

AMENDED IN ASSEMBLY SEPTEMBER 4, 2015

AMENDED IN ASSEMBLY SEPTEMBER 1, 2015

SENATE BILL

No. 804

**Introduced by Committee on Health (Senators Hernandez (Chair),
Hall, Mitchell, Monning, Nguyen, Nielsen, Pan, Roth, and Wolk)**

March 26, 2015

An act to amend Sections ~~1366.22~~, 11801, 11811.6, 11830.1, 11835, ~~24100~~, 103577, 104151, 128456, 130302, and 130304 of, ~~to amend,~~ repeal, and add Sections 1366.24 and 1366.25 of, and to repeal Sections 130316 and 130317 of, the Health and Safety Code, ~~to amend Section~~ 10128.52 of, and to amend, repeal, and add Sections ~~10128.54 and~~ 10128.55 of, the Insurance Code, and to amend Sections 729.12, 4033, 4040, 4095, ~~4096.5~~, 4117, 5121, 5150, 5152.1, 5152.2, 5250.1, 5305, 5306.5, 5307, 5308, 5326.95, 5328, 5328.2, 5346, 5400, 5585.22, 5601, 5611, 5664, 5694.7, 5701.1, 5701.2, 5717, 5750, 5814.5, ~~5845~~, 5847, 5848, 5848.5, 5892, 5899, 5902, 6002.25, 8103, 11467, 11469, 14021.4, 14124.24, 14251, 14499.71, 14682.1, 14707, 14711, 14717, 14718, 14725, 15204.8, and 15847.7 of the Welfare and Institutions Code, relating to public health.

LEGISLATIVE COUNSEL'S DIGEST

SB 804, as amended, Committee on Health. Public health.

~~(1) The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. The California Continuation Benefits Replacement Act (Cal-COBRA) requires health care service plans and health insurers providing coverage under a group benefit plan~~

~~to employers of 2 to 19 eligible employees to offer a continuation of that coverage for a specified period of time to certain qualified beneficiaries, as specified. Existing law requires a group benefit plan that is subject to Cal-COBRA to make specified disclosures to covered employees, including that a covered employee who is considering declining continuation of coverage should be aware that companies selling individual health insurance may require a review of the employee's medical history that could result in a higher premium or denial of coverage.~~

~~This bill would eliminate the disclosure requirement described above. If federal law requiring an individual to maintain minimum health coverage is repealed or amended to no longer apply to the individual market, as specified, the bill would reenact that disclosure requirement to become operative 12 months after that repeal or amendment. The bill would also, under those same conditions, require a contract between a group benefit plan that is subject to Cal-COBRA and an employer to require the employer to make the same disclosure to a qualified beneficiary in connection with a notice regarding election of continuation coverage. The bill would require a group benefit plan that is subject to Cal-COBRA and that issues, amends, or renews a disclosure on or after July 1, 2016, to include a notice regarding additional health care coverage options in that disclosure, as specified. The bill would require a group contract that is issued, amended, or renewed on or after July 1, 2016, between a group benefit plan that is subject to Cal-COBRA and an employer to require the employer to give that notice regarding additional health care coverage options to a qualified beneficiary of the contract in connection with a notice regarding election of continuation coverage. The bill would make conforming changes to related provisions.~~

~~Because a willful violation of the bill's requirements relative to health care service plans would be a crime, this bill would impose a state-mandated local program:~~

~~(2)~~

~~(1) Existing law regulates provision of programs and services relating to mental health and alcohol and drug abuse at the state and local levels and serving various populations. These provisions contain various obsolete references to the California Mental Health Directors Association, the County Alcohol and Drug Program Administrators' Association of California, and similar entities.~~

This bill would delete those obsolete references and would refer instead to the County Behavioral Health Directors Association of California, and would make additional conforming changes to certain provisions relating to mental health directors and alcohol and drug program administrators.

(3)

(2) Existing law requires the State Department of Health Care Services to provide, no later than January 10 and concurrently with the May Revision of the annual budget, the fiscal committees of the Legislature with an estimate package for the Every Woman Counts Program for early detection of breast and cervical cancer.

This bill would require the department additionally to provide to the fiscal and appropriate policy committees of the Legislature quarterly updates on caseload, estimated expenditures, and related program monitoring data for the Every Woman Counts Program, as prescribed. The bill would declare the intent of the Legislature that these provisions supersede similar reporting requirements imposed on the State Department of Public Health by specified uncodified legislation.

(4)

(3) Existing law, for purposes of Medi-Cal provisions relating to entities that provide payment for certain covered services on behalf of eligible persons, enrollees, or subscribers, includes a nonprofit hospital service plan within the descriptions of a fiscal intermediary, a prepaid health plan, and group health coverage.

This bill would delete a nonprofit hospital service plan from inclusion as a fiscal intermediary, prepaid health plan, or group health coverage, under the above circumstances.

(5)

(4) Existing law establishes the State Department of Public Health and sets forth its powers and duties, including, but not limited to, duties as State Registrar relating to the uniform administration of provisions relating to vital records and health statistics. Existing law requires the State Registrar, local registrar, or county recorder to, upon request and payment of the required fee, supply to an applicant a certified copy of the record of a birth, fetal death, death, marriage, or marriage dissolution registered with the official. Existing law authorizes the issuance of certain records without payment of the fee.

Existing law, on and after July 1, 2015, requires each local registrar or county recorder to issue, without a fee, a certified record of live birth

to any person who can verify his or her status as a homeless person or a homeless child or youth, as defined.

This bill would specify that no issuance or other related fee would be charged under the above circumstances.

~~(6)~~

(5) Under the Health Insurance Portability and Accountability Implementation Act of 2001, the Office of HIPAA Implementation assumes statewide leadership, coordination, policy formulation, direction, and oversight responsibilities for HIPAA implementation, and exercises full authority relative to state entities to establish policy, provide direction to state entities, monitor progress, and report on implementation efforts. Under existing law, these duties have been assumed by a successor entity, the Office of Health Information Integrity. These provisions become inoperative and are repealed as of June 30, 2016, at which time funds appropriated for purposes of the act that remain unexpended and unencumbered, revert to the General Fund.

This bill would indefinitely extend the act and the operation of the office by deleting the June 30, 2016 repeal date. The bill would update references to the office to refer instead to the Office of Health Information Integrity.

~~(7) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that no reimbursement is required by this act for a specified reason.~~

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

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

1 ~~SECTION 1. Section 1366.22 of the Health and Safety Code~~
 2 ~~is amended to read:~~
 3 ~~1366.22. The continuation coverage requirements of this article~~
 4 ~~do not apply to the following individuals:~~
 5 ~~(a) Individuals who are entitled to Medicare benefits or become~~
 6 ~~entitled to Medicare benefits pursuant to Title XVIII of the United~~
 7 ~~States Social Security Act, as amended or superseded. Entitlement~~
 8 ~~to Medicare Part A only constitutes entitlement to benefits under~~
 9 ~~Medicare.~~

1 ~~(b) Individuals who have other hospital, medical, or surgical~~
2 ~~coverage or who are covered or become covered under another~~
3 ~~group benefit plan, including a self-insured employee welfare~~
4 ~~benefit plan, that provides coverage for individuals and that does~~
5 ~~not impose any exclusion or limitation with respect to any~~
6 ~~preexisting condition of the individual, other than a preexisting~~
7 ~~condition limitation or exclusion that does not apply to or is~~
8 ~~satisfied by the qualified beneficiary pursuant to Sections 1357~~
9 ~~and 1357.06. A group conversion option under any group benefit~~
10 ~~plan shall not be considered as an arrangement under which an~~
11 ~~individual is or becomes covered.~~

12 ~~(c) Individuals who are covered, become covered, or are eligible~~
13 ~~for federal COBRA coverage pursuant to Section 4980B of the~~
14 ~~United States Internal Revenue Code or Chapter 18 of the~~
15 ~~Employee Retirement Income Security Act (29 U.S.C. Sec. 1161~~
16 ~~et seq.).~~

17 ~~(d) Individuals who are covered, become covered, or are eligible~~
18 ~~for coverage pursuant to Chapter 6A of the Public Health Service~~
19 ~~Act (42 U.S.C. Section 300bb-1 et seq.).~~

20 ~~(e) Qualified beneficiaries who fail to meet the requirements of~~
21 ~~subdivision (b) of Section 1366.24 or subdivision (i) of Section~~
22 ~~1366.25 regarding notification of a qualifying event or election of~~
23 ~~continuation coverage within the specified time limits.~~

24 ~~(f) Except as provided in Section 3001 of ARRA, qualified~~
25 ~~beneficiaries who fail to submit the correct premium amount~~
26 ~~required by subdivision (b) of Section 1366.24 and Section~~
27 ~~1366.26, in accordance with the terms and conditions of the plan~~
28 ~~contract, or fail to satisfy other terms and conditions of the plan~~
29 ~~contract.~~

30 ~~SEC. 2. Section 1366.24 of the Health and Safety Code is~~
31 ~~amended to read:~~

32 ~~1366.24. (a) Every health care service plan evidence of~~
33 ~~coverage, provided for group benefit plans subject to this article,~~
34 ~~that is issued, amended, or renewed on or after January 1, 1999,~~
35 ~~shall disclose to covered employees of group benefit plans subject~~
36 ~~to this article the ability to continue coverage pursuant to this~~
37 ~~article, as required by this section.~~

38 ~~(b) This disclosure shall state that all enrollees who are eligible~~
39 ~~to be qualified beneficiaries, as defined in subdivision (c) of~~
40 ~~Section 1366.21, shall be required, as a condition of receiving~~

1 benefits pursuant to this article, to notify, in writing, the health
2 care service plan, or the employer if the employer contracts to
3 perform the administrative services as provided for in Section
4 1366.25, of all qualifying events as specified in paragraphs (1),
5 (3), (4), and (5) of subdivision (d) of Section 1366.21 within 60
6 days of the date of the qualifying event. This disclosure shall
7 inform enrollees that failure to make the notification to the health
8 care service plan, or to the employer when under contract to
9 provide the administrative services, within the required 60 days
10 will disqualify the qualified beneficiary from receiving continuation
11 coverage pursuant to this article. The disclosure shall further state
12 that a qualified beneficiary who wishes to continue coverage under
13 the group benefit plan pursuant to this article shall request the
14 continuation in writing and deliver the written request, by first-class
15 mail, or other reliable means of delivery, including personal
16 delivery, express mail, or private courier company, to the health
17 care service plan, or to the employer if the plan has contracted
18 with the employer for administrative services pursuant to
19 subdivision (d) of Section 1366.25, within the 60-day period
20 following the later of (1) the date that the enrollee's coverage under
21 the group benefit plan terminated or will terminate by reason of a
22 qualifying event, or (2) the date the enrollee was sent notice
23 pursuant to subdivision (c) of Section 1366.25 of the ability to
24 continue coverage under the group benefit plan. The disclosure
25 required by this section shall also state that a qualified beneficiary
26 electing continuation shall pay to the health care service plan, in
27 accordance with the terms and conditions of the plan contract,
28 which shall be set forth in the notice to the qualified beneficiary
29 pursuant to subdivision (d) of Section 1366.25, the amount of the
30 required premium payment, as set forth in Section 1366.26. The
31 disclosure shall further require that the qualified beneficiary's first
32 premium payment required to establish premium payment be
33 delivered by first-class mail, certified mail, or other reliable means
34 of delivery, including personal delivery, express mail, or private
35 courier company, to the health care service plan, or to the employer
36 if the employer has contracted with the plan to perform the
37 administrative services pursuant to subdivision (d) of Section
38 1366.25, within 45 days of the date the qualified beneficiary
39 provided written notice to the health care service plan or the
40 employer, if the employer has contracted to perform the

1 administrative services, of the election to continue coverage in
2 order for coverage to be continued under this article. This
3 disclosure shall also state that the first premium payment shall
4 equal an amount sufficient to pay any required premiums and all
5 premiums due, and that failure to submit the correct premium
6 amount within the 45-day period will disqualify the qualified
7 beneficiary from receiving continuation coverage pursuant to this
8 article.

9 (e) The disclosure required by this section shall also describe
10 separately how qualified beneficiaries whose continuation coverage
11 terminates under a prior group benefit plan pursuant to subdivision
12 (b) of Section 1366.27 may continue their coverage for the balance
13 of the period that the qualified beneficiary would have remained
14 covered under the prior group benefit plan, including the
15 requirements for election and payment. The disclosure shall clearly
16 state that continuation coverage shall terminate if the qualified
17 beneficiary fails to comply with the requirements pertaining to
18 enrollment in, and payment of premiums to, the new group benefit
19 plan within 30 days of receiving notice of the termination of the
20 prior group benefit plan.

21 (d) Prior to August 1, 1998, every health care service plan shall
22 provide to all covered employees of employers subject to this
23 article a written notice containing the disclosures required by this
24 section, or shall provide to all covered employees of employers
25 subject to this section a new or amended evidence of coverage that
26 includes the disclosures required by this section. Any specialized
27 health care service plan that, in the ordinary course of business,
28 maintains only the addresses of employer group purchasers of
29 benefits and does not maintain addresses of covered employees,
30 may comply with the notice requirements of this section through
31 the provision of the notices to its employer group purchasers of
32 benefits.

33 (e) Every plan disclosure form issued, amended, or renewed on
34 and after January 1, 1999, for a group benefit plan subject to this
35 article shall provide a notice that, under state law, an enrollee may
36 be entitled to continuation of group coverage and that additional
37 information regarding eligibility for this coverage may be found
38 in the plan's evidence of coverage.

1 (f) A disclosure issued, amended, or renewed on or after July
2 1, 2016, for a group benefit plan subject to this article shall include
3 the following notice:

4 “In addition to your coverage continuation options, you may be
5 eligible for the following:

6 1. Coverage through the state health insurance marketplace, also
7 known as Covered California. By enrolling through Covered
8 California, you may qualify for lower monthly premiums and lower
9 out-of-pocket costs. Your family members may also qualify for
10 coverage through Covered California.

11 2. Coverage through Medi-Cal. Depending on your income, you
12 may qualify for low- or no-cost coverage through Medi-Cal. Your
13 family members may also qualify for Medi-Cal.

14 3. Coverage through an insured spouse. If your spouse has
15 coverage that extends to family members, you may be able to be
16 added on that benefit plan.

17 Be aware that there is a deadline to enroll in Covered California
18 although you can apply for Medi-Cal anytime. To find out more
19 about how to apply for Covered California and Medi-Cal, visit the
20 Covered California Internet Web site at

21 <http://www.coveredca.com>.”

22 (g) (1) If Section 5000A of the Internal Revenue Code, as added
23 by Section 1501 of PPACA, is repealed or amended to no longer
24 apply to the individual market, as defined in Section 2791 of the
25 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
26 section shall become inoperative and is repealed 12 months after
27 the date of that repeal or amendment.

28 (2) For purposes of this subdivision, “PPACA” means the federal
29 Patient Protection and Affordable Care Act (Public Law 111-148),
30 as amended by the federal Health Care and Education
31 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
32 regulations, or guidance issued pursuant to that law.

33 SEC. 3. Section 1366.24 is added to the Health and Safety
34 Code, to read:

35 1366.24. (a) Every health care service plan evidence of
36 coverage, provided for group benefit plans subject to this article,
37 that is issued, amended, or renewed on or after January 1, 1999,
38 shall disclose to covered employees of group benefit plans subject
39 to this article the ability to continue coverage pursuant to this
40 article, as required by this section.

1 ~~(b) This disclosure shall state that all enrollees who are eligible~~
2 ~~to be qualified beneficiaries, as defined in subdivision (c) of~~
3 ~~Section 1366.21, shall be required, as a condition of receiving~~
4 ~~benefits pursuant to this article, to notify, in writing, the health~~
5 ~~care service plan, or the employer if the employer contracts to~~
6 ~~perform the administrative services as provided for in Section~~
7 ~~1366.25, of all qualifying events as specified in paragraphs (1),~~
8 ~~(3), (4), and (5) of subdivision (d) of Section 1366.21 within 60~~
9 ~~days of the date of the qualifying event. This disclosure shall~~
10 ~~inform enrollees that failure to make the notification to the health~~
11 ~~care service plan, or to the employer when under contract to~~
12 ~~provide the administrative services, within the required 60 days~~
13 ~~will disqualify the qualified beneficiary from receiving continuation~~
14 ~~coverage pursuant to this article. The disclosure shall further state~~
15 ~~that a qualified beneficiary who wishes to continue coverage under~~
16 ~~the group benefit plan pursuant to this article must request the~~
17 ~~continuation in writing and deliver the written request, by first-class~~
18 ~~mail, or other reliable means of delivery, including personal~~
19 ~~delivery, express mail, or private courier company, to the health~~
20 ~~care service plan, or to the employer if the plan has contracted~~
21 ~~with the employer for administrative services pursuant to~~
22 ~~subdivision (d) of Section 1366.25, within the 60-day period~~
23 ~~following the later of either (1) the date that the enrollee's coverage~~
24 ~~under the group benefit plan terminated or will terminate by reason~~
25 ~~of a qualifying event, or (2) the date the enrollee was sent notice~~
26 ~~pursuant to subdivision (e) of Section 1366.25 of the ability to~~
27 ~~continue coverage under the group benefit plan. The disclosure~~
28 ~~required by this section shall also state that a qualified beneficiary~~
29 ~~electing continuation shall pay to the health care service plan, in~~
30 ~~accordance with the terms and conditions of the plan contract,~~
31 ~~which shall be set forth in the notice to the qualified beneficiary~~
32 ~~pursuant to subdivision (d) of Section 1366.25, the amount of the~~
33 ~~required premium payment, as set forth in Section 1366.26. The~~
34 ~~disclosure shall further require that the qualified beneficiary's first~~
35 ~~premium payment required to establish premium payment be~~
36 ~~delivered by first-class mail, certified mail, or other reliable means~~
37 ~~of delivery, including personal delivery, express mail, or private~~
38 ~~courier company, to the health care service plan, or to the employer~~
39 ~~if the employer has contracted with the plan to perform the~~
40 ~~administrative services pursuant to subdivision (d) of Section~~

1 1366.25, within 45 days of the date the qualified beneficiary
2 provided written notice to the health care service plan or the
3 employer, if the employer has contracted to perform the
4 administrative services, of the election to continue coverage in
5 order for coverage to be continued under this article. This
6 disclosure shall also state that the first premium payment must
7 equal an amount sufficient to pay any required premiums and all
8 premiums due, and that failure to submit the correct premium
9 amount within the 45-day period will disqualify the qualified
10 beneficiary from receiving continuation coverage pursuant to this
11 article.

12 (e) The disclosure required by this section shall also describe
13 separately how qualified beneficiaries whose continuation coverage
14 terminates under a prior group benefit plan pursuant to subdivision
15 (b) of Section 1366.27 may continue their coverage for the balance
16 of the period that the qualified beneficiary would have remained
17 covered under the prior group benefit plan, including the
18 requirements for election and payment. The disclosure shall clearly
19 state that continuation coverage shall terminate if the qualified
20 beneficiary fails to comply with the requirements pertaining to
21 enrollment in, and payment of premiums to, the new group benefit
22 plan within 30 days of receiving notice of the termination of the
23 prior group benefit plan.

24 (d) Prior to August 1, 1998, every health care service plan shall
25 provide to all covered employees of employers subject to this
26 article a written notice containing the disclosures required by this
27 section, or shall provide to all covered employees of employers
28 subject to this section a new or amended evidence of coverage that
29 includes the disclosures required by this section. Any specialized
30 health care service plan that, in the ordinary course of business,
31 maintains only the addresses of employer group purchasers of
32 benefits and does not maintain addresses of covered employees;
33 may comply with the notice requirements of this section through
34 the provision of the notices to its employer group purchasers of
35 benefits.

36 (e) Every plan disclosure form issued, amended, or renewed on
37 or after January 1, 1999, for a group benefit plan subject to this
38 article shall provide a notice that, under state law, an enrollee may
39 be entitled to continuation of group coverage and that additional

1 information regarding eligibility for this coverage may be found
2 in the plan’s evidence of coverage.

3 (f) Every disclosure issued, amended, or renewed on or after
4 the operative date of this section for a group benefit plan subject
5 to this article shall include the following notice:

6 “Please examine your options carefully before declining this
7 coverage. You should be aware that companies selling individual
8 health insurance typically require a review of your medical history
9 that could result in a higher premium or you could be denied
10 coverage entirely.”

11 (g) A disclosure issued, amended, or renewed on or after July
12 1, 2016, for a group benefit plan subject to this article shall include
13 the following

14 notice:

15 “In addition to your coverage continuation options, you may be
16 eligible for the following:

17 1. Coverage through the state health insurance marketplace, also
18 known as Covered California. By enrolling through Covered
19 California, you may qualify for lower monthly premiums and lower
20 out-of-pocket costs. Your family members may also qualify for
21 coverage through Covered California.

22 2. Coverage through Medi-Cal. Depending on your income, you
23 may qualify for low- or no-cost coverage through Medi-Cal. Your
24 family members may also qualify for Medi-Cal.

25 3. Coverage through an insured spouse. If your spouse has
26 coverage that extends to family members, you may be able to be
27 added on that benefit plan.

28 Be aware that there is a deadline to enroll in Covered California
29 although you can apply for Medi-Cal anytime. To find out more
30 about how to apply for Covered California and Medi-Cal, visit the
31 Covered California Internet Web site at

32 <http://www.coveredca.com>.”

33 (h) (1) If Section 5000A of the Internal Revenue Code, as added
34 by Section 1501 of PPACA, is repealed or amended to no longer
35 apply to the individual market, as defined in Section 2791 of the
36 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
37 section shall become operative 12 months after the date of that
38 repeal or amendment.

39 (2) For purposes of this subdivision, “PPACA” means the federal
40 Patient Protection and Affordable Care Act (Public Law 111-148),

1 as amended by the federal Health Care and Education
2 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
3 regulations, or guidance issued pursuant to that law.

4 SEC. 4. Section 1366.25 of the Health and Safety Code is
5 amended to read:

6 1366.25. (a) Every group contract between a health care service
7 plan and an employer subject to this article that is issued, amended,
8 or renewed on or after July 1, 1998, shall require the employer to
9 notify the plan, in writing, of any employee who has had a
10 qualifying event, as defined in paragraph (2) of subdivision (d) of
11 Section 1366.21, within 30 days of the qualifying event. The group
12 contract shall also require the employer to notify the plan, in
13 writing, within 30 days of the date, when the employer becomes
14 subject to Section 4980B of the United States Internal Revenue
15 Code or Chapter 18 of the Employee Retirement Income Security
16 Act (29 U.S.C. Sec. 1161 et seq.).

17 (b) Every group contract between a plan and an employer subject
18 to this article that is issued, amended, or renewed on or after July
19 1, 1998, shall require the employer to notify qualified beneficiaries
20 currently receiving continuation coverage, whose continuation
21 coverage will terminate under one group benefit plan prior to the
22 end of the period the qualified beneficiary would have remained
23 covered, as specified in Section 1366.27, of the qualified
24 beneficiary's ability to continue coverage under a new group
25 benefit plan for the balance of the period the qualified beneficiary
26 would have remained covered under the prior group benefit plan.
27 This notice shall be provided either 30 days prior to the termination
28 or when all enrolled employees are notified, whichever is later.

29 Every health care service plan and specialized health care service
30 plan shall provide to the employer replacing a health care service
31 plan contract issued by the plan, or to the employer's agent or
32 broker representative, within 15 days of any written request,
33 information in possession of the plan reasonably required to
34 administer the notification requirements of this subdivision and
35 subdivision (c).

36 (c) Notwithstanding subdivision (a), the group contract between
37 the health care service plan and the employer shall require the
38 employer to notify the successor plan in writing of the qualified
39 beneficiaries currently receiving continuation coverage so that the
40 successor plan, or contracting employer or administrator, may

1 provide those qualified beneficiaries with the necessary premium
2 information, enrollment forms, and instructions consistent with
3 the disclosure required by subdivision (c) of Section 1366.24 and
4 subdivision (c) of this section to allow the qualified beneficiary to
5 continue coverage. This information shall be sent to all qualified
6 beneficiaries who are enrolled in the plan and those qualified
7 beneficiaries who have been notified, pursuant to Section 1366.24,
8 of their ability to continue their coverage and may still elect
9 coverage within the specified 60-day period. This information
10 shall be sent to the qualified beneficiary's last known address, as
11 provided to the employer by the health care service plan or
12 disability insurer currently providing continuation coverage to the
13 qualified beneficiary. The successor plan shall not be obligated to
14 provide this information to qualified beneficiaries if the employer
15 or prior plan or insurer fails to comply with this section.

16 (d) A health care service plan may contract with an employer,
17 or an administrator, to perform the administrative obligations of
18 the plan as required by this article, including required notifications
19 and collecting and forwarding premiums to the health care service
20 plan. Except for the requirements of subdivisions (a), (b), and (c),
21 this subdivision shall not be construed to permit a plan to require
22 an employer to perform the administrative obligations of the plan
23 as required by this article as a condition of the issuance or renewal
24 of coverage.

25 (e) Every health care service plan, or employer or administrator
26 that contracts to perform the notice and administrative services
27 pursuant to this section, shall, within 14 days of receiving a notice
28 of a qualifying event, provide to the qualified beneficiary the
29 necessary benefits information, premium information, enrollment
30 forms, and disclosures consistent with the notice requirements
31 contained in subdivisions (b) and (c) of Section 1366.24 to allow
32 the qualified beneficiary to formally elect continuation coverage.
33 This information shall be sent to the qualified beneficiary's last
34 known address.

35 (f) Every health care service plan, or employer or administrator
36 that contracts to perform the notice and administrative services
37 pursuant to this section, shall, during the 180-day period ending
38 on the date that continuation coverage is terminated pursuant to
39 paragraphs (1), (3), and (5) of subdivision (a) of Section 1366.27,
40 notify a qualified beneficiary who has elected continuation

1 coverage pursuant to this article of the date that his or her coverage
2 will terminate, and shall notify the qualified beneficiary of any
3 conversion coverage available to that qualified beneficiary. This
4 requirement shall not apply when the continuation coverage is
5 terminated because the group contract between the plan and the
6 employer is being terminated.

7 ~~(g) (1) A health care service plan shall provide to a qualified~~
8 ~~beneficiary who has a qualifying event during the period specified~~
9 ~~in subparagraph (A) of paragraph (3) of subdivision (a) of Section~~
10 ~~3001 of ARRA, a written notice containing information on the~~
11 ~~availability of premium assistance under ARRA. This notice shall~~
12 ~~be sent to the qualified beneficiary's last known address. The notice~~
13 ~~shall include clear and easily understandable language to inform~~
14 ~~the qualified beneficiary that changes in federal law provide a new~~
15 ~~opportunity to elect continuation coverage with a 65-percent~~
16 ~~premium subsidy and shall include all of the following:~~

17 ~~(A) The amount of the premium the person will pay. For~~
18 ~~qualified beneficiaries who had a qualifying event between~~
19 ~~September 1, 2008, and May 12, 2009, inclusive, if a health care~~
20 ~~service plan is unable to provide the correct premium amount in~~
21 ~~the notice, the notice may contain the last known premium amount~~
22 ~~and an opportunity for the qualified beneficiary to request, through~~
23 ~~a toll-free telephone number, the correct premium that would apply~~
24 ~~to the beneficiary.~~

25 ~~(B) Enrollment forms and any other information required to be~~
26 ~~included pursuant to subdivision (c) to allow the qualified~~
27 ~~beneficiary to elect continuation coverage. This information shall~~
28 ~~not be included in notices sent to qualified beneficiaries currently~~
29 ~~enrolled in continuation coverage.~~

30 ~~(C) A description of the option to enroll in different coverage~~
31 ~~as provided in subparagraph (B) of paragraph (1) of subdivision~~
32 ~~(a) of Section 3001 of ARRA. This description shall advise the~~
33 ~~qualified beneficiary to contact the covered employee's former~~
34 ~~employer for prior approval to choose this option.~~

35 ~~(D) The eligibility requirements for premium assistance in the~~
36 ~~amount of 65 percent of the premium under Section 3001 of~~
37 ~~ARRA.~~

38 ~~(E) The duration of premium assistance available under ARRA.~~

1 ~~(F) A statement that a qualified beneficiary eligible for premium~~
2 ~~assistance under ARRA may elect continuation coverage no later~~
3 ~~than 60 days of the date of the notice.~~

4 ~~(G) A statement that a qualified beneficiary eligible for premium~~
5 ~~assistance under ARRA who rejected or discontinued continuation~~
6 ~~coverage prior to receiving the notice required by this subdivision~~
7 ~~has the right to withdraw that rejection and elect continuation~~
8 ~~coverage with the premium assistance.~~

9 ~~(H) A statement that reads as follows:~~

10
11 ~~“IF YOU ARE HAVING ANY DIFFICULTIES READING OR~~
12 ~~UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name~~
13 ~~of health plan] at [insert appropriate telephone number].”~~

14
15 ~~(2) With respect to qualified beneficiaries who had a qualifying~~
16 ~~event between September 1, 2008, and May 12, 2009, inclusive,~~
17 ~~the notice described in this subdivision shall be provided by the~~
18 ~~later of May 26, 2009, or seven business days after the date the~~
19 ~~plan receives notice of the qualifying event.~~

20 ~~(3) With respect to qualified beneficiaries who had or have a~~
21 ~~qualifying event between May 13, 2009, and the later date specified~~
22 ~~in subparagraph (A) of paragraph (3) of subdivision (a) of Section~~
23 ~~3001 of ARRA, inclusive, the notice described in this subdivision~~
24 ~~shall be provided within the period of time specified in subdivision~~
25 ~~(e).~~

26 ~~(4) Nothing in this section shall be construed to require a health~~
27 ~~care service plan to provide the plan’s evidence of coverage as a~~
28 ~~part of the notice required by this subdivision, and nothing in this~~
29 ~~section shall be construed to require a health care service plan to~~
30 ~~amend its existing evidence of coverage to comply with the changes~~
31 ~~made to this section by the enactment of Assembly Bill 23 of the~~
32 ~~2009–10 Regular Session or by the act amending this section during~~
33 ~~the second year of the 2009–10 Regular Session.~~

34 ~~(5) The requirement under this subdivision to provide a written~~
35 ~~notice to a qualified beneficiary and the requirement under~~
36 ~~paragraph (1) of subdivision (i) to provide a new opportunity to a~~
37 ~~qualified beneficiary to elect continuation coverage shall be deemed~~
38 ~~satisfied if a health care service plan previously provided a written~~
39 ~~notice and additional election opportunity under Section 3001 of~~

1 ~~ARRA to that qualified beneficiary prior to the effective date of~~
2 ~~the act adding this paragraph.~~

3 ~~(h) A group contract between a group benefit plan and an~~
4 ~~employer subject to this article that is issued, amended, or renewed~~
5 ~~on or after July 1, 2016, shall require the employer to give the~~
6 ~~following notice to a qualified beneficiary in connection with a~~
7 ~~notice regarding election of continuation coverage:~~

8 ~~“In addition to your coverage continuation options, you may be~~
9 ~~eligible for the following:~~

10 ~~1. Coverage through the state health insurance marketplace, also~~
11 ~~known as Covered California. By enrolling through Covered~~
12 ~~California, you may qualify for lower monthly premiums and lower~~
13 ~~out-of-pocket costs. Your family members may also qualify for~~
14 ~~coverage through Covered California.~~

15 ~~2. Coverage through Medi-Cal. Depending on your income, you~~
16 ~~may qualify for low- or no-cost coverage through Medi-Cal. Your~~
17 ~~family members may also qualify for Medi-Cal.~~

18 ~~3. Coverage through an insured spouse. If your spouse has~~
19 ~~coverage that extends to family members, you may be able to be~~
20 ~~added on that benefit plan.~~

21 ~~Be aware that there is a deadline to enroll in Covered California~~
22 ~~although you can apply for Medi-Cal anytime. To find out more~~
23 ~~about how to apply for Covered California and Medi-Cal, visit the~~
24 ~~Covered California Internet Web site at~~
25 ~~<http://www.coveredca.com>.”~~

26 ~~(i) (1) Notwithstanding any other law, a qualified beneficiary~~
27 ~~eligible for premium assistance under ARRA may elect~~
28 ~~continuation coverage no later than 60 days after the date of the~~
29 ~~notice required by subdivision (g).~~

30 ~~(2) For a qualified beneficiary who elects to continue coverage~~
31 ~~pursuant to this subdivision, the period beginning on the date of~~
32 ~~the qualifying event and ending on the effective date of the~~
33 ~~continuation coverage shall be disregarded for purposes of~~
34 ~~calculating a break in coverage in determining whether a~~
35 ~~preexisting condition provision applies under subdivision (c) of~~
36 ~~Section 1357.06 or subdivision (e) of Section 1357.51.~~

37 ~~(3) For a qualified beneficiary who had a qualifying event~~
38 ~~between September 1, 2008, and February 16, 2009, inclusive, and~~
39 ~~who elects continuation coverage pursuant to paragraph (1), the~~

1 continuation coverage shall commence on the first day of the month
2 following the election.

3 (4) For a qualified beneficiary who had a qualifying event
4 between February 17, 2009, and May 12, 2009, inclusive, and who
5 elects continuation coverage pursuant to paragraph (1), the effective
6 date of the continuation coverage shall be either of the following,
7 at the option of the beneficiary, provided that the beneficiary pays
8 the applicable premiums:

9 (A) The date of the qualifying event.

10 (B) The first day of the month following the election.

11 (5) Notwithstanding any other law, a qualified beneficiary who
12 is eligible for the special election opportunity described in
13 paragraph (17) of subdivision (a) of Section 3001 of ARRA may
14 elect continuation coverage no later than 60 days after the date of
15 the notice required under subdivision (k). For a qualified
16 beneficiary who elects coverage pursuant to this paragraph, the
17 continuation coverage shall be effective as of the first day of the
18 first period of coverage after the date of termination of
19 employment, except, if federal law permits, coverage shall take
20 effect on the first day of the month following the election.
21 However, for purposes of calculating the duration of continuation
22 coverage pursuant to Section 1366.27, the period of that coverage
23 shall be determined as though the qualifying event was a reduction
24 of hours of the employee.

25 (6) Notwithstanding any other law, a qualified beneficiary who
26 is eligible for any other special election opportunity under ARRA
27 may elect continuation coverage no later than 60 days after the
28 date of the special election notice required under ARRA.

29 (j) A health care service plan shall provide a qualified
30 beneficiary eligible for premium assistance under ARRA written
31 notice of the extension of that premium assistance as required
32 under Section 3001 of ARRA.

33 (k) A health care service plan, or an administrator or employer
34 if administrative obligations have been assumed by those entities
35 pursuant to subdivision (d), shall give the qualified beneficiaries
36 described in subparagraph (C) of paragraph (17) of subdivision
37 (a) of Section 3001 of ARRA the written notice required by that
38 paragraph by implementing the following procedures:

39 (1) The health care service plan shall, within 14 days of the
40 effective date of the act adding this subdivision, send a notice to

1 employers currently contracting with the health care service plan
2 for a group benefit plan subject to this article. The notice shall do
3 all of the following:

4 (A) Advise the employer that employees whose employment is
5 terminated on or after March 2, 2010, who were previously enrolled
6 in any group health care service plan or health insurance policy
7 offered by the employer may be entitled to special health coverage
8 rights, including a subsidy paid by the federal government for a
9 portion of the premium.

10 (B) Ask the employer to provide the health care service plan
11 with the name, address, and date of termination of employment
12 for any employee whose employment is terminated on or after
13 March 2, 2010, and who was at any time covered by any health
14 care service plan or health insurance policy offered to their
15 employees on or after September 1, 2008.

16 (C) Provide employers with a format and instructions for
17 submitting the information to the health care service plan, or their
18 administrator or employer who has assumed administrative
19 obligations pursuant to subdivision (d), by telephone, fax,
20 electronic mail, or mail.

21 (2) Within 14 days of receipt of the information specified in
22 paragraph (1) from the employer, the health care service plan shall
23 send the written notice specified in paragraph (17) of subdivision
24 (a) of Section 3001 of ARRA to those individuals.

25 (3) If an individual contacts his or her health care service plan
26 and indicates that he or she experienced a qualifying event that
27 entitles him or her to the special election period described in
28 paragraph (17) of subdivision (a) of Section 3001 of ARRA or any
29 other special election provision of ARRA, the plan shall provide
30 the individual with the written notice required under paragraph
31 (17) of subdivision (a) of Section 3001 of ARRA or any other
32 applicable provision of ARRA, regardless of whether the plan
33 receives information from the individual's previous employer
34 regarding that individual pursuant to Section 24100. The plan shall
35 review the individual's application for coverage under this special
36 election notice to determine if the individual qualifies for the
37 special election period and the premium assistance under ARRA.
38 The plan shall comply with paragraph (5) if the individual does
39 not qualify for either the special election period or premium
40 assistance under ARRA.

