rate shall
25 be three hundred seventy-four dollars and ninety-one cents
26 (\$374.91) for the two remaining subject fiscal quarters in the
27 2013–14 subject fiscal year, four hundred twenty-five dollars and
28 twenty-two cents (\$425.22) for the subject fiscal quarters in the
29 2014–15 subject fiscal year, four hundred eighty dollars and eleven
30 cents (\$480.11) for the subject fiscal quarters in the 2015–16
31 subject fiscal year, and five hundred forty-two dollars and ten cents
32 (\$542.10) for the first two subject fiscal quarters in the 2016–17
33 subject fiscal year.

34 (B) The managed care per diem quality assurance fee rate shall
35 be one hundred forty-five dollars (\$145) for the two remaining
36 subject fiscal quarters in the 2013–14 subject fiscal year, one
37 hundred forty-five dollars (\$145) for the subject fiscal quarters in
38 the 2014–15 subject fiscal year, one hundred seventy dollars (\$170)
39 for the subject fiscal quarters in the 2015–16 subject fiscal year,

1 and one hundred seventy dollars (\$170) for the first two subject
2 fiscal quarters in the 2016–17 subject fiscal year.

3 (C) The Medi-Cal per diem quality assurance fee rate shall be
4 four hundred fifty-seven dollars and ten cents (\$457.10) for the
5 two remaining subject fiscal quarters in the 2013–14 subject fiscal
6 year, four hundred ninety-seven dollars and eight cents (\$497.08)
7 for the subject fiscal quarters in the 2014–15 subject fiscal year,
8 five hundred sixty-eight dollars and fifteen cents (\$568.15) for the
9 subject fiscal quarters in the 2015–16 subject fiscal year, and six
10 hundred eighteen dollars and fourteen cents (\$618.14) for the first
11 two subject fiscal quarters in the 2016–17 subject fiscal year.

12 (D) The prepaid health plan hospital managed care per diem
13 quality assurance fee rate shall be eighty-one dollars and twenty
14 cents (\$81.20) for the two remaining subject fiscal quarters in the
15 2013–14 subject fiscal year, eighty-one dollars and twenty cents
16 (\$81.20) for the subject fiscal quarters in the 2014–15 subject fiscal
17 year, ninety-five dollars and twenty cents (\$95.20) for the subject
18 fiscal quarters in the 2015–16 subject fiscal year, and ninety-five
19 dollars and twenty cents (\$95.20) for the first two subject fiscal
20 quarters in the 2016–17 subject fiscal year.

21 (E) The prepaid health plan hospital Medi-Cal managed care
22 per diem quality assurance fee rate shall be two hundred fifty-five
23 dollars and ninety-seven cents (\$255.97) for the two remaining
24 subject fiscal quarters in the 2013–14 subject fiscal year, two
25 hundred seventy-eight dollars and thirty-seven cents (\$278.37) for
26 the subject fiscal quarters in the 2014–15 subject fiscal year, three
27 hundred eighteen dollars and sixteen cents (\$318.16) for the subject
28 fiscal quarters in the 2015–16 subject fiscal year, and three hundred
29 forty-six dollars and sixteen cents (\$346.16) for the first two subject
30 fiscal quarters in the 2016–17 subject fiscal year.

31 (F) Upon federal approval or conditional federal approval
32 described in Section 14169.63, the director shall have the discretion
33 to revise the fee-for-service per diem quality assurance fee rate,
34 the managed care per diem quality assurance fee rate, the Medi-Cal
35 per diem quality assurance fee rate, the prepaid health plan hospital
36 managed care per diem quality assurance fee rate, or the prepaid
37 health plan hospital Medi-Cal managed care per diem quality
38 assurance fee rate, based on the funds required to make the
39 payments specified in this article, in consultation with the hospital
40 community.