1 ~~(4) The requirement under this subdivision to provide the written~~
2 ~~notice described in paragraph (17) of subdivision (a) of Section~~
3 ~~3001 of ARRA to a qualified beneficiary and the requirement~~
4 ~~under paragraph (5) of subdivision (i) to provide a new opportunity~~
5 ~~to a qualified beneficiary to elect continuation coverage shall be~~
6 ~~deemed satisfied if a health care service plan previously provided~~
7 ~~the written notice and additional election opportunity described in~~
8 ~~paragraph (17) of subdivision (a) of Section 3001 of ARRA to that~~
9 ~~qualified beneficiary prior to the effective date of the act adding~~
10 ~~this paragraph.~~

11 ~~(5) If an individual does not qualify for either a special election~~
12 ~~period or the premium assistance under ARRA, the health care~~
13 ~~service plan shall provide a written notice to that individual that~~
14 ~~shall include information on the right to appeal as set forth in~~
15 ~~Section 3001 of ARRA.~~

16 ~~(6) A health care service plan shall provide information on its~~
17 ~~publicly accessible Internet Web site regarding the premium~~
18 ~~assistance made available under ARRA and any special election~~
19 ~~period provided under that law. A plan may fulfill this requirement~~
20 ~~by linking or otherwise directing consumers to the information~~
21 ~~regarding COBRA continuation coverage premium assistance~~
22 ~~located on the Internet Web site of the United States Department~~
23 ~~of Labor. The information required by this paragraph shall be~~
24 ~~located in a section of the plan's Internet Web site that is readily~~
25 ~~accessible to consumers, such as the Web site's Frequently Asked~~
26 ~~Questions section.~~

27 ~~(l) For purposes of implementing federal premium assistance~~
28 ~~for continuation coverage, the department may designate a model~~
29 ~~notice or notices that may be used by health care service plans.~~
30 ~~Use of the model notice or notices shall not require prior approval~~
31 ~~of the department. Any model notice or notices designated by the~~
32 ~~department for purposes of this subdivision shall not be subject to~~
33 ~~the Administrative Procedure Act (Chapter 3.5 (commencing with~~
34 ~~Section 11340) of Part 1 of Division 3 of Title 2 of the Government~~
35 ~~Code).~~

36 ~~(m) Notwithstanding any other law, a qualified beneficiary~~
37 ~~eligible for premium assistance under ARRA may elect to enroll~~
38 ~~in different coverage subject to the criteria provided under~~
39 ~~subparagraph (B) of paragraph (1) of subdivision (a) of Section~~
40 ~~3001 of ARRA.~~

1 ~~(n) A qualified beneficiary enrolled in continuation coverage~~
2 ~~as of February 17, 2009, who is eligible for premium assistance~~
3 ~~under ARRA may request application of the premium assistance~~
4 ~~as of March 1, 2009, or later, consistent with ARRA.~~

5 ~~(o) A health care service plan that receives an election notice~~
6 ~~from a qualified beneficiary eligible for premium assistance under~~
7 ~~ARRA, pursuant to subdivision (i), shall be considered a person~~
8 ~~entitled to reimbursement, as defined in Section 6432(b)(3) of the~~
9 ~~Internal Revenue Code, as amended by paragraph (12) of~~
10 ~~subdivision (a) of Section 3001 of ARRA.~~

11 ~~(p) (1) For purposes of compliance with ARRA, in the absence~~
12 ~~of guidance from, or if specifically required for state-only~~
13 ~~continuation coverage by, the United States Department of Labor,~~
14 ~~the Internal Revenue Service, or the Centers for Medicare and~~
15 ~~Medicaid Services, a health care service plan may request~~
16 ~~verification of the involuntary termination of a covered employee's~~
17 ~~employment from the covered employee's former employer or the~~
18 ~~qualified beneficiary seeking premium assistance under ARRA.~~

19 ~~(2) A health care service plan that requests verification pursuant~~
20 ~~to paragraph (1) directly from a covered employee's former~~
21 ~~employer shall do so by providing a written notice to the employer.~~
22 ~~This written notice shall be sent by mail or facsimile to the covered~~
23 ~~employee's former employer within seven business days from the~~
24 ~~date the plan receives the qualified beneficiary's election notice~~
25 ~~pursuant to subdivision (i). Within 10 calendar days of receipt of~~
26 ~~written notice required by this paragraph, the former employer~~
27 ~~shall furnish to the health care service plan written verification as~~
28 ~~to whether the covered employee's employment was involuntarily~~
29 ~~terminated.~~

30 ~~(3) A qualified beneficiary requesting premium assistance under~~
31 ~~ARRA may furnish to the health care service plan a written~~
32 ~~document or other information from the covered employee's former~~
33 ~~employer indicating that the covered employee's employment was~~
34 ~~involuntarily terminated. This document or information shall be~~
35 ~~deemed sufficient by the health care service plan to establish that~~
36 ~~the covered employee's employment was involuntarily terminated~~
37 ~~for purposes of ARRA, unless the plan makes a reasonable and~~
38 ~~timely determination that the documents or information provided~~
39 ~~by the qualified beneficiary are legally insufficient to establish~~
40 ~~involuntary termination of employment.~~

1 ~~(4) If a health care service plan requests verification pursuant~~
2 ~~to this subdivision and cannot verify involuntary termination of~~
3 ~~employment within 14 business days from the date the employer~~
4 ~~receives the verification request or from the date the plan receives~~
5 ~~documentation or other information from the qualified beneficiary~~
6 ~~pursuant to paragraph (3), the health care service plan shall either~~
7 ~~provide continuation coverage with the federal premium assistance~~
8 ~~to the qualified beneficiary or send the qualified beneficiary a~~
9 ~~denial letter which shall include notice of his or her right to appeal~~
10 ~~that determination pursuant to ARRA.~~

11 ~~(5) No person shall intentionally delay verification of~~
12 ~~involuntary termination of employment under this subdivision.~~

13 ~~(q) The provision of information and forms related to the~~
14 ~~premium assistance available pursuant to ARRA to individuals by~~
15 ~~a health care service plan shall not be considered a violation of~~
16 ~~this chapter provided that the plan complies with all of the~~
17 ~~requirements of this article.~~

18 ~~(r) (1) If Section 5000A of the Internal Revenue Code, as added~~
19 ~~by Section 1501 of PPACA, is repealed or amended to no longer~~
20 ~~apply to the individual market, as defined in Section 2791 of the~~
21 ~~federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this~~
22 ~~section shall become inoperative and is repealed 12 months after~~
23 ~~the date of that repeal or amendment.~~

24 ~~(2) For purposes of this subdivision, “PPACA” means the federal~~
25 ~~Patient Protection and Affordable Care Act (Public Law 111-148),~~
26 ~~as amended by the federal Health Care and Education~~
27 ~~Reconciliation Act of 2010 (Public Law 111-152), and any rules,~~
28 ~~regulations, or guidance issued pursuant to that law.~~

29 ~~SEC. 5. Section 1366.25 is added to the Health and Safety~~
30 ~~Code, to read:~~

31 ~~1366.25. (a) Every group contract between a health care service~~
32 ~~plan and an employer subject to this article that is issued, amended,~~
33 ~~or renewed on or after July 1, 1998, shall require the employer to~~
34 ~~notify the plan, in writing, of any employee who has had a~~
35 ~~qualifying event, as defined in paragraph (2) of subdivision (d) of~~
36 ~~Section 1366.21, within 30 days of the qualifying event. The group~~
37 ~~contract shall also require the employer to notify the plan, in~~
38 ~~writing, within 30 days of the date, when the employer becomes~~
39 ~~subject to Section 4980B of the United States Internal Revenue~~

1 Code or Chapter 18 of the Employee Retirement Income Security
2 Act (29 U.S.C. Sec. 1161 et seq.):

3 ~~(b) Every group contract between a plan and an employer subject~~
4 ~~to this article that is issued, amended, or renewed on or after July~~
5 ~~1, 1998, shall require the employer to notify qualified beneficiaries~~
6 ~~currently receiving continuation coverage, whose continuation~~
7 ~~coverage will terminate under one group benefit plan prior to the~~
8 ~~end of the period the qualified beneficiary would have remained~~
9 ~~covered, as specified in Section 1366.27, of the qualified~~
10 ~~beneficiary's ability to continue coverage under a new group~~
11 ~~benefit plan for the balance of the period the qualified beneficiary~~
12 ~~would have remained covered under the prior group benefit plan.~~
13 ~~This notice shall be provided either 30 days prior to the termination~~
14 ~~or when all enrolled employees are notified, whichever is later.~~

15 Every health care service plan and specialized health care service
16 plan shall provide to the employer replacing a health care service
17 plan contract issued by the plan, or to the employer's agent or
18 broker representative, within 15 days of any written request,
19 information in possession of the plan reasonably required to
20 administer the notification requirements of this subdivision and
21 subdivision (e):

22 ~~(e) Notwithstanding subdivision (a), the group contract between~~
23 ~~the health care service plan and the employer shall require the~~
24 ~~employer to notify the successor plan in writing of the qualified~~
25 ~~beneficiaries currently receiving continuation coverage so that the~~
26 ~~successor plan, or contracting employer or administrator, may~~
27 ~~provide those qualified beneficiaries with the necessary premium~~
28 ~~information, enrollment forms, and instructions consistent with~~
29 ~~the disclosure required by subdivision (c) of Section 1366.24 and~~
30 ~~subdivision (e) of this section to allow the qualified beneficiary to~~
31 ~~continue coverage. This information shall be sent to all qualified~~
32 ~~beneficiaries who are enrolled in the plan and those qualified~~
33 ~~beneficiaries who have been notified, pursuant to Section 1366.24,~~
34 ~~of their ability to continue their coverage and may still elect~~
35 ~~coverage within the specified 60-day period. This information~~
36 ~~shall be sent to the qualified beneficiary's last known address, as~~
37 ~~provided to the employer by the health care service plan or~~
38 ~~disability insurer currently providing continuation coverage to the~~
39 ~~qualified beneficiary. The successor plan shall not be obligated to~~

1 provide this information to qualified beneficiaries if the employer
2 or prior plan or insurer fails to comply with this section.

3 ~~(d) A health care service plan may contract with an employer,
4 or an administrator, to perform the administrative obligations of
5 the plan as required by this article, including required notifications
6 and collecting and forwarding premiums to the health care service
7 plan. Except for the requirements of subdivisions (a), (b), and (c),
8 this subdivision shall not be construed to permit a plan to require
9 an employer to perform the administrative obligations of the plan
10 as required by this article as a condition of the issuance or renewal
11 of coverage.~~

12 ~~(e) Every health care service plan, or employer or administrator
13 that contracts to perform the notice and administrative services
14 pursuant to this section, shall, within 14 days of receiving a notice
15 of a qualifying event, provide to the qualified beneficiary the
16 necessary benefits information, premium information, enrollment
17 forms, and disclosures consistent with the notice requirements
18 contained in subdivisions (b) and (e) of Section 1366.24 to allow
19 the qualified beneficiary to formally elect continuation coverage.
20 This information shall be sent to the qualified beneficiary's last
21 known address.~~

22 ~~(f) Every health care service plan, or employer or administrator
23 that contracts to perform the notice and administrative services
24 pursuant to this section, shall, during the 180-day period ending
25 on the date that continuation coverage is terminated pursuant to
26 paragraphs (1), (3), and (5) of subdivision (a) of Section 1366.27,
27 notify a qualified beneficiary who has elected continuation
28 coverage pursuant to this article of the date that his or her coverage
29 will terminate, and shall notify the qualified beneficiary of any
30 conversion coverage available to that qualified beneficiary. This
31 requirement shall not apply when the continuation coverage is
32 terminated because the group contract between the plan and the
33 employer is being terminated.~~

34 ~~(g) (1) A health care service plan shall provide to a qualified
35 beneficiary who has a qualifying event during the period specified
36 in subparagraph (A) of paragraph (3) of subdivision (a) of Section
37 3001 of ARRA, a written notice containing information on the
38 availability of premium assistance under ARRA. This notice shall
39 be sent to the qualified beneficiary's last known address. The notice
40 shall include clear and easily understandable language to inform~~

1 the qualified beneficiary that changes in federal law provide a new
2 opportunity to elect continuation coverage with a 65-percent
3 premium subsidy and shall include all of the following:

4 (A) The amount of the premium the person will pay. For
5 qualified beneficiaries who had a qualifying event between
6 September 1, 2008, and May 12, 2009, inclusive, if a health care
7 service plan is unable to provide the correct premium amount in
8 the notice, the notice may contain the last known premium amount
9 and an opportunity for the qualified beneficiary to request, through
10 a toll-free telephone number, the correct premium that would apply
11 to the beneficiary.

12 (B) Enrollment forms and any other information required to be
13 included pursuant to subdivision (c) to allow the qualified
14 beneficiary to elect continuation coverage. This information shall
15 not be included in notices sent to qualified beneficiaries currently
16 enrolled in continuation coverage.

17 (C) A description of the option to enroll in different coverage
18 as provided in subparagraph (B) of paragraph (1) of subdivision
19 (a) of Section 3001 of ARRA. This description shall advise the
20 qualified beneficiary to contact the covered employee's former
21 employer for prior approval to choose this option.

22 (D) The eligibility requirements for premium assistance in the
23 amount of 65 percent of the premium under Section 3001 of
24 ARRA.

25 (E) The duration of premium assistance available under ARRA.

26 (F) A statement that a qualified beneficiary eligible for premium
27 assistance under ARRA may elect continuation coverage no later
28 than 60 days of the date of the notice.

29 (G) A statement that a qualified beneficiary eligible for premium
30 assistance under ARRA who rejected or discontinued continuation
31 coverage prior to receiving the notice required by this subdivision
32 has the right to withdraw that rejection and elect continuation
33 coverage with the premium assistance.

34 (H) A statement that reads as follows:

35 “IF YOU ARE HAVING ANY DIFFICULTIES READING OR
36 UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name
37 of health plan] at [insert appropriate telephone number].”

38 (2) With respect to qualified beneficiaries who had a qualifying
39 event between September 1, 2008, and May 12, 2009, inclusive,
40 the notice described in this subdivision shall be provided by the

1 later of May 26, 2009, or seven business days after the date the
2 plan receives notice of the qualifying event.

3 ~~(3) With respect to qualified beneficiaries who had or have a~~
4 ~~qualifying event between May 13, 2009, and the later date specified~~
5 ~~in subparagraph (A) of paragraph (3) of subdivision (a) of Section~~
6 ~~3001 of ARRA, inclusive, the notice described in this subdivision~~
7 ~~shall be provided within the period of time specified in subdivision~~
8 ~~(e).~~

9 ~~(4) Nothing in this section shall be construed to require a health~~
10 ~~care service plan to provide the plan's evidence of coverage as a~~
11 ~~part of the notice required by this subdivision, and nothing in this~~
12 ~~section shall be construed to require a health care service plan to~~
13 ~~amend its existing evidence of coverage to comply with the changes~~
14 ~~made to this section by the enactment of Assembly Bill 23 of the~~
15 ~~2009-10 Regular Session or by the act amending this section during~~
16 ~~the second year of the 2009-10 Regular Session.~~

17 ~~(5) The requirement under this subdivision to provide a written~~
18 ~~notice to a qualified beneficiary and the requirement under~~
19 ~~paragraph (1) of subdivision (k) to provide a new opportunity to~~
20 ~~a qualified beneficiary to elect continuation coverage shall be~~
21 ~~deemed satisfied if a health care service plan previously provided~~
22 ~~a written notice and additional election opportunity under Section~~
23 ~~3001 of ARRA to that qualified beneficiary prior to the effective~~
24 ~~date of the act adding this paragraph.~~

25 ~~(h) A group contract between a group benefit plan and an~~
26 ~~employer subject to this article that is issued, amended, or renewed~~
27 ~~on or after the operative date of this section shall require the~~
28 ~~employer to give the following notice to a qualified beneficiary in~~
29 ~~connection with a notice regarding election of continuation~~
30 ~~coverage:~~

31 ~~“Please examine your options carefully before declining this~~
32 ~~coverage. You should be aware that companies selling individual~~
33 ~~health insurance typically require a review of your medical history~~
34 ~~that could result in a higher premium or you could be denied~~
35 ~~coverage entirely.”~~

36 ~~(i) A group contract between a group benefit plan and an~~
37 ~~employer subject to this article that is issued, amended, or renewed~~
38 ~~on or after July 1, 2016, shall require the employer to give the~~
39 ~~following notice to a qualified beneficiary in connection with a~~
40 ~~notice regarding election of continuation coverage:~~

1 “In addition to your coverage continuation options, you may be
2 eligible for the following:

3 1. Coverage through the state health insurance marketplace, also
4 known as Covered California. By enrolling through Covered
5 California, you may qualify for lower monthly premiums and lower
6 out-of-pocket costs. Your family members may also qualify for
7 coverage through Covered California.

8 2. Coverage through Medi-Cal. Depending on your income, you
9 may qualify for low- or no-cost coverage through Medi-Cal. Your
10 family members may also qualify for Medi-Cal.

11 3. Coverage through an insured spouse. If your spouse has
12 coverage that extends to family members, you may be able to be
13 added on that benefit plan.

14 Be aware that there is a deadline to enroll in Covered California
15 although you can apply for Medi-Cal anytime. To find out more
16 about how to apply for Covered California and Medi-Cal, visit the
17 Covered California Internet Web site at
18 <http://www.coveredca.com>.”

19 (j) (1) Notwithstanding any other law, a qualified beneficiary
20 eligible for premium assistance under ARRA may elect
21 continuation coverage no later than 60 days after the date of the
22 notice required by subdivision (g).

23 (2) For a qualified beneficiary who elects to continue coverage
24 pursuant to this subdivision, the period beginning on the date of
25 the qualifying event and ending on the effective date of the
26 continuation coverage shall be disregarded for purposes of
27 calculating a break in coverage in determining whether a
28 preexisting condition provision applies under subdivision (c) of
29 Section 1357.06 or subdivision (e) of Section 1357.51.

30 (3) For a qualified beneficiary who had a qualifying event
31 between September 1, 2008, and February 16, 2009, inclusive, and
32 who elects continuation coverage pursuant to paragraph (1), the
33 continuation coverage shall commence on the first day of the month
34 following the election.

35 (4) For a qualified beneficiary who had a qualifying event
36 between February 17, 2009, and May 12, 2009, inclusive, and who
37 elects continuation coverage pursuant to paragraph (1), the effective
38 date of the continuation coverage shall be either of the following,
39 at the option of the beneficiary, provided that the beneficiary pays
40 the applicable premiums:

1 (A) The date of the qualifying event.

2 (B) The first day of the month following the election.

3 ~~(5) Notwithstanding any other law, a qualified beneficiary who~~
4 ~~is eligible for the special election opportunity described in~~
5 ~~paragraph (17) of subdivision (a) of Section 3001 of ARRA may~~
6 ~~elect continuation coverage no later than 60 days after the date of~~
7 ~~the notice required under subdivision (l). For a qualified beneficiary~~
8 ~~who elects coverage pursuant to this paragraph, the continuation~~
9 ~~coverage shall be effective as of the first day of the first period of~~
10 ~~coverage after the date of termination of employment, except, if~~
11 ~~federal law permits, coverage shall take effect on the first day of~~
12 ~~the month following the election. However, for purposes of~~
13 ~~calculating the duration of continuation coverage pursuant to~~
14 ~~Section 1366.27, the period of that coverage shall be determined~~
15 ~~as though the qualifying event was a reduction of hours of the~~
16 ~~employee.~~

17 ~~(6) Notwithstanding any other law, a qualified beneficiary who~~
18 ~~is eligible for any other special election opportunity under ARRA~~
19 ~~may elect continuation coverage no later than 60 days after the~~
20 ~~date of the special election notice required under ARRA.~~

21 ~~(k) A health care service plan shall provide a qualified~~
22 ~~beneficiary eligible for premium assistance under ARRA written~~
23 ~~notice of the extension of that premium assistance as required~~
24 ~~under Section 3001 of ARRA.~~

25 ~~(l) A health care service plan, or an administrator or employer~~
26 ~~if administrative obligations have been assumed by those entities~~
27 ~~pursuant to subdivision (d), shall give the qualified beneficiaries~~
28 ~~described in subparagraph (C) of paragraph (17) of subdivision~~
29 ~~(a) of Section 3001 of ARRA the written notice required by that~~
30 ~~paragraph by implementing the following procedures:~~

31 ~~(1) The health care service plan shall, within 14 days of the~~
32 ~~effective date of the act adding this subdivision, send a notice to~~
33 ~~employers currently contracting with the health care service plan~~
34 ~~for a group benefit plan subject to this article. The notice shall do~~
35 ~~all of the following:~~

36 ~~(A) Advise the employer that employees whose employment is~~
37 ~~terminated on or after March 2, 2010, who were previously enrolled~~
38 ~~in any group health care service plan or health insurance policy~~
39 ~~offered by the employer may be entitled to special health coverage~~

1 rights, including a subsidy paid by the federal government for a
2 portion of the premium.

3 (B) Ask the employer to provide the health care service plan
4 with the name, address, and date of termination of employment
5 for any employee whose employment is terminated on or after
6 March 2, 2010, and who was at any time covered by any health
7 care service plan or health insurance policy offered to their
8 employees on or after September 1, 2008.

9 (C) Provide employers with a format and instructions for
10 submitting the information to the health care service plan, or their
11 administrator or employer who has assumed administrative
12 obligations pursuant to subdivision (d), by telephone, fax,
13 electronic mail, or mail.

14 (2) Within 14 days of receipt of the information specified in
15 paragraph (1) from the employer, the health care service plan shall
16 send the written notice specified in paragraph (17) of subdivision
17 (a) of Section 3001 of ARRA to those individuals.

18 (3) If an individual contacts his or her health care service plan
19 and indicates that he or she experienced a qualifying event that
20 entitles him or her to the special election period described in
21 paragraph (17) of subdivision (a) of Section 3001 of ARRA or any
22 other special election provision of ARRA, the plan shall provide
23 the individual with the written notice required under paragraph
24 (17) of subdivision (a) of Section 3001 of ARRA or any other
25 applicable provision of ARRA, regardless of whether the plan
26 receives information from the individual's previous employer
27 regarding that individual pursuant to Section 24100. The plan shall
28 review the individual's application for coverage under this special
29 election notice to determine if the individual qualifies for the
30 special election period and the premium assistance under ARRA.
31 The plan shall comply with paragraph (5) if the individual does
32 not qualify for either the special election period or premium
33 assistance under ARRA.

34 (4) The requirement under this subdivision to provide the written
35 notice described in paragraph (17) of subdivision (a) of Section
36 3001 of ARRA to a qualified beneficiary and the requirement
37 under paragraph (5) of subdivision (j) to provide a new opportunity
38 to a qualified beneficiary to elect continuation coverage shall be
39 deemed satisfied if a health care service plan previously provided
40 the written notice and additional election opportunity described in

1 paragraph (17) of subdivision (a) of Section 3001 of ARRA to that
2 qualified beneficiary prior to the effective date of the act adding
3 this paragraph.

4 (5) If an individual does not qualify for either a special election
5 period or the premium assistance under ARRA, the health care
6 service plan shall provide a written notice to that individual that
7 shall include information on the right to appeal as set forth in
8 Section 3001 of ARRA.

9 (6) A health care service plan shall provide information on its
10 publicly accessible Internet Web site regarding the premium
11 assistance made available under ARRA and any special election
12 period provided under that law. A plan may fulfill this requirement
13 by linking or otherwise directing consumers to the information
14 regarding COBRA continuation coverage premium assistance
15 located on the Internet Web site of the United States Department
16 of Labor. The information required by this paragraph shall be
17 located in a section of the plan's Internet Web site that is readily
18 accessible to consumers, such as the Web site's Frequently Asked
19 Questions section.

20 (m) For purposes of implementing federal premium assistance
21 for continuation coverage, the department may designate a model
22 notice or notices that may be used by health care service plans.
23 Use of the model notice or notices shall not require prior approval
24 of the department. Any model notice or notices designated by the
25 department for purposes of this subdivision shall not be subject to
26 the Administrative Procedure Act (Chapter 3.5 (commencing with
27 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
28 Code).

29 (n) Notwithstanding any other law, a qualified beneficiary
30 eligible for premium assistance under ARRA may elect to enroll
31 in different coverage subject to the criteria provided under
32 subparagraph (B) of paragraph (1) of subdivision (a) of Section
33 3001 of ARRA.

34 (o) A qualified beneficiary enrolled in continuation coverage
35 as of February 17, 2009, who is eligible for premium assistance
36 under ARRA may request application of the premium assistance
37 as of March 1, 2009, or later, consistent with ARRA.

38 (p) A health care service plan that receives an election notice
39 from a qualified beneficiary eligible for premium assistance under
40 ARRA, pursuant to subdivision (j), shall be considered a person

1 entitled to reimbursement, as defined in Section 6432(b)(3) of the
2 Internal Revenue Code, as amended by paragraph (12) of
3 subdivision (a) of Section 3001 of ARRA.

4 (q) (1) For purposes of compliance with ARRA, in the absence
5 of guidance from, or if specifically required for state-only
6 continuation coverage by, the United States Department of Labor,
7 the Internal Revenue Service, or the Centers for Medicare and
8 Medicaid Services, a health care service plan may request
9 verification of the involuntary termination of a covered employee's
10 employment from the covered employee's former employer or the
11 qualified beneficiary seeking premium assistance under ARRA.

12 (2) A health care service plan that requests verification pursuant
13 to paragraph (1) directly from a covered employee's former
14 employer shall do so by providing a written notice to the employer.
15 This written notice shall be sent by mail or facsimile to the covered
16 employee's former employer within seven business days from the
17 date the plan receives the qualified beneficiary's election notice
18 pursuant to subdivision (j). Within 10 calendar days of receipt of
19 written notice required by this paragraph, the former employer
20 shall furnish to the health care service plan written verification as
21 to whether the covered employee's employment was involuntarily
22 terminated.

23 (3) A qualified beneficiary requesting premium assistance under
24 ARRA may furnish to the health care service plan a written
25 document or other information from the covered employee's former
26 employer indicating that the covered employee's employment was
27 involuntarily terminated. This document or information shall be
28 deemed sufficient by the health care service plan to establish that
29 the covered employee's employment was involuntarily terminated
30 for purposes of ARRA, unless the plan makes a reasonable and
31 timely determination that the documents or information provided
32 by the qualified beneficiary are legally insufficient to establish
33 involuntary termination of employment.

34 (4) If a health care service plan requests verification pursuant
35 to this subdivision and cannot verify involuntary termination of
36 employment within 14 business days from the date the employer
37 receives the verification request or from the date the plan receives
38 documentation or other information from the qualified beneficiary
39 pursuant to paragraph (3), the health care service plan shall either
40 provide continuation coverage with the federal premium assistance

1 to the qualified beneficiary or send the qualified beneficiary a
2 denial letter which shall include notice of his or her right to appeal
3 that determination pursuant to ARRA.

4 (5) No person shall intentionally delay verification of
5 involuntary termination of employment under this subdivision.

6 (r) The provision of information and forms related to the
7 premium assistance available pursuant to ARRA to individuals by
8 a health care service plan shall not be considered a violation of
9 this chapter provided that the plan complies with all of the
10 requirements of this article.

11 (s) (1) If Section 5000A of the Internal Revenue Code, as added
12 by Section 1501 of PPACA, is repealed or amended to no longer
13 apply to the individual market, as defined in Section 2791 of the
14 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
15 section shall become operative 12 months after the date of that
16 repeal or amendment.

17 (2) For purposes of this subdivision, “PPACA” means the federal
18 Patient Protection and Affordable Care Act (Public Law 111-148),
19 as amended by the federal Health Care and Education
20 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
21 regulations, or guidance issued pursuant to that law.

22 **SEC. 6.**

23 *SECTION 1.* Section 11801 of the Health and Safety Code is
24 amended to read:

25 11801. The alcohol and drug program administrator, acting
26 through administrative channels designated pursuant to Section
27 11795, shall do all of the following:

28 (a) Coordinate and be responsible for the preparation of the
29 county contract.

30 (b) Ensure compliance with applicable laws relating to
31 discrimination against any person because of any characteristic
32 listed or defined in Section 11135 of the Government Code.

33 (c) Submit an annual report to the board of supervisors reporting
34 all activities of the alcohol and other drug program, including a
35 financial accounting of expenditures, number of persons served,
36 and a forecast of anticipated needs for the upcoming year.

37 (d) Be directly responsible for the administration of all alcohol
38 or other drug program funds allocated to the county under this
39 part, administration of county operated programs, and coordination

1 and monitoring of programs that have contracts with the county
2 to provide alcohol and other drug services.

3 (e) Ensure the evaluation of alcohol and other drug programs,
4 including the collection of appropriate and necessary client data
5 and program information, pursuant to Chapter 6 (commencing
6 with Section 11825).

7 (f) Ensure program quality in compliance with appropriate
8 standards pursuant to Chapter 7 (commencing with Section 11830).

9 (g) Participate and represent the county in meetings of the
10 County Behavioral Health Directors Association of California
11 pursuant to Section 11811.5 for the purposes of representing the
12 counties in their relationship with the state with respect to policies,
13 standards, and administration for alcohol and other drug abuse
14 services.

15 (h) Perform any other acts that may be necessary, desirable, or
16 proper to carry out the purposes of this part.

17 ~~SEC. 7.~~

18 *SEC. 2.* Section 11811.6 of the Health and Safety Code is
19 amended to read:

20 11811.6. The department shall consult with county behavioral
21 health directors, alcohol and drug program administrators, or both,
22 in establishing standards pursuant to Chapter 7 (commencing with
23 Section 11830) and regulations pursuant to Chapter 8 (commencing
24 with Section 11835), shall consult with alcohol and drug program
25 administrators on matters of major policy and administration, and
26 may consult with alcohol and drug program administrators on other
27 matters affecting persons with alcohol and other drug problems.
28 The administrators shall consist of all legally appointed alcohol
29 and drug administrators in the state as designated pursuant to
30 subdivision (a) of Section 11800.

31 ~~SEC. 8.~~

32 *SEC. 3.* Section 11830.1 of the Health and Safety Code is
33 amended to read:

34 11830.1. In order to ensure quality assurance of alcohol and
35 other drug programs and expand the availability of funding
36 resources, the department shall implement a program certification
37 procedure for alcohol and other drug treatment recovery services.
38 The department, after consultation with the County Behavioral
39 Health Directors Association of California, and other interested
40 organizations and individuals, shall develop standards and

1 regulations for the alcohol and other drug treatment recovery
2 services describing the minimal level of service quality required
3 of the service providers to qualify for and obtain state certification.
4 The standards shall be excluded from the rulemaking requirements
5 of the Administrative Procedure Act (Chapter 3.5 (commencing
6 with Section 11340) of Part 1 of Division 3 of Title 2 of the
7 Government Code). Compliance with these standards shall be
8 voluntary on the part of programs. For the purposes of Section
9 2626.2 of the Unemployment Insurance Code, certification shall
10 be equivalent to program review.

11 ~~SEC. 9.~~

12 *SEC. 4.* Section 11835 of the Health and Safety Code is
13 amended to read:

14 11835. (a) The purposes of any regulations adopted by the
15 department shall be to implement, interpret, or make specific the
16 provisions of this part and shall not exceed the authority granted
17 to the department pursuant to this part. To the extent possible, the
18 regulations shall be written in clear and concise language and
19 adopted only when necessary to further the purposes of this part.

20 (b) Except as provided in this section and Sections 11772,
21 11798, 11798.2, 11814, 11817.8, and 11852.5, the department
22 may adopt regulations in accordance with the rulemaking
23 provisions of the Administrative Procedure Act (Chapter 3.5
24 (commencing with Section 11340) of Part 1 of Division 3 of Title
25 2 of the Government Code) necessary for the proper execution of
26 the powers and duties granted to and imposed upon the department
27 by this part. However, these regulations may be adopted only upon
28 the following conditions:

29 (1) Prior to adoption of regulations, the department shall consult
30 with the County Behavioral Health Directors Association of
31 California and may consult with any other appropriate persons
32 relating to the proposed regulations.

33 (2) If an absolute majority of the designated county behavioral
34 health directors who represent counties that have submitted county
35 contracts, vote at a public meeting called by the department, for
36 which 45 days' advance notice shall be given by the department,
37 to reject the proposed regulations, the department shall refer the
38 matter for a decision to a committee, consisting of a representative
39 of the county behavioral health directors, the director, the secretary,
40 and one designee of the secretary. The decision shall be made by

1 a majority vote of this committee at a public meeting convened
2 by the department. Upon a majority vote of the committee
3 recommending adoption of the proposed regulations, the
4 department may then adopt them. Upon a majority vote
5 recommending that the department not adopt the proposed
6 regulations, the department shall then consult again with the County
7 Behavioral Health Directors Association of California and resubmit
8 the proposed regulations to the county behavioral health directors
9 for a vote pursuant to this subdivision.

10 (3) In the voting process described in paragraph (2), no proxies
11 shall be allowed nor may anyone other than the designated county
12 behavioral health director, director, secretary, and secretary's
13 designee vote at the meetings.

14 ~~SEC. 10. Section 24100 of the Health and Safety Code is~~
15 ~~amended to read:~~

16 ~~24100. (a) For purposes of this section, the following~~
17 ~~definitions apply:~~

18 ~~(1) "ARRA" means Title III of Division B of the federal~~
19 ~~American Recovery and Reinvestment Act of 2009 or any~~
20 ~~amendment to that federal law extending federal premium~~
21 ~~assistance to qualified beneficiaries, as defined in Section 1366.21~~
22 ~~of this code or Section 10128.51 of the Insurance Code.~~

23 ~~(2) "Employer" means an employer as defined in Section~~
24 ~~1366.21 of this code or an employer as defined in Section 10128.51~~
25 ~~of the Insurance Code.~~

26 ~~(b) An employer shall provide the information described in~~
27 ~~subparagraph (B) of paragraph (1) of subdivision (k) of Section~~
28 ~~1366.25 of this code or subparagraph (B) of paragraph (1) of~~
29 ~~subdivision (k) of Section 10128.55 of the Insurance Code, as~~
30 ~~applicable, with respect to any employee whose employment is~~
31 ~~terminated on or after March 2, 2010, and who was enrolled at any~~
32 ~~time in a health care service plan or health insurance policy offered~~
33 ~~by the employer on or after September 1, 2008. This information~~
34 ~~shall be provided to the requesting health care service plan or~~
35 ~~health insurer within 14 days of receipt of the notification described~~
36 ~~in paragraph (1) of subdivision (k) of Section 1366.25 of this code~~
37 ~~or paragraph (1) of subdivision (k) of Section 10128.55 of the~~
38 ~~Insurance Code. The employer shall continue to provide the~~
39 ~~information to the health care service plan or health insurer within~~
40 ~~14 days after the end of each month for any employee whose~~

1 employment is terminated in the prior month until the last date
2 specified in subparagraph (A) of paragraph (3) of subdivision (a)
3 of Section 3001 of ARRA.

4 ~~SEC. 11.~~

5 *SEC. 5.* Section 103577 of the Health and Safety Code is
6 amended to read:

7 103577. (a) On or after July 1, 2015, each local registrar or
8 county recorder shall, without an issuance fee or any other
9 associated fee, issue a certified record of live birth to any person
10 who can verify his or her status as a homeless person or a homeless
11 child or youth. A homeless services provider that has knowledge
12 of a person's housing status shall verify a person's status for the
13 purposes of this subdivision. In accordance with all other
14 application requirements as set forth in Section 103526, a request
15 for a certified record of live birth made pursuant to this subdivision
16 shall be made by a homeless person or a homeless child or youth
17 on behalf of themselves, or by any person lawfully entitled to
18 request a certified record of live birth on behalf of a child, if the
19 child has been verified as a homeless person or a homeless child
20 or youth pursuant to this section. A person applying for a certified
21 record of live birth under this subdivision is entitled to one birth
22 record, per application, for each eligible person verified as a
23 homeless person or a homeless child or youth. For purposes of this
24 subdivision, an affidavit developed pursuant to subdivision (b)
25 shall constitute sufficient verification that a person is a homeless
26 person or a homeless child or youth. A person applying for a
27 certified record of live birth under this subdivision shall not be
28 charged a fee for verification of his or her eligibility.

29 (b) The State Department of Public Health shall develop an
30 affidavit attesting to an applicant's status as a homeless person or
31 homeless child or youth. For purposes of this section, the affidavit
32 shall not be deemed complete unless it is signed by both the person
33 making a request for a certified record of live birth pursuant to
34 subdivision (a) and a homeless services provider that has
35 knowledge of the applicant's housing status.

36 (c) Notwithstanding the rulemaking provisions of the
37 Administrative Procedure Act (Chapter 3.5 (commencing with
38 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
39 Code), the department may implement and administer this section

1 through an all-county letter or similar instructions from the director
2 or State Registrar without taking regulatory action.

3 (d) For the purposes of this section, the following definitions
4 apply:

5 (1) A “homeless child or youth” has the same meaning as the
6 definition of “homeless children and youths” as set forth in the
7 federal McKinney-Vento Homeless Assistance Act (42 U.S.C.
8 Sec. 11301 et seq.).

9 (2) A “homeless person” has the same meaning as the definition
10 of that term set forth in the federal McKinney-Vento Homeless
11 Assistance Act (42 U.S.C. Sec. 11301 et seq.).

12 (3) A “homeless services provider” includes:

13 (A) A governmental or nonprofit agency receiving federal, state,
14 or county or municipal funding to provide services to a “homeless
15 person” or “homeless child or youth,” or that is otherwise
16 sanctioned to provide those services by a local homeless continuum
17 of care organization.

18 (B) An attorney licensed to practice law in this state.

19 (C) A local educational agency liaison for homeless children
20 and youth, pursuant to Section 11432(g)(1)(J)(ii) of Title 42 of the
21 United States Code, or a school social worker.

22 (D) A human services provider or public social services provider
23 funded by the State of California to provide homeless children or
24 youth services, health services, mental or behavioral health
25 services, substance use disorder services, or public assistance or
26 employment services.

27 (E) A law enforcement officer designated as a liaison to the
28 homeless population by a local police department or sheriff’s
29 department within the state.

30 ~~SEC. 12.~~

31 *SEC. 6.* Section 104151 of the Health and Safety Code is
32 amended to read:

33 104151. (a) Notwithstanding Section 10231.5 of the
34 Government Code, each year, by no later than January 10 and
35 concurrently with the release of the May Revision, the State
36 Department of Health Care Services shall provide the fiscal
37 committees of the Legislature with an estimate package for the
38 Every Woman Counts Program. This estimate package shall
39 include all significant assumptions underlying the estimate for the
40 Every Woman Counts Program’s current-year and budget-year

1 proposals, and shall contain concise information identifying
2 applicable estimate components, such as caseload; a breakout of
3 costs, including, but not limited to, clinical service activities,
4 including office visits and consults, screening mammograms,
5 diagnostic mammograms, diagnostic breast procedures, case
6 management, and other clinical services; policy changes; contractor
7 information; General Fund, special fund, and federal fund
8 information; and other assumptions necessary to support the
9 estimate.

10 (b) Notwithstanding Section 10231.5 of the Government Code,
11 each year, the State Department of Health Care Services shall
12 provide the fiscal and appropriate policy committees of the
13 Legislature with quarterly updates on caseload, estimated
14 expenditures, and related program monitoring data for the Every
15 Woman Counts Program. These updates shall be provided no later
16 than November 30, February 28, May 31, and August 31 of each
17 year. The purpose of the updates is to provide the Legislature with
18 the most recent information on the program, and shall include a
19 breakdown of expenditures for each quarter for clinical service
20 activities, including, but not limited to, office visits and consults,
21 screening mammograms, diagnostic mammograms, diagnostic
22 breast procedures, case management, and other clinical services.
23 This subdivision supersedes the requirements of Section 169 of
24 Chapter 717 of the Statutes of 2010 (SB 853).

25 ~~SEC. 13.~~

26 *SEC. 7.* Section 128456 of the Health and Safety Code is
27 amended to read:

28 128456. In developing the program established pursuant to this
29 article, the Health Professions Education Foundation shall solicit
30 the advice of representatives of the Board of Behavioral Sciences,
31 the Board of Psychology, the State Department of Health Care
32 Services, the County Behavioral Health Directors Association of
33 California, the California Mental Health Planning Council,
34 professional mental health care organizations, the California
35 Healthcare Association, the Chancellor of the California
36 Community Colleges, and the Chancellor of the California State
37 University. The foundation shall solicit the advice of
38 representatives who reflect the demographic, cultural, and linguistic
39 diversity of the state.

1 ~~SEC. 14.~~

2 *SEC. 8.* Section 130302 of the Health and Safety Code is
3 amended to read:

4 130302. For the purposes of this division, the following
5 definitions apply:

6 (a) “Director” means the Director of the Office of Health
7 Information Integrity.

8 (b) “HIPAA” means the federal Health Insurance Portability
9 and Accountability Act.

10 (c) “Office” means the Office of Health Information Integrity
11 established by the office of the Governor in the Health and Human
12 Services Agency.

13 (d) “State entities” means all state departments, boards,
14 commissions, programs, and other organizational units of the
15 executive branch of state government.

16 ~~SEC. 15.~~

17 *SEC. 9.* Section 130304 of the Health and Safety Code is
18 amended to read:

19 130304. The office shall be under the supervision and control
20 of a director, known as the Director of the Office of Health
21 Information Integrity, who shall be appointed by, and serve at the
22 pleasure of, the Secretary of the Health and Human Services
23 Agency.

24 ~~SEC. 16.~~

25 *SEC. 10.* Section 130316 of the Health and Safety Code is
26 repealed.

27 ~~SEC. 17.~~

28 *SEC. 11.* Section 130317 of the Health and Safety Code is
29 repealed.

30 ~~SEC. 18.~~ Section 10128.52 of the Insurance Code is amended
31 to read:

32 ~~10128.52.~~ The continuation coverage requirements of this
33 article do not apply to the following individuals:

34 (a) ~~Individuals who are entitled to Medicare benefits or become~~
35 ~~entitled to Medicare benefits pursuant to Title XVIII of the United~~
36 ~~States Social Security Act, as amended or superseded. Entitlement~~
37 ~~to Medicare Part A only constitutes entitlement to benefits under~~
38 ~~Medicare.~~

39 (b) ~~Individuals who have other hospital, medical, or surgical~~
40 ~~coverage, or who are covered or become covered under another~~

1 ~~group benefit plan, including a self-insured employee welfare~~
2 ~~benefit plan, that provides coverage for individuals and that does~~
3 ~~not impose any exclusion or limitation with respect to any~~
4 ~~preexisting condition of the individual, other than a preexisting~~
5 ~~condition limitation or exclusion that does not apply to or is~~
6 ~~satisfied by the qualified beneficiary pursuant to Sections 10198.6~~
7 ~~and 10198.7. A group conversion option under any group benefit~~
8 ~~plan shall not be considered as an arrangement under which an~~
9 ~~individual is or becomes covered.~~

10 ~~(e) Individuals who are covered, become covered, or are eligible~~
11 ~~for federal COBRA coverage pursuant to Section 4980B of the~~
12 ~~United States Internal Revenue Code or Chapter 18 of the~~
13 ~~Employee Retirement Income Security Act (29 U.S.C. Sec. 1161~~
14 ~~et seq.).~~

15 ~~(d) Individuals who are covered, become covered, or are eligible~~
16 ~~for coverage pursuant to Chapter 6A of the Public Health Service~~
17 ~~Act (42 U.S.C. Sec. 300bb-1 et seq.).~~

18 ~~(e) Qualified beneficiaries who fail to meet the requirements of~~
19 ~~subdivision (b) of Section 10128.54 or subdivision (i) of Section~~
20 ~~10128.55 regarding notification of a qualifying event or election~~
21 ~~of continuation coverage within the specified time limits.~~

22 ~~(f) Except as provided in Section 3001 of ARRA, qualified~~
23 ~~beneficiaries who fail to submit the correct premium amount~~
24 ~~required by subdivision (b) of Section 10128.55 and Section~~
25 ~~10128.57, in accordance with the terms and conditions of the policy~~
26 ~~or contract, or fail to satisfy other terms and conditions of the~~
27 ~~policy or contract.~~

28 ~~SEC. 19. Section 10128.54 of the Insurance Code is amended~~
29 ~~to read:~~

30 ~~10128.54. (a) Every insurer's evidence of coverage for group~~
31 ~~benefit plans subject to this article, that is issued, amended, or~~
32 ~~renewed on or after January 1, 1999, shall disclose to covered~~
33 ~~employees of group benefit plans subject to this article the ability~~
34 ~~to continue coverage pursuant to this article, as required by this~~
35 ~~section.~~

36 ~~(b) This disclosure shall state that all insureds who are eligible~~
37 ~~to be qualified beneficiaries, as defined in subdivision (c) of~~
38 ~~Section 10128.51, shall be required, as a condition of receiving~~
39 ~~benefits pursuant to this article, to notify, in writing, the insurer,~~
40 ~~or the employer if the employer contracts to perform the~~

1 administrative services as provided for in Section 10128.55, of all
2 qualifying events as specified in paragraphs (1), (3), (4), and (5)
3 of subdivision (d) of Section 10128.51 within 60 days of the date
4 of the qualifying event. This disclosure shall inform insureds that
5 failure to make the notification to the insurer, or to the employer
6 when under contract to provide the administrative services, within
7 the required 60 days will disqualify the qualified beneficiary from
8 receiving continuation coverage pursuant to this article. The
9 disclosure shall further state that a qualified beneficiary who wishes
10 to continue coverage under the group benefit plan pursuant to this
11 article shall request the continuation in writing and deliver the
12 written request, by first-class mail, or other reliable means of
13 delivery, including personal delivery, express mail, or private
14 courier company, to the disability insurer, or to the employer if
15 the plan has contracted with the employer for administrative
16 services pursuant to subdivision (d) of Section 10128.55, within
17 the 60-day period following the later of either (1) the date that the
18 insured's coverage under the group benefit plan terminated or will
19 terminate by reason of a qualifying event, or (2) the date the insured
20 was sent notice pursuant to subdivision (e) of Section 10128.55
21 of the ability to continue coverage under the group benefit plan.
22 The disclosure required by this section shall also state that a
23 qualified beneficiary electing continuation shall pay to the disability
24 insurer, in accordance with the terms and conditions of the policy
25 or contract, which shall be set forth in the notice to the qualified
26 beneficiary pursuant to subdivision (d) of Section 10128.55, the
27 amount of the required premium payment, as set forth in Section
28 10128.56. The disclosure shall further require that the qualified
29 beneficiary's first premium payment required to establish premium
30 payment be delivered by first-class mail, certified mail, or other
31 reliable means of delivery, including personal delivery, express
32 mail, or private courier company, to the disability insurer, or to
33 the employer if the employer has contracted with the insurer to
34 perform the administrative services pursuant to subdivision (d) of
35 Section 10128.55, within 45 days of the date the qualified
36 beneficiary provided written notice to the insurer or the employer,
37 if the employer has contracted to perform the administrative
38 services, of the election to continue coverage in order for coverage
39 to be continued under this article. This disclosure shall also state
40 that the first premium payment shall equal an amount sufficient

1 to pay all required premiums and all premiums due, and that failure
2 to submit the correct premium amount within the 45-day period
3 will disqualify the qualified beneficiary from receiving continuation
4 coverage pursuant to this article.

5 ~~(e) The disclosure required by this section shall also describe~~
6 ~~separately how qualified beneficiaries whose continuation coverage~~
7 ~~terminates under a prior group benefit plan pursuant to Section~~
8 ~~10128.57 may continue their coverage for the balance of the period~~
9 ~~that the qualified beneficiary would have remained covered under~~
10 ~~the prior group benefit plan, including the requirements for election~~
11 ~~and payment. The disclosure shall clearly state that continuation~~
12 ~~coverage shall terminate if the qualified beneficiary fails to comply~~
13 ~~with the requirements pertaining to enrollment in, and payment of~~
14 ~~premiums to, the new group benefit plan within 30 days of~~
15 ~~receiving notice of the termination of the prior group benefit plan.~~

16 ~~(d) Prior to August 1, 1998, every insurer shall provide to all~~
17 ~~covered employees of employers subject to this article written~~
18 ~~notice containing the disclosures required by this section, or shall~~
19 ~~provide to all covered employees of employers subject to this~~
20 ~~article a new or amended evidence of coverage that includes the~~
21 ~~disclosures required by this section. Any insurer that, in the~~
22 ~~ordinary course of business, maintains only the addresses of~~
23 ~~employer group purchasers of benefits, and does not maintain~~
24 ~~addresses of covered employees, may comply with the notice~~
25 ~~requirements of this section through the provision of the notices~~
26 ~~to its employer group purchases of benefits.~~

27 ~~(e) Every disclosure form issued, amended, or renewed on and~~
28 ~~after January 1, 1999, for a group benefit plan subject to this article~~
29 ~~shall provide a notice that, under state law, an insured may be~~
30 ~~entitled to continuation of group coverage and that additional~~
31 ~~information regarding eligibility for this coverage may be found~~
32 ~~in the evidence of coverage.~~

33 ~~(f) A disclosure issued, amended, or renewed on or after July~~
34 ~~1, 2016, for a group benefit plan subject to this article shall include~~
35 ~~the following notice:~~

36 ~~“In addition to your coverage continuation options, you may be~~
37 ~~eligible for the following:~~

38 ~~1. Coverage through the state health insurance marketplace, also~~
39 ~~known as Covered California. By enrolling through Covered~~
40 ~~California, you may qualify for lower monthly premiums and lower~~

1 out-of-pocket costs. Your family members may also qualify for
2 coverage through Covered California.

3 2. Coverage through Medi-Cal. Depending on your income, you
4 may qualify for low- or no-cost coverage through Medi-Cal. Your
5 family members may also qualify for Medi-Cal.

6 3. Coverage through an insured spouse. If your spouse has
7 coverage that extends to family members, you may be able to be
8 added on that benefit plan.

9 Be aware that there is a deadline to enroll in Covered California
10 although you can apply for Medi-Cal at anytime. To find out more
11 about how to apply for Covered California and Medi-Cal, visit the
12 Covered California Internet Web site at

13 <http://www.coveredca.com>.”

14 (g) (1) If Section 5000A of the Internal Revenue Code, as added
15 by Section 1501 of PPACA, is repealed or amended to no longer
16 apply to the individual market, as defined in Section 2791 of the
17 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
18 section shall become inoperative and is repealed 12 months after
19 the date of that repeal or amendment.

20 (2) For purposes of this subdivision, “PPACA” means the federal
21 Patient Protection and Affordable Care Act (Public Law 111-148),
22 as amended by the federal Health Care and Education
23 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
24 regulations, or guidance issued pursuant to that law.

25 SEC. 20. Section 10128.54 is added to the Insurance Code, to
26 read:

27 10128.54. (a) Every insurer’s evidence of coverage for group
28 benefit plans subject to this article, that is issued, amended, or
29 renewed on or after January 1, 1999, shall disclose to covered
30 employees of group benefit plans subject to this article the ability
31 to continue coverage pursuant to this article, as required by this
32 section.

33 (b) This disclosure shall state that all insureds who are eligible
34 to be qualified beneficiaries, as defined in subdivision (c) of
35 Section 10128.51, shall be required, as a condition of receiving
36 benefits pursuant to this article, to notify, in writing, the insurer,
37 or the employer if the employer contracts to perform the
38 administrative services as provided for in Section 10128.55, of all
39 qualifying events as specified in paragraphs (1), (3), (4), and (5)
40 of subdivision (d) of Section 10128.51 within 60 days of the date

1 of the qualifying event. This disclosure shall inform insureds that
2 failure to make the notification to the insurer, or to the employer
3 when under contract to provide the administrative services, within
4 the required 60 days will disqualify the qualified beneficiary from
5 receiving continuation coverage pursuant to this article. The
6 disclosure shall further state that a qualified beneficiary who wishes
7 to continue coverage under the group benefit plan pursuant to this
8 article must request the continuation in writing and deliver the
9 written request, by first-class mail, or other reliable means of
10 delivery, including personal delivery, express mail, or private
11 courier company, to the disability insurer, or to the employer if
12 the plan has contracted with the employer for administrative
13 services pursuant to subdivision (d) of Section 10128.55, within
14 the 60-day period following the later of either (1) the date that the
15 insured's coverage under the group benefit plan terminated or will
16 terminate by reason of a qualifying event, or (2) the date the insured
17 was sent notice pursuant to subdivision (e) of Section 10128.55
18 of the ability to continue coverage under the group benefit plan.
19 The disclosure required by this section shall also state that a
20 qualified beneficiary electing continuation shall pay to the disability
21 insurer, in accordance with the terms and conditions of the policy
22 or contract, which shall be set forth in the notice to the qualified
23 beneficiary pursuant to subdivision (d) of Section 10128.55, the
24 amount of the required premium payment, as set forth in Section
25 10128.56. The disclosure shall further require that the qualified
26 beneficiary's first premium payment required to establish premium
27 payment be delivered by first-class mail, certified mail, or other
28 reliable means of delivery, including personal delivery, express
29 mail, or private courier company, to the disability insurer, or to
30 the employer if the employer has contracted with the insurer to
31 perform the administrative services pursuant to subdivision (d) of
32 Section 10128.55, within 45 days of the date the qualified
33 beneficiary provided written notice to the insurer or the employer,
34 if the employer has contracted to perform the administrative
35 services, of the election to continue coverage in order for coverage
36 to be continued under this article. This disclosure shall also state
37 that the first premium payment must equal an amount sufficient
38 to pay all required premiums and all premiums due, and that failure
39 to submit the correct premium amount within the 45-day period

1 will disqualify the qualified beneficiary from receiving continuation
2 coverage pursuant to this article.

3 ~~(e) The disclosure required by this section shall also describe~~
4 ~~separately how qualified beneficiaries whose continuation coverage~~
5 ~~terminates under a prior group benefit plan pursuant to Section~~
6 ~~10128.57 may continue their coverage for the balance of the period~~
7 ~~that the qualified beneficiary would have remained covered under~~
8 ~~the prior group benefit plan, including the requirements for election~~
9 ~~and payment. The disclosure shall clearly state that continuation~~
10 ~~coverage shall terminate if the qualified beneficiary fails to comply~~
11 ~~with the requirements pertaining to enrollment in, and payment of~~
12 ~~premiums to, the new group benefit plan within 30 days of~~
13 ~~receiving notice of the termination of the prior group benefit plan.~~

14 ~~(d) Prior to August 1, 1998, every insurer shall provide to all~~
15 ~~covered employees of employers subject to this article written~~
16 ~~notice containing the disclosures required by this section, or shall~~
17 ~~provide to all covered employees of employers subject to this~~
18 ~~article a new or amended evidence of coverage that includes the~~
19 ~~disclosures required by this section. Any insurer that, in the~~
20 ~~ordinary course of business, maintains only the addresses of~~
21 ~~employer group purchasers of benefits, and does not maintain~~
22 ~~addresses of covered employees, may comply with the notice~~
23 ~~requirements of this section through the provision of the notices~~
24 ~~to its employer group purchases of benefits.~~

25 ~~(e) Every disclosure form issued, amended, or renewed on or~~
26 ~~after January 1, 1999, for a group benefit plan subject to this article~~
27 ~~shall provide a notice that, under state law, an insured may be~~
28 ~~entitled to continuation of group coverage and that additional~~
29 ~~information regarding eligibility for this coverage may be found~~
30 ~~in the evidence of coverage.~~

31 ~~(f) Every disclosure issued, amended, or renewed on or after~~
32 ~~the operative date of this section for a group benefit plan subject~~
33 ~~to this article shall include the following notice:~~

34 ~~“Please examine your options carefully before declining this~~
35 ~~coverage. You should be aware that companies selling individual~~
36 ~~health insurance typically require a review of your medical history~~
37 ~~that could result in a higher premium or you could be denied~~
38 ~~coverage entirely.”~~

1 ~~(g) A disclosure issued, amended, or renewed on or after July~~
2 ~~1, 2016, for a group benefit plan subject to this article shall include~~
3 ~~the following notice:~~

4 ~~“In addition to your coverage continuation options, you may be~~
5 ~~eligible for the following:~~

6 ~~1. Coverage through the state health insurance marketplace, also~~
7 ~~known as Covered California. By enrolling through Covered~~
8 ~~California, you may qualify for lower monthly premiums and lower~~
9 ~~out-of-pocket costs. Your family members may also qualify for~~
10 ~~coverage through Covered California.~~

11 ~~2. Coverage through Medi-Cal. Depending on your income, you~~
12 ~~may qualify for low- or no-cost coverage through Medi-Cal. Your~~
13 ~~family members may also qualify for Medi-Cal.~~

14 ~~3. Coverage through an insured spouse. If your spouse has~~
15 ~~coverage that extends to family members, you may be able to be~~
16 ~~added on that benefit plan.~~

17 ~~Be aware that there is a deadline to enroll in Covered California~~
18 ~~although you can apply for Medi-Cal anytime. To find out more~~
19 ~~about how to apply for Covered California and Medi-Cal, visit the~~
20 ~~Covered California Internet Web site at~~
21 ~~<http://www.coveredca.com>.”~~

22 ~~(h) (1) If Section 5000A of the Internal Revenue Code, as added~~
23 ~~by Section 1501 of PPACA, is repealed or amended to no longer~~
24 ~~apply to the individual market, as defined in Section 2791 of the~~
25 ~~federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this~~
26 ~~section shall become operative 12 months after the date of that~~
27 ~~repeal or amendment.~~

28 ~~(2) For purposes of this subdivision, “PPACA” means the federal~~
29 ~~Patient Protection and Affordable Care Act (Public Law 111-148),~~
30 ~~as amended by the federal Health Care and Education~~
31 ~~Reconciliation Act of 2010 (Public Law 111-152), and any rules,~~
32 ~~regulations, or guidance issued pursuant to that law.~~

33 ~~SEC. 21. Section 10128.55 of the Insurance Code is amended~~
34 ~~to read:~~

35 ~~10128.55. (a) Every group benefit plan contract between a~~
36 ~~disability insurer and an employer subject to this article that is~~
37 ~~issued, amended, or renewed on or after July 1, 1998, shall require~~
38 ~~the employer to notify the insurer in writing of any employee who~~
39 ~~has had a qualifying event, as defined in paragraph (2) of~~
40 ~~subdivision (d) of Section 10128.51, within 30 days of the~~

1 qualifying event. The group contract shall also require the employer
2 to notify the insurer, in writing, within 30 days of the date when
3 the employer becomes subject to Section 4980B of the United
4 States Internal Revenue Code or Chapter 18 of the Employee
5 Retirement Income Security Act (29 U.S.C. Sec. 1161 et seq.).

6 ~~(b) Every group benefit plan contract between a disability insurer
7 and an employer subject to this article that is issued, amended, or
8 renewed after July 1, 1998, shall require the employer to notify
9 qualified beneficiaries currently receiving continuation coverage,
10 whose continuation coverage will terminate under one group
11 benefit plan prior to the end of the period the qualified beneficiary
12 would have remained covered, as specified in Section 10128.57,
13 of the qualified beneficiary's ability to continue coverage under a
14 new group benefit plan for the balance of the period the qualified
15 beneficiary would have remained covered under the prior group
16 benefit plan. This notice shall be provided either 30 days prior to
17 the termination or when all enrolled employees are notified,
18 whichever is later.~~

19 Every disability insurer shall provide to the employer replacing
20 a group benefit plan policy issued by the insurer, or to the
21 employer's agent or broker representative, within 15 days of any
22 written request, information in possession of the insurer reasonably
23 required to administer the notification requirements of this
24 subdivision and subdivision (c).

25 ~~(e) Notwithstanding subdivision (a), the group benefit plan
26 contract between the insurer and the employer shall require the
27 employer to notify the successor plan in writing of the qualified
28 beneficiaries currently receiving continuation coverage so that the
29 successor plan, or contracting employer or administrator, may
30 provide those qualified beneficiaries with the necessary premium
31 information, enrollment forms, and instructions consistent with
32 the disclosure required by subdivision (c) of Section 10128.54 and
33 subdivision (e) of this section to allow the qualified beneficiary to
34 continue coverage. This information shall be sent to all qualified
35 beneficiaries who are enrolled in the group benefit plan and those
36 qualified beneficiaries who have been notified, pursuant to Section
37 10128.54 of their ability to continue their coverage and may still
38 elect coverage within the specified 60-day period. This information
39 shall be sent to the qualified beneficiary's last known address, as
40 provided to the employer by the health care service plan or,~~

1 ~~disability insurer currently providing continuation coverage to the~~
2 ~~qualified beneficiary. The successor insurer shall not be obligated~~
3 ~~to provide this information to qualified beneficiaries if the~~
4 ~~employer or prior insurer or health care service plan fails to comply~~
5 ~~with this section.~~

6 ~~(d) A disability insurer may contract with an employer, or an~~
7 ~~administrator, to perform the administrative obligations of the plan~~
8 ~~as required by this article, including required notifications and~~
9 ~~collecting and forwarding premiums to the insurer. Except for the~~
10 ~~requirements of subdivisions (a), (b), and (c), this subdivision shall~~
11 ~~not be construed to permit an insurer to require an employer to~~
12 ~~perform the administrative obligations of the insurer as required~~
13 ~~by this article as a condition of the issuance or renewal of coverage.~~

14 ~~(e) Every insurer, or employer or administrator that contracts~~
15 ~~to perform the notice and administrative services pursuant to this~~
16 ~~section, shall, within 14 days of receiving a notice of a qualifying~~
17 ~~event, provide to the qualified beneficiary the necessary premium~~
18 ~~information, enrollment forms, and disclosures consistent with the~~
19 ~~notice requirements contained in subdivisions (b) and (c) of Section~~
20 ~~10128.54 to allow the qualified beneficiary to formally elect~~
21 ~~continuation coverage. This information shall be sent to the~~
22 ~~qualified beneficiary's last known address.~~

23 ~~(f) Every insurer, or employer or administrator that contracts~~
24 ~~to perform the notice and administrative services pursuant to this~~
25 ~~section, shall, during the 180-day period ending on the date that~~
26 ~~continuation coverage is terminated pursuant to paragraphs (1),~~
27 ~~(3), and (5) of subdivision (a) of Section 10128.57, notify a~~
28 ~~qualified beneficiary who has elected continuation coverage~~
29 ~~pursuant to this article of the date that his or her coverage will~~
30 ~~terminate, and shall notify the qualified beneficiary of any~~
31 ~~conversion coverage available to that qualified beneficiary. This~~
32 ~~requirement shall not apply when the continuation coverage is~~
33 ~~terminated because the group contract between the insurer and the~~
34 ~~employer is being terminated.~~

35 ~~(g) (1) An insurer shall provide to a qualified beneficiary who~~
36 ~~has a qualifying event during the period specified in subparagraph~~
37 ~~(A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA,~~
38 ~~a written notice containing information on the availability of~~
39 ~~premium assistance under ARRA. This notice shall be sent to the~~
40 ~~qualified beneficiary's last known address. The notice shall include~~

1 clear and easily understandable language to inform the qualified
2 beneficiary that changes in federal law provide a new opportunity
3 to elect continuation coverage with a 65-percent premium subsidy
4 and shall include all of the following:

5 (A) The amount of the premium the person will pay. For
6 qualified beneficiaries who had a qualifying event between
7 September 1, 2008, and May 12, 2009, inclusive, if an insurer is
8 unable to provide the correct premium amount in the notice, the
9 notice may contain the last known premium amount and an
10 opportunity for the qualified beneficiary to request, through a
11 toll-free telephone number, the correct premium that would apply
12 to the beneficiary.

13 (B) Enrollment forms and any other information required to be
14 included pursuant to subdivision (c) to allow the qualified
15 beneficiary to elect continuation coverage. This information shall
16 not be included in notices sent to qualified beneficiaries currently
17 enrolled in continuation coverage.

18 (C) A description of the option to enroll in different coverage
19 as provided in subparagraph (B) of paragraph (1) of subdivision
20 (a) of Section 3001 of ARRA. This description shall advise the
21 qualified beneficiary to contact the covered employee's former
22 employer for prior approval to choose this option.

23 (D) The eligibility requirements for premium assistance in the
24 amount of 65 percent of the premium under Section 3001 of
25 ARRA.

26 (E) The duration of premium assistance available under ARRA.

27 (F) A statement that a qualified beneficiary eligible for premium
28 assistance under ARRA may elect continuation coverage no later
29 than 60 days of the date of the notice.

30 (G) A statement that a qualified beneficiary eligible for premium
31 assistance under ARRA who rejected or discontinued continuation
32 coverage prior to receiving the notice required by this subdivision
33 has the right to withdraw that rejection and elect continuation
34 coverage with the premium assistance.

35 (H) A statement that reads as follows:

36
37 “IF YOU ARE HAVING ANY DIFFICULTIES READING OR
38 UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name
39 of insurer] at [insert appropriate telephone number].”
40

1 ~~(2) With respect to qualified beneficiaries who had a qualifying~~
2 ~~event between September 1, 2008, and May 12, 2009, inclusive,~~
3 ~~the notice described in this subdivision shall be provided by the~~
4 ~~later of May 26, 2009, or seven business days after the date the~~
5 ~~insurer receives notice of the qualifying event.~~

6 ~~(3) With respect to qualified beneficiaries who had or have a~~
7 ~~qualifying event between May 13, 2009, and the later date specified~~
8 ~~in subparagraph (A) of paragraph (3) of subdivision (a) of Section~~
9 ~~3001 of ARRA, inclusive, the notice described in this subdivision~~
10 ~~shall be provided within the period of time specified in subdivision~~
11 ~~(e).~~

12 ~~(4) Nothing in this section shall be construed to require an~~
13 ~~insurer to provide the insurer's evidence of coverage as a part of~~
14 ~~the notice required by this subdivision, and nothing in this section~~
15 ~~shall be construed to require an insurer to amend its existing~~
16 ~~evidence of coverage to comply with the changes made to this~~
17 ~~section by the enactment of Assembly Bill 23 of the 2009-10~~
18 ~~Regular Session or by the act amending this section during the~~
19 ~~second year of the 2009-10 Regular Session.~~

20 ~~(5) The requirement under this subdivision to provide a written~~
21 ~~notice to a qualified beneficiary and the requirement under~~
22 ~~paragraph (1) of subdivision (i) to provide a new opportunity to a~~
23 ~~qualified beneficiary to elect continuation coverage shall be deemed~~
24 ~~satisfied if an insurer previously provided a written notice and~~
25 ~~additional election opportunity under Section 3001 of ARRA to~~
26 ~~that qualified beneficiary prior to the effective date of the act~~
27 ~~adding this paragraph.~~

28 ~~(h) A group contract between a group benefit plan and an~~
29 ~~employer subject to this article that is issued, amended, or renewed~~
30 ~~on or after July 1, 2016, shall require the employer to give the~~
31 ~~following notice to a qualified beneficiary in connection with a~~
32 ~~notice regarding election of continuation coverage:~~

33 ~~“In addition to your coverage continuation options, you may be~~
34 ~~eligible for the following:~~

35 ~~1. Coverage through the state health insurance marketplace, also~~
36 ~~known as Covered California. By enrolling through Covered~~
37 ~~California, you may qualify for lower monthly premiums and lower~~
38 ~~out-of-pocket costs. Your family members may also qualify for~~
39 ~~coverage through Covered California.~~

1 ~~2. Coverage through Medi-Cal. Depending on your income, you~~
2 ~~may qualify for low- or no-cost coverage through Medi-Cal. Your~~
3 ~~family members may also qualify for Medi-Cal.~~

4 ~~3. Coverage through an insured spouse. If your spouse has~~
5 ~~coverage that extends to family members, you may be able to be~~
6 ~~added on that benefit plan.~~

7 ~~Be aware that there is a deadline to enroll in Covered California~~
8 ~~although you can apply for Medi-Cal anytime. To find out more~~
9 ~~about how to apply for Covered California and Medi-Cal, visit the~~
10 ~~Covered California Internet Web site at~~

11 ~~<http://www.coveredca.com>.~~

12 ~~(i) (1) Notwithstanding any other law, a qualified beneficiary~~
13 ~~eligible for premium assistance under ARRA may elect~~
14 ~~continuation coverage no later than 60 days after the date of the~~
15 ~~notice required by subdivision (g).~~

16 ~~(2) For a qualified beneficiary who elects to continue coverage~~
17 ~~pursuant to this subdivision, the period beginning on the date of~~
18 ~~the qualifying event and ending on the effective date of the~~
19 ~~continuation coverage shall be disregarded for purposes of~~
20 ~~calculating a break in coverage in determining whether a~~
21 ~~preexisting condition provision applies under subdivision (e) of~~
22 ~~Section 10198.7 or subdivision (e) of Section 10708.~~

23 ~~(3) For a qualified beneficiary who had a qualifying event~~
24 ~~between September 1, 2008, and February 16, 2009, inclusive, and~~
25 ~~who elects continuation coverage pursuant to paragraph (1), the~~
26 ~~continuation coverage shall commence on the first day of the month~~
27 ~~following the election.~~

28 ~~(4) For a qualified beneficiary who had a qualifying event~~
29 ~~between February 17, 2009, and May 12, 2009, inclusive, and who~~
30 ~~elects continuation coverage pursuant to paragraph (1), the effective~~
31 ~~date of the continuation coverage shall be either of the following,~~
32 ~~at the option of the beneficiary, provided that the beneficiary pays~~
33 ~~the applicable premiums:~~

34 ~~(A) The date of the qualifying event.~~

35 ~~(B) The first day of the month following the election.~~

36 ~~(5) Notwithstanding any other law, a qualified beneficiary who~~
37 ~~is eligible for the special election period described in paragraph~~
38 ~~(17) of subdivision (a) of Section 3001 of ARRA may elect~~
39 ~~continuation coverage no later than 60 days after the date of the~~
40 ~~notice required under subdivision (k). For a qualified beneficiary~~

1 who elects coverage pursuant to this paragraph, the continuation
2 coverage shall be effective as of the first day of the first period of
3 coverage after the date of termination of employment, except, if
4 federal law permits, coverage shall take effect on the first day of
5 the month following the election. However, for purposes of
6 calculating the duration of continuation coverage pursuant to
7 Section 10128.57, the period of that coverage shall be determined
8 as though the qualifying event was a reduction of hours of the
9 employee.

10 (6) Notwithstanding any other law, a qualified beneficiary who
11 is eligible for any other special election period under ARRA may
12 elect continuation coverage no later than 60 days after the date of
13 the special election notice required under ARRA.

14 (j) An insurer shall provide a qualified beneficiary eligible for
15 premium assistance under ARRA written notice of the extension
16 of that premium assistance as required under Section 3001 of
17 ARRA.

18 (k) A health insurer, or an administrator or employer if
19 administrative obligations have been assumed by those entities
20 pursuant to subdivision (d), shall give the qualified beneficiaries
21 described in subparagraph (C) of paragraph (17) of subdivision
22 (a) of Section 3001 of ARRA the written notice required by that
23 paragraph by implementing the following procedures:

24 (1) The insurer shall, within 14 days of the effective date of the
25 act adding this subdivision, send a notice to employers currently
26 contracting with the insurer for a group benefit plan subject to this
27 article. The notice shall do all of the following:

28 (A) Advise the employer that employees whose employment is
29 terminated on or after March 2, 2010, who were previously enrolled
30 in any group health care service plan or health insurance policy
31 offered by the employer may be entitled to special health coverage
32 rights, including a subsidy paid by the federal government for a
33 portion of the premium.

34 (B) Ask the employer to provide the insurer with the name,
35 address, and date of termination of employment for any employee
36 whose employment is terminated on or after March 2, 2010, and
37 who was at any time covered by any health care service plan or
38 health insurance policy offered to their employees on or after
39 September 1, 2008.