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

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

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

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

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

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

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

18 (B) To the extent permitted by federal law or other federal
19 requirements, the department shall use the best available and
20 reasonable current estimates or projections made with respect to
21 the hospital for an annual period as to the data, including, but not
22 limited to, the days data source and data described as being derived
23 from a state paid claims file, used for all purposes, including, but
24 not limited to, the calculation of supplemental payments and the
25 quality assurance fee. The estimates and projections shall be
26 deemed to reflect paid claims and shall be used for each data
27 element regardless of the time period otherwise applicable to the
28 data element. The data elements include, but are not limited to,
29 acute psychiatric days, annual fee-for-service days, annual managed
30 care days, annual Medi-Cal days, fee-for-service days, general
31 acute care days, high acuity days, managed care days, Medi-Cal
32 days, Medi-Cal fee-for-service days, Medi-Cal managed care days,
33 Medi-Cal managed care fee days, outpatient base amount, and
34 transplant days.

35 (h) Commencing January 2016, the department shall provide a
36 clear narrative description along with fiscal detail in the Medi-Cal
37 estimate package, submitted to the Legislature in January and May
38 of each year, of all of the calculations made by the department
39 pursuant to this section for the second program period and every
40 program period thereafter.

1 ~~SEC. 35.~~

2 *SEC. 33.* Section 14169.61 of the Welfare and Institutions
3 Code is amended to read:

4 14169.61. (a) (1) Except as provided in this section, all data
5 and other information relating to a hospital that are used for the
6 purposes of this article, including, without limitation, the days data
7 source, shall continue to be used to determine the payments to that
8 hospital, regardless of whether the hospital has undergone one or
9 more changes of ownership.

10 (2) All supplemental payments to a hospital under this article
11 shall be made to the licensee of a hospital on the date the
12 supplemental payment is made. All quality assurance fee payments
13 under this article shall be paid by the licensee of a hospital on the
14 date the quarterly quality assurance fee payment is due.

15 (b) The data of separate facilities prior to a consolidation shall
16 be aggregated for the purposes of this article if: (1) a private
17 hospital consolidates with another private hospital, (2) the facilities
18 operate under a consolidated hospital license, (3) data for a period
19 prior to the consolidation is used for purposes of this article, and
20 (4) neither hospital has had a change of ownership on or after the
21 effective date of this article unless paragraph (2) of subdivision
22 (d) has been satisfied by the new owner. Data of a facility that was
23 a separately licensed hospital prior to the consolidation shall not
24 be included in the data, including the days data source, for the
25 purpose of determining payments to the facility or the quality
26 assurance fees due from the facility under the article for any time
27 period during which the facility is closed. A facility shall be
28 deemed to be closed for purposes of this subdivision on the first
29 day of any period during which the facility has no general acute,
30 psychiatric, or rehabilitation inpatients for at least 30 consecutive
31 days. A facility that has been deemed to be closed under this
32 subdivision shall no longer be deemed to be closed on the first
33 subsequent day on which it has general acute, psychiatric, or
34 rehabilitation inpatients.

35 (c) The payments to a hospital under this article shall not be
36 made, and the quality assurance fees shall not be due, for any
37 period during which the hospital is closed. A hospital shall be
38 deemed to be closed on the first day of any period during which
39 the hospital has no general acute, psychiatric, or rehabilitation
40 inpatients for at least 30 consecutive days. A hospital that has been

1 deemed to be closed under this subdivision shall no longer be
2 deemed to be closed on the first subsequent day on which it has
3 general acute, psychiatric, or rehabilitation inpatients. Payments
4 under this article to a hospital and installment payments of the
5 aggregate quality assurance fee due from a hospital that is closed
6 during any portion of a subject fiscal quarter shall be reduced by
7 applying a fraction, expressed as a percentage, the numerator of
8 which shall be the number of days during the applicable subject
9 fiscal quarter that the hospital is closed during the subject fiscal
10 year and the denominator of which shall be the number of days in
11 the subject fiscal quarter.

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

16 (1) The director shall develop and describe in provider bulletins
17 and on the department's Internet Web site a process by which the
18 new operator of a hospital that has a days data source in whole or
19 in part from a previous operator may enter into an agreement with
20 the department to confirm that it is financially responsible or to
21 become financially responsible to the department for the
22 outstanding monetary obligation to the Medi-Cal program of the
23 previous operator in order to avoid being classified as a new
24 hospital for purposes of this article. This process shall be available
25 for changes of ownership that occur before, on, or after January
26 1, 2014, but only in regard to payments under this article and
27 otherwise shall have no retroactive effect.

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

31 (A) Payment of the quality assurance fee established pursuant
32 to this article.

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

37 (C) Overpayments that are asserted after such date and arise
38 from customary reconciliations of payments, such as cost report
39 settlements, and, with the exception of overpayments described in
40 subparagraph (B), shall exclude liabilities arising from the

1 fraudulent or intentionally criminal act of a prior operator if the
2 new operator did not knowingly participate in or continue the
3 fraudulent or criminal act after becoming the licensee.

4 (3) The department shall have the discretion to determine
5 whether the new owner properly and fully agreed to be financially
6 responsible for the outstanding monetary obligation in connection
7 with the Medi-Cal program and seek additional assurances as the
8 department deems necessary, except that a new owner that executes
9 an agreement with the department to be financially responsible for
10 the monetary obligations as described in paragraph (1) shall be
11 conclusively deemed to have agreed to be financially responsible
12 for the outstanding monetary obligation in connection with the
13 Medi-Cal program. The department shall have the discretion to
14 establish the terms for satisfying the outstanding monetary
15 obligation in connection with the Medi-Cal program, including,
16 but not limited to, recoupment from amounts payable to the hospital
17 under this section.

18 ~~SEC. 36.~~

19 *SEC. 34.* Section 14169.63 of the Welfare and Institutions
20 Code is amended to read:

21 14169.63. (a) Notwithstanding any other provision of this
22 article requiring federal approvals, the department may impose
23 and collect the quality assurance fee and may make payments
24 under this article, including increased capitation payments, based
25 upon receiving a letter from the federal Centers for Medicare and
26 Medicaid Services or the United States Department of Health and
27 Human Services that indicates likely federal approval, but only if
28 and to the extent that the letter is sufficient as set forth in
29 subdivision (b).

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

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

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

1 (c) Nothing in this section shall be construed as modifying the
2 requirement under Section 14169.69 that payments shall be made
3 only to the extent a sufficient amount of funds collected as the
4 quality assurance fee are available to cover the nonfederal share
5 of those payments.

6 (d) Upon notice from the federal government that final federal
7 approval for the fee model under this article or for the supplemental
8 payments to private hospitals under Section 14169.54 or 14169.55
9 has been denied, any fees collected pursuant to this section shall
10 be refunded and any payments made pursuant to this article shall
11 be recouped, including, but not limited to, supplemental payments
12 and grants, increased capitation payments, payments to hospitals
13 by health care plans resulting from the increased capitation
14 payments, and payments for the health care coverage of children.
15 To the extent fees were paid by a hospital that also received
16 payments under this section, the payments may first be recouped
17 from fees that would otherwise be refunded to the hospital prior
18 to the use of any other recoupment method allowed under law.

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

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

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

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

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

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

36 ~~SEC. 37.~~

37 *SEC. 35.* Section 14169.65 of the Welfare and Institutions
38 Code is amended to read:

39 14169.65. (a) Upon receipt of a letter that indicates likely
40 federal approval that the director determines is sufficient for

1 implementation under Section 14169.63, or upon the receipt of
2 federal approval, the following shall occur:

3 (1) To the maximum extent possible, and consistent with the
4 availability of funds in the fund, the department shall make all of
5 the payments under Sections 14169.54, 14169.55, and 14169.56,
6 including, but not limited to, supplemental payments and increased
7 capitation payments, prior to the end of a program period, except
8 that the increased capitation payments under Section 14169.56
9 shall not be made until federal approval is obtained for these
10 payments.

11 (2) The department shall make supplemental payments to
12 hospitals under this article consistent with the timeframe described
13 in Section 14169.66 or a modified timeline developed pursuant to
14 Section 14169.64.