1 ~~(C) Provide employers with a format and instructions for~~
2 ~~submitting the information to the insurer, or their administrator or~~
3 ~~employer who has assumed administrative obligations pursuant~~
4 ~~to subdivision (d), by telephone, fax, electronic mail, or mail.~~

5 ~~(2) Within 14 days of receipt of the information specified in~~
6 ~~paragraph (1) from the employer, the insurer shall send the written~~
7 ~~notice specified in paragraph (17) of subdivision (a) of Section~~
8 ~~3001 of ARRA to those individuals.~~

9 ~~(3) If an individual contacts his or her health insurer and~~
10 ~~indicates that he or she experienced a qualifying event that entitles~~
11 ~~him or her to the special election period described in paragraph~~
12 ~~(17) of subdivision (a) of Section 3001 of ARRA or any other~~
13 ~~special election provision of ARRA, the insurer shall provide the~~
14 ~~individual with the notice required under paragraph (17) of~~
15 ~~subdivision (a) of Section 3001 of ARRA or any other applicable~~
16 ~~provision of ARRA, regardless of whether the insurer receives or~~
17 ~~received information from the individual's previous employer~~
18 ~~regarding that individual pursuant to Section 24100 of the Health~~
19 ~~and Safety Code. The insurer shall review the individual's~~
20 ~~application for coverage under this special election notice to~~
21 ~~determine if the individual qualifies for the special election period~~
22 ~~and the premium assistance under ARRA. The insurer shall comply~~
23 ~~with paragraph (5) if the individual does not qualify for either the~~
24 ~~special election period or premium assistance under ARRA.~~

25 ~~(4) The requirement under this subdivision to provide the written~~
26 ~~notice described in paragraph (17) of subdivision (a) of Section~~
27 ~~3001 of ARRA to a qualified beneficiary and the requirement~~
28 ~~under paragraph (5) of subdivision (i) to provide a new opportunity~~
29 ~~to a qualified beneficiary to elect continuation coverage shall be~~
30 ~~deemed satisfied if a health insurer previously provided the written~~
31 ~~notice and additional election opportunity described in paragraph~~
32 ~~(17) of subdivision (a) of Section 3001 of ARRA to that qualified~~
33 ~~beneficiary prior to the effective date of the act adding this~~
34 ~~paragraph.~~

35 ~~(5) If an individual does not qualify for either a special election~~
36 ~~period or the subsidy under ARRA, the insurer shall provide a~~
37 ~~written notice to that individual that shall include information on~~
38 ~~the right to appeal as set forth in Section 3001 of ARRA.~~

39 ~~(6) A health insurer shall provide information on its publicly~~
40 ~~accessible Internet Web site regarding the premium assistance~~

1 made available under ARRA and any special election period
2 provided under that law. An insurer may fulfill this requirement
3 by linking or otherwise directing consumers to the information
4 regarding COBRA continuation coverage premium assistance
5 located on the Internet Web site of the United States Department
6 of Labor. The information required by this paragraph shall be
7 located in a section of the insurer's Internet Web site that is readily
8 accessible to consumers, such as the Web site's Frequently Asked
9 Questions section.

10 (l) Notwithstanding any other law, a qualified beneficiary
11 eligible for premium assistance under ARRA may elect to enroll
12 in different coverage subject to the criteria provided under
13 subparagraph (B) of paragraph (1) of subdivision (a) of Section
14 3001 of ARRA.

15 (m) A qualified beneficiary enrolled in continuation coverage
16 as of February 17, 2009, who is eligible for premium assistance
17 under ARRA may request application of the premium assistance
18 as of March 1, 2009, or later, consistent with ARRA.

19 (n) An insurer that receives an election notice from a qualified
20 beneficiary eligible for premium assistance under ARRA, pursuant
21 to subdivision (i), shall be considered a person entitled to
22 reimbursement, as defined in Section 6432(b)(3) of the Internal
23 Revenue Code, as amended by paragraph (12) of subdivision (a)
24 of Section 3001 of ARRA.

25 (o) (1) For purposes of compliance with ARRA, in the absence
26 of guidance from, or if specifically required for state-only
27 continuation coverage by, the United States Department of Labor,
28 the Internal Revenue Service, or the Centers for Medicare and
29 Medicaid Services, an insurer may request verification of the
30 involuntary termination of a covered employee's employment from
31 the covered employee's former employer or the qualified
32 beneficiary seeking premium assistance under ARRA.

33 (2) An insurer that requests verification pursuant to paragraph
34 (1) directly from a covered employee's former employer shall do
35 so by providing a written notice to the employer. This written
36 notice shall be sent by mail or facsimile to the covered employee's
37 former employer within seven business days from the date the
38 insurer receives the qualified beneficiary's election notice pursuant
39 to subdivision (i). Within 10 calendar days of receipt of written
40 notice required by this paragraph, the former employer shall furnish

1 to the insurer written verification as to whether the covered
2 employee's employment was involuntarily terminated.

3 (3) A qualified beneficiary requesting premium assistance under
4 ARRA may furnish to the insurer a written document or other
5 information from the covered employee's former employer
6 indicating that the covered employee's employment was
7 involuntarily terminated. This document or information shall be
8 deemed sufficient by the insurer to establish that the covered
9 employee's employment was involuntarily terminated for purposes
10 of ARRA, unless the insurer makes a reasonable and timely
11 determination that the documents or information provided by the
12 qualified beneficiary are legally insufficient to establish involuntary
13 termination of employment.

14 (4) If an insurer requests verification pursuant to this subdivision
15 and cannot verify involuntary termination of employment within
16 14 business days from the date the employer receives the
17 verification request or from the date the insurer receives
18 documentation or other information from the qualified beneficiary
19 pursuant to paragraph (3), the insurer shall either provide
20 continuation coverage with the federal premium assistance to the
21 qualified beneficiary or send the qualified beneficiary a denial
22 letter which shall include notice of his or her right to appeal that
23 determination pursuant to ARRA.

24 (5) No person shall intentionally delay verification of
25 involuntary termination of employment under this subdivision.

26 (p) (1) If Section 5000A of the Internal Revenue Code, as added
27 by Section 1501 of PPACA, is repealed or amended to no longer
28 apply to the individual market, as defined in Section 2791 of the
29 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
30 section shall become inoperative and is repealed 12 months after
31 the date of that repeal or amendment.

32 (2) For purposes of this subdivision, "PPACA" means the federal
33 Patient Protection and Affordable Care Act (Public Law 111-148),
34 as amended by the federal Health Care and Education
35 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
36 regulations, or guidance issued pursuant to that law.

37 SEC. 22. Section 10128.55 is added to the Insurance Code, to
38 read:

39 10128.55. (a) Every group benefit plan contract between a
40 disability insurer and an employer subject to this article that is

1 issued, amended, or renewed on or after July 1, 1998, shall require
2 the employer to notify the insurer in writing of any employee who
3 has had a qualifying event, as defined in paragraph (2) of
4 subdivision (d) of Section 10128.51, within 30 days of the
5 qualifying event. The group contract shall also require the employer
6 to notify the insurer, in writing, within 30 days of the date when
7 the employer becomes subject to Section 4980B of the United
8 States Internal Revenue Code or Chapter 18 of the Employee
9 Retirement Income Security Act (29 U.S.C. Sec. 1161 et seq.).

10 (b) Every group benefit plan contract between a disability insurer
11 and an employer subject to this article that is issued, amended, or
12 renewed after July 1, 1998, shall require the employer to notify
13 qualified beneficiaries currently receiving continuation coverage,
14 whose continuation coverage will terminate under one group
15 benefit plan prior to the end of the period the qualified beneficiary
16 would have remained covered, as specified in Section 10128.57,
17 of the qualified beneficiary's ability to continue coverage under a
18 new group benefit plan for the balance of the period the qualified
19 beneficiary would have remained covered under the prior group
20 benefit plan. This notice shall be provided either 30 days prior to
21 the termination or when all enrolled employees are notified,
22 whichever is later.

23 Every disability insurer shall provide to the employer replacing
24 a group benefit plan policy issued by the insurer, or to the
25 employer's agent or broker representative, within 15 days of any
26 written request, information in possession of the insurer reasonably
27 required to administer the notification requirements of this
28 subdivision and subdivision (c).

29 (c) Notwithstanding subdivision (a), the group benefit plan
30 contract between the insurer and the employer shall require the
31 employer to notify the successor plan in writing of the qualified
32 beneficiaries currently receiving continuation coverage so that the
33 successor plan, or contracting employer or administrator, may
34 provide those qualified beneficiaries with the necessary premium
35 information, enrollment forms, and instructions consistent with
36 the disclosure required by subdivision (c) of Section 10128.54 and
37 subdivision (c) of this section to allow the qualified beneficiary to
38 continue coverage. This information shall be sent to all qualified
39 beneficiaries who are enrolled in the group benefit plan and those
40 qualified beneficiaries who have been notified, pursuant to Section

1 ~~10128.54 of their ability to continue their coverage and may still~~
2 ~~elect coverage within the specified 60-day period. This information~~
3 ~~shall be sent to the qualified beneficiary's last known address, as~~
4 ~~provided to the employer by the health care service plan or,~~
5 ~~disability insurer currently providing continuation coverage to the~~
6 ~~qualified beneficiary. The successor insurer shall not be obligated~~
7 ~~to provide this information to qualified beneficiaries if the~~
8 ~~employer or prior insurer or health care service plan fails to comply~~
9 ~~with this section.~~

10 (d) ~~A disability insurer may contract with an employer, or an~~
11 ~~administrator, to perform the administrative obligations of the plan~~
12 ~~as required by this article, including required notifications and~~
13 ~~collecting and forwarding premiums to the insurer. Except for the~~
14 ~~requirements of subdivisions (a), (b), and (c), this subdivision shall~~
15 ~~not be construed to permit an insurer to require an employer to~~
16 ~~perform the administrative obligations of the insurer as required~~
17 ~~by this article as a condition of the issuance or renewal of coverage.~~

18 (e) ~~Every insurer, or employer or administrator that contracts~~
19 ~~to perform the notice and administrative services pursuant to this~~
20 ~~section, shall, within 14 days of receiving a notice of a qualifying~~
21 ~~event, provide to the qualified beneficiary the necessary premium~~
22 ~~information, enrollment forms, and disclosures consistent with the~~
23 ~~notice requirements contained in subdivisions (b) and (c) of Section~~
24 ~~10128.54 to allow the qualified beneficiary to formally elect~~
25 ~~continuation coverage. This information shall be sent to the~~
26 ~~qualified beneficiary's last known address.~~

27 (f) ~~Every insurer, or employer or administrator that contracts~~
28 ~~to perform the notice and administrative services pursuant to this~~
29 ~~section, shall, during the 180-day period ending on the date that~~
30 ~~continuation coverage is terminated pursuant to paragraphs (1),~~
31 ~~(3), and (5) of subdivision (a) of Section 10128.57, notify a~~
32 ~~qualified beneficiary who has elected continuation coverage~~
33 ~~pursuant to this article of the date that his or her coverage will~~
34 ~~terminate, and shall notify the qualified beneficiary of any~~
35 ~~conversion coverage available to that qualified beneficiary. This~~
36 ~~requirement shall not apply when the continuation coverage is~~
37 ~~terminated because the group contract between the insurer and the~~
38 ~~employer is being terminated.~~

39 (g) (1) ~~An insurer shall provide to a qualified beneficiary who~~
40 ~~has a qualifying event during the period specified in subparagraph~~

1 ~~(A) of paragraph (3) of subdivision (a) of Section 3001 of ARRA,~~
2 ~~a written notice containing information on the availability of~~
3 ~~premium assistance under ARRA. This notice shall be sent to the~~
4 ~~qualified beneficiary's last known address. The notice shall include~~
5 ~~clear and easily understandable language to inform the qualified~~
6 ~~beneficiary that changes in federal law provide a new opportunity~~
7 ~~to elect continuation coverage with a 65-percent premium subsidy~~
8 ~~and shall include all of the following:~~

9 ~~(A) The amount of the premium the person will pay. For~~
10 ~~qualified beneficiaries who had a qualifying event between~~
11 ~~September 1, 2008, and May 12, 2009, inclusive, if an insurer is~~
12 ~~unable to provide the correct premium amount in the notice, the~~
13 ~~notice may contain the last known premium amount and an~~
14 ~~opportunity for the qualified beneficiary to request, through a~~
15 ~~toll-free telephone number, the correct premium that would apply~~
16 ~~to the beneficiary.~~

17 ~~(B) Enrollment forms and any other information required to be~~
18 ~~included pursuant to subdivision (c) to allow the qualified~~
19 ~~beneficiary to elect continuation coverage. This information shall~~
20 ~~not be included in notices sent to qualified beneficiaries currently~~
21 ~~enrolled in continuation coverage.~~

22 ~~(C) A description of the option to enroll in different coverage~~
23 ~~as provided in subparagraph (B) of paragraph (1) of subdivision~~
24 ~~(a) of Section 3001 of ARRA. This description shall advise the~~
25 ~~qualified beneficiary to contact the covered employee's former~~
26 ~~employer for prior approval to choose this option.~~

27 ~~(D) The eligibility requirements for premium assistance in the~~
28 ~~amount of 65 percent of the premium under Section 3001 of~~
29 ~~ARRA.~~

30 ~~(E) The duration of premium assistance available under ARRA.~~

31 ~~(F) A statement that a qualified beneficiary eligible for premium~~
32 ~~assistance under ARRA may elect continuation coverage no later~~
33 ~~than 60 days of the date of the notice.~~

34 ~~(G) A statement that a qualified beneficiary eligible for premium~~
35 ~~assistance under ARRA who rejected or discontinued continuation~~
36 ~~coverage prior to receiving the notice required by this subdivision~~
37 ~~has the right to withdraw that rejection and elect continuation~~
38 ~~coverage with the premium assistance.~~

39 ~~(H) A statement that reads as follows:~~

1 ~~“IF YOU ARE HAVING ANY DIFFICULTIES READING OR~~
 2 ~~UNDERSTANDING THIS NOTICE, PLEASE CONTACT [name~~
 3 ~~of insurer] at [insert appropriate telephone number].”~~

4 ~~(2) With respect to qualified beneficiaries who had a qualifying~~
 5 ~~event between September 1, 2008, and May 12, 2009, inclusive,~~
 6 ~~the notice described in this subdivision shall be provided by the~~
 7 ~~later of May 26, 2009, or seven business days after the date the~~
 8 ~~insurer receives notice of the qualifying event.~~

9 ~~(3) With respect to qualified beneficiaries who had or have a~~
 10 ~~qualifying event between May 13, 2009, and the later date specified~~
 11 ~~in subparagraph (A) of paragraph (3) of subdivision (a) of Section~~
 12 ~~3001 of ARRA, inclusive, the notice described in this subdivision~~
 13 ~~shall be provided within the period of time specified in subdivision~~
 14 ~~(e).~~

15 ~~(4) Nothing in this section shall be construed to require an~~
 16 ~~insurer to provide the insurer’s evidence of coverage as a part of~~
 17 ~~the notice required by this subdivision, and nothing in this section~~
 18 ~~shall be construed to require an insurer to amend its existing~~
 19 ~~evidence of coverage to comply with the changes made to this~~
 20 ~~section by the enactment of Assembly Bill 23 of the 2009–10~~
 21 ~~Regular Session or by the act amending this section during the~~
 22 ~~second year of the 2009–10 Regular Session.~~

23 ~~(5) The requirement under this subdivision to provide a written~~
 24 ~~notice to a qualified beneficiary and the requirement under~~
 25 ~~paragraph (1) of subdivision (h) to provide a new opportunity to~~
 26 ~~a qualified beneficiary to elect continuation coverage shall be~~
 27 ~~deemed satisfied if an insurer previously provided a written notice~~
 28 ~~and additional election opportunity under Section 3001 of ARRA~~
 29 ~~to that qualified beneficiary prior to the effective date of the act~~
 30 ~~adding this paragraph.~~

31 ~~(h) A group contract between a group benefit plan and an~~
 32 ~~employer subject to this article that is issued, amended, or renewed~~
 33 ~~on or after the operative date of this section shall require the~~
 34 ~~employer to give the following notice to a qualified beneficiary in~~
 35 ~~connection with a notice regarding election of continuation~~
 36 ~~coverage:~~

37 ~~“Please examine your options carefully before declining this~~
 38 ~~coverage. You should be aware that companies selling individual~~
 39 ~~health insurance typically require a review of your medical history~~

1 that could result in a higher premium or you could be denied
2 coverage entirely.”

3 (i) ~~A group contract between a group benefit plan and an~~
4 ~~employer subject to this article that is issued, amended, or renewed~~
5 ~~on or after July 1, 2016, shall require the employer to give the~~
6 ~~following notice to a qualified beneficiary in connection with a~~
7 ~~notice regarding election of continuation coverage:~~

8 ~~“In addition to your coverage continuation options, you may be~~
9 ~~eligible for the following:~~

10 ~~1. Coverage through the state health insurance marketplace, also~~
11 ~~known as Covered California. By enrolling through Covered~~
12 ~~California, you may qualify for lower monthly premiums and lower~~
13 ~~out-of-pocket costs. Your family members may also qualify for~~
14 ~~coverage through Covered California.~~

15 ~~2. Coverage through Medi-Cal. Depending on your income, you~~
16 ~~may qualify for low- or no-cost coverage through Medi-Cal. Your~~
17 ~~family members may also qualify for Medi-Cal.~~

18 ~~3. Coverage through an insured spouse. If your spouse has~~
19 ~~coverage that extends to family members, you may be able to be~~
20 ~~added on that benefit plan.~~

21 ~~Be aware that there is a deadline to enroll in Covered California~~
22 ~~although you can apply for Medi-Cal anytime. To find out more~~
23 ~~about how to apply for Covered California and Medi-Cal, visit the~~
24 ~~Covered California Internet Web site at~~
25 ~~<http://www.coveredca.com>.~~”

26 (j) (1) ~~Notwithstanding any other law, a qualified beneficiary~~
27 ~~eligible for premium assistance under ARRA may elect~~
28 ~~continuation coverage no later than 60 days after the date of the~~
29 ~~notice required by subdivision (g).~~

30 (2) ~~For a qualified beneficiary who elects to continue coverage~~
31 ~~pursuant to this subdivision, the period beginning on the date of~~
32 ~~the qualifying event and ending on the effective date of the~~
33 ~~continuation coverage shall be disregarded for purposes of~~
34 ~~calculating a break in coverage in determining whether a~~
35 ~~preexisting condition provision applies under subdivision (e) of~~
36 ~~Section 10198.7 or subdivision (e) of Section 10708.~~

37 (3) ~~For a qualified beneficiary who had a qualifying event~~
38 ~~between September 1, 2008, and February 16, 2009, inclusive, and~~
39 ~~who elects continuation coverage pursuant to paragraph (1), the~~

1 continuation coverage shall commence on the first day of the month
2 following the election.

3 (4) For a qualified beneficiary who had a qualifying event
4 between February 17, 2009, and May 12, 2009, inclusive, and who
5 elects continuation coverage pursuant to paragraph (1), the effective
6 date of the continuation coverage shall be either of the following,
7 at the option of the beneficiary, provided that the beneficiary pays
8 the applicable premiums:

9 (A) The date of the qualifying event.

10 (B) The first day of the month following the election.

11 (5) Notwithstanding any other law, a qualified beneficiary who
12 is eligible for the special election period described in paragraph
13 (17) of subdivision (a) of Section 3001 of ARRA may elect
14 continuation coverage no later than 60 days after the date of the
15 notice required under subdivision (l). For a qualified beneficiary
16 who elects coverage pursuant to this paragraph, the continuation
17 coverage shall be effective as of the first day of the first period of
18 coverage after the date of termination of employment, except, if
19 federal law permits, coverage shall take effect on the first day of
20 the month following the election. However, for purposes of
21 calculating the duration of continuation coverage pursuant to
22 Section 10128.57, the period of that coverage shall be determined
23 as though the qualifying event was a reduction of hours of the
24 employee.

25 (6) Notwithstanding any other law, a qualified beneficiary who
26 is eligible for any other special election period under ARRA may
27 elect continuation coverage no later than 60 days after the date of
28 the special election notice required under ARRA.

29 (k) An insurer shall provide a qualified beneficiary eligible for
30 premium assistance under ARRA written notice of the extension
31 of that premium assistance as required under Section 3001 of
32 ARRA.

33 (l) A health insurer, or an administrator or employer if
34 administrative obligations have been assumed by those entities
35 pursuant to subdivision (d), shall give the qualified beneficiaries
36 described in subparagraph (C) of paragraph (17) of subdivision
37 (a) of Section 3001 of ARRA the written notice required by that
38 paragraph by implementing the following procedures:

39 (1) The insurer shall, within 14 days of the effective date of the
40 act adding this subdivision, send a notice to employers currently

1 contracting with the insurer for a group benefit plan subject to this
2 article. The notice shall do all of the following:

3 (A) Advise the employer that employees whose employment is
4 terminated on or after March 2, 2010, who were previously enrolled
5 in any group health care service plan or health insurance policy
6 offered by the employer may be entitled to special health coverage
7 rights, including a subsidy paid by the federal government for a
8 portion of the premium.

9 (B) Ask the employer to provide the insurer with the name,
10 address, and date of termination of employment for any employee
11 whose employment is terminated on or after March 2, 2010, and
12 who was at any time covered by any health care service plan or
13 health insurance policy offered to their employees on or after
14 September 1, 2008.

15 (C) Provide employers with a format and instructions for
16 submitting the information to the insurer, or their administrator or
17 employer who has assumed administrative obligations pursuant
18 to subdivision (d), by telephone, fax, electronic mail, or mail.

19 (2) Within 14 days of receipt of the information specified in
20 paragraph (1) from the employer, the insurer shall send the written
21 notice specified in paragraph (17) of subdivision (a) of Section
22 3001 of ARRA to those individuals.

23 (3) If an individual contacts his or her health insurer and
24 indicates that he or she experienced a qualifying event that entitles
25 him or her to the special election period described in paragraph
26 (17) of subdivision (a) of Section 3001 of ARRA or any other
27 special election provision of ARRA, the insurer shall provide the
28 individual with the notice required under paragraph (17) of
29 subdivision (a) of Section 3001 of ARRA or any other applicable
30 provision of ARRA, regardless of whether the insurer receives or
31 received information from the individual's previous employer
32 regarding that individual pursuant to Section 24100 of the Health
33 and Safety Code. The insurer shall review the individual's
34 application for coverage under this special election notice to
35 determine if the individual qualifies for the special election period
36 and the premium assistance under ARRA. The insurer shall comply
37 with paragraph (5) if the individual does not qualify for either the
38 special election period or premium assistance under ARRA.

39 (4) The requirement under this subdivision to provide the written
40 notice described in paragraph (17) of subdivision (a) of Section

1 3001 of ARRA to a qualified beneficiary and the requirement
2 under paragraph (5) of subdivision (j) to provide a new opportunity
3 to a qualified beneficiary to elect continuation coverage shall be
4 deemed satisfied if a health insurer previously provided the written
5 notice and additional election opportunity described in paragraph
6 (17) of subdivision (a) of Section 3001 of ARRA to that qualified
7 beneficiary prior to the effective date of the act adding this
8 paragraph:

9 (5) If an individual does not qualify for either a special election
10 period or the subsidy under ARRA, the insurer shall provide a
11 written notice to that individual that shall include information on
12 the right to appeal as set forth in Section 3001 of ARRA.

13 (6) A health insurer shall provide information on its publicly
14 accessible Internet Web site regarding the premium assistance
15 made available under ARRA and any special election period
16 provided under that law. An insurer may fulfill this requirement
17 by linking or otherwise directing consumers to the information
18 regarding COBRA continuation coverage premium assistance
19 located on the Internet Web site of the United States Department
20 of Labor. The information required by this paragraph shall be
21 located in a section of the insurer's Internet Web site that is readily
22 accessible to consumers, such as the Web site's Frequently Asked
23 Questions section.

24 (m) Notwithstanding any other law, a qualified beneficiary
25 eligible for premium assistance under ARRA may elect to enroll
26 in different coverage subject to the criteria provided under
27 subparagraph (B) of paragraph (1) of subdivision (a) of Section
28 3001 of ARRA.

29 (n) A qualified beneficiary enrolled in continuation coverage
30 as of February 17, 2009, who is eligible for premium assistance
31 under ARRA may request application of the premium assistance
32 as of March 1, 2009, or later, consistent with ARRA.

33 (o) An insurer that receives an election notice from a qualified
34 beneficiary eligible for premium assistance under ARRA, pursuant
35 to subdivision (j), shall be considered a person entitled to
36 reimbursement, as defined in Section 6432(b)(3) of the Internal
37 Revenue Code, as amended by paragraph (12) of subdivision (a)
38 of Section 3001 of ARRA.

39 (p) (1) For purposes of compliance with ARRA, in the absence
40 of guidance from, or if specifically required for state-only

1 continuation coverage by, the United States Department of Labor,
2 the Internal Revenue Service, or the Centers for Medicare and
3 Medicaid Services, an insurer may request verification of the
4 involuntary termination of a covered employee's employment from
5 the covered employee's former employer or the qualified
6 beneficiary seeking premium assistance under ARRA.

7 (2) ~~An insurer that requests verification pursuant to paragraph
8 (1) directly from a covered employee's former employer shall do
9 so by providing a written notice to the employer. This written
10 notice shall be sent by mail or facsimile to the covered employee's
11 former employer within seven business days from the date the
12 insurer receives the qualified beneficiary's election notice pursuant
13 to subdivision (h). Within 10 calendar days of receipt of written
14 notice required by this paragraph, the former employer shall furnish
15 to the insurer written verification as to whether the covered
16 employee's employment was involuntarily terminated.~~

17 (3) ~~A qualified beneficiary requesting premium assistance under
18 ARRA may furnish to the insurer a written document or other
19 information from the covered employee's former employer
20 indicating that the covered employee's employment was
21 involuntarily terminated. This document or information shall be
22 deemed sufficient by the insurer to establish that the covered
23 employee's employment was involuntarily terminated for purposes
24 of ARRA, unless the insurer makes a reasonable and timely
25 determination that the documents or information provided by the
26 qualified beneficiary are legally insufficient to establish involuntary
27 termination of employment.~~

28 (4) ~~If an insurer requests verification pursuant to this subdivision
29 and cannot verify involuntary termination of employment within
30 14 business days from the date the employer receives the
31 verification request or from the date the insurer receives
32 documentation or other information from the qualified beneficiary
33 pursuant to paragraph (3), the insurer shall either provide
34 continuation coverage with the federal premium assistance to the
35 qualified beneficiary or send the qualified beneficiary a denial
36 letter which shall include notice of his or her right to appeal that
37 determination pursuant to ARRA.~~

38 (5) ~~No person shall intentionally delay verification of
39 involuntary termination of employment under this subdivision.~~

1 ~~(q) (1) If Section 5000A of the Internal Revenue Code, as added~~
 2 ~~by Section 1501 of PPACA, is repealed or amended to no longer~~
 3 ~~apply to the individual market, as defined in Section 2791 of the~~
 4 ~~federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this~~
 5 ~~section shall become operative 12 months after the date of that~~
 6 ~~repeal or amendment.~~

7 ~~(2) For purposes of this subdivision, “PPACA” means the federal~~
 8 ~~Patient Protection and Affordable Care Act (Public Law 111-148),~~
 9 ~~as amended by the federal Health Care and Education~~
 10 ~~Reconciliation Act of 2010 (Public Law 111-152), and any rules,~~
 11 ~~regulations, or guidance issued pursuant to that law.~~

12 ~~SEC. 23.~~

13 ~~SEC. 12.~~ Section 729.12 of the Welfare and Institutions Code
 14 is amended to read:

15 729.12. (a) It is the intent of the Legislature to authorize an
 16 Assessment, Orientation, and Volunteer Mentor Pilot Program in
 17 San Diego County. The pilot project will operate under the
 18 authority of the county behavioral health director in conjunction
 19 with the San Diego Juvenile Court and the County of San Diego
 20 Probation Department.

21 (b) Whenever a judge of the San Diego County Juvenile Court
 22 or a referee of the San Diego Juvenile Court finds a minor to be a
 23 person described in Section 601 or 602 for any reason, the minor
 24 may be assessed and screened for drug and alcohol use and abuse;
 25 and if the assessment and screening determines the need for drug
 26 and alcohol education and intervention, the minor may be required
 27 to participate in, and successfully complete, an alcohol and drug
 28 orientation, and to participate in, and successfully complete, an
 29 alcohol or drug program with a local community-based service
 30 provider, as designated by the court.

31 (c) The Assessment, Orientation, and Volunteer Mentor Pilot
 32 Program may operate for a minimum of three years and may screen
 33 and assess for drug and alcohol problems, minors who are declared
 34 wards of San Diego Juvenile Court.

35 (d) Drug and alcohol assessments may be conducted utilizing
 36 a standardized instrument that shall be approved by the county
 37 behavioral health director in conjunction with San Diego Juvenile
 38 Court and the San Diego County Probation Department.

39 (e) Those minors who are determined to have drug and alcohol
 40 problems, may be required to participate in, and successfully

1 complete, a drug and alcohol orientation. The orientation may
2 provide drug and alcohol education and intervention, referral to
3 community resources for followup education and intervention and
4 arrange for volunteers to serve as mentors to assist each minor in
5 addressing their drug and alcohol problem. Parents or guardians
6 of minors will have the opportunity to participate in the orientation
7 program in order to help juveniles address drug and alcohol use
8 or abuse problems.

9 (f) As a condition of probation, each minor may be required to
10 submit to drug testing. Drug testing may be conducted on a random
11 basis by a qualified drug and alcohol service provider in
12 coordination with the county probation department. All contested
13 drug tests may be confirmed by a National Institute for Drug Abuse
14 certified drug laboratory and the findings may be reported to the
15 probation officer for appropriate action. The drug testing protocol
16 may be approved by the county behavioral health director in
17 conjunction with San Diego Juvenile Court and the County of San
18 Diego Probation Department.

19 (g) An evaluation of the pilot program shall be conducted and
20 results of the program shall be submitted to state alcohol and drug
21 programs and to the Legislature at the conclusion of the pilot
22 program. The evaluation shall include, but not be limited to, all of
23 the following:

- 24 (1) The number and percentage of juveniles screened.
- 25 (2) The number and percentage of juveniles given followup
26 education and intervention.
- 27 (3) The number of mentors recruited and trained.
- 28 (4) The number and percentage of juveniles assigned to a
29 mentor.
- 30 (5) The length of time in an education and intervention program.
- 31 (6) The program completion rates.
- 32 (7) The number of subsequent violations.
- 33 (8) The number of re-arrests.
- 34 (9) The urine test results.
- 35 (10) The subsequent drug or alcohol use.
- 36 (11) The participant's perceptions of program utility.
- 37 (12) The provider's perceptions of program utility.
- 38 (13) The mentor's perceptions of program utility.

1 ~~SEC. 24.~~

2 *SEC. 13.* Section 4033 of the Welfare and Institutions Code is
3 amended to read:

4 4033. (a) The State Department of Health Care Services shall,
5 to the extent resources are available, comply with the Substance
6 Abuse and Mental Health Services Administration federal planning
7 requirements. The department shall update and issue a state plan,
8 which may also be any federally required state service plan, so
9 that citizens may be informed regarding the implementation of,
10 and long-range goals for, programs to serve mentally ill persons
11 in the state. The department shall gather information from counties
12 necessary to comply with this section.

13 (b) (1) If the State Department of Health Care Services makes
14 a decision not to comply with any Substance Abuse and Mental
15 Health Services Administration federal planning requirement to
16 which this section applies, the State Department of Health Care
17 Services shall submit the decision, for consultation, to the County
18 Behavioral Health Directors Association of California, the
19 California Mental Health Planning Council, and affected mental
20 health entities.

21 (2) The State Department of Health Care Services shall not
22 implement any decision not to comply with the Substance Abuse
23 and Mental Health Services Administration federal planning
24 requirements sooner than 30 days after notification of that decision,
25 in writing, by the Department of Finance, to the chairperson of the
26 committee in each house of the Legislature that considers
27 appropriations, and the Chairperson of the Joint Legislative Budget
28 Committee.

29 ~~SEC. 25.~~

30 *SEC. 14.* Section 4040 of the Welfare and Institutions Code is
31 amended to read:

32 4040. The State Department of Health Care Services or State
33 Department of State Hospitals may conduct, or contract for,
34 research or evaluation studies that have application to mental health
35 policy and management issues. In selecting areas for study the
36 department shall be guided by the information needs of state and
37 local policymakers and managers, and suggestions from the County
38 Behavioral Health Directors Association of California.

1 ~~SEC. 26.~~

2 *SEC. 15.* Section 4095 of the Welfare and Institutions Code is
3 amended to read:

4 4095. (a) It is the intent of the Legislature that essential and
5 culturally relevant mental health assessment, case management,
6 and treatment services be available to wards of the court and
7 dependent children of the court placed out of home or who are at
8 risk of requiring out-of-home care. This can be best achieved at
9 the community level through the active collaboration of county
10 social service, probation, education, mental health agencies, and
11 foster care providers.

12 (b) Therefore, using the Children’s Mental Health Services Act
13 (Part 4 (commencing with Section 5850) of Division 5) as a
14 guideline, the State Department of Health Care Services, in
15 consultation with the County Behavioral Health Directors
16 Association of California, the State Department of Social Services,
17 the County Welfare Directors Association of California, the Chief
18 Probation Officers of California, and foster care providers, shall
19 do all of the following:

20 (1) By July 1, 1994, develop an individualized mental health
21 treatment needs assessment protocol for wards of the court and
22 dependent children of the court.

23 (2) Define supplemental services to be made available to the
24 target population, including, but not limited to, services defined
25 in Section 540 and following of Title 9 of the California Code of
26 Regulations as of January 1, 1994, family therapy, prevocational
27 services, and crisis support activities.

28 (3) Establish statewide standardized rates for the various types
29 of services defined by the department in accordance with paragraph
30 (2), and provided pursuant to this section. The rates shall be
31 designed to reduce the impact of competition for scarce treatment
32 resources on the cost and availability of care. The rates shall be
33 implemented only when the state provides funding for the services
34 described in this section.

35 (4) By January 1, 1994, to the extent state funds are available
36 to implement this section, establish, by regulation, all of the
37 following:

38 (A) Definitions of priority ranking of subsets of the court wards
39 and dependents target population.

40 (B) A procedure to certify the mental health programs.

1 (c) (1) Only those individuals within the target population as
2 defined in regulation and determined to be eligible for services as
3 a result of a mental health treatment needs assessment may receive
4 services pursuant to this section.

5 (2) Allocation of funds appropriated for the purposes of this
6 section shall be based on the number of wards and dependents and
7 may be adjusted in subsequent fiscal years to reflect costs.

8 (3) The counties shall be held harmless for failure to provide
9 any assessment, case management, and treatment services to those
10 children identified in need of services for whom there is no funding.

11 (d) (1) The State Department of Health Care Services shall
12 make information available to the Legislature, on request, on the
13 service populations provided mental health treatment services
14 pursuant to this section, the types and costs of services provided,
15 and the number of children identified in need of treatment services
16 who did not receive the services.

17 (2) The information required by paragraph (1) may include
18 information on need, cost, and service impact experience from the
19 following:

- 20 (A) Family preservation pilot programs.
- 21 (B) Pilot programs implemented under the former Children’s
22 Mental Health Services Act, as contained in Chapter 6.8
23 (commencing with Section 5565.10) of Part 1 of Division 5.
- 24 (C) Programs implemented under Chapter 26 (commencing
25 with Section 7570) of Division 7 of Title 1 of the Government
26 Code and Section 11401.
- 27 (D) County experience in the implementation of Section 4096.

28 ~~SEC. 27.— Section 4096.5 of the Welfare and Institutions Code~~
29 ~~is amended to read:~~

30 ~~4096.5.— (a) The State Department of Health Care Services~~
31 ~~shall make a determination, within 45 days of receiving a request~~
32 ~~from a group home to be classified at RCL 13 or RCL 14 pursuant~~
33 ~~to Section 11462.01, to certify or deny certification that the group~~
34 ~~home program includes provisions for mental health treatment~~
35 ~~services that meet the needs of seriously emotionally disturbed~~
36 ~~children. The department shall issue each certification for a period~~
37 ~~of one year and shall specify the effective date the program met~~
38 ~~the certification requirements. A program may be recertified if the~~
39 ~~program continues to meet the criteria for certification.~~

1 ~~(b) The State Department of Health Care Services shall, in~~
2 ~~consultation with County Behavioral Health Directors Association~~
3 ~~of California and representatives of provider organizations, develop~~
4 ~~the criteria for the certification required by subdivision (a) by July~~
5 ~~1, 1992.~~

6 ~~(e) (1) The State Department of Health Care Services may,~~
7 ~~upon the request of a county, delegate to that county the~~
8 ~~certification task.~~

9 ~~(2) Any county to which the certification task is delegated~~
10 ~~pursuant to paragraph (1) shall use the criteria and format~~
11 ~~developed by the department.~~

12 ~~(d) The State Department of Health Care Services or delegated~~
13 ~~county shall notify the State Department of Social Services~~
14 ~~Community Care Licensing Division immediately upon the~~
15 ~~termination of any certification issued in accordance with~~
16 ~~subdivision (a).~~

17 ~~(e) Upon receipt of notification from the State Department of~~
18 ~~Social Services Community Care Licensing Division of any adverse~~
19 ~~licensing action taken after the finding of noncompliance during~~
20 ~~an inspection conducted pursuant to Section 1538.7 of the Health~~
21 ~~and Safety Code, the State Department of Health Care Services or~~
22 ~~the delegated county shall review the certification issued pursuant~~
23 ~~to this section.~~

24 ~~SEC. 28.~~

25 *SEC. 16.* Section 4117 of the Welfare and Institutions Code,
26 as amended by Section 47 of Chapter 26 of the Statutes of 2015,
27 is amended to read:

28 4117. (a) Whenever a trial is had of any person charged with
29 escape or attempt to escape from a state hospital, whenever a
30 hearing is had on the return of a writ of habeas corpus prosecuted
31 by or on behalf of any person confined in a state hospital except
32 in a proceeding to which Section 5110 applies, whenever a hearing
33 is had on a petition under Section 1026.2, subdivision (b) of Section
34 1026.5, Section 2966, or Section 2972 of the Penal Code, Section
35 7361 of this code, or former Section 6316.2 of this code for the
36 release of a person confined in a state hospital, whenever a hearing
37 is had for an order seeking involuntary treatment with psychotropic
38 medication, or any other medication for which an order is required,
39 of a person confined in a state hospital pursuant to Section 2962
40 of the Penal Code, and whenever a person confined in a state

1 hospital is tried for a crime committed therein, the appropriate
2 financial officer or other designated official of the county in which
3 the trial or hearing is had shall make out a statement of all mental
4 health treatment costs and shall make out a separate statement of
5 all nontreatment costs incurred by the county for investigation and
6 other preparation for the trial or hearing, and the actual trial or
7 hearing, all costs of maintaining custody of the patient and
8 transporting him or her to and from the hospital, and costs of
9 appeal. The statements shall be properly certified by a judge of
10 the superior court of that county. The statement of mental health
11 treatment costs shall be sent to the State Department of State
12 Hospitals and the statement of all nontreatment costs, except as
13 provided in subdivision (c), shall be sent to the Controller for
14 approval. After approval, the department shall cause the amount
15 of mental health treatment costs incurred on or after July 1, 1987,
16 to be paid to the county behavioral health director or his or her
17 designee when the trial or hearing was held out of the money
18 appropriated for this purpose by the Legislature. In addition, the
19 Controller shall cause the amount of all nontreatment costs incurred
20 on and after July 1, 1987, to be paid out of the money appropriated
21 by the Legislature, to the county treasurer of the county where the
22 trial or hearing was had.