15 (b) If any payment or payments made pursuant to this section
16 are found to be inconsistent with federal law, the department shall
17 recoup the payments by means of withholding or any other
18 available remedy.

19 (c) This section shall not affect the department's ongoing
20 authority to continue, after the end of a program period, to collect
21 quality assurance fees imposed on or before the end of the program
22 period.

23 ~~SEC. 38.~~

24 *SEC. 36.* Section 14169.66 of the Welfare and Institutions
25 Code is amended to read:

26 14169.66. The department shall make disbursements from the
27 fund consistent with the following:

28 (a) Fund disbursements shall be made periodically within 15
29 days of each date on which quality assurance fees are due from
30 hospitals.

31 (b) The funds shall be disbursed in accordance with the order
32 of priority set forth in subdivision (b) of Section 14169.53, except
33 that funds may be set aside for increased capitation payments to
34 managed care health plans pursuant to subdivision (e) of Section
35 14169.56.

36 (c) The funds shall be disbursed in each payment cycle in
37 accordance with the order of priority set forth in subdivision (b)
38 of Section 14169.53 as modified by subdivision (b), and so that
39 the supplemental payments and direct grants to hospitals and the

1 increased capitation payments to managed health care plans are
2 made to the maximum extent for which funds are available.

3 (d) To the maximum extent possible, consistent with the
4 availability of funds in the fund and the timing of federal approvals,
5 the supplemental payments and direct grants to hospitals and
6 increased capitation payments to managed health care plans under
7 this article shall be made before the last day of a program period.

8 (e) The aggregate amount of funds to be disbursed to private
9 hospitals shall be determined under Sections 14169.54 and
10 14169.55. The aggregate amount of funds to be disbursed to
11 managed health care plans shall be determined under Section
12 14169.56. The aggregate amount of direct grants to designated
13 and nondesignated public hospitals shall be determined under
14 Section 14169.58.

15 ~~SEC. 39.~~

16 *SEC. 37.* Section 14169.72 of the Welfare and Institutions
17 Code is amended to read:

18 14169.72. This article shall become inoperative if any of the
19 following occurs:

20 (a) The effective date of a final judicial determination made by
21 any court of appellate jurisdiction or a final determination by the
22 United States Department of Health and Human Services or the
23 federal Centers for Medicare and Medicaid Services that the quality
24 assurance fee established pursuant to this article, or Section
25 14169.54 or 14169.55, cannot be implemented. This subdivision
26 shall not apply to any final judicial determination made by any
27 court of appellate jurisdiction in a case brought by hospitals located
28 outside the state.

29 (b) The federal Centers for Medicare and Medicaid Services
30 denies approval for, or does not approve on or before the last day
31 of a program period, the implementation of Sections 14169.52,
32 14169.53, 14169.54, and 14169.55, and the department fails to
33 modify Section 14169.52, 14169.53, 14169.54, or 14169.55
34 pursuant to subdivision (d) of Section 14169.53 in order to meet
35 the requirements of federal law or to obtain federal approval.

36 (c) A final judicial determination by the California Supreme
37 Court or any California Court of Appeal that the revenues collected
38 pursuant to this article that are deposited in the fund are either of
39 the following:

1 (1) “General Fund proceeds of taxes appropriated pursuant to
2 Article XIII B of the California Constitution,” as used in
3 subdivision (b) of Section 8 of Article XVI of the California
4 Constitution.

5 (2) “Allocated local proceeds of taxes,” as used in subdivision
6 (b) of Section 8 of Article XVI of the California Constitution.

7 (d) The department has sought but has not received federal
8 financial participation for the supplemental payments and other
9 costs required by this article for which federal financial
10 participation has been sought.

11 (e) A lawsuit related to this article is filed against the state and
12 a preliminary injunction or other order has been issued that results
13 in a financial disadvantage to the state. For purposes of this
14 subdivision, “financial disadvantage to the state” means either of
15 the following:

16 (1) A loss of federal financial participation.

17 (2) A cost to the General Fund that is equal to or greater than
18 one-quarter of 1 percent of the General Fund expenditures
19 authorized in the most recent annual Budget Act.

20 (f) The proceeds of the fee and any interest and dividends earned
21 on deposits are not deposited into the fund or are not used as
22 provided in Section 14169.53.

23 (g) The proceeds of the fee, the matching amount provided by
24 the federal government, and interest and dividends earned on
25 deposits in the fund are not used as provided in Section 14169.68.

26 ~~SEC. 40.~~

27 *SEC. 38.* Section 14312 of the Welfare and Institutions Code
28 is amended to read:

29 14312. The director shall adopt all necessary rules and
30 regulations to carry out the provisions of this chapter. In adopting
31 such rules and regulations, the director shall be guided by the needs
32 of eligible persons as well as prevailing practices in the delivery
33 of health care on a prepaid basis. Except where otherwise required
34 by federal law or by this part, the rules and regulations shall be
35 consistent with the requirements of the Knox-Keene Health Care
36 Service Plan Act of 1975.

37 ~~SEC. 41.~~

38 *SEC. 39.* Section 14451 of the Welfare and Institutions Code
39 is amended to read:

1 14451. Services under a prepaid health plan contract shall be
2 provided in accordance with the requirements of the Knox-Keene
3 Health Care Service Plan Act of 1975.

4 ~~SEC. 42.~~

5 *SEC. 40.* Section 15657.8 of the Welfare and Institutions Code
6 is amended to read:

7 15657.8. (a) An agreement to settle a civil action for physical
8 abuse, as defined in Section 15610.63, neglect, as defined in
9 Section 15610.57, or financial abuse, as defined in Section
10 15610.30, of an elder or dependent adult shall not include any of
11 the following provisions, whether the agreement is made before
12 or after filing the action:

13 (1) A provision that prohibits any party to the dispute from
14 contacting or cooperating with the county adult protective services
15 agency, the local law enforcement agency, the long-term care
16 ombudsman, the California Department of Aging, the Department
17 of Justice, the Licensing and Certification Division of the State
18 Department of Public Health, the State Department of
19 Developmental Services, the State Department of State Hospitals,
20 a licensing or regulatory agency that has jurisdiction over the
21 license or certification of the defendant, any other governmental
22 entity, a protection and advocacy agency, as defined in Section
23 4900, or the defendant's current employer if the defendant's job
24 responsibilities include contact with elders, dependent adults, or
25 children, provided that the party contacting or cooperating with
26 one of these entities had a good faith belief that the information
27 he or she provided is relevant to the concerns, duties, or obligations
28 of that entity.

29 (2) A provision that prohibits any party to the dispute from filing
30 a complaint with, or reporting any violation of law to, the county
31 adult protective services agency, the local law enforcement agency,
32 the long-term care ombudsman, the California Department of
33 Aging, the Department of Justice, the Licensing and Certification
34 Division of the State Department of Public Health, the State
35 Department of Developmental Services, the State Department of
36 State Hospitals, a licensing or regulatory agency that has
37 jurisdiction over the license or certification of the defendant, any
38 other governmental entity, a protection and advocacy agency, as
39 defined in Section 4900, or the defendant's current employer if

1 the defendant's job responsibilities include contact with elders,
2 dependent adults, or children.

3 (3) A provision that requires any party to the dispute to withdraw
4 a complaint he or she has filed with, or a violation he or she has
5 reported to, the county adult protective services agency, the local
6 law enforcement agency, the long-term care ombudsman, the
7 California Department of Aging, the Department of Justice, the
8 Licensing and Certification Division of the State Department of
9 Public Health, the State Department of Developmental Services,
10 the State Department of State Hospitals, a licensing or regulatory
11 agency that has jurisdiction over the license or certification of the
12 defendant, any other governmental entity, a protection and
13 advocacy agency, as defined in Section 4900, or the defendant's
14 current employer if the defendant's job responsibilities include
15 contact with elders, dependent adults, or children.

16 (b) A provision described in subdivision (a) is void as against
17 public policy.