23 (b) Commencing January 1, 2012, the nontreatment costs
24 associated with Section 2966 of the Penal Code and approved by
25 the Controller, as required by subdivision (a), shall be paid by the
26 Department of Corrections and Rehabilitation pursuant to Section
27 4750 of the Penal Code.

28 (c) The nontreatment costs associated with any hearing for an
29 order seeking involuntary treatment with psychotropic medication,
30 or any other medication for which an order is required, of a person
31 confined in a state hospital pursuant to Section 1026, 1026.5, or
32 2972 of the Penal Code, as provided in subdivision (a), shall be
33 paid by the county of commitment. As used in this subdivision,
34 “county of commitment” means the county seeking the continued
35 treatment of a mentally disordered offender pursuant to Section
36 2972 of the Penal Code or the county committing a patient who
37 has been found not guilty by reason of insanity pursuant to Section
38 1026 or 1026.5 of the Penal Code. The appropriate financial officer
39 or other designated official of the county in which the proceeding
40 is held shall make out a statement of all of the costs incurred by

1 the county for the investigation, preparation, and conduct of the
2 proceedings, and the costs of appeal, if any. The statement shall
3 be certified by a judge of the superior court of the county. The
4 statement shall then be sent to the county of commitment, which
5 shall reimburse the county providing the services.

6 (d) (1) Whenever a hearing is held pursuant to Section 1604,
7 1608, 1609, or 2966 of the Penal Code, all transportation costs to
8 and from a state hospital or a facility designated by the community
9 program director during the hearing shall be paid by the Controller
10 as provided in this subdivision. The appropriate financial officer
11 or other designated official of the county in which a hearing is
12 held shall make out a statement of all transportation costs incurred
13 by the county. The statement shall be properly certified by a judge
14 of the superior court of that county and sent to the Controller for
15 approval. The Controller shall cause the amount of transportation
16 costs incurred on and after July 1, 1987, to be paid to the county
17 treasurer of the county where the hearing was had out of the money
18 appropriated by the Legislature.

19 (2) As used in this subdivision, “community program director”
20 means the person designated pursuant to Section 1605 of the Penal
21 Code.

22 ~~SEC. 29.~~

23 *SEC. 17.* Section 5121 of the Welfare and Institutions Code is
24 amended to read:

25 5121. The county behavioral health director may develop
26 procedures for the county’s designation and training of
27 professionals who will be designated to perform functions under
28 Section 5150. These procedures may include, but are not limited
29 to, the following:

30 (a) The license types, practice disciplines, and clinical
31 experience of professionals eligible to be designated by the county.

32 (b) The initial and ongoing training and testing requirements
33 for professionals eligible to be designated by the county.

34 (c) The application and approval processes for professionals
35 seeking to be designated by the county, including the timeframe
36 for initial designation and procedures for renewal of the
37 designation.

38 (d) The county’s process for monitoring and reviewing
39 professionals designated by the county to ensure appropriate
40 compliance with state law, regulations, and county procedures.

1 ~~SEC. 30.~~

2 ~~SEC. 18.~~ Section 5150 of the Welfare and Institutions Code is
3 amended to read:

4 5150. (a) When a person, as a result of a mental health
5 disorder, is a danger to others, or to himself or herself, or gravely
6 disabled, a peace officer, professional person in charge of a facility
7 designated by the county for evaluation and treatment, member of
8 the attending staff, as defined by regulation, of a facility designated
9 by the county for evaluation and treatment, designated members
10 of a mobile crisis team, or professional person designated by the
11 county may, upon probable cause, take, or cause to be taken, the
12 person into custody for a period of up to 72 hours for assessment,
13 evaluation, and crisis intervention, or placement for evaluation
14 and treatment in a facility designated by the county for evaluation
15 and treatment and approved by the State Department of Health
16 Care Services. At a minimum, assessment, as defined in Section
17 5150.4, and evaluation, as defined in subdivision (a) of Section
18 5008, shall be conducted and provided on an ongoing basis. Crisis
19 intervention, as defined in subdivision (e) of Section 5008, may
20 be provided concurrently with assessment, evaluation, or any other
21 service.

22 (b) The professional person in charge of a facility designated
23 by the county for evaluation and treatment, member of the
24 attending staff, or professional person designated by the county
25 shall assess the person to determine whether he or she can be
26 properly served without being detained. If in the judgment of the
27 professional person in charge of the facility designated by the
28 county for evaluation and treatment, member of the attending staff,
29 or professional person designated by the county, the person can
30 be properly served without being detained, he or she shall be
31 provided evaluation, crisis intervention, or other inpatient or
32 outpatient services on a voluntary basis. Nothing in this subdivision
33 shall be interpreted to prevent a peace officer from delivering
34 individuals to a designated facility for assessment under this
35 section. Furthermore, the assessment requirement of this
36 subdivision shall not be interpreted to require peace officers to
37 perform any additional duties other than those specified in Sections
38 5150.1 and 5150.2.

39 (c) Whenever a person is evaluated by a professional person in
40 charge of a facility designated by the county for evaluation or

1 treatment, member of the attending staff, or professional person
2 designated by the county and is found to be in need of mental
3 health services, but is not admitted to the facility, all available
4 alternative services provided pursuant to subdivision (b) shall be
5 offered as determined by the county behavioral health director.

6 (d) If, in the judgment of the professional person in charge of
7 the facility designated by the county for evaluation and treatment,
8 member of the attending staff, or the professional person designated
9 by the county, the person cannot be properly served without being
10 detained, the admitting facility shall require an application in
11 writing stating the circumstances under which the person's
12 condition was called to the attention of the peace officer,
13 professional person in charge of the facility designated by the
14 county for evaluation and treatment, member of the attending staff,
15 or professional person designated by the county, and stating that
16 the peace officer, professional person in charge of the facility
17 designated by the county for evaluation and treatment, member of
18 the attending staff, or professional person designated by the county
19 has probable cause to believe that the person is, as a result of a
20 mental health disorder, a danger to others, or to himself or herself,
21 or gravely disabled. If the probable cause is based on the statement
22 of a person other than the peace officer, professional person in
23 charge of the facility designated by the county for evaluation and
24 treatment, member of the attending staff, or professional person
25 designated by the county, the person shall be liable in a civil action
26 for intentionally giving a statement that he or she knows to be
27 false.

28 (e) At the time a person is taken into custody for evaluation, or
29 within a reasonable time thereafter, unless a responsible relative
30 or the guardian or conservator of the person is in possession of the
31 person's personal property, the person taking him or her into
32 custody shall take reasonable precautions to preserve and safeguard
33 the personal property in the possession of or on the premises
34 occupied by the person. The person taking him or her into custody
35 shall then furnish to the court a report generally describing the
36 person's property so preserved and safeguarded and its disposition,
37 in substantially the form set forth in Section 5211, except that if
38 a responsible relative or the guardian or conservator of the person
39 is in possession of the person's property, the report shall include
40 only the name of the relative or guardian or conservator and the

1 location of the property, whereupon responsibility of the person
 2 taking him or her into custody for that property shall terminate.
 3 As used in this section, “responsible relative” includes the spouse,
 4 parent, adult child, domestic partner, grandparent, grandchild, or
 5 adult brother or sister of the person.

6 (f) (1) Each person, at the time he or she is first taken into
 7 custody under this section, shall be provided, by the person who
 8 takes him or her into custody, the following information orally in
 9 a language or modality accessible to the person. If the person
 10 cannot understand an oral advisement, the information shall be
 11 provided in writing. The information shall be in substantially the
 12 following form:

13
 14 My name is _____ .
 15 I am a _____ .
 16 (peace officer/mental health professional)
 17 with _____ .
 18 (name of agency)
 19 You are not under criminal arrest, but I am taking you for an examination by
 20 mental health professionals at _____ .
 21 _____
 22 (name of facility)

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

24
 25 (2) If taken into custody at his or her own residence, the person
 26 shall also be provided the following information:

27
 28 You may bring a few personal items with you, which I will have
 29 to approve. Please inform me if you need assistance turning off
 30 any appliance or water. You may make a phone call and leave a
 31 note to tell your friends or family where you have been taken.

32
 33 (g) The designated facility shall keep, for each patient evaluated,
 34 a record of the advisement given pursuant to subdivision (f) which
 35 shall include all of the following:

- 36 (1) The name of the person detained for evaluation.
- 37 (2) The name and position of the peace officer or mental health
- 38 professional taking the person into custody.
- 39 (3) The date the advisement was completed.

- 1 (4) Whether the advisement was completed.
- 2 (5) The language or modality used to give the advisement.
- 3 (6) If the advisement was not completed, a statement of good
- 4 cause, as defined by regulations of the State Department of Health
- 5 Care Services.

6 (h) (1) Each person admitted to a facility designated by the
 7 county for evaluation and treatment shall be given the following
 8 information by admission staff of the facility. The information
 9 shall be given orally and in writing and in a language or modality
 10 accessible to the person. The written information shall be available
 11 to the person in English and in the language that is the person's
 12 primary means of communication. Accommodations for other
 13 disabilities that may affect communication shall also be provided.
 14 The information shall be in substantially the following form:

15
 16 My name is _____.

17 My position here is _____.

18 You are being placed into this psychiatric facility because it is our
 19 professional opinion that, as a result of a mental health disorder, you are likely
 20 to (check applicable):

- 21 Harm yourself.
- 22 Harm someone else.
- 23 Be unable to take care of your own food, clothing, and housing needs.

24 We believe this is true because
 25 _____

26 (list of the facts upon which the allegation of dangerous
 27 or gravely disabled due to mental health disorder is based, including pertinent
 28 facts arising from the admission interview).

29 You will be held for a period up to 72 hours. During the 72 hours you may
 30 also be transferred to another facility. You may request to be evaluated or
 31 treated at a facility of your choice. You may request to be evaluated or treated
 32 by a mental health professional of your choice. We cannot guarantee the facility
 33 or mental health professional you choose will be available, but we will honor
 34 your choice if we can.

35 During these 72 hours you will be evaluated by the facility staff, and you
 36 may be given treatment, including medications. It is possible for you to be
 37 released before the end of the 72 hours. But if the staff decides that you need
 38 continued treatment you can be held for a longer period of time. If you are
 39 held longer than 72 hours, you have the right to a lawyer and a qualified

1 interpreter and a hearing before a judge. If you are unable to pay for the lawyer,
2 then one will be provided to you free of charge.

3 If you have questions about your legal rights, you may contact the county
4 Patients' Rights Advocate at _____

5 (phone number for the county Patients' Rights

6 _____.

7 Advocacy office)

8 Your 72-hour period began _____.

9 (date/time)

10

11 (2) If the notice is given in a county where weekends and
12 holidays are excluded from the 72-hour period, the patient shall
13 be informed of this fact.

14 (i) For each patient admitted for evaluation and treatment, the
15 facility shall keep with the patient's medical record a record of the
16 advisement given pursuant to subdivision (h), which shall include
17 all of the following:

18 (1) The name of the person performing the advisement.

19 (2) The date of the advisement.

20 (3) Whether the advisement was completed.

21 (4) The language or modality used to communicate the
22 advisement.

23 (5) If the advisement was not completed, a statement of good
24 cause.

25 ~~SEC. 31.~~

26 *SEC. 19.* Section 5152.1 of the Welfare and Institutions Code
27 is amended to read:

28 5152.1. The professional person in charge of the facility
29 providing 72-hour evaluation and treatment, or his or her designee,
30 shall notify the county behavioral health director or the director's
31 designee and the peace officer who makes the written application
32 pursuant to Section 5150 or a person who is designated by the law
33 enforcement agency that employs the peace officer, when the
34 person has been released after 72-hour detention, when the person
35 is not detained, or when the person is released before the full period
36 of allowable 72-hour detention if all of the following conditions
37 apply:

38 (a) The peace officer requests such notification at the time he
39 or she makes the application and the peace officer certifies at that
40 time in writing that the person has been referred to the facility

1 under circumstances which, based upon an allegation of facts
2 regarding actions witnessed by the officer or another person, would
3 support the filing of a criminal complaint.

4 (b) The notice is limited to the person's name, address, date of
5 admission for 72-hour evaluation and treatment, and date of release.

6 If a police officer, law enforcement agency, or designee of the
7 law enforcement agency, possesses any record of information
8 obtained pursuant to the notification requirements of this section,
9 the officer, agency, or designee shall destroy that record two years
10 after receipt of notification.

11 ~~SEC. 32.~~

12 *SEC. 20.* Section 5152.2 of the Welfare and Institutions Code
13 is amended to read:

14 5152.2. Each law enforcement agency within a county shall
15 arrange with the county behavioral health director a method for
16 giving prompt notification to peace officers pursuant to Section
17 5152.1.

18 ~~SEC. 33.~~

19 *SEC. 21.* Section 5250.1 of the Welfare and Institutions Code
20 is amended to read:

21 5250.1. The professional person in charge of a facility
22 providing intensive treatment, pursuant to Section 5250 or 5270.15,
23 or that person's designee, shall notify the county behavioral health
24 director, or the director's designee, and the peace officer who made
25 the original written application for 72-hour evaluation pursuant to
26 Section 5150 or a person who is designated by the law enforcement
27 agency that employs the peace officer, that the person admitted
28 pursuant to the application has been released unconditionally if
29 all of the following conditions apply:

30 (a) The peace officer has requested notification at the time he
31 or she makes the application for 72-hour evaluation.

32 (b) The peace officer has certified in writing at the time he or
33 she made the application that the person has been referred to the
34 facility under circumstances which, based upon an allegation of
35 facts regarding actions witnessed by the officer or another person,
36 would support the filing of a criminal complaint.

37 (c) The notice is limited to the person's name, address, date of
38 admission for 72-hour evaluation, date of certification for intensive
39 treatment, and date of release.

1 If a police officer, law enforcement agency, or designee of the
2 law enforcement agency, possesses any record of information
3 obtained pursuant to the notification requirements of this section,
4 the officer, agency, or designee shall destroy that record two years
5 after receipt of notification.

6 ~~SEC. 34.~~

7 *SEC. 22.* Section 5305 of the Welfare and Institutions Code is
8 amended to read:

9 5305. (a) Any person committed pursuant to Section 5300
10 may be placed on outpatient status if all of the following conditions
11 are satisfied:

12 (1) In the evaluation of the superintendent or professional person
13 in charge of the licensed health facility, the person named in the
14 petition will no longer be a danger to the health and safety of others
15 while on outpatient status and will benefit from outpatient status.

16 (2) The county behavioral health director advises the court that
17 the person named in the petition will benefit from outpatient status
18 and identifies an appropriate program of supervision and treatment.

19 (b) After actual notice to the public officer, pursuant to Section
20 5114, and to counsel of the person named in the petition, to the
21 court and to the county behavioral health director, the plan for
22 outpatient treatment shall become effective within five judicial
23 days unless a court hearing on that action is requested by any of
24 the aforementioned parties, in which case the release on outpatient
25 status shall not take effect until approved by the court after a
26 hearing. This hearing shall be held within five judicial days of the
27 actual notice required by this subdivision.

28 (c) The county behavioral health director shall be the outpatient
29 supervisor of persons placed on outpatient status under this section.
30 The county behavioral health director may delegate outpatient
31 supervision responsibility to a designee.

32 (d) The outpatient treatment supervisor shall, when the person
33 is placed on outpatient status at least three months, submit at 90-day
34 intervals to the court, the public officer, pursuant to Section 5114,
35 and counsel of the person named in the petition and to the
36 supervisor or professional person in charge of the licensed health
37 facility, when appropriate, a report setting forth the status and
38 progress of the person named in the petition. Notwithstanding the
39 length of the outpatient status, a final report shall be submitted by

1 the outpatient treatment supervisor at the conclusion of the 180-day
2 commitment setting forth the status and progress of the person.

3 ~~SEC. 35.~~

4 *SEC. 23.* Section 5306.5 of the Welfare and Institutions Code
5 is amended to read:

6 5306.5. (a) If at any time during the outpatient period, the
7 outpatient treatment supervisor is of the opinion that the person
8 receiving treatment requires extended inpatient treatment or refuses
9 to accept further outpatient treatment and supervision, the county
10 behavioral health director shall notify the superior court in either
11 the county that approved outpatient status or in the county where
12 outpatient treatment is being provided of that opinion by means
13 of a written request for revocation of outpatient status. The county
14 behavioral health director shall furnish a copy of this request to
15 the counsel of the person named in the request for revocation and
16 to the public officer, pursuant to Section 5114, in both counties if
17 the request is made in the county of treatment, rather than the
18 county of commitment.

19 (b) Within 15 judicial days, the court where the request was
20 filed shall hold a hearing and shall either approve or disapprove
21 the request for revocation of outpatient status. If the court approves
22 the request for revocation, the court shall order that the person be
23 confined in a state hospital or other treatment facility approved by
24 the county behavioral health director. The court shall transmit a
25 copy of its order to the county behavioral health director or a
26 designee and to the Director of State Hospitals. When the county
27 of treatment and the county of commitment differ and revocation
28 occurs in the county of treatment, the court shall enter the name
29 of the committing county and its case number on the order of
30 revocation and shall send a copy of the order to the committing
31 court and the public officer, pursuant to Section 5114, and counsel
32 of the person named in the request for revocation in the county of
33 commitment.

34 ~~SEC. 36.~~

35 *SEC. 24.* Section 5307 of the Welfare and Institutions Code is
36 amended to read:

37 5307. If at any time during the outpatient period the public
38 officer, pursuant to Section 5114, is of the opinion that the person
39 is a danger to the health and safety of others while on outpatient
40 status, the public officer, pursuant to Section 5114, may petition

1 the court for a hearing to determine whether the person shall be
2 continued on outpatient status. Upon receipt of the petition, the
3 court shall calendar the case for further proceedings within 15
4 judicial days and the clerk shall notify the person, the county
5 behavioral health director, and the attorney of record for the person
6 of the hearing date. Upon failure of the person to appear as noticed,
7 if a proper affidavit of service and advisement has been filed with
8 the court, the court may issue a body attachment for that person.
9 If, after a hearing in court the judge determines that the person is
10 a danger to the health and safety of others, the court shall order
11 that the person be confined in a state hospital or other treatment
12 facility that has been approved by the county behavioral health
13 director.

14 ~~SEC. 37.~~

15 *SEC. 25.* Section 5308 of the Welfare and Institutions Code is
16 amended to read:

17 5308. Upon the filing of a request for revocation of outpatient
18 status under Section 5306.5 or 5307 and pending the court's
19 decision on revocation, the person subject to revocation may be
20 confined in a state hospital or other treatment facility by the county
21 behavioral health director when it is the opinion of that director
22 that the person will now be a danger to self or to another while on
23 outpatient status and that to delay hospitalization until the
24 revocation hearing would pose a demonstrated danger of harm to
25 the person or to another. Upon the request of the county behavioral
26 health director or a designee, a peace officer shall take, or cause
27 to be taken, the person into custody and transport the person to a
28 treatment facility for hospitalization under this section. The county
29 behavioral health director shall notify the court in writing of the
30 admission of the person to inpatient status and of the factual basis
31 for the opinion that immediate return to inpatient treatment was
32 necessary. The court shall supply a copy of these documents to
33 the public officer, pursuant to Section 5114, and counsel of the
34 person subject to revocation.

35 A person hospitalized under this section shall have the right to
36 judicial review of the detention in the manner prescribed in Article
37 5 (commencing with Section 5275) of Chapter 2 and to an
38 explanation of rights in the manner prescribed in Section 5252.1.

39 Nothing in this section shall prevent hospitalization pursuant to
40 the provisions of Section 5150, 5250, 5350, or 5353.

1 A person whose confinement in a treatment facility under Section
2 5306.5 or 5307 is approved by the court shall not be released again
3 to outpatient status unless court approval is obtained under Section
4 5305.

5 ~~SEC. 38.~~

6 *SEC. 26.* Section 5326.95 of the Welfare and Institutions Code
7 is amended to read:

8 5326.95. The Director of State Hospitals shall adopt regulations
9 to carry out the provisions of this chapter, including standards
10 defining excessive use of convulsive treatment, which shall be
11 developed in consultation with the State Department of Health
12 Care Services and the County Behavioral Health Directors
13 Association of California.

14 ~~SEC. 39.~~

15 *SEC. 27.* Section 5328 of the Welfare and Institutions Code is
16 amended to read:

17 5328. All information and records obtained in the course of
18 providing services under Division 4 (commencing with Section
19 4000), Division 4.1 (commencing with Section 4400), Division
20 4.5 (commencing with Section 4500), Division 5 (commencing
21 with Section 5000), Division 6 (commencing with Section 6000),
22 or Division 7 (commencing with Section 7100), to either voluntary
23 or involuntary recipients of services shall be confidential.
24 Information and records obtained in the course of providing similar
25 services to either voluntary or involuntary recipients prior to 1969
26 shall also be confidential. Information and records shall be
27 disclosed only in any of the following cases:

28 (a) In communications between qualified professional persons
29 in the provision of services or appropriate referrals, or in the course
30 of conservatorship proceedings. The consent of the patient, or his
31 or her guardian or conservator, shall be obtained before information
32 or records may be disclosed by a professional person employed
33 by a facility to a professional person not employed by the facility
34 who does not have the medical or psychological responsibility for
35 the patient's care.

36 (b) When the patient, with the approval of the physician and
37 surgeon, licensed psychologist, social worker with a master's
38 degree in social work, licensed marriage and family therapist, or
39 licensed professional clinical counselor, who is in charge of the
40 patient, designates persons to whom information or records may

1 be released, except that nothing in this article shall be construed
 2 to compel a physician and surgeon, licensed psychologist, social
 3 worker with a master’s degree in social work, licensed marriage
 4 and family therapist, licensed professional clinical counselor, nurse,
 5 attorney, or other professional person to reveal information that
 6 has been given to him or her in confidence by members of a
 7 patient’s family. Nothing in this subdivision shall be construed to
 8 authorize a licensed marriage and family therapist or licensed
 9 professional clinical counselor to provide services or to be in charge
 10 of a patient’s care beyond his or her lawful scope of practice.

11 (c) To the extent necessary for a recipient to make a claim, or
 12 for a claim to be made on behalf of a recipient for aid, insurance,
 13 or medical assistance to which he or she may be entitled.

14 (d) If the recipient of services is a minor, ward, dependent, or
 15 conservatee, and his or her parent, guardian, guardian ad litem,
 16 conservator, or authorized representative designates, in writing,
 17 persons to whom records or information may be disclosed, except
 18 that nothing in this article shall be construed to compel a physician
 19 and surgeon, licensed psychologist, social worker with a master’s
 20 degree in social work, licensed marriage and family therapist,
 21 licensed professional clinical counselor, nurse, attorney, or other
 22 professional person to reveal information that has been given to
 23 him or her in confidence by members of a patient’s family.

24 (e) For research, provided that the Director of Health Care
 25 Services, the Director of State Hospitals, the Director of Social
 26 Services, or the Director of Developmental Services designates
 27 by regulation, rules for the conduct of research and requires the
 28 research to be first reviewed by the appropriate institutional review
 29 board or boards. The rules shall include, but need not be limited
 30 to, the requirement that all researchers shall sign an oath of
 31 confidentiality as follows:

32
 33

Date

34
 35
 36 As a condition of doing research concerning persons who have
 37 received services from ____ (fill in the facility, agency or person),
 38 I, ____, agree to obtain the prior informed consent of such persons
 39 who have received services to the maximum degree possible as
 40 determined by the appropriate institutional review board or boards

1 for protection of human subjects reviewing my research, and I
2 further agree not to divulge any information obtained in the course
3 of such research to unauthorized persons, and not to publish or
4 otherwise make public any information regarding persons who
5 have received services such that the person who received services
6 is identifiable.

7 I recognize that the unauthorized release of confidential
8 information may make me subject to a civil action under provisions
9 of the Welfare and Institutions Code.

10

11 (f) To the courts, as necessary to the administration of justice.

12 (g) To governmental law enforcement agencies as needed for
13 the protection of federal and state elective constitutional officers
14 and their families.

15 (h) To the Senate Committee on Rules or the Assembly
16 Committee on Rules for the purposes of legislative investigation
17 authorized by the committee.

18 (i) If the recipient of services who applies for life or disability
19 insurance designates in writing the insurer to which records or
20 information may be disclosed.

21 (j) To the attorney for the patient in any and all proceedings
22 upon presentation of a release of information signed by the patient,
23 except that when the patient is unable to sign the release, the staff
24 of the facility, upon satisfying itself of the identity of the attorney,
25 and of the fact that the attorney does represent the interests of the
26 patient, may release all information and records relating to the
27 patient except that nothing in this article shall be construed to
28 compel a physician and surgeon, licensed psychologist, social
29 worker with a master's degree in social work, licensed marriage
30 and family therapist, licensed professional clinical counselor, nurse,
31 attorney, or other professional person to reveal information that
32 has been given to him or her in confidence by members of a
33 patient's family.

34 (k) Upon written agreement by a person previously confined in
35 or otherwise treated by a facility, the professional person in charge
36 of the facility or his or her designee may release any information,
37 except information that has been given in confidence by members
38 of the person's family, requested by a probation officer charged
39 with the evaluation of the person after his or her conviction of a
40 crime if the professional person in charge of the facility determines

1 that the information is relevant to the evaluation. The agreement
2 shall only be operative until sentence is passed on the crime of
3 which the person was convicted. The confidential information
4 released pursuant to this subdivision shall be transmitted to the
5 court separately from the probation report and shall not be placed
6 in the probation report. The confidential information shall remain
7 confidential except for purposes of sentencing. After sentencing,
8 the confidential information shall be sealed.

9 (l) (1) Between persons who are trained and qualified to serve
10 on multidisciplinary personnel teams pursuant to subdivision (d)
11 of Section 18951. The information and records sought to be
12 disclosed shall be relevant to the provision of child welfare services
13 or the investigation, prevention, identification, management, or
14 treatment of child abuse or neglect pursuant to Chapter 11
15 (commencing with Section 18950) of Part 6 of Division 9.
16 Information obtained pursuant to this subdivision shall not be used
17 in any criminal or delinquency proceeding. Nothing in this
18 subdivision shall prohibit evidence identical to that contained
19 within the records from being admissible in a criminal or
20 delinquency proceeding, if the evidence is derived solely from
21 means other than this subdivision, as permitted by law.

22 (2) As used in this subdivision, “child welfare services” means
23 those services that are directed at preventing child abuse or neglect.

24 (m) To county patients’ rights advocates who have been given
25 knowing voluntary authorization by a client or a guardian ad litem.
26 The client or guardian ad litem, whoever entered into the
27 agreement, may revoke the authorization at any time, either in
28 writing or by oral declaration to an approved advocate.

29 (n) To a committee established in compliance with Section
30 14725.

31 (o) In providing information as described in Section 7325.5.
32 Nothing in this subdivision shall permit the release of any
33 information other than that described in Section 7325.5.

34 (p) To the county behavioral health director or the director’s
35 designee, or to a law enforcement officer, or to the person
36 designated by a law enforcement agency, pursuant to Sections
37 5152.1 and 5250.1.

38 (q) If the patient gives his or her consent, information
39 specifically pertaining to the existence of genetically handicapping
40 conditions, as defined in Section 125135 of the Health and Safety

1 Code, may be released to qualified professional persons for
2 purposes of genetic counseling for blood relatives upon request of
3 the blood relative. For purposes of this subdivision, “qualified
4 professional persons” means those persons with the qualifications
5 necessary to carry out the genetic counseling duties under this
6 subdivision as determined by the genetic disease unit established
7 in the State Department of Health Care Services under Section
8 125000 of the Health and Safety Code. If the patient does not
9 respond or cannot respond to a request for permission to release
10 information pursuant to this subdivision after reasonable attempts
11 have been made over a two-week period to get a response, the
12 information may be released upon request of the blood relative.

13 (r) When the patient, in the opinion of his or her psychotherapist,
14 presents a serious danger of violence to a reasonably foreseeable
15 victim or victims, then any of the information or records specified
16 in this section may be released to that person or persons and to
17 law enforcement agencies and county child welfare agencies as
18 the psychotherapist determines is needed for the protection of that
19 person or persons. For purposes of this subdivision,
20 “psychotherapist” means anyone so defined within Section 1010
21 of the Evidence Code.

22 (s) (1) To the designated officer of an emergency response
23 employee, and from that designated officer to an emergency
24 response employee regarding possible exposure to HIV or AIDS,
25 but only to the extent necessary to comply with provisions of the
26 federal Ryan White Comprehensive AIDS Resources Emergency
27 Act of 1990 (Public Law 101-381; 42 U.S.C. Sec. 201).

28 (2) For purposes of this subdivision, “designated officer” and
29 “emergency response employee” have the same meaning as these
30 terms are used in the federal Ryan White Comprehensive AIDS
31 Resources Emergency Act of 1990 (Public Law 101-381; 42 U.S.C.
32 Sec. 201).

33 (3) The designated officer shall be subject to the confidentiality
34 requirements specified in Section 120980, and may be personally
35 liable for unauthorized release of any identifying information about
36 the HIV results. Further, the designated officer shall inform the
37 exposed emergency response employee that the employee is also
38 subject to the confidentiality requirements specified in Section
39 120980, and may be personally liable for unauthorized release of
40 any identifying information about the HIV test results.

1 (t) (1) To a law enforcement officer who personally lodges with
2 a facility, as defined in paragraph (2), a warrant of arrest or an
3 abstract of such a warrant showing that the person sought is wanted
4 for a serious felony, as defined in Section 1192.7 of the Penal
5 Code, or a violent felony, as defined in Section 667.5 of the Penal
6 Code. The information sought and released shall be limited to
7 whether or not the person named in the arrest warrant is presently
8 confined in the facility. This paragraph shall be implemented with
9 minimum disruption to health facility operations and patients, in
10 accordance with Section 5212. If the law enforcement officer is
11 informed that the person named in the warrant is confined in the
12 facility, the officer may not enter the facility to arrest the person
13 without obtaining a valid search warrant or the permission of staff
14 of the facility.

15 (2) For purposes of paragraph (1), a facility means all of the
16 following:

17 (A) A state hospital, as defined in Section 4001.

18 (B) A general acute care hospital, as defined in subdivision (a)
19 of Section 1250 of the Health and Safety Code, solely with regard
20 to information pertaining to a person with mental illness subject
21 to this section.

22 (C) An acute psychiatric hospital, as defined in subdivision (b)
23 of Section 1250 of the Health and Safety Code.

24 (D) A psychiatric health facility, as described in Section 1250.2
25 of the Health and Safety Code.

26 (E) A mental health rehabilitation center, as described in Section
27 5675.

28 (F) A skilled nursing facility with a special treatment program
29 for individuals with mental illness, as described in Sections 51335
30 and 72445 to 72475, inclusive, of Title 22 of the California Code
31 of Regulations.

32 (u) Between persons who are trained and qualified to serve on
33 multidisciplinary personnel teams pursuant to Section 15610.55,
34 15753.5, or 15761. The information and records sought to be
35 disclosed shall be relevant to the prevention, identification,
36 management, or treatment of an abused elder or dependent adult
37 pursuant to Chapter 13 (commencing with Section 15750) of Part
38 3 of Division 9.

1 (v) The amendment of subdivision (d) enacted at the 1970
2 Regular Session of the Legislature does not constitute a change
3 in, but is declaratory of, the preexisting law.

4 (w) This section shall not be limited by Section 5150.05 or 5332.

5 (x) (1) When an employee is served with a notice of adverse
6 action, as defined in Section 19570 of the Government Code, the
7 following information and records may be released:

8 (A) All information and records that the appointing authority
9 relied upon in issuing the notice of adverse action.

10 (B) All other information and records that are relevant to the
11 adverse action, or that would constitute relevant evidence as
12 defined in Section 210 of the Evidence Code.

13 (C) The information described in subparagraphs (A) and (B)
14 may be released only if both of the following conditions are met:

15 (i) The appointing authority has provided written notice to the
16 consumer and the consumer's legal representative or, if the
17 consumer has no legal representative or if the legal representative
18 is a state agency, to the clients' rights advocate, and the consumer,
19 the consumer's legal representative, or the clients' rights advocate
20 has not objected in writing to the appointing authority within five
21 business days of receipt of the notice, or the appointing authority,
22 upon review of the objection has determined that the circumstances
23 on which the adverse action is based are egregious or threaten the
24 health, safety, or life of the consumer or other consumers and
25 without the information the adverse action could not be taken.

26 (ii) The appointing authority, the person against whom the
27 adverse action has been taken, and the person's representative, if
28 any, have entered into a stipulation that does all of the following:

29 (I) Prohibits the parties from disclosing or using the information
30 or records for any purpose other than the proceedings for which
31 the information or records were requested or provided.

32 (II) Requires the employee and the employee's legal
33 representative to return to the appointing authority all records
34 provided to them under this subdivision, including, but not limited
35 to, all records and documents from any source containing
36 confidential information protected by this section, and all copies
37 of those records and documents, within 10 days of the date that
38 the adverse action becomes final except for the actual records and
39 documents or copies thereof that are no longer in the possession
40 of the employee or the employee's legal representative because

1 they were submitted to the administrative tribunal as a component
2 of an appeal from the adverse action.

3 (III) Requires the parties to submit the stipulation to the
4 administrative tribunal with jurisdiction over the adverse action
5 at the earliest possible opportunity.

6 (2) For the purposes of this subdivision, the State Personnel
7 Board may, prior to any appeal from adverse action being filed
8 with it, issue a protective order, upon application by the appointing
9 authority, for the limited purpose of prohibiting the parties from
10 disclosing or using information or records for any purpose other
11 than the proceeding for which the information or records were
12 requested or provided, and to require the employee or the
13 employee's legal representative to return to the appointing authority
14 all records provided to them under this subdivision, including, but
15 not limited to, all records and documents from any source
16 containing confidential information protected by this section, and
17 all copies of those records and documents, within 10 days of the
18 date that the adverse action becomes final, except for the actual
19 records and documents or copies thereof that are no longer in the
20 possession of the employee or the employee's legal representatives
21 because they were submitted to the administrative tribunal as a
22 component of an appeal from the adverse action.

23 (3) Individual identifiers, including, but not limited to, names,
24 social security numbers, and hospital numbers, that are not
25 necessary for the prosecution or defense of the adverse action,
26 shall not be disclosed.

27 (4) All records, documents, or other materials containing
28 confidential information protected by this section that have been
29 submitted or otherwise disclosed to the administrative agency or
30 other person as a component of an appeal from an adverse action
31 shall, upon proper motion by the appointing authority to the
32 administrative tribunal, be placed under administrative seal and
33 shall not, thereafter, be subject to disclosure to any person or entity
34 except upon the issuance of an order of a court of competent
35 jurisdiction.

36 (5) For purposes of this subdivision, an adverse action becomes
37 final when the employee fails to answer within the time specified
38 in Section 19575 of the Government Code, or, after filing an
39 answer, withdraws the appeal, or, upon exhaustion of the

1 administrative appeal or of the judicial review remedies as
2 otherwise provided by law.

3 (y) To the person appointed as the developmental services
4 decisionmaker for a minor, dependent, or ward pursuant to Section
5 319, 361, or 726.