18 (c) This section shall apply only to an agreement entered on or
19 after January 1, 2013.

20 ~~SEC. 43.~~

21 *SEC. 41.* Section 16541 of the Welfare and Institutions Code
22 is amended to read:

23 16541. The council shall be comprised of the following
24 members:

25 (a) The Secretary of California Health and Human Services,
26 who shall serve as cochair.

27 (b) The Chief Justice of the California Supreme Court, or his
28 or her designee, who shall serve as cochair.

29 (c) The Superintendent of Public Instruction, or his or her
30 designee.

31 (d) The Chancellor of the California Community Colleges, or
32 his or her designee.

33 (e) The executive director of the State Board of Education.

34 (f) The Director of Social Services.

35 (g) The Director of Health *Care* Services.

36 (h) The Director of State Hospitals.

37 ~~(i) The Director of Alcohol and Drug Programs.~~

38 ~~(j)~~

39 (i) The Director of Developmental Services.

40 ~~(k)~~

1 (j) The Director of the Youth Authority.

2 ~~(t)~~

3 (k) The Administrative Director of the Courts.

4 ~~(m)~~

5 (l) The State Foster Care Ombudsperson.

6 ~~(n)~~

7 (m) Four foster youth or former foster youth.

8 ~~(o)~~

9 (n) The chairpersons of the Assembly Human Services
10 Committee and the Assembly Judiciary Committee, or two other
11 Members of the Assembly as appointed by the Speaker of the
12 Assembly.

13 ~~(p)~~

14 (o) The chairpersons of the Senate Human Services Committee
15 and the Senate Judiciary Committee, or two other members
16 appointed by the President pro Tempore of the Senate.

17 ~~(q)~~

18 (p) Leaders and representatives of county child welfare, foster
19 care, health, education, probation, and mental health agencies and
20 departments, child advocacy organizations; labor organizations,
21 recognized professional associations that represent child welfare
22 and foster care social workers, tribal representatives, and other
23 groups and stakeholders that provide benefits, services, and
24 advocacy to families and children in the child welfare and foster
25 care systems, as recommended by representatives of these groups
26 and as designated by the cochairs.

27 ~~SEC. 44. Section 17608.05 of the Welfare and Institutions~~
28 ~~Code is amended to read:~~

29 ~~17608.05. (a) As a condition of deposit of funds from the Sales~~
30 ~~Tax Account of the Local Revenue Fund into a county's local~~
31 ~~health and welfare trust fund mental health account, the county or~~
32 ~~city shall deposit each month local matching funds in accordance~~
33 ~~with a schedule developed by the State Department of Mental~~
34 ~~Health, or its successor the State Department of State Hospitals,~~
35 ~~based on county or city standard matching obligations for the~~
36 ~~1990-91 fiscal year for mental health programs.~~

37 ~~(b) A county, city, or city and county may limit its deposit of~~
38 ~~matching funds to the amount necessary to meet minimum federal~~
39 ~~maintenance of effort requirements, as calculated by the State~~
40 ~~Department of State Hospitals, subject to the approval of the~~

1 Department of Finance. However, the amount of the reduction
2 permitted by the limitation provided for by this subdivision shall
3 not exceed twenty-five million dollars (\$25,000,000) per fiscal
4 year on a statewide basis.

5 (e) Any county, city, or city and county that elects not to apply
6 maintenance of effort funds for community mental health programs
7 shall not use the loss of these expenditures from local mental health
8 programs for realignment purposes, including any calculation for
9 poverty-population shortfall for clause (iv) of subparagraph (B)
10 of paragraph (2) of subdivision (c) of Section 17606.05.

11 ~~SEC. 45.~~

12 *SEC. 42.* This act is an urgency statute necessary for the
13 immediate preservation of the public peace, health, or safety within
14 the meaning of Article IV of the Constitution and shall go into
15 immediate effect. The facts constituting the necessity are:

16 In order to ensure the health and safety of Californians by
17 updating existing law consistent with current practices at the
18 earliest possible time, it is necessary that this act take effect
19 immediately.