6 ~~SEC. 40.~~

7 *SEC. 28.* Section 5328.2 of the Welfare and Institutions Code
8 is amended to read:

9 5328.2. Notwithstanding Section 5328, movement and
10 identification information and records regarding a patient who is
11 committed to the department, state hospital, or any other public
12 or private mental health facility approved by the county behavioral
13 health director for observation or for an indeterminate period as a
14 mentally disordered sex offender, or for a person who is civilly
15 committed as a sexually violent predator pursuant to Article 4
16 (commencing with Section 6600) of Chapter 2 of Part 2 of Division
17 6, or regarding a patient who is committed to the department, to a
18 state hospital, or any other public or private mental health facility
19 approved by the county behavioral health director under Section
20 1026 or 1370 of the Penal Code or receiving treatment pursuant
21 to Section 5300 of this code, shall be forwarded immediately
22 without prior request to the Department of Justice. Except as
23 otherwise provided by law, information automatically reported
24 under this section shall be restricted to name, address, fingerprints,
25 date of admission, date of discharge, date of escape or return from
26 escape, date of any home leave, parole or leave of absence and, if
27 known, the county in which the person will reside upon release.
28 The Department of Justice may in turn furnish information reported
29 under this section pursuant to Section 11105 or 11105.1 of the
30 Penal Code. It shall be a misdemeanor for recipients furnished
31 with this information to in turn furnish the information to any
32 person or agency other than those specified in Section 11105 or
33 11105.1 of the Penal Code.

34 ~~SEC. 41.~~

35 *SEC. 29.* Section 5346 of the Welfare and Institutions Code is
36 amended to read:

37 5346. (a) In any county in which services are available as
38 provided in Section 5348, a court may order a person who is the
39 subject of a petition filed pursuant to this section to obtain assisted
40 outpatient treatment if the court finds, by clear and convincing

1 evidence, that the facts stated in the verified petition filed in
2 accordance with this section are true and establish that all of the
3 requisite criteria set forth in this section are met, including, but
4 not limited to, each of the following:

5 (1) The person is 18 years of age or older.

6 (2) The person is suffering from a mental illness as defined in
7 paragraphs (2) and (3) of subdivision (b) of Section 5600.3.

8 (3) There has been a clinical determination that the person is
9 unlikely to survive safely in the community without supervision.

10 (4) The person has a history of lack of compliance with
11 treatment for his or her mental illness, in that at least one of the
12 following is true:

13 (A) The person's mental illness has, at least twice within the
14 last 36 months, been a substantial factor in necessitating
15 hospitalization, or receipt of services in a forensic or other mental
16 health unit of a state correctional facility or local correctional
17 facility, not including any period during which the person was
18 hospitalized or incarcerated immediately preceding the filing of
19 the petition.

20 (B) The person's mental illness has resulted in one or more acts
21 of serious and violent behavior toward himself or herself or
22 another, or threats, or attempts to cause serious physical harm to
23 himself or herself or another within the last 48 months, not
24 including any period in which the person was hospitalized or
25 incarcerated immediately preceding the filing of the petition.

26 (5) The person has been offered an opportunity to participate
27 in a treatment plan by the director of the local mental health
28 department, or his or her designee, provided the treatment plan
29 includes all of the services described in Section 5348, and the
30 person continues to fail to engage in treatment.

31 (6) The person's condition is substantially deteriorating.

32 (7) Participation in the assisted outpatient treatment program
33 would be the least restrictive placement necessary to ensure the
34 person's recovery and stability.

35 (8) In view of the person's treatment history and current
36 behavior, the person is in need of assisted outpatient treatment in
37 order to prevent a relapse or deterioration that would be likely to
38 result in grave disability or serious harm to himself or herself, or
39 to others, as defined in Section 5150.

1 (9) It is likely that the person will benefit from assisted
2 outpatient treatment.

3 (b) (1) A petition for an order authorizing assisted outpatient
4 treatment may be filed by the county behavioral health director,
5 or his or her designee, in the superior court in the county in which
6 the person who is the subject of the petition is present or reasonably
7 believed to be present.

8 (2) A request may be made only by any of the following persons
9 to the county mental health department for the filing of a petition
10 to obtain an order authorizing assisted outpatient treatment:

11 (A) Any person 18 years of age or older with whom the person
12 who is the subject of the petition resides.

13 (B) Any person who is the parent, spouse, or sibling or child
14 18 years of age or older of the person who is the subject of the
15 petition.

16 (C) The director of any public or private agency, treatment
17 facility, charitable organization, or licensed residential care facility
18 providing mental health services to the person who is the subject
19 of the petition in whose institution the subject of the petition
20 resides.

21 (D) The director of a hospital in which the person who is the
22 subject of the petition is hospitalized.

23 (E) A licensed mental health treatment provider who is either
24 supervising the treatment of, or treating for a mental illness, the
25 person who is the subject of the petition.

26 (F) A peace officer, parole officer, or probation officer assigned
27 to supervise the person who is the subject of the petition.

28 (3) Upon receiving a request pursuant to paragraph (2), the
29 county behavioral health director shall conduct an investigation
30 into the appropriateness of the filing of the petition. The director
31 shall file the petition only if he or she determines that there is a
32 reasonable likelihood that all the necessary elements to sustain the
33 petition can be proven in a court of law by clear and convincing
34 evidence.

35 (4) The petition shall state all of the following:

36 (A) Each of the criteria for assisted outpatient treatment as set
37 forth in subdivision (a).

38 (B) Facts that support the petitioner's belief that the person who
39 is the subject of the petition meets each criterion, provided that
40 the hearing on the petition shall be limited to the stated facts in

1 the verified petition, and the petition contains all the grounds on
2 which the petition is based, in order to ensure adequate notice to
3 the person who is the subject of the petition and his or her counsel.

4 (C) That the person who is the subject of the petition is present,
5 or is reasonably believed to be present, within the county where
6 the petition is filed.

7 (D) That the person who is the subject of the petition has the
8 right to be represented by counsel in all stages of the proceeding
9 under the petition, in accordance with subdivision (c).

10 (5) The petition shall be accompanied by an affidavit of a
11 licensed mental health treatment provider designated by the local
12 mental health director who shall state, if applicable, either of the
13 following:

14 (A) That the licensed mental health treatment provider has
15 personally examined the person who is the subject of the petition
16 no more than 10 days prior to the submission of the petition, the
17 facts and reasons why the person who is the subject of the petition
18 meets the criteria in subdivision (a), that the licensed mental health
19 treatment provider recommends assisted outpatient treatment for
20 the person who is the subject of the petition, and that the licensed
21 mental health treatment provider is willing and able to testify at
22 the hearing on the petition.

23 (B) That no more than 10 days prior to the filing of the petition,
24 the licensed mental health treatment provider, or his or her
25 designee, has made appropriate attempts to elicit the cooperation
26 of the person who is the subject of the petition, but has not been
27 successful in persuading that person to submit to an examination,
28 that the licensed mental health treatment provider has reason to
29 believe that the person who is the subject of the petition meets the
30 criteria for assisted outpatient treatment, and that the licensed
31 mental health treatment provider is willing and able to examine
32 the person who is the subject of the petition and testify at the
33 hearing on the petition.

34 (c) The person who is the subject of the petition shall have the
35 right to be represented by counsel at all stages of a proceeding
36 commenced under this section. If the person so elects, the court
37 shall immediately appoint the public defender or other attorney to
38 assist the person in all stages of the proceedings. The person shall
39 pay the cost of the legal services if he or she is able.

1 (d) (1) Upon receipt by the court of a petition submitted
2 pursuant to subdivision (b), the court shall fix the date for a hearing
3 at a time not later than five days from the date the petition is
4 received by the court, excluding Saturdays, Sundays, and holidays.
5 The petitioner shall promptly cause service of a copy of the
6 petition, together with written notice of the hearing date, to be
7 made personally on the person who is the subject of the petition,
8 and shall send a copy of the petition and notice to the county office
9 of patient rights, and to the current health care provider appointed
10 for the person who is the subject of the petition, if any such
11 provider is known to the petitioner. Continuances shall be permitted
12 only for good cause shown. In granting continuances, the court
13 shall consider the need for further examination by a physician or
14 the potential need to provide expeditiously assisted outpatient
15 treatment. Upon the hearing date, or upon any other date or dates
16 to which the proceeding may be continued, the court shall hear
17 testimony. If it is deemed advisable by the court, and if the person
18 who is the subject of the petition is available and has received
19 notice pursuant to this section, the court may examine in or out of
20 court the person who is the subject of the petition who is alleged
21 to be in need of assisted outpatient treatment. If the person who is
22 the subject of the petition does not appear at the hearing, and
23 appropriate attempts to elicit the attendance of the person have
24 failed, the court may conduct the hearing in the person's absence.
25 If the hearing is conducted without the person present, the court
26 shall set forth the factual basis for conducting the hearing without
27 the person's presence.

28 (2) The court shall not order assisted outpatient treatment unless
29 an examining licensed mental health treatment provider, who has
30 personally examined, and has reviewed the available treatment
31 history of, the person who is the subject of the petition within the
32 time period commencing 10 days before the filing of the petition,
33 testifies in person at the hearing.

34 (3) If the person who is the subject of the petition has refused
35 to be examined by a licensed mental health treatment provider,
36 the court may request that the person consent to an examination
37 by a licensed mental health treatment provider appointed by the
38 court. If the person who is the subject of the petition does not
39 consent and the court finds reasonable cause to believe that the
40 allegations in the petition are true, the court may order any person

1 designated under Section 5150 to take into custody the person who
2 is the subject of the petition and transport him or her, or cause him
3 or her to be transported, to a hospital for examination by a licensed
4 mental health treatment provider as soon as is practicable.
5 Detention of the person who is the subject of the petition under
6 the order may not exceed 72 hours. If the examination is performed
7 by another licensed mental health treatment provider, the
8 examining licensed mental health treatment provider may consult
9 with the licensed mental health treatment provider whose
10 affirmation or affidavit accompanied the petition regarding the
11 issues of whether the allegations in the petition are true and whether
12 the person meets the criteria for assisted outpatient treatment.

13 (4) The person who is the subject of the petition shall have all
14 of the following rights:

15 (A) To adequate notice of the hearings to the person who is the
16 subject of the petition, as well as to parties designated by the person
17 who is the subject of the petition.

18 (B) To receive a copy of the court-ordered evaluation.

19 (C) To counsel. If the person has not retained counsel, the court
20 shall appoint a public defender.

21 (D) To be informed of his or her right to judicial review by
22 habeas corpus.

23 (E) To be present at the hearing unless he or she waives the
24 right to be present.

25 (F) To present evidence.

26 (G) To call witnesses on his or her behalf.

27 (H) To cross-examine witnesses.

28 (I) To appeal decisions, and to be informed of his or her right
29 to appeal.

30 (5) (A) If after hearing all relevant evidence, the court finds
31 that the person who is the subject of the petition does not meet the
32 criteria for assisted outpatient treatment, the court shall dismiss
33 the petition.

34 (B) If after hearing all relevant evidence, the court finds that
35 the person who is the subject of the petition meets the criteria for
36 assisted outpatient treatment, and there is no appropriate and
37 feasible less restrictive alternative, the court may order the person
38 who is the subject of the petition to receive assisted outpatient
39 treatment for an initial period not to exceed six months. In
40 fashioning the order, the court shall specify that the proposed

1 treatment is the least restrictive treatment appropriate and feasible
2 for the person who is the subject of the petition. The order shall
3 state the categories of assisted outpatient treatment, as set forth in
4 Section 5348, that the person who is the subject of the petition is
5 to receive, and the court may not order treatment that has not been
6 recommended by the examining licensed mental health treatment
7 provider and included in the written treatment plan for assisted
8 outpatient treatment as required by subdivision (e). If the person
9 has executed an advance health care directive pursuant to Chapter
10 2 (commencing with Section 4650) of Part 1 of Division 4.7 of
11 the Probate Code, any directions included in the advance health
12 care directive shall be considered in formulating the written
13 treatment plan.

14 (6) If the person who is the subject of a petition for an order for
15 assisted outpatient treatment pursuant to subparagraph (B) of
16 paragraph (5) of subdivision (d) refuses to participate in the assisted
17 outpatient treatment program, the court may order the person to
18 meet with the assisted outpatient treatment team designated by the
19 director of the assisted outpatient treatment program. The treatment
20 team shall attempt to gain the person's cooperation with treatment
21 ordered by the court. The person may be subject to a 72-hour hold
22 pursuant to subdivision (f) only after the treatment team has
23 attempted to gain the person's cooperation with treatment ordered
24 by the court, and has been unable to do so.

25 (e) Assisted outpatient treatment shall not be ordered unless the
26 licensed mental health treatment provider recommending assisted
27 outpatient treatment to the court has submitted to the court a written
28 treatment plan that includes services as set forth in Section 5348,
29 and the court finds, in consultation with the county behavioral
30 health director, or his or her designee, all of the following:

31 (1) That the services are available from the county, or a provider
32 approved by the county, for the duration of the court order.

33 (2) That the services have been offered to the person by the
34 local director of mental health, or his or her designee, and the
35 person has been given an opportunity to participate on a voluntary
36 basis, and the person has failed to engage in, or has refused,
37 treatment.

38 (3) That all of the elements of the petition required by this article
39 have been met.

1 (4) That the treatment plan will be delivered to the county
2 behavioral health director, or to his or her appropriate designee.

3 (f) If, in the clinical judgment of a licensed mental health
4 treatment provider, the person who is the subject of the petition
5 has failed or has refused to comply with the treatment ordered by
6 the court, and, in the clinical judgment of the licensed mental health
7 treatment provider, efforts were made to solicit compliance, and,
8 in the clinical judgment of the licensed mental health treatment
9 provider, the person may be in need of involuntary admission to
10 a hospital for evaluation, the provider may request that persons
11 designated under Section 5150 take into custody the person who
12 is the subject of the petition and transport him or her, or cause him
13 or her to be transported, to a hospital, to be held up to 72 hours for
14 examination by a licensed mental health treatment provider to
15 determine if the person is in need of treatment pursuant to Section
16 5150. Any continued involuntary retention in a hospital beyond
17 the initial 72-hour period shall be pursuant to Section 5150. If at
18 any time during the 72-hour period the person is determined not
19 to meet the criteria of Section 5150, and does not agree to stay in
20 the hospital as a voluntary patient, he or she shall be released and
21 any subsequent involuntary detention in a hospital shall be pursuant
22 to Section 5150. Failure to comply with an order of assisted
23 outpatient treatment alone may not be grounds for involuntary
24 civil commitment or a finding that the person who is the subject
25 of the petition is in contempt of court.

26 (g) If the director of the assisted outpatient treatment program
27 determines that the condition of the patient requires further assisted
28 outpatient treatment, the director shall apply to the court, prior to
29 the expiration of the period of the initial assisted outpatient
30 treatment order, for an order authorizing continued assisted
31 outpatient treatment for a period not to exceed 180 days from the
32 date of the order. The procedures for obtaining any order pursuant
33 to this subdivision shall be in accordance with subdivisions (a) to
34 (f), inclusive. The period for further involuntary outpatient
35 treatment authorized by any subsequent order under this
36 subdivision may not exceed 180 days from the date of the order.

37 (h) At intervals of not less than 60 days during an assisted
38 outpatient treatment order, the director of the outpatient treatment
39 program shall file an affidavit with the court that ordered the
40 outpatient treatment affirming that the person who is the subject

1 of the order continues to meet the criteria for assisted outpatient
2 treatment. At these times, the person who is the subject of the order
3 shall have the right to a hearing on whether or not he or she still
4 meets the criteria for assisted outpatient treatment if he or she
5 disagrees with the director's affidavit. The burden of proof shall
6 be on the director.

7 (i) During each 60-day period specified in subdivision (h), if
8 the person who is the subject of the order believes that he or she
9 is being wrongfully retained in the assisted outpatient treatment
10 program against his or her wishes, he or she may file a petition for
11 a writ of habeas corpus, thus requiring the director of the assisted
12 outpatient treatment program to prove that the person who is the
13 subject of the order continues to meet the criteria for assisted
14 outpatient treatment.

15 (j) Any person ordered to undergo assisted outpatient treatment
16 pursuant to this article, who was not present at the hearing at which
17 the order was issued, may immediately petition the court for a writ
18 of habeas corpus. Treatment under the order for assisted outpatient
19 treatment may not commence until the resolution of that petition.

20 ~~SEC. 42.~~

21 *SEC. 30.* Section 5400 of the Welfare and Institutions Code is
22 amended to read:

23 5400. (a) The Director of Health Care Services shall administer
24 this part and shall adopt rules, regulations, and standards as
25 necessary. In developing rules, regulations, and standards, the
26 Director of Health Care Services shall consult with the County
27 Behavioral Health Directors Association of California, the
28 California Mental Health Planning Council, and the office of the
29 Attorney General. Adoption of these standards, rules, and
30 regulations shall require approval by the County Behavioral Health
31 Directors Association of California by majority vote of those
32 present at an official session.

33 (b) Wherever feasible and appropriate, rules, regulations, and
34 standards adopted under this part shall correspond to comparable
35 rules, regulations, and standards adopted under the
36 Bronzan-McCorquodale Act. These corresponding rules,
37 regulations, and standards shall include qualifications for
38 professional personnel.

39 (c) Regulations adopted pursuant to this part may provide
40 standards for services for persons with chronic alcoholism that

1 differ from the standards for services for persons with mental health
2 disorders.

3 ~~SEC. 43.~~

4 *SEC. 31.* Section 5585.22 of the Welfare and Institutions Code
5 is amended to read:

6 5585.22. The Director of Health Care Services, in consultation
7 with the County Behavioral Health Directors Association of
8 California, may develop the appropriate educational materials and
9 a training curriculum, and may provide training as necessary to
10 ensure that those persons providing services pursuant to this part
11 fully understand its purpose.

12 ~~SEC. 44.~~

13 *SEC. 32.* Section 5601 of the Welfare and Institutions Code is
14 amended to read:

15 5601. As used in this part:

16 (a) “Governing body” means the county board of supervisors
17 or boards of supervisors in the case of counties acting jointly; and
18 in the case of a city, the city council or city councils acting jointly.

19 (b) “Conference” means the County Behavioral Health Directors
20 Association of California as established under former Section
21 5757.

22 (c) Unless the context requires otherwise, “to the extent
23 resources are available” means to the extent that funds deposited
24 in the mental health account of the local health and welfare fund
25 are available to an entity qualified to use those funds.

26 (d) “Part 1” refers to the Lanterman-Petris-Short Act (Part 1
27 commencing with Section 5000).

28 (e) “Director of Health Care Services” or “director” means the
29 Director of the State Department of Health Care Services.

30 (f) “Institution” includes a general acute care hospital, a state
31 hospital, a psychiatric hospital, a psychiatric health facility, a
32 skilled nursing facility, including an institution for mental disease
33 as described in Chapter 1 (commencing with Section 5900) of Part
34 5, an intermediate care facility, a community care facility or other
35 residential treatment facility, or a juvenile or criminal justice
36 institution.

37 (g) “Mental health service” means any service directed toward
38 early intervention in, or alleviation or prevention of, mental
39 disorder, including, but not limited to, diagnosis, evaluation,
40 treatment, personal care, day care, respite care, special living

1 arrangements, community skill training, sheltered employment,
2 socialization, case management, transportation, information,
3 referral, consultation, and community services.

4 ~~SEC. 45.~~

5 *SEC. 33.* Section 5611 of the Welfare and Institutions Code is
6 amended to read:

7 5611. (a) The Director of State Hospitals shall establish a
8 Performance Outcome Committee, to be comprised of
9 representatives from the Public Law 99-660 Planning Council and
10 the County Behavioral Health Directors Association of California.
11 Any costs associated with the performance of the duties of the
12 committee shall be absorbed within the resources of the
13 participants.

14 (b) Major mental health professional organizations representing
15 licensed clinicians may participate as members of the committee
16 at their own expense.

17 (c) The committee may seek private funding for costs associated
18 with the performance of its duties.

19 ~~SEC. 46.~~

20 *SEC. 34.* Section 5664 of the Welfare and Institutions Code is
21 amended to read:

22 5664. In consultation with the County Behavioral Health
23 Directors Association of California, the State Department of Health
24 Care Services, the Mental Health Services Oversight and
25 Accountability Commission, the California Mental Health Planning
26 Council, and the California Health and Human Services Agency,
27 county behavioral health systems shall provide reports and data
28 to meet the information needs of the state, as necessary.

29 ~~SEC. 47.~~

30 *SEC. 35.* Section 5694.7 of the Welfare and Institutions Code
31 is amended to read:

32 5694.7. When the director of behavioral health in a county is
33 notified pursuant to Section 319.1 or 635.1, or Section 7572.5 of
34 the Government Code about a specific case, the county behavioral
35 health director shall assign the responsibility either directly or
36 through contract with a private provider, to review the information
37 and assess whether or not the child is seriously emotionally
38 disturbed as well as to determine the level of involvement in the
39 case needed to assure access to appropriate mental health treatment
40 services and whether appropriate treatment is available through

1 the minor's own resources, those of the family or another private
2 party, including a third-party payer, or through another agency,
3 and to ensure access to services available within the county's
4 program. This determination shall be submitted in writing to the
5 notifying agency within 30 days. If in the course of evaluating the
6 minor, the county behavioral health director determines that the
7 minor may be dangerous, the county behavioral health director
8 may request the court to direct counsel not to reveal information
9 to the minor relating to the name and address of the person who
10 prepared the subject report. If appropriate treatment is not available
11 within the county's Bronzan-McCorquodale program, nothing in
12 this section shall prevent the court from ordering treatment directly
13 or through a family's private resources.

14 ~~SEC. 48:~~

15 *SEC. 36.* Section 5701.1 of the Welfare and Institutions Code
16 is amended to read:

17 5701.1. Notwithstanding Section 5701, the State Department
18 of Health Care Services, in consultation with the County Behavioral
19 Health Directors Association of California and the California
20 Mental Health Planning Council, may utilize funding from the
21 Substance Abuse and Mental Health Services Administration Block
22 Grant, awarded to the State Department of Health Care Services,
23 above the funding level provided in federal fiscal year 1998, for
24 the development of innovative programs for identified target
25 populations, upon appropriation by the Legislature.

26 ~~SEC. 49:~~

27 *SEC. 37.* Section 5701.2 of the Welfare and Institutions Code
28 is amended to read:

29 5701.2. (a) The State Department of Mental Health, or its
30 successor, the State Department of State Hospitals, shall maintain
31 records of any transfer of funds or state hospital beds made
32 pursuant to Chapter 1341 of the Statutes of 1991.

33 (b) Commencing with the 1991-92 fiscal year, the State
34 Department of Mental Health, or its successor, the State
35 Department of State Hospitals, shall maintain records that set forth
36 that portion of each county's allocation of state mental health
37 moneys that represent the dollar equivalent attributed to each
38 county's state hospital beds or bed days, or both, that were
39 allocated as of May 1, 1991. The State Department of Mental
40 Health, or its successor, the State Department of State Hospitals,

1 shall provide a written summary of these records to the appropriate
2 committees of the Legislature and the County Behavioral Health
3 Directors Association of California within 30 days after the
4 enactment of the annual Budget Act.

5 (c) Nothing in this section is intended to change the counties'
6 base allocations as provided in subdivisions (a) and (b) of Section
7 17601.

8 ~~SEC. 50.~~

9 *SEC. 38.* Section 5717 of the Welfare and Institutions Code is
10 amended to read:

11 5717. (a) Expenditures that may be funded from amounts
12 allocated to the county by the State Department of Health Care
13 Services from funds appropriated to the department shall include,
14 salaries of personnel, approved facilities and services provided
15 through contract, and operation, maintenance, and service costs,
16 including insurance costs or departmental charges for participation
17 in a county self-insurance program if the charges are not in excess
18 of comparable available commercial insurance premiums and on
19 the condition that any surplus reserves be used to reduce future
20 year contributions; depreciation of county facilities as established
21 in the state's uniform accounting manual, disregarding depreciation
22 on the facility to the extent it was financed by state funds under
23 this part; lease of facilities where there is no intention to, nor option
24 to, purchase; expenses incurred under this act by members of the
25 County Behavioral Health Directors Association of California for
26 attendance at regular meetings of these conferences; expenses
27 incurred by either the chairperson or elected representative of the
28 local mental health advisory boards for attendance at regular
29 meetings of the organization of mental health advisory boards;
30 expenditures included in approved countywide cost allocation
31 plans submitted in accordance with the Controller's guidelines,
32 including, but not limited to, adjustments of prior year estimated
33 general county overhead to actual costs, but excluding allowable
34 costs otherwise compensated by state funding; net costs of
35 conservatorship investigation, approved by the Director of Health
36 Care Services. Except for expenditures made pursuant to Article
37 6 (commencing with Section 129225) of Chapter 1 of Part 6 of
38 Division 107 of the Health and Safety Code, it shall not include
39 expenditures for initial capital improvements; the purchaser or
40 construction of buildings except for equipment items and

1 remodeling expense as may be provided for in regulations of the
2 State Department of Health Care Services; compensation to
3 members of a local mental health advisory board, except actual
4 and necessary expenses incurred in the performance of official
5 duties that may include travel, lodging, and meals while on official
6 business; or expenditures for a purpose for which state
7 reimbursement is claimed under any other provision of law.

8 (b) The Director of Health Care Services may make
9 investigations and audits of expenditures the director may deem
10 necessary.

11 (c) With respect to funds allocated to a county by the State
12 Department of Health Care Services from funds appropriated to
13 the department, the county shall repay to the state amounts found
14 not to have been expended in accordance with the requirements
15 set forth in this part. Repayment shall be within 30 days after it is
16 determined that an expenditure has been made that is not in
17 accordance with the requirements. In the event that repayment is
18 not made in a timely manner, the department shall offset any
19 amount improperly expended against the amount of any current
20 or future advance payment or cost report settlement from the state
21 for mental health services. Repayment provisions shall not apply
22 to Short-Doyle funds allocated by the department for fiscal years
23 up to and including the 1990–91 fiscal year.

24 ~~SEC. 51.~~

25 *SEC. 39.* Section 5750 of the Welfare and Institutions Code is
26 amended to read:

27 5750. The State Department of Health Care Services shall
28 administer this part and shall adopt standards for the approval of
29 mental health services, and rules and regulations necessary thereto.
30 However, these standards, rules, and regulations shall be adopted
31 only after consultation with the County Behavioral Health Directors
32 Association of California and the California Mental Health
33 Planning Council.

34 ~~SEC. 52.~~

35 *SEC. 40.* Section 5814.5 of the Welfare and Institutions Code
36 is amended to read:

37 5814.5. (a) (1) In any year in which funds are appropriated
38 for this purpose through the annual Budget Act, counties funded
39 under this part in the 1999–2000 fiscal year are eligible for funding
40 to continue their programs if they have successfully demonstrated

1 the effectiveness of their grants received in that year and to expand
2 their programs if they also demonstrate significant continued unmet
3 need and capacity for expansion without compromising quality or
4 effectiveness of care.

5 (2) In any year in which funds are appropriated for this purpose
6 through the annual Budget Act, other counties or portions of
7 counties, or cities that operate independent public mental health
8 programs pursuant to Section 5615 of the Welfare and Institutions
9 Code, are eligible for funding to establish programs if a county or
10 eligible city demonstrates that it can provide comprehensive
11 services, as set forth in this part, to a substantial number of adults
12 who are severely mentally ill, as defined in Section 5600.3, and
13 are homeless or recently released from the county jail or who are
14 untreated, unstable, and at significant risk of incarceration or
15 homelessness unless treatment is provided.

16 (b) (1) Counties eligible for funding pursuant to subdivision
17 (a) shall be those that have or can develop integrated adult service
18 programs that meet the criteria for an adult system of care, as set
19 forth in Section 5806, and that have, or can develop, integrated
20 forensic programs with similar characteristics for parolees and
21 those recently released from county jail who meet the target
22 population requirements of Section 5600.3 and are at risk of
23 incarceration unless the services are provided. Before a city or
24 county submits a proposal to the state to establish or expand a
25 program, the proposal shall be reviewed by a local advisory
26 committee or mental health board, which may be an existing body,
27 that includes clients, family members, private providers of services,
28 and other relevant stakeholders. Local enrollment for integrated
29 adult service programs and for integrated forensic programs funded
30 pursuant to subdivision (a) shall adhere to all conditions set forth
31 by the department, including the total number of clients to be
32 enrolled, the providers to which clients are enrolled and the
33 maximum cost for each provider, the maximum number of clients
34 to be served at any one time, the outreach and screening process
35 used to identify enrollees, and the total cost of the program. Local
36 enrollment of each individual for integrated forensic programs
37 shall be subject to the approval of the county behavioral health
38 director or his or her designee.

39 (2) Each county shall ensure that funds provided by these grants
40 are used to expand existing integrated service programs that meet

1 the criteria of the adult system of care to provide new services in
2 accordance with the purpose for which they were appropriated and
3 allocated, and that none of these funds shall be used to supplant
4 existing services to severely mentally ill adults. In order to ensure
5 that this requirement is met, the department shall develop methods
6 and contractual requirements, as it determines necessary. At a
7 minimum, these assurances shall include that state and federal
8 requirements regarding tracking of funds are met and that patient
9 records are maintained in a manner that protects privacy and
10 confidentiality, as required under federal and state law.

11 (c) Each county selected to receive a grant pursuant to this
12 section shall provide data as the department may require, that
13 demonstrates the outcomes of the adult system of care programs,
14 shall specify the additional numbers of severely mentally ill adults
15 to whom they will provide comprehensive services for each million
16 dollars of additional funding that may be awarded through either
17 an integrated adult service grant or an integrated forensic grant,
18 and shall agree to provide services in accordance with Section
19 5806. Each county's plan shall identify and include sufficient
20 funding to provide housing for the individuals to be served, and
21 shall ensure that any hospitalization of individuals participating
22 in the program are coordinated with the provision of other mental
23 health services provided under the program.

24 ~~SEC. 53.— Section 5845 of the Welfare and Institutions Code is~~
25 ~~amended to read:~~

26 ~~5845.— (a) The Mental Health Services Oversight and~~
27 ~~Accountability Commission is hereby established to oversee Part~~
28 ~~3 (commencing with Section 5800), the Adult and Older Adult~~
29 ~~Mental Health System of Care Act; Part 3.1 (commencing with~~
30 ~~Section 5820), Human Resources, Education, and Training~~
31 ~~Programs; Part 3.2 (commencing with Section 5830), Innovative~~
32 ~~Programs; Part 3.6 (commencing with Section 5840), Prevention~~
33 ~~and Early Intervention Programs; and Part 4 (commencing with~~
34 ~~Section 5850), the Children's Mental Health Services Act. The~~
35 ~~commission shall replace the advisory committee established~~
36 ~~pursuant to Section 5814. The commission shall consist of 16~~
37 ~~voting members as follows:~~

38 (1) ~~The Attorney General or his or her designee.~~

39 (2) ~~The Superintendent of Public Instruction or his or her~~
40 ~~designee.~~

1 ~~(3) The Chairperson of the Senate Health and Human Services~~
2 ~~Committee or another Member of the Senate selected by the~~
3 ~~President pro Tempore of the Senate.~~

4 ~~(4) The Chairperson of the Assembly Health Committee or~~
5 ~~another member of the Assembly selected by the Speaker of the~~
6 ~~Assembly.~~

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

19 ~~(b) Members shall serve without compensation, but shall be~~
20 ~~reimbursed for all actual and necessary expenses incurred in the~~
21 ~~performance of their duties.~~

22 ~~(c) The term of each member shall be three years, to be~~
23 ~~staggered so that approximately one-third of the appointments~~
24 ~~expire in each year.~~

25 ~~(d) In carrying out its duties and responsibilities, the commission~~
26 ~~may do all of the following:~~

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

30 ~~(2) Within the limit of funds allocated for these purposes,~~
31 ~~pursuant to the laws and regulations governing state civil service,~~
32 ~~employ staff, including any clerical, legal, and technical assistance~~
33 ~~as may appear necessary. The commission shall administer its~~
34 ~~operations separate and apart from the State Department of Health~~
35 ~~Care Services and the California Health and Human Services~~
36 ~~Agency.~~

37 ~~(3) Establish technical advisory committees, such as a committee~~
38 ~~of consumers and family members.~~

39 ~~(4) Employ all other appropriate strategies necessary or~~
40 ~~convenient to enable it to fully and adequately perform its duties~~

1 and exercise the powers expressly granted, notwithstanding any
2 authority expressly granted to any officer or employee of state
3 government.

4 (5) Enter into contracts.

5 (6) Obtain data and information from the State Department of
6 Health Care Services, the Office of Statewide Health Planning and
7 Development, or other state or local entities that receive Mental
8 Health Services Act funds, for the commission to utilize in its
9 oversight, review, training and technical assistance, accountability,
10 and evaluation capacity regarding projects and programs supported
11 with Mental Health Services Act funds.

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

16 (8) Develop strategies to overcome stigma and discrimination,
17 and accomplish all other objectives of Part 3.2 (commencing with
18 Section 5830), Part 3.6 (commencing with Section 5840), and the
19 other provisions of the act establishing this commission.

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

23 (10) If the commission identifies a critical issue related to the
24 performance of a county mental health program, it may refer the
25 issue to the State Department of Health Care Services pursuant to
26 Section 5655.

27 (11) Assist in providing technical assistance to accomplish the
28 purposes of the Mental Health Services Act, Part 3 (commencing
29 with Section 5800) and Part 4 (commencing with Section 5850)
30 in collaboration with the State Department of Health Care Services
31 and in consultation with the County Behavioral Health Directors
32 Association of California.

33 (12) Work in collaboration with the State Department of Health
34 Care Services and the California Mental Health Planning Council,
35 and in consultation with the County Behavioral Health Directors
36 Association of California, in designing a comprehensive joint plan
37 for a coordinated evaluation of client outcomes in the
38 community-based mental health system, including, but not limited
39 to, parts listed in subdivision (a). The California Health and Human
40 Services Agency shall lead this comprehensive joint plan effort.

1 ~~SEC. 54.~~

2 *SEC. 41.* Section 5847 of the Welfare and Institutions Code is
3 amended to read:

4 5847. Integrated Plans for Prevention, Innovation, and System
5 of Care Services.

6 (a) Each county mental health program shall prepare and submit
7 a three-year program and expenditure plan, and annual updates,
8 adopted by the county board of supervisors, to the Mental Health
9 Services Oversight and Accountability Commission within 30 days
10 after adoption.

11 (b) The three-year program and expenditure plan shall be based
12 on available unspent funds and estimated revenue allocations
13 provided by the state and in accordance with established
14 stakeholder engagement and planning requirements as required in
15 Section 5848. The three-year program and expenditure plan and
16 annual updates shall include all of the following:

17 (1) A program for prevention and early intervention in
18 accordance with Part 3.6 (commencing with Section 5840).

19 (2) A program for services to children in accordance with Part
20 4 (commencing with Section 5850), to include a program pursuant
21 to Chapter 4 (commencing with Section 18250) of Part 6 of
22 Division 9 or provide substantial evidence that it is not feasible to
23 establish a wraparound program in that county.

24 (3) A program for services to adults and seniors in accordance
25 with Part 3 (commencing with Section 5800).

26 (4) A program for innovations in accordance with Part 3.2
27 (commencing with Section 5830).

28 (5) A program for technological needs and capital facilities
29 needed to provide services pursuant to Part 3 (commencing with
30 Section 5800), Part 3.6 (commencing with Section 5840), and Part
31 4 (commencing with Section 5850). All plans for proposed facilities
32 with restrictive settings shall demonstrate that the needs of the
33 people to be served cannot be met in a less restrictive or more
34 integrated setting.

35 (6) Identification of shortages in personnel to provide services
36 pursuant to the above programs and the additional assistance
37 needed from the education and training programs established
38 pursuant to Part 3.1 (commencing with Section 5820).

39 (7) Establishment and maintenance of a prudent reserve to
40 ensure the county program will continue to be able to serve

1 children, adults, and seniors that it is currently serving pursuant
2 to Part 3 (commencing with Section 5800), the Adult and Older
3 Adult Mental Health System of Care Act, Part 3.6 (commencing
4 with Section 5840), Prevention and Early Intervention Programs,
5 and Part 4 (commencing with Section 5850), the Children's Mental
6 Health Services Act, during years in which revenues for the Mental
7 Health Services Fund are below recent averages adjusted by
8 changes in the state population and the California Consumer Price
9 Index.

10 (8) Certification by the county behavioral health director, which
11 ensures that the county has complied with all pertinent regulations,
12 laws, and statutes of the Mental Health Services Act, including
13 stakeholder participation and nonsupplantation requirements.

14 (9) Certification by the county behavioral health director and
15 by the county auditor-controller that the county has complied with
16 any fiscal accountability requirements as directed by the State
17 Department of Health Care Services, and that all expenditures are
18 consistent with the requirements of the Mental Health Services
19 Act.

20 (c) The programs established pursuant to paragraphs (2) and
21 (3) of subdivision (b) shall include services to address the needs
22 of transition age youth 16 to 25 years of age. In implementing this
23 subdivision, county mental health programs shall consider the
24 needs of transition age foster youth.

25 (d) Each year, the State Department of Health Care Services
26 shall inform the County Behavioral Health Directors Association
27 of California and the Mental Health Services Oversight and
28 Accountability Commission of the methodology used for revenue
29 allocation to the counties.

30 (e) Each county mental health program shall prepare expenditure
31 plans pursuant to Part 3 (commencing with Section 5800) for adults
32 and seniors, Part 3.2 (commencing with Section 5830) for
33 innovative programs, Part 3.6 (commencing with Section 5840)
34 for prevention and early intervention programs, and Part 4
35 (commencing with Section 5850) for services for children, and
36 updates to the plans developed pursuant to this section. Each
37 expenditure update shall indicate the number of children, adults,
38 and seniors to be served pursuant to Part 3 (commencing with
39 Section 5800), and Part 4 (commencing with Section 5850), and
40 the cost per person. The expenditure update shall include utilization

1 of unspent funds allocated in the previous year and the proposed
2 expenditure for the same purpose.

3 (f) A county mental health program shall include an allocation
4 of funds from a reserve established pursuant to paragraph (7) of
5 subdivision (b) for services pursuant to paragraphs (2) and (3) of
6 subdivision (b) in years in which the allocation of funds for services
7 pursuant to subdivision (e) are not adequate to continue to serve
8 the same number of individuals as the county had been serving in
9 the previous fiscal year.

10 ~~SEC. 55.~~

11 *SEC. 42.* Section 5848 of the Welfare and Institutions Code is
12 amended to read:

13 5848. (a) Each three-year program and expenditure plan and
14 update shall be developed with local stakeholders, including adults
15 and seniors with severe mental illness, families of children, adults,
16 and seniors with severe mental illness, providers of services, law
17 enforcement agencies, education, social services agencies, veterans,
18 representatives from veterans organizations, providers of alcohol
19 and drug services, health care organizations, and other important
20 interests. Counties shall demonstrate a partnership with constituents
21 and stakeholders throughout the process that includes meaningful
22 stakeholder involvement on mental health policy, program
23 planning, and implementation, monitoring, quality improvement,
24 evaluation, and budget allocations. A draft plan and update shall
25 be prepared and circulated for review and comment for at least 30
26 days to representatives of stakeholder interests and any interested
27 party who has requested a copy of the draft plans.

28 (b) The mental health board established pursuant to Section
29 5604 shall conduct a public hearing on the draft three-year program
30 and expenditure plan and annual updates at the close of the 30-day
31 comment period required by subdivision (a). Each adopted
32 three-year program and expenditure plan and update shall include
33 any substantive written recommendations for revisions. The
34 adopted three-year program and expenditure plan or update shall
35 summarize and analyze the recommended revisions. The mental
36 health board shall review the adopted plan or update and make
37 recommendations to the county mental health department for
38 revisions.

39 (c) The plans shall include reports on the achievement of
40 performance outcomes for services pursuant to Part 3 (commencing

1 with Section 5800), Part 3.6 (commencing with Section 5840),
2 and Part 4 (commencing with Section 5850) funded by the Mental
3 Health Services Fund and established jointly by the State
4 Department of Health Care Services and the Mental Health Services
5 Oversight and Accountability Commission, in collaboration with
6 the County Behavioral Health Directors Association of California.

7 (d) Mental health services provided pursuant to Part 3
8 (commencing with Section 5800) and Part 4 (commencing with
9 Section 5850) shall be included in the review of program
10 performance by the California Mental Health Planning Council
11 required by paragraph (2) of subdivision (c) of Section 5772 and
12 in the local mental health board's review and comment on the
13 performance outcome data required by paragraph (7) of subdivision
14 (a) of Section 5604.2.

15 ~~SEC. 56.~~

16 *SEC. 43.* Section 5848.5 of the Welfare and Institutions Code
17 is amended to read:

18 5848.5. (a) The Legislature finds and declares all of the
19 following:

20 (1) California has realigned public community mental health
21 services to counties and it is imperative that sufficient
22 community-based resources be available to meet the mental health
23 needs of eligible individuals.

24 (2) Increasing access to effective outpatient and crisis
25 stabilization services provides an opportunity to reduce costs
26 associated with expensive inpatient and emergency room care and
27 to better meet the needs of individuals with mental health disorders
28 in the least restrictive manner possible.

29 (3) Almost one-fifth of people with mental health disorders visit
30 a hospital emergency room at least once per year. If an adequate
31 array of crisis services is not available, it leaves an individual with
32 little choice but to access an emergency room for assistance and,
33 potentially, an unnecessary inpatient hospitalization.

34 (4) Recent reports have called attention to a continuing problem
35 of inappropriate and unnecessary utilization of hospital emergency
36 rooms in California due to limited community-based services for
37 individuals in psychological distress and acute psychiatric crisis.
38 Hospitals report that 70 percent of people taken to emergency
39 rooms for psychiatric evaluation can be stabilized and transferred
40 to a less intensive level of crisis care. Law enforcement personnel

1 report that their personnel need to stay with people in the
2 emergency room waiting area until a placement is found, and that
3 less intensive levels of care tend not to be available.

4 (5) Comprehensive public and private partnerships at both local
5 and regional levels, including across physical health services,
6 mental health, substance use disorder, law enforcement, social
7 services, and related supports, are necessary to develop and
8 maintain high quality, patient-centered, and cost-effective care for
9 individuals with mental health disorders that facilitates their
10 recovery and leads towards wellness.

11 (6) The recovery of individuals with mental health disorders is
12 important for all levels of government, business, and the local
13 community.

14 (b) This section shall be known, and may be cited, as the
15 Investment in Mental Health Wellness Act of 2013. The objectives
16 of this section are to do all of the following:

17 (1) Expand access to early intervention and treatment services
18 to improve the client experience, achieve recovery and wellness,
19 and reduce costs.

20 (2) Expand the continuum of services to address crisis
21 intervention, crisis stabilization, and crisis residential treatment
22 needs that are wellness, resiliency, and recovery oriented.

23 (3) Add at least 25 mobile crisis support teams and at least 2,000
24 crisis stabilization and crisis residential treatment beds to bolster
25 capacity at the local level to improve access to mental health crisis
26 services and address unmet mental health care needs.

27 (4) Add at least 600 triage personnel to provide intensive case
28 management and linkage to services for individuals with mental
29 health care disorders at various points of access, such as at
30 designated community-based service points, homeless shelters,
31 and clinics.

32 (5) Reduce unnecessary hospitalizations and inpatient days by
33 appropriately utilizing community-based services and improving
34 access to timely assistance.

35 (6) Reduce recidivism and mitigate unnecessary expenditures
36 of local law enforcement.

37 (7) Provide local communities with increased financial resources
38 to leverage additional public and private funding sources to achieve
39 improved networks of care for individuals with mental health
40 disorders.

1 (c) Through appropriations provided in the annual Budget Act
2 for this purpose, it is the intent of the Legislature to authorize the
3 California Health Facilities Financing Authority, hereafter referred
4 to as the authority, and the Mental Health Services Oversight and
5 Accountability Commission, hereafter referred to as the
6 commission, to administer competitive selection processes as
7 provided in this section for capital capacity and program expansion
8 to increase capacity for mobile crisis support, crisis intervention,
9 crisis stabilization services, crisis residential treatment, and
10 specified personnel resources.

11 (d) Funds appropriated by the Legislature to the authority for
12 purposes of this section shall be made available to selected
13 counties, or counties acting jointly. The authority may, at its
14 discretion, also give consideration to private nonprofit corporations
15 and public agencies in an area or region of the state if a county, or
16 counties acting jointly, affirmatively supports this designation and
17 collaboration in lieu of a county government directly receiving
18 grant funds.

19 (1) Grant awards made by the authority shall be used to expand
20 local resources for the development, capital, equipment acquisition,
21 and applicable program startup or expansion costs to increase
22 capacity for client assistance and services in the following areas:

23 (A) Crisis intervention, as authorized by Sections 14021.4,
24 14680, and 14684.

25 (B) Crisis stabilization, as authorized by Sections 14021.4,
26 14680, and 14684.

27 (C) Crisis residential treatment, as authorized by Sections
28 14021.4, 14680, and 14684.

29 (D) Rehabilitative mental health services, as authorized by
30 Sections 14021.4, 14680, and 14684.

31 (E) Mobile crisis support teams, including personnel and
32 equipment, such as the purchase of vehicles.

33 (2) The authority shall develop selection criteria to expand local
34 resources, including those described in paragraph (1), and processes
35 for awarding grants after consulting with representatives and
36 interested stakeholders from the mental health community,
37 including, but not limited to, the County Behavioral Health
38 Directors Association of California, service providers, consumer
39 organizations, and other appropriate interests, such as health care
40 providers and law enforcement, as determined by the authority.

1 The authority shall ensure that grants result in cost-effective
2 expansion of the number of community-based crisis resources in
3 regions and communities selected for funding. The authority shall
4 also take into account at least the following criteria and factors
5 when selecting recipients of grants and determining the amount
6 of grant awards:

7 (A) Description of need, including, at a minimum, a
8 comprehensive description of the project, community need,
9 population to be served, linkage with other public systems of health
10 and mental health care, linkage with local law enforcement, social
11 services, and related assistance, as applicable, and a description
12 of the request for funding.

13 (B) Ability to serve the target population, which includes
14 individuals eligible for Medi-Cal and individuals eligible for county
15 health and mental health services.

16 (C) Geographic areas or regions of the state to be eligible for
17 grant awards, which may include rural, suburban, and urban areas,
18 and may include use of the five regional designations utilized by
19 the County Behavioral Health Directors Association of California.

20 (D) Level of community engagement and commitment to project
21 completion.

22 (E) Financial support that, in addition to a grant that may be
23 awarded by the authority, will be sufficient to complete and operate
24 the project for which the grant from the authority is awarded.

25 (F) Ability to provide additional funding support to the project,
26 including public or private funding, federal tax credits and grants,
27 foundation support, and other collaborative efforts.

28 (G) Memorandum of understanding among project partners, if
29 applicable.

30 (H) Information regarding the legal status of the collaborating
31 partners, if applicable.

32 (I) Ability to measure key outcomes, including improved access
33 to services, health and mental health outcomes, and cost benefit
34 of the project.

35 (3) The authority shall determine maximum grants awards,
36 which shall take into consideration the number of projects awarded
37 to the grantee, as described in paragraph (1), and shall reflect
38 reasonable costs for the project and geographic region. The
39 authority may allocate a grant in increments contingent upon the
40 phases of a project.

1 (4) Funds awarded by the authority pursuant to this section may
2 be used to supplement, but not to supplant, existing financial and
3 resource commitments of the grantee or any other member of a
4 collaborative effort that has been awarded a grant.

5 (5) All projects that are awarded grants by the authority shall
6 be completed within a reasonable period of time, to be determined
7 by the authority. Funds shall not be released by the authority until
8 the applicant demonstrates project readiness to the authority's
9 satisfaction. If the authority determines that a grant recipient has
10 failed to complete the project under the terms specified in awarding
11 the grant, the authority may require remedies, including the return
12 of all or a portion of the grant.

13 (6) A grantee that receives a grant from the authority under this
14 section shall commit to using that capital capacity and program
15 expansion project, such as the mobile crisis team, crisis
16 stabilization unit, or crisis residential treatment program, for the
17 duration of the expected life of the project.

18 (7) The authority may consult with a technical assistance entity,
19 as described in paragraph (5) of subdivision (a) of Section 4061,
20 for purposes of implementing this section.

21 (8) The authority may adopt emergency regulations relating to
22 the grants for the capital capacity and program expansion projects
23 described in this section, including emergency regulations that
24 define eligible costs and determine minimum and maximum grant
25 amounts.

26 (9) The authority shall provide reports to the fiscal and policy
27 committees of the Legislature on or before May 1, 2014, and on
28 or before May 1, 2015, on the progress of implementation, that
29 include, but are not limited to, the following:

30 (A) A description of each project awarded funding.

31 (B) The amount of each grant issued.

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

33 (D) The total amount of grants issued.

34 (E) A description of project operation and implementation,
35 including who is being served.

36 (10) A recipient of a grant provided pursuant to paragraph (1)
37 shall adhere to all applicable laws relating to scope of practice,
38 licensure, certification, staffing, and building codes.

39 (e) Funds appropriated by the Legislature to the commission
40 for purposes of this section shall be allocated for triage personnel

1 to provide intensive case management and linkage to services for
2 individuals with mental health disorders at various points of access.
3 These funds shall be made available to selected counties, counties
4 acting jointly, or city mental health departments, as determined
5 by the commission through a selection process. It is the intent of
6 the Legislature for these funds to be allocated in an efficient manner
7 to encourage early intervention and receipt of needed services for
8 individuals with mental health disorders, and to assist in navigating
9 the local service sector to improve efficiencies and the delivery of
10 services.

11 (1) Triage personnel may provide targeted case management
12 services face to face, by telephone, or by telehealth with the
13 individual in need of assistance or his or her significant support
14 person, and may be provided anywhere in the community. These
15 service activities may include, but are not limited to, the following:

- 16 (A) Communication, coordination, and referral.
- 17 (B) Monitoring service delivery to ensure the individual accesses
18 and receives services.
- 19 (C) Monitoring the individual's progress.
- 20 (D) Providing placement service assistance and service plan
21 development.

22 (2) The commission shall take into account at least the following
23 criteria and factors when selecting recipients and determining the
24 amount of grant awards for triage personnel as follows:

- 25 (A) Description of need, including potential gaps in local service
26 connections.
- 27 (B) Description of funding request, including personnel and use
28 of peer support.
- 29 (C) Description of how triage personnel will be used to facilitate
30 linkage and access to services, including objectives and anticipated
31 outcomes.
- 32 (D) Ability to obtain federal Medicaid reimbursement, when
33 applicable.
- 34 (E) Ability to administer an effective service program and the
35 degree to which local agencies and service providers will support
36 and collaborate with the triage personnel effort.
- 37 (F) Geographic areas or regions of the state to be eligible for
38 grant awards, which shall include rural, suburban, and urban areas,
39 and may include use of the five regional designations utilized by
40 the County Behavioral Health Directors Association of California.

1 (3) The commission shall determine maximum grant awards,
2 and shall take into consideration the level of need, population to
3 be served, and related criteria, as described in paragraph (2), and
4 shall reflect reasonable costs.

5 (4) Funds awarded by the commission for purposes of this
6 section may be used to supplement, but not supplant, existing
7 financial and resource commitments of the county, counties acting
8 jointly, or city mental health department that received the grant.

9 (5) Notwithstanding any other law, a county, counties acting
10 jointly, or city mental health department that receives an award of
11 funds for the purpose of supporting triage personnel pursuant to
12 this subdivision is not required to provide a matching contribution
13 of local funds.

14 (6) Notwithstanding any other law, the commission, without
15 taking any further regulatory action, may implement, interpret, or
16 make specific this section by means of informational letters,
17 bulletins, or similar instructions.

18 (7) The commission shall provide a status report to the fiscal
19 and policy committees of the Legislature on the progress of
20 implementation no later than March 1, 2014.

21 ~~SEC. 57.~~

22 *SEC. 44.* Section 5892 of the Welfare and Institutions Code is
23 amended to read:

24 5892. (a) In order to promote efficient implementation of this
25 act, the county shall use funds distributed from the Mental Health
26 Services Fund as follows:

27 (1) In 2005–06, 2006–07, and in 2007–08, 10 percent shall be
28 placed in a trust fund to be expended for education and training
29 programs pursuant to Part 3.1.

30 (2) In 2005–06, 2006–07, and in 2007–08, 10 percent for capital
31 facilities and technological needs distributed to counties in
32 accordance with a formula developed in consultation with the
33 County Behavioral Health Directors Association of California to
34 implement plans developed pursuant to Section 5847.

35 (3) Twenty percent of funds distributed to the counties pursuant
36 to subdivision (c) of Section 5891 shall be used for prevention and
37 early intervention programs in accordance with Part 3.6
38 (commencing with Section 5840) of this division.

39 (4) The expenditure for prevention and early intervention may
40 be increased in any county in which the department determines

1 that the increase will decrease the need and cost for additional
2 services to severely mentally ill persons in that county by an
3 amount at least commensurate with the proposed increase.

4 (5) The balance of funds shall be distributed to county mental
5 health programs for services to persons with severe mental illnesses
6 pursuant to Part 4 (commencing with Section 5850) for the
7 children’s system of care and Part 3 (commencing with Section
8 5800) for the adult and older adult system of care.

9 (6) Five percent of the total funding for each county mental
10 health program for Part 3 (commencing with Section 5800), Part
11 3.6 (commencing with Section 5840), and Part 4 (commencing
12 with Section 5850) of this division, shall be utilized for innovative
13 programs in accordance with Sections 5830, 5847, and 5848.

14 (b) In any year after 2007–08, programs for services pursuant
15 to Part 3 (commencing with Section 5800) and Part 4 (commencing
16 with Section 5850) of this division may include funds for
17 technological needs and capital facilities, human resource needs,
18 and a prudent reserve to ensure services do not have to be
19 significantly reduced in years in which revenues are below the
20 average of previous years. The total allocation for purposes
21 authorized by this subdivision shall not exceed 20 percent of the
22 average amount of funds allocated to that county for the previous
23 five years pursuant to this section.

24 (c) The allocations pursuant to subdivisions (a) and (b) shall
25 include funding for annual planning costs pursuant to Section 5848.
26 The total of these costs shall not exceed 5 percent of the total of
27 annual revenues received for the fund. The planning costs shall
28 include funds for county mental health programs to pay for the
29 costs of consumers, family members, and other stakeholders to
30 participate in the planning process and for the planning and
31 implementation required for private provider contracts to be
32 significantly expanded to provide additional services pursuant to
33 Part 3 (commencing with Section 5800) and Part 4 (commencing
34 with Section 5850) of this division.

35 (d) Prior to making the allocations pursuant to subdivisions (a),
36 (b), and (c), funds shall be reserved for the costs for the State
37 Department of Health Care Services, the California Mental Health
38 Planning Council, the Office of Statewide Health Planning and
39 Development, the Mental Health Services Oversight and
40 Accountability Commission, the State Department of Public Health,

1 and any other state agency to implement all duties pursuant to the
2 programs set forth in this section. These costs shall not exceed 5
3 percent of the total of annual revenues received for the fund. The
4 administrative costs shall include funds to assist consumers and
5 family members to ensure the appropriate state and county agencies
6 give full consideration to concerns about quality, structure of
7 service delivery, or access to services. The amounts allocated for
8 administration shall include amounts sufficient to ensure adequate
9 research and evaluation regarding the effectiveness of services
10 being provided and achievement of the outcome measures set forth
11 in Part 3 (commencing with Section 5800), Part 3.6 (commencing
12 with Section 5840), and Part 4 (commencing with Section 5850)
13 of this division. The amount of funds available for the purposes
14 of this subdivision in any fiscal year shall be subject to
15 appropriation in the annual Budget Act.

16 (e) In 2004–05, funds shall be allocated as follows:

17 (1) Forty-five percent for education and training pursuant to
18 Part 3.1 (commencing with Section 5820) of this division.

19 (2) Forty-five percent for capital facilities and technology needs
20 in the manner specified by paragraph (2) of subdivision (a).

21 (3) Five percent for local planning in the manner specified in
22 subdivision (c).

23 (4) Five percent for state implementation in the manner specified
24 in subdivision (d).

25 (f) Each county shall place all funds received from the State
26 Mental Health Services Fund in a local Mental Health Services
27 Fund. The Local Mental Health Services Fund balance shall be
28 invested consistent with other county funds and the interest earned
29 on the investments shall be transferred into the fund. The earnings
30 on investment of these funds shall be available for distribution
31 from the fund in future years.

32 (g) All expenditures for county mental health programs shall
33 be consistent with a currently approved plan or update pursuant
34 to Section 5847.

35 (h) Other than funds placed in a reserve in accordance with an
36 approved plan, any funds allocated to a county that have not been
37 spent for their authorized purpose within three years shall revert
38 to the state to be deposited into the fund and available for other
39 counties in future years, provided however, that funds for capital

1 facilities, technological needs, or education and training may be
2 retained for up to 10 years before reverting to the fund.

3 (i) If there are still additional revenues available in the fund
4 after the Mental Health Services Oversight and Accountability
5 Commission has determined there are prudent reserves and no
6 unmet needs for any of the programs funded pursuant to this
7 section, including all purposes of the Prevention and Early
8 Intervention Program, the commission shall develop a plan for
9 expenditures of these revenues to further the purposes of this act
10 and the Legislature may appropriate these funds for any purpose
11 consistent with the commission's adopted plan that furthers the
12 purposes of this act.

13 (j) For the 2011–12 fiscal year, General Fund revenues will be
14 insufficient to fully fund many existing mental health programs,
15 including Early and Periodic Screening, Diagnosis, and Treatment
16 (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and
17 mental health services provided for special education pupils. In
18 order to adequately fund those programs for the 2011–12 fiscal
19 year and avoid deeper reductions in programs that serve individuals
20 with severe mental illness and the most vulnerable, medically
21 needy citizens of the state, prior to distribution of funds under
22 paragraphs (1) to (6), inclusive, of subdivision (a), effective July
23 1, 2011, moneys shall be allocated from the Mental Health Services
24 Fund to the counties as follows:

25 (1) Commencing July 1, 2011, one hundred eighty-three million
26 six hundred thousand dollars (\$183,600,000) of the funds available
27 as of July 1, 2011, in the Mental Health Services Fund, shall be
28 allocated in a manner consistent with subdivision (c) of Section
29 5778 and based on a formula determined by the state in
30 consultation with the County Behavioral Health Directors
31 Association of California to meet the fiscal year 2011–12 General
32 Fund obligation for Medi-Cal Specialty Mental Health Managed
33 Care.

34 (2) Upon completion of the allocation in paragraph (1), the
35 Controller shall distribute to counties ninety-eight million five
36 hundred eighty-six thousand dollars (\$98,586,000) from the Mental
37 Health Services Fund for mental health services for special
38 education pupils based on a formula determined by the state in
39 consultation with the County Behavioral Health Directors
40 Association of California.

1 (3) Upon completion of the allocation in paragraph (2), the
2 Controller shall distribute to counties 50 percent of their 2011–12
3 Mental Health Services Act component allocations consistent with
4 Sections 5847 and 5891, not to exceed four hundred eighty-eight
5 million dollars (\$488,000,000). This allocation shall commence
6 beginning August 1, 2011.

7 (4) Upon completion of the allocation in paragraph (3), and as
8 revenues are deposited into the Mental Health Services Fund, the
9 Controller shall distribute five hundred seventy-nine million dollars
10 (\$579,000,000) from the Mental Health Services Fund to counties
11 to meet the General Fund obligation for EPSDT for the 2011–12
12 fiscal year. These revenues shall be distributed to counties on a
13 quarterly basis and based on a formula determined by the state in
14 consultation with the County Behavioral Health Directors
15 Association of California. These funds shall not be subject to
16 reconciliation or cost settlement.

17 (5) The Controller shall distribute to counties the remaining
18 2011–12 Mental Health Services Act component allocations
19 consistent with Sections 5847 and 5891, beginning no later than
20 April 30, 2012. These remaining allocations shall be made on a
21 monthly basis.

22 (6) The total one-time allocation from the Mental Health
23 Services Fund for EPSDT, Medi-Cal Specialty Mental Health
24 Managed Care, and mental health services provided to special
25 education pupils as referenced shall not exceed eight hundred
26 sixty-two million dollars (\$862,000,000). Any revenues deposited
27 in the Mental Health Services Fund in the 2011–12 fiscal year that
28 exceed this obligation shall be distributed to counties for remaining
29 fiscal year 2011–12 Mental Health Services Act component
30 allocations, consistent with Sections 5847 and 5891.

31 (k) Subdivision (j) shall not be subject to repayment.

32 (l) Subdivision (j) shall become inoperative on July 1, 2012.

33 ~~SEC. 58.~~

34 *SEC. 45.* Section 5899 of the Welfare and Institutions Code is
35 amended to read:

36 5899. (a) The State Department of Health Care Services, in
37 consultation with the Mental Health Services Oversight and
38 Accountability Commission and the County Behavioral Health
39 Directors Association of California, shall develop and administer
40 instructions for the Annual Mental Health Services Act Revenue

1 and Expenditure Report. This report shall be submitted
2 electronically to the department and to the Mental Health Services
3 Oversight and Accountability Commission.

4 (b) The purpose of the Annual Mental Health Services Act
5 Revenue and Expenditure Report is as follows:

6 (1) Identify the expenditures of Mental Health Services Act
7 (MHSA) funds that were distributed to each county.

8 (2) Quantify the amount of additional funds generated for the
9 mental health system as a result of the MHSA.

10 (3) Identify unexpended funds, and interest earned on MHSA
11 funds.

12 (4) Determine reversion amounts, if applicable, from prior fiscal
13 year distributions.

14 (c) This report is intended to provide information that allows
15 for the evaluation of all of the following:

16 (1) Children’s systems of care.

17 (2) Prevention and early intervention strategies.

18 (3) Innovative projects.

19 (4) Workforce education and training.

20 (5) Adults and older adults systems of care.

21 (6) Capital facilities and technology needs.

22 ~~SEC. 59.~~

23 *SEC. 46.* Section 5902 of the Welfare and Institutions Code is
24 amended to read:

25 5902. (a) In the 1991–92 fiscal year, funding sufficient to
26 cover the cost of the basic level of care in institutions for mental
27 disease at the rate established by the State Department of Health
28 Care Services shall be made available to the department for skilled
29 nursing facilities, plus the rate established for special treatment
30 programs. The department may authorize a county to administer
31 institutions for mental disease services if the county with the
32 consent of the affected providers makes a request to administer
33 services and an allocation is made to the county for these services.
34 The department shall continue to contract with these providers for
35 the services necessary for the operation of the institutions for
36 mental disease.

37 (b) In the 1992–93 fiscal year, the department shall consider
38 county-specific requests to continue to provide administrative
39 services relative to institutions for mental disease facilities when
40 no viable alternatives are found to exist.

1 (c) (1) By October 1, 1991, the department, in consultation
2 with the County Behavioral Health Directors Association of
3 California and the California Association of Health Facilities, shall
4 develop and publish a county-specific allocation of institutions for
5 mental disease funds that will take effect on July 1, 1992.

6 (2) By November 1, 1991, counties shall notify the providers
7 of any intended change in service levels to be effective on July 1,
8 1992.

9 (3) By April 1, 1992, counties and providers shall have entered
10 into contracts for basic institutions for mental disease services at
11 the rate described in subdivision (e) for the 1992–93 fiscal year at
12 the level expressed on or before November 1, 1991, except that a
13 county shall be permitted additional time, until June 1, 1992, to
14 complete the processing of the contract, when any of the following
15 conditions are met:

16 (A) The county and the affected provider have agreed on all
17 substantive institutions for mental disease contract issues by April
18 1, 1992.

19 (B) Negotiations are in process with the county on April 1, 1992,
20 and the affected provider has agreed in writing to the extension.

21 (C) The service level committed to on November 1, 1991,
22 exceeds the affected provider's bed capacity.

23 (D) The county can document that the affected provider has
24 refused to enter into negotiations by April 1, 1992, or has
25 substantially delayed negotiations.

26 (4) If a county and a provider are unable to reach agreement on
27 substantive contract issues by June 1, 1992, the department may,
28 upon request of either the affected county or the provider, mediate
29 the disputed issues.

30 (5) When contracts for service at the level committed to on
31 November 1, 1991, have not been completed by April 1, 1992,
32 and additional time is not permitted pursuant to the exceptions
33 specified in paragraph (3) the funds allocated to those counties
34 shall revert for reallocation in a manner that shall promote equity
35 of funding among counties. With respect to counties with
36 exceptions permitted pursuant to paragraph (3), funds shall not
37 revert unless contracts are not completed by June 1, 1992. In no
38 event shall funds revert under this section if there is no harm to
39 the provider as a result of the county contract not being completed.
40 During the 1992–93 fiscal year, funds reverted under this paragraph

1 shall be used to purchase institution for mental disease/skilled
2 nursing/special treatment program services in existing facilities.

3 (6) Nothing in this section shall apply to negotiations regarding
4 supplemental payments beyond the rate specified in subdivision
5 (e).

6 (d) On or before April 1, 1992, counties may complete contracts
7 with facilities for the direct purchase of services in the 1992–93
8 fiscal year. Those counties for which facility contracts have not
9 been completed by that date shall be deemed to continue to accept
10 financial responsibility for those patients during the subsequent
11 fiscal year at the rate specified in subdivision (a).

12 (e) As long as contracts with institutions for mental disease
13 providers require the facilities to maintain skilled nursing facility
14 licensure and certification, reimbursement for basic services shall
15 be at the rate established by the State Department of Health Care
16 Services. Except as provided in this section, reimbursement rates
17 for services in institutions for mental diseases shall be the same
18 as the rates in effect on July 31, 2004. Effective July 1, 2005,
19 through June 30, 2008, the reimbursement rate for institutions for
20 mental disease shall increase by 6.5 percent annually. Effective
21 July 1, 2008, the reimbursement rate for institutions for mental
22 disease shall increase by 4.7 percent annually.

23 (f) (1) Providers that agree to contract with the county for
24 services under an alternative mental health program pursuant to
25 Section 5768 that does not require skilled nursing facility licensure
26 shall retain return rights to licensure as skilled nursing facilities.

27 (2) Providers participating in an alternative program that elect
28 to return to skilled nursing facility licensure shall only be required
29 to meet those requirements under which they previously operated
30 as a skilled nursing facility.

31 (g) In the 1993–94 fiscal year and thereafter, the department
32 shall consider requests to continue administrative services related
33 to institutions for mental disease facilities from counties with a
34 population of 150,000 or less based on the most recent available
35 estimates of population data as determined by the Population
36 Research Unit of the Department of Finance.

37 ~~SEC. 60.~~

38 *SEC. 47.* Section 6002.25 of the Welfare and Institutions Code
39 is amended to read:

1 6002.25. The independent clinical review shall be conducted
 2 by a licensed psychiatrist with training and experience in treating
 3 psychiatric adolescent patients, who is a neutral party to the review,
 4 having no direct financial relationship with the treating clinician,
 5 nor a personal or financial relationship with the patient, or his or
 6 her parents or guardian. Nothing in this section shall prevent a
 7 psychiatrist affiliated with a health maintenance organization, as
 8 defined in subdivision (b) of Section 1373.10 of the Health and
 9 Safety Code, from providing the independent clinical review where
 10 the admitting, treating, and reviewing psychiatrists are affiliated
 11 with a health maintenance organization that predominantly serves
 12 members of a prepaid health care service plan. The independent
 13 clinical reviewer shall be assigned, on a rotating basis, from a list
 14 prepared by the facility, and submitted to the county behavioral
 15 health director prior to March 1, 1990, and annually thereafter, or
 16 more frequently when necessary. The county behavioral health
 17 director shall, on an annual basis, or at the request of the facility,
 18 review the facility's list of independent clinical reviewers. The
 19 county behavioral health director shall approve or disapprove the
 20 list of reviewers within 30 days of submission. If there is no
 21 response from the county behavioral health director, the facility's
 22 list shall be deemed approved. If the county behavioral health
 23 director disapproves one or more of the persons on the list of
 24 reviewers, the county behavioral health director shall notify the
 25 facility in writing of the reasons for the disapproval. The county
 26 behavioral health director, in consultation with the facility, may
 27 develop a list of one or more additional reviewers within 30 days.
 28 The final list shall be mutually agreeable to the county behavioral
 29 health director and the facility. Sections 6002.10 to 6002.40,
 30 inclusive, shall not be construed to prohibit the treatment of minors
 31 prior to the existence of an approved list of independent clinical
 32 reviewers. The independent clinical reviewer may be an active
 33 member of the medical staff of the facility who has no direct
 34 financial relationship, including, but not limited to, an employment
 35 or other contract arrangement with the facility except for
 36 compensation received for the service of providing clinical reviews.

37 ~~SEC. 61.~~

38 *SEC. 48.* Section 8103 of the Welfare and Institutions Code is
 39 amended to read:

1 8103. (a) (1) No person who after October 1, 1955, has been
2 adjudicated by a court of any state to be a danger to others as a
3 result of a mental disorder or mental illness, or who has been
4 adjudicated to be a mentally disordered sex offender, shall purchase
5 or receive, or attempt to purchase or receive, or have in his or her
6 possession, custody, or control a firearm or any other deadly
7 weapon unless there has been issued to the person a certificate by
8 the court of adjudication upon release from treatment or at a later
9 date stating that the person may possess a firearm or any other
10 deadly weapon without endangering others, and the person has
11 not, subsequent to the issuance of the certificate, again been
12 adjudicated by a court to be a danger to others as a result of a
13 mental disorder or mental illness.

14 (2) The court shall notify the Department of Justice of the court
15 order finding the individual to be a person described in paragraph
16 (1) as soon as possible, but not later than one court day after issuing
17 the order. The court shall also notify the Department of Justice of
18 any certificate issued as described in paragraph (1) as soon as
19 possible, but not later than one court day after issuing the
20 certificate.

21 (b) (1) No person who has been found, pursuant to Section
22 1026 of the Penal Code or the law of any other state or the United
23 States, not guilty by reason of insanity of murder, mayhem, a
24 violation of Section 207, 209, or 209.5 of the Penal Code in which
25 the victim suffers intentionally inflicted great bodily injury,
26 carjacking or robbery in which the victim suffers great bodily
27 injury, a violation of Section 451 or 452 of the Penal Code
28 involving a trailer coach, as defined in Section 635 of the Vehicle
29 Code, or any dwelling house, a violation of paragraph (1) or (2)
30 of subdivision (a) of Section 262 or paragraph (2) or (3) of
31 subdivision (a) of Section 261 of the Penal Code, a violation of
32 Section 459 of the Penal Code in the first degree, assault with
33 intent to commit murder, a violation of Section 220 of the Penal
34 Code in which the victim suffers great bodily injury, a violation
35 of Section 18715, 18725, 18740, 18745, 18750, or 18755 of the
36 Penal Code, or of a felony involving death, great bodily injury, or
37 an act which poses a serious threat of bodily harm to another
38 person, or a violation of the law of any other state or the United
39 States that includes all the elements of any of the above felonies
40 as defined under California law, shall purchase or receive, or

1 attempt to purchase or receive, or have in his or her possession or
2 under his or her custody or control any firearm or any other deadly
3 weapon.

4 (2) The court shall notify the Department of Justice of the court
5 order finding the person to be a person described in paragraph (1)
6 as soon as possible, but not later than, one court day after issuing
7 the order.

8 (c) (1) No person who has been found, pursuant to Section 1026
9 of the Penal Code or the law of any other state or the United States,
10 not guilty by reason of insanity of any crime other than those
11 described in subdivision (b) shall purchase or receive, or attempt
12 to purchase or receive, or shall have in his or her possession,
13 custody, or control any firearm or any other deadly weapon unless
14 the court of commitment has found the person to have recovered
15 sanity, pursuant to Section 1026.2 of the Penal Code or the law of
16 any other state or the United States.

17 (2) The court shall notify the Department of Justice of the court
18 order finding the person to be a person described in paragraph (1)
19 as soon as possible, but not later than one court day after issuing
20 the order. The court shall also notify the Department of Justice
21 when it finds that the person has recovered his or her sanity as
22 soon as possible, but not later than one court day after making the
23 finding.

24 (d) (1) No person found by a court to be mentally incompetent
25 to stand trial, pursuant to Section 1370 or 1370.1 of the Penal Code
26 or the law of any other state or the United States, shall purchase
27 or receive, or attempt to purchase or receive, or shall have in his
28 or her possession, custody, or control, any firearm or any other
29 deadly weapon, unless there has been a finding with respect to the
30 person of restoration to competence to stand trial by the committing
31 court, pursuant to Section 1372 of the Penal Code or the law of
32 any other state or the United States.

33 (2) The court shall notify the Department of Justice of the court
34 order finding the person to be mentally incompetent as described
35 in paragraph (1) as soon as possible, but not later than one court
36 day after issuing the order. The court shall also notify the
37 Department of Justice when it finds that the person has recovered
38 his or her competence as soon as possible, but not later than one
39 court day after making the finding.

1 (e) (1) No person who has been placed under conservatorship
2 by a court, pursuant to Section 5350 or the law of any other state
3 or the United States, because the person is gravely disabled as a
4 result of a mental disorder or impairment by chronic alcoholism,
5 shall purchase or receive, or attempt to purchase or receive, or
6 shall have in his or her possession, custody, or control, any firearm
7 or any other deadly weapon while under the conservatorship if, at
8 the time the conservatorship was ordered or thereafter, the court
9 that imposed the conservatorship found that possession of a firearm
10 or any other deadly weapon by the person would present a danger
11 to the safety of the person or to others. Upon placing a person
12 under conservatorship, and prohibiting firearm or any other deadly
13 weapon possession by the person, the court shall notify the person
14 of this prohibition.

15 (2) The court shall notify the Department of Justice of the court
16 order placing the person under conservatorship and prohibiting
17 firearm or any other deadly weapon possession by the person as
18 described in paragraph (1) as soon as possible, but not later than
19 one court day after placing the person under conservatorship. The
20 notice shall include the date the conservatorship was imposed and
21 the date the conservatorship is to be terminated. If the
22 conservatorship is subsequently terminated before the date listed
23 in the notice to the Department of Justice or the court subsequently
24 finds that possession of a firearm or any other deadly weapon by
25 the person would no longer present a danger to the safety of the
26 person or others, the court shall notify the Department of Justice
27 as soon as possible, but not later than one court day after
28 terminating the conservatorship.

29 (3) All information provided to the Department of Justice
30 pursuant to paragraph (2) shall be kept confidential, separate, and
31 apart from all other records maintained by the Department of
32 Justice, and shall be used only to determine eligibility to purchase
33 or possess firearms or other deadly weapons. A person who
34 knowingly furnishes that information for any other purpose is
35 guilty of a misdemeanor. All the information concerning any person
36 shall be destroyed upon receipt by the Department of Justice of
37 notice of the termination of conservatorship as to that person
38 pursuant to paragraph (2).

39 (f) (1) No person who has been (A) taken into custody as
40 provided in Section 5150 because that person is a danger to himself,

1 herself, or to others, (B) assessed within the meaning of Section
2 5151, and (C) admitted to a designated facility within the meaning
3 of Sections 5151 and 5152 because that person is a danger to
4 himself, herself, or others, shall own, possess, control, receive, or
5 purchase, or attempt to own, possess, control, receive, or purchase
6 any firearm for a period of five years after the person is released
7 from the facility. A person described in the preceding sentence,
8 however, may own, possess, control, receive, or purchase, or
9 attempt to own, possess, control, receive, or purchase any firearm
10 if the superior court has, pursuant to paragraph (5), found that the
11 people of the State of California have not met their burden pursuant
12 to paragraph (6).

13 (2) (A) For each person subject to this subdivision, the facility
14 shall, within 24 hours of the time of admission, submit a report to
15 the Department of Justice, on a form prescribed by the Department
16 of Justice, containing information that includes, but is not limited
17 to, the identity of the person and the legal grounds upon which the
18 person was admitted to the facility.

19 Any report submitted pursuant to this paragraph shall be
20 confidential, except for purposes of the court proceedings described
21 in this subdivision and for determining the eligibility of the person
22 to own, possess, control, receive, or purchase a firearm.

23 (B) Commencing July 1, 2012, facilities shall submit reports
24 pursuant to this paragraph exclusively by electronic means, in a
25 manner prescribed by the Department of Justice.

26 (3) Prior to, or concurrent with, the discharge, the facility shall
27 inform a person subject to this subdivision that he or she is
28 prohibited from owning, possessing, controlling, receiving, or
29 purchasing any firearm for a period of five years. Simultaneously,
30 the facility shall inform the person that he or she may request a
31 hearing from a court, as provided in this subdivision, for an order
32 permitting the person to own, possess, control, receive, or purchase
33 a firearm. The facility shall provide the person with a form for a
34 request for a hearing. The Department of Justice shall prescribe
35 the form. Where the person requests a hearing at the time of
36 discharge, the facility shall forward the form to the superior court
37 unless the person states that he or she will submit the form to the
38 superior court.

39 (4) The Department of Justice shall provide the form upon
40 request to any person described in paragraph (1). The Department

1 of Justice shall also provide the form to the superior court in each
2 county. A person described in paragraph (1) may make a single
3 request for a hearing at any time during the five-year period. The
4 request for hearing shall be made on the form prescribed by the
5 department or in a document that includes equivalent language.

6 (5) A person who is subject to paragraph (1) who has requested
7 a hearing from the superior court of his or her county of residence
8 for an order that he or she may own, possess, control, receive, or
9 purchase firearms shall be given a hearing. The clerk of the court
10 shall set a hearing date and notify the person, the Department of
11 Justice, and the district attorney. The people of the State of
12 California shall be the plaintiff in the proceeding and shall be
13 represented by the district attorney. Upon motion of the district
14 attorney, or on its own motion, the superior court may transfer the
15 hearing to the county in which the person resided at the time of
16 his or her detention, the county in which the person was detained,
17 or the county in which the person was evaluated or treated. Within
18 seven days after the request for a hearing, the Department of Justice
19 shall file copies of the reports described in this section with the
20 superior court. The reports shall be disclosed upon request to the
21 person and to the district attorney. The court shall set the hearing
22 within 30 days of receipt of the request for a hearing. Upon
23 showing good cause, the district attorney shall be entitled to a
24 continuance not to exceed 14 days after the district attorney was
25 notified of the hearing date by the clerk of the court. If additional
26 continuances are granted, the total length of time for continuances
27 shall not exceed 60 days. The district attorney may notify the
28 county behavioral health director of the hearing who shall provide
29 information about the detention of the person that may be relevant
30 to the court and shall file that information with the superior court.
31 That information shall be disclosed to the person and to the district
32 attorney. The court, upon motion of the person subject to paragraph
33 (1) establishing that confidential information is likely to be
34 discussed during the hearing that would cause harm to the person,
35 shall conduct the hearing in camera with only the relevant parties
36 present, unless the court finds that the public interest would be
37 better served by conducting the hearing in public. Notwithstanding
38 any other law, declarations, police reports, including criminal
39 history information, and any other material and relevant evidence

1 that is not excluded under Section 352 of the Evidence Code shall
2 be admissible at the hearing under this section.

3 (6) The people shall bear the burden of showing by a
4 preponderance of the evidence that the person would not be likely
5 to use firearms in a safe and lawful manner.

6 (7) If the court finds at the hearing set forth in paragraph (5)
7 that the people have not met their burden as set forth in paragraph
8 (6), the court shall order that the person shall not be subject to the
9 five-year prohibition in this section on the ownership, control,
10 receipt, possession, or purchase of firearms, and that person shall
11 comply with the procedure described in Chapter 2 (commencing
12 with Section 33850) of Division 11 of Title 4 of Part 6 of the Penal
13 Code for the return of any firearms. A copy of the order shall be
14 submitted to the Department of Justice. Upon receipt of the order,
15 the Department of Justice shall delete any reference to the
16 prohibition against firearms from the person's state mental health
17 firearms prohibition system information.

18 (8) Where the district attorney declines or fails to go forward
19 in the hearing, the court shall order that the person shall not be
20 subject to the five-year prohibition required by this subdivision
21 on the ownership, control, receipt, possession, or purchase of
22 firearms. A copy of the order shall be submitted to the Department
23 of Justice. Upon receipt of the order, the Department of Justice
24 shall, within 15 days, delete any reference to the prohibition against
25 firearms from the person's state mental health firearms prohibition
26 system information, and that person shall comply with the
27 procedure described in Chapter 2 (commencing with Section
28 33850) of Division 11 of Title 4 of Part 6 of the Penal Code for
29 the return of any firearms.

30 (9) Nothing in this subdivision shall prohibit the use of reports
31 filed pursuant to this section to determine the eligibility of persons
32 to own, possess, control, receive, or purchase a firearm if the person
33 is the subject of a criminal investigation, a part of which involves
34 the ownership, possession, control, receipt, or purchase of a
35 firearm.

36 (g) (1) No person who has been certified for intensive treatment
37 under Section 5250, 5260, or 5270.15 shall own, possess, control,
38 receive, or purchase, or attempt to own, possess, control, receive,
39 or purchase, any firearm for a period of five years.

1 Any person who meets the criteria contained in subdivision (e)
2 or (f) who is released from intensive treatment shall nevertheless,
3 if applicable, remain subject to the prohibition contained in
4 subdivision (e) or (f).

5 (2) (A) For each person certified for intensive treatment under
6 paragraph (1), the facility shall, within 24 hours of the certification,
7 submit a report to the Department of Justice, on a form prescribed
8 by the department, containing information regarding the person,
9 including, but not limited to, the legal identity of the person and
10 the legal grounds upon which the person was certified. A report
11 submitted pursuant to this paragraph shall only be used for the
12 purposes specified in paragraph (2) of subdivision (f).

13 (B) Commencing July 1, 2012, facilities shall submit reports
14 pursuant to this paragraph exclusively by electronic means, in a
15 manner prescribed by the Department of Justice.

16 (3) Prior to, or concurrent with, the discharge of each person
17 certified for intensive treatment under paragraph (1), the facility
18 shall inform the person of that information specified in paragraph
19 (3) of subdivision (f).

20 (4) A person who is subject to paragraph (1) may petition the
21 superior court of his or her county of residence for an order that
22 he or she may own, possess, control, receive, or purchase firearms.
23 At the time the petition is filed, the clerk of the court shall set a
24 hearing date and notify the person, the Department of Justice, and
25 the district attorney. The people of the State of California shall be
26 the respondent in the proceeding and shall be represented by the
27 district attorney. Upon motion of the district attorney, or on its
28 own motion, the superior court may transfer the petition to the
29 county in which the person resided at the time of his or her
30 detention, the county in which the person was detained, or the
31 county in which the person was evaluated or treated. Within seven
32 days after receiving notice of the petition, the Department of Justice
33 shall file copies of the reports described in this section with the
34 superior court. The reports shall be disclosed upon request to the
35 person and to the district attorney. The district attorney shall be
36 entitled to a continuance of the hearing to a date of not less than
37 14 days after the district attorney was notified of the hearing date
38 by the clerk of the court. The district attorney may notify the county
39 behavioral health director of the petition, and the county behavioral
40 health director shall provide information about the detention of

1 the person that may be relevant to the court and shall file that
2 information with the superior court. That information shall be
3 disclosed to the person and to the district attorney. The court, upon
4 motion of the person subject to paragraph (1) establishing that
5 confidential information is likely to be discussed during the hearing
6 that would cause harm to the person, shall conduct the hearing in
7 camera with only the relevant parties present, unless the court finds
8 that the public interest would be better served by conducting the
9 hearing in public. Notwithstanding any other law, any declaration,
10 police reports, including criminal history information, and any
11 other material and relevant evidence that is not excluded under
12 Section 352 of the Evidence Code, shall be admissible at the
13 hearing under this section. If the court finds by a preponderance
14 of the evidence that the person would be likely to use firearms in
15 a safe and lawful manner, the court may order that the person may
16 own, control, receive, possess, or purchase firearms, and that person
17 shall comply with the procedure described in Chapter 2
18 (commencing with Section 33850) of Division 11 of Title 4 of Part
19 6 of the Penal Code for the return of any firearms. A copy of the
20 order shall be submitted to the Department of Justice. Upon receipt
21 of the order, the Department of Justice shall delete any reference
22 to the prohibition against firearms from the person's state mental
23 health firearms prohibition system information.

24 (h) (1) For all persons identified in subdivisions (f) and (g),
25 facilities shall report to the Department of Justice as specified in
26 those subdivisions, except facilities shall not report persons under
27 subdivision (g) if the same persons previously have been reported
28 under subdivision (f).

29 (2) Additionally, all facilities shall report to the Department of
30 Justice upon the discharge of persons from whom reports have
31 been submitted pursuant to subdivision (f) or (g). However, a report
32 shall not be filed for persons who are discharged within 31 days
33 after the date of admission.

34 (i) Every person who owns or possesses or has under his or her
35 custody or control, or purchases or receives, or attempts to purchase
36 or receive, any firearm or any other deadly weapon in violation of
37 this section shall be punished by imprisonment pursuant to
38 subdivision (h) of Section 1170 of the Penal Code or in a county
39 jail for not more than one year.

1 (j) “Deadly weapon,” as used in this section, has the meaning
2 prescribed by Section 8100.

3 (k) Any notice or report required to be submitted to the
4 Department of Justice pursuant to this section shall be submitted
5 in an electronic format, in a manner prescribed by the Department
6 of Justice.

7 ~~SEC. 62.~~

8 *SEC. 49.* Section 11467 of the Welfare and Institutions Code
9 is amended to read:

10 11467. (a) The State Department of Social Services, with the
11 advice and assistance of the County Welfare Directors Association
12 of California, the Chief Probation Officers of California, the
13 County Behavioral Health Directors Association of California,
14 research entities, foster youth and advocates for foster youth, foster
15 care provider business entities organized and operated on a
16 nonprofit basis, tribes, and other stakeholders, shall establish a
17 working group to develop performance standards and outcome
18 measures for providers of out-of-home care placements made under
19 the AFDC-FC program, including, but not limited to, foster family
20 agency, group home, and THP-Plus providers, and for the effective
21 and efficient administration of the AFDC-FC program.

22 (b) The performance standards and outcome measures shall
23 employ the applicable performance standards and outcome
24 measures as set forth in Sections 11469 and 11469.1, designed to
25 identify the degree to which foster care providers, including
26 business entities organized and operated on a nonprofit basis, are
27 providing out-of-home placement services that meet the needs of
28 foster children, and the degree to which these services are
29 supporting improved outcomes, including those identified by the
30 California Child and Family Service Review System.

31 (c) In addition to the process described in subdivision (a), the
32 working group may also develop the following:

33 (1) A means of identifying the child’s needs and determining
34 which is the most appropriate out-of-home placement for a child.

35 (2) A procedure for identifying children who have been in
36 congregate care for one year or longer, determining the reasons
37 each child remains in congregate care, and developing a plan for
38 each child to transition to a less restrictive, more family-like setting.

1 (d) The department shall provide updates regarding its progress
2 toward meeting the requirements of this section during the 2013
3 and 2014 budget hearings.

4 (e) Notwithstanding the rulemaking provisions of the
5 Administrative Procedure Act (Chapter 3.5 (commencing with
6 Section 13340) of Part 1 of Division 3 of Title 2 of the Government
7 Code), until the enactment of applicable state law, or October 1,
8 2015, whichever is earlier, the department may implement the
9 changes made pursuant to this section through all-county letters,
10 or similar instructions from the director.

11 ~~SEC. 63.~~

12 *SEC. 50.* Section 11469 of the Welfare and Institutions Code
13 is amended to read:

14 11469. (a) The department, in consultation with group home
15 providers, the County Welfare Directors Association of California,
16 the Chief Probation Officers of California, the County Behavioral
17 Health Directors Association of California, and the State
18 Department of Health Care Services, shall develop performance
19 standards and outcome measures for determining the effectiveness
20 of the care and supervision, as defined in subdivision (b) of Section
21 11460, provided by group homes under the AFDC-FC program
22 pursuant to Sections 11460 and 11462. These standards shall be
23 designed to measure group home program performance for the
24 client group that the group home program is designed to serve.

25 (1) The performance standards and outcome measures shall be
26 designed to measure the performance of group home programs in
27 areas over which the programs have some degree of influence, and
28 in other areas of measurable program performance that the
29 department can demonstrate are areas over which group home
30 programs have meaningful managerial or administrative influence.

31 (2) These standards and outcome measures shall include, but
32 are not limited to, the effectiveness of services provided by each
33 group home program, and the extent to which the services provided
34 by the group home assist in obtaining the child welfare case plan
35 objectives for the child.

36 (3) In addition, when the group home provider has identified
37 as part of its program for licensing, ratesetting, or county placement
38 purposes, or has included as a part of a child’s case plan by mutual
39 agreement between the group home and the placing agency,
40 specific mental health, education, medical, and other child-related

1 services, the performance standards and outcome measures may
2 also measure the effectiveness of those services.

3 (b) Regulations regarding the implementation of the group home
4 performance standards system required by this section shall be
5 adopted no later than one year prior to implementation. The
6 regulations shall specify both the performance standards system
7 and the manner by which the AFDC-FC rate of a group home
8 program shall be adjusted if performance standards are not met.

9 (c) Except as provided in subdivision (d), effective July 1, 1995,
10 group home performance standards shall be implemented. Any
11 group home program not meeting the performance standards shall
12 have its AFDC-FC rate, set pursuant to Section 11462, adjusted
13 according to the regulations required by this section.

14 (d) Effective July 1, 1995, group home programs shall be
15 classified at rate classification level 13 or 14 only if all of the
16 following are met:

17 (1) The program generates the requisite number of points for
18 rate classification level 13 or 14.

19 (2) The program only accepts children with special treatment
20 needs as determined through the assessment process pursuant to
21 paragraph (2) of subdivision (a) of Section 11462.01.

22 (3) The program meets the performance standards designed
23 pursuant to this section.

24 (e) Notwithstanding subdivision (c), the group home program
25 performance standards system shall not be implemented prior to
26 the implementation of the AFDC-FC performance standards
27 system.

28 (f) By January 1, 2016, the department, in consultation with the
29 County Welfare Directors Association of California, the Chief
30 Probation Officers of California, the County Behavioral Health
31 Directors Association of California, research entities, foster youth
32 and advocates for foster youth, foster care provider business entities
33 organized and operated on a nonprofit basis, Indian tribes, and
34 other stakeholders, shall develop additional performance standards
35 and outcome measures that require group homes to implement
36 programs and services to minimize law enforcement contacts and
37 delinquency petition filings arising from incidents of allegedly
38 unlawful behavior by minors occurring in group homes or under
39 the supervision of group home staff, including individualized

1 behavior management programs, emergency intervention plans,
2 and conflict resolution processes.

3 ~~SEC. 64.~~

4 *SEC. 51.* Section 14021.4 of the Welfare and Institutions Code
5 is amended to read:

6 14021.4. (a) California’s plan for federal Medi-Cal grants for
7 medical assistance programs, pursuant to Subchapter XIX
8 (commencing with Section 1396) of Title 42 of the United States
9 Code, shall accomplish the following objectives:

10 (1) Expansion of the location and type of therapeutic services
11 offered to persons with mental illnesses under Medi-Cal by the
12 category of “other diagnostic, screening, preventative, and
13 rehabilitative services” that is available to states under the federal
14 Social Security Act and its implementing regulations (42 U.S.C.
15 Sec. 1396d(a)(13); 42 C.F.R. 440.130).

16 (2) Expansion of federal financial participation in the costs of
17 specialty mental health services provided by local mental health
18 plans or under contract with the mental health plans.

19 (3) Expansion of the location where reimbursable specialty
20 mental health services can be provided, including home, school,
21 and community-based sites.

22 (4) Expansion of federal financial participation for services that
23 meet the rehabilitation needs of persons with mental illnesses,
24 including, but not limited to, medication management, functional
25 rehabilitation assessments of clients, and rehabilitative services
26 that include remedial services directed at restoration to the highest
27 possible functional level for persons with mental illnesses and
28 maximum reduction of symptoms of mental illness.

29 (5) Improvement of fiscal systems and accountability structures
30 for specialty mental health services, costs, and rates, with the goal
31 of achieving federal fiscal requirements.

32 (b) The department’s state plan revision shall be completed with
33 review and comments by the County Behavioral Health Directors
34 Association of California and other appropriate groups.

35 (c) Services under the rehabilitative option shall be limited to
36 specialty mental health plans certified to provide Medi-Cal under
37 this option.

38 (d) It is the intent of the Legislature that the rehabilitation option
39 of the state Medicaid plan be implemented to expand and provide

1 flexibility to treatment services and to increase the federal
2 participation without increasing the costs to the General Fund.

3 (e) The department shall review and revise the quality assurance
4 standards and guidelines required by Section 14725 to ensure that
5 quality services are delivered to the eligible population. Any
6 reviews shall include, but not be limited to, appropriate use of
7 mental health professionals, including psychiatrists, in the treatment
8 and rehabilitation of clients under this model. The existing quality
9 assurance standards and guidelines shall remain in effect until the
10 adoption of the new quality assurance standards and guidelines.

11 (f) Consistent with services offered to persons with mental
12 illnesses under the Medi-Cal program, as required by this section,
13 it is the intent of the Legislature for the department to include care
14 and treatment of persons with mental illnesses who are eligible
15 for the Medi-Cal program in facilities with a bed capacity of 16
16 beds or less.

17 ~~SEC. 65.~~

18 *SEC. 52.* Section 14124.24 of the Welfare and Institutions
19 Code is amended to read:

20 14124.24. (a) For purposes of this section, “Drug Medi-Cal
21 reimbursable services” means the substance use disorder services
22 described in the California Medicaid State Plan and includes, but
23 is not limited to, all of the following services, administered by the
24 department, and to the extent consistent with state and federal law:

25 (1) Narcotic treatment program services, as set forth in Section
26 14021.51.

27 (2) Day care rehabilitative services.

28 (3) Perinatal residential services for pregnant women and women
29 in the postpartum period.

30 (4) Naltrexone services.

31 (5) Outpatient drug-free services.

32 (6) Other services upon approval of a federal Medicaid state
33 plan amendment or waiver authorizing federal financial
34 participation.

35 (b) (1) While seeking federal approval for any federal Medicaid
36 state plan amendment or waiver associated with Drug Medi-Cal
37 services, the department shall consult with the counties and
38 stakeholders in the development of the state plan amendment or
39 waiver.

1 (2) Upon federal approval of a federal Medicaid state plan
2 amendment authorizing federal financial participation in the
3 following services, and subject to appropriation of funds, “Drug
4 Medi-Cal reimbursable services” shall also include the following
5 services, administered by the department, and to the extent
6 consistent with state and federal law:

7 (A) Notwithstanding subdivision (a) of Section 14132.90, day
8 care habilitative services, which, for purposes of this paragraph,
9 are outpatient counseling and rehabilitation services provided to
10 persons with substance use disorder diagnoses.

11 (B) Case management services, including supportive services
12 to assist persons with substance use disorder diagnoses in gaining
13 access to medical, social, educational, and other needed services.

14 (C) Aftercare services.

15 (c) (1) The nonfederal share for Drug Medi-Cal services shall
16 be funded through a county’s Behavioral Health Subaccount of
17 the Support Services Account of the Local Revenue Fund 2011,
18 and any other available county funds eligible under federal law
19 for federal Medicaid reimbursement. The funds contained in each
20 county’s Behavioral Health Subaccount of the Support Services
21 Account of the Local Revenue Fund 2011 shall be considered state
22 funds distributed by the principal state agency for the purposes of
23 receipt of the federal block grant funds for prevention and treatment
24 of substance abuse found at Subchapter XVII of Chapter 6A of
25 Title 42 of the United States Code. Pursuant to applicable federal
26 Medicaid law and regulations including Section 433.51 of Title
27 42 of the Code of Federal Regulations, counties may claim
28 allowable Medicaid federal financial participation for Drug
29 Medi-Cal services based on the counties certifying their actual
30 total funds expenditures for eligible Drug Medi-Cal services to
31 the department.

32 (2) (A) If the director determines that a county’s provision of
33 Drug Medi-Cal treatment services are disallowed by the federal
34 government or by state or federal audit or review, the impacted
35 county shall be responsible for repayment of all disallowed federal
36 funds. In addition to any other recovery methods available,
37 including, but not limited to, offset of Medicaid federal financial
38 participation funds owed to the impacted county, the director may
39 offset these amounts in accordance with Section 12419.5 of the
40 Government Code.

1 (B) A county subject to an action by the director pursuant to
2 subparagraph (A) may challenge that action by requesting a hearing
3 in writing no later than 30 days from receipt of notice of the
4 department's action. The proceeding shall be conducted in
5 accordance with Chapter 5 (commencing with Section 11500) of
6 Part 1 of Division 3 of Title 2 of the Government Code, and the
7 director has all the powers granted therein. Upon a county's timely
8 request for hearing, the county's obligation to make payment as
9 determined by the director shall be stayed pending the county's
10 exhaustion of administrative remedies provided herein but no
11 longer than will ensure the department's compliance with Section
12 1903(d)(2)(C) of the federal Social Security Act (42 U.S.C. Sec.
13 1396b).

14 (d) Drug Medi-Cal services are only reimbursable to Drug
15 Medi-Cal providers with an approved Drug Medi-Cal contract.

16 (e) Counties shall negotiate contracts only with providers
17 certified to provide Drug Medi-Cal services.

18 (f) The department shall develop methods to ensure timely
19 payment of Drug Medi-Cal claims.

20 (g) (1) A county or a contracted provider, except for a provider
21 to whom subdivision (h) applies, shall submit accurate and
22 complete cost reports for the previous fiscal year by November 1,
23 following the end of the fiscal year. The department may settle
24 Drug Medi-Cal reimbursable services, based on the cost report as
25 the final amendment to the approved county Drug Medi-Cal
26 contract.

27 (2) Amounts paid for services provided to Drug Medi-Cal
28 beneficiaries shall be audited by the department in the manner and
29 form described in Section 14170.

30 (3) Administrative appeals to review grievances or complaints
31 arising from the findings of an audit or examination made pursuant
32 to this section shall be subject to Section 14171.

33 (h) Certified narcotic treatment program providers that are
34 exclusively billing the state or the county for services rendered to
35 persons subject to Section 1210.1 or 3063.1 of the Penal Code or
36 Section 14021.52 of this code shall submit accurate and complete
37 performance reports for the previous state fiscal year by November
38 1 following the end of that fiscal year. A provider to which this
39 subdivision applies shall estimate its budgets using the uniform
40 state daily reimbursement rate. The format and content of the

1 performance reports shall be mutually agreed to by the department,
2 the County Behavioral Health Directors Association of California,
3 and representatives of the treatment providers.

4 (i) Contracts entered into pursuant to this section shall be exempt
5 from the requirements of Chapter 1 (commencing with Section
6 10100) and Chapter 2 (commencing with Section 10290) of Part
7 2 of Division 2 of the Public Contract Code.

8 (j) Annually, the department shall publish procedures for
9 contracting for Drug Medi-Cal services with certified providers
10 and for claiming payments, including procedures and specifications
11 for electronic data submission for services rendered.

12 (k) If the department commences a preliminary criminal
13 investigation of a certified provider, the department shall promptly
14 notify each county that currently contracts with the provider for
15 Drug Medi-Cal services that a preliminary criminal investigation
16 has commenced. If the department concludes a preliminary criminal
17 investigation of a certified provider, the department shall promptly
18 notify each county that currently contracts with the provider for
19 Drug Medi-Cal services that a preliminary criminal investigation
20 has concluded.

21 (1) Notice of the commencement and conclusion of a
22 preliminary criminal investigation pursuant to this section shall
23 be made to the county behavioral health director or his or her
24 equivalent.

25 (2) Communication between the department and a county
26 specific to the commencement or conclusion of a preliminary
27 criminal investigation pursuant to this section shall be deemed
28 confidential and shall not be subject to any disclosure request,
29 including, but not limited to, the Information Practices Act of 1977
30 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part
31 4 of Division 3 of the Civil Code), the California Public Records
32 Act (Chapter 3.5 (commencing with Section 6250) of Division 7
33 of Title 1 of the Government Code), requests pursuant to a
34 subpoena, or for any other public purpose, including, but not
35 limited to, court testimony.

36 (3) Information shared by the department with a county
37 regarding a preliminary criminal investigation shall be maintained
38 in a manner to ensure protection of the confidentiality of the
39 criminal investigation.

1 (4) The information provided to a county pursuant to this section
2 shall only include the provider name, national provider identifier
3 (NPI) number, address, and the notice that an investigation has
4 commenced or concluded.

5 (5) A county shall not take any adverse action against a provider
6 based solely upon the preliminary criminal investigation
7 information disclosed to the county pursuant to this section.

8 (6) In the event of a preliminary criminal investigation of a
9 county owned or operated program, the department has the option
10 to, but is not required to, notify the county pursuant to this section
11 when the department commences or concludes a preliminary
12 criminal investigation.

13 (7) This section shall not limit the voluntary or otherwise legally
14 mandated or contractually mandated sharing of information
15 between the department and a county of information regarding
16 audits and investigations of Drug Medi-Cal providers.

17 (8) “Commenced” means the time at which a complaint or
18 allegation is assigned to an investigator for a field investigation.

19 (9) “Preliminary criminal investigation” means an investigation
20 to gather information to determine if criminal law or statutes have
21 been violated.

22 ~~SEC. 66.~~

23 *SEC. 53.* Section 14251 of the Welfare and Institutions Code
24 is amended to read:

25 14251. (a) (1) “Prepaid health plan” means a plan that meets
26 all of the following criteria:

27 (A) Is licensed as a health care service plan by the Director of
28 the Department of Managed Health Care pursuant to the
29 Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2
30 (commencing with Section 1340) of Division 2 of the Health and
31 Safety Code), other than a plan organized and operating pursuant
32 to Section 10810 of the Corporations Code that substantially
33 indemnifies subscribers or enrollees for the cost of provided
34 services, or has an application for licensure pending and was
35 registered under the Knox-Mills Health Plan Act prior to its repeal.

36 (B) Meets the requirements for participation in the Medicaid
37 Program (Title XIX of the Social Security Act) on an at risk basis.

38 (C) Agrees with the State Department of Health Care Services
39 to furnish directly or indirectly health services to Medi-Cal
40 beneficiaries on a predetermined periodic rate basis.

1 (2) “Prepaid health plan” includes any organization that is
2 licensed as a plan pursuant to the Knox-Keene Health Care Service
3 Plan Act of 1975 and is subject to regulation by the Department
4 of Managed Health Care pursuant to that act, and that contracts
5 with the State Department of Health Care Services solely as a fiscal
6 intermediary at risk.

7 (b) (1) Except for the requirement of licensure pursuant to the
8 Knox-Keene Health Care Service Plan Act of 1975, the State
9 Director of Health Care Services may waive any provision of this
10 chapter that the director determines is inappropriate for a fiscal
11 intermediary at risk. An exemption or waiver shall be set forth in
12 the fiscal intermediary at-risk contract with the State Department
13 of Health Care Services.

14 (2) “Fiscal intermediary at risk” means any entity that entered
15 into a contract with the State Department of Health Care Services
16 on a pilot basis pursuant to subdivision (f) of Section 14000, as in
17 effect June 1, 1973, in accordance with which the entity received
18 capitated payments from the state and reimbursed providers of
19 health care services on a fee-for-service or other basis for at least
20 the basic scope of health care services, as defined in Section 14256,
21 provided to all beneficiaries covered by the contract residing within
22 a specified geographic region of the state. The fiscal intermediary
23 at risk shall be at risk for the cost of administration and utilization
24 of services or the cost of services, or both, for at least the basic
25 scope of health care services, as defined in Section 14256, provided
26 to all beneficiaries covered by the contract residing within a
27 specified geographic region of the state. The fiscal intermediary
28 at risk may share the risk with providers or reinsuring agencies or
29 both. Eligibility of beneficiaries shall be determined by the State
30 Department of Health Care Services and capitation payments shall
31 be based on the number of beneficiaries so determined.

32 ~~SEC. 67:~~

33 *SEC. 54.* Section 14499.71 of the Welfare and Institutions
34 Code is amended to read:

35 14499.71. For the purposes of this article, “fiscal intermediary”
36 means an entity that agrees to pay for covered services provided
37 to Medi-Cal eligibles in exchange for a premium, subscription
38 charge, or capitation payment; to assume an underwriting risk; and
39 is licensed by the Director of the Department of Managed Health
40 Care under the Knox-Keene Health Care Service Plan Act of 1975

1 (Chapter 2.2 (commencing with Section 1340) of Division 2 of
2 the Health and Safety Code).

3 ~~SEC. 68.~~

4 *SEC. 55.* Section 14682.1 of the Welfare and Institutions Code
5 is amended to read:

6 14682.1. (a) The State Department of Health Care Services
7 shall be designated as the state agency responsible for development,
8 consistent with the requirements of Section 4060, and
9 implementation of, mental health plans for Medi-Cal beneficiaries.

10 (b) The department shall convene a steering committee for the
11 purpose of providing advice and recommendations on the transition
12 and continuing development of the Medi-Cal mental health
13 managed care systems pursuant to subdivision (a). The committee
14 shall include work groups to advise the department of major issues
15 to be addressed in the managed mental health care plan, as well
16 as system transition and transformation issues pertaining to the
17 delivery of mental health care services to Medi-Cal beneficiaries,
18 including services to children provided through the Early and
19 Periodic Screening, Diagnosis and Treatment Program.

20 (c) The committee shall consist of diverse representatives of
21 concerned and involved communities, including, but not limited
22 to, beneficiaries, their families, providers, mental health
23 professionals, substance use disorder treatment professionals,
24 statewide representatives of health care service plans,
25 representatives of the California Mental Health Planning Council,
26 public and private organizations, county behavioral health directors,
27 and others as determined by the department. The department has
28 the authority to structure this steering committee process in a
29 manner that is conducive for addressing issues effectively, and for
30 providing a transparent, collaborative, meaningful process to ensure
31 a more diverse and representative approach to problem-solving
32 and dissemination of information.

33 ~~SEC. 69.~~

34 *SEC. 56.* Section 14707 of the Welfare and Institutions Code
35 is amended to read:

36 14707. (a) In the case of federal audit exceptions, the
37 department shall follow federal audit appeal processes unless the
38 department, in consultation with the County Behavioral Health
39 Directors Association of California, determines that those appeals
40 are not cost beneficial.

1 (b) Whenever there is a final federal audit exception against the
2 state resulting from expenditure of federal funds by individual
3 counties, the department may offset federal reimbursement and
4 request the Controller's office to offset the distribution of funds
5 to the counties from the Mental Health Subaccount, the Mental
6 Health Equity Subaccount, and the Vehicle License Collection
7 Account of the Local Revenue Fund, funds from the Mental Health
8 Account and the Behavioral Health Subaccount of the Local
9 Revenue Fund 2011, and any other mental health realignment
10 funds from which the Controller makes distributions to the counties
11 by the amount of the exception. The department shall provide
12 evidence to the Controller that the county has been notified of the
13 amount of the audit exception no less than 30 days before the offset
14 is to occur. The department shall involve the appropriate counties
15 in developing responses to any draft federal audit reports that
16 directly impact the county.

17 ~~SEC. 70.~~

18 *SEC. 57.* Section 14711 of the Welfare and Institutions Code
19 is amended to read:

20 14711. (a) The department shall develop, in consultation with
21 the County Behavioral Health Directors Association of California,
22 a reimbursement methodology for use in the Medi-Cal claims
23 processing and interim payment system that maximizes federal
24 funding and utilizes, as much as practicable, federal Medicaid and
25 Medicare reimbursement principles. The department shall work
26 with the federal Centers for Medicare and Medicaid Services in
27 the development of the methodology required by this section.

28 (b) Reimbursement amounts developed through the methodology
29 required by this section shall be consistent with federal Medicaid
30 requirements and the approved Medicaid state plan and waivers.

31 (c) Administrative costs shall be claimed separately in a manner
32 consistent with federal Medicaid requirements and the approved
33 Medicaid state plan and waivers and shall be limited to 15 percent
34 of the total actual cost of direct client services.

35 (d) The cost of performing quality assurance and utilization
36 review activities shall be reimbursed separately and shall not be
37 included in administrative cost.

38 (e) The reimbursement methodology established pursuant to
39 this section shall be based upon certified public expenditures,
40 which encourage economy and efficiency in service delivery.

1 (f) The reimbursement amounts established for direct client
2 services pursuant to this section shall be based on increments of
3 time for all noninpatient services.

4 (g) The reimbursement methodology shall not be implemented
5 until it has received any necessary federal approvals.

6 (h) This section shall become operative on July 1, 2012.

7 ~~SEC. 71.~~

8 *SEC. 58.* Section 14717 of the Welfare and Institutions Code
9 is amended to read:

10 14717. (a) In order to facilitate the receipt of medically
11 necessary specialty mental health services by a foster child who
12 is placed outside his or her county of original jurisdiction, the
13 department shall take all of the following actions:

14 (1) On or before July 1, 2008, create all of the following items,
15 in consultation with stakeholders, including, but not limited to,
16 the California Institute for Mental Health, the Child and Family
17 Policy Institute of California, the County Behavioral Health
18 Directors Association of California, and the California Alliance
19 of Child and Family Services:

20 (A) A standardized contract for the purchase of medically
21 necessary specialty mental health services from organizational
22 providers when a contract is required.

23 (B) A standardized specialty mental health service authorization
24 procedure.

25 (C) A standardized set of documentation standards and forms,
26 including, but not limited to, forms for treatment plans, annual
27 treatment plan updates, day treatment intensive and day treatment
28 rehabilitative progress notes, and treatment authorization requests.

29 (2) On or before January 1, 2009, use the standardized items as
30 described in paragraph (1) to provide medically necessary specialty
31 mental health services to a foster child who is placed outside his
32 or her county of original jurisdiction, so that organizational
33 providers who are already certified by a mental health plan are not
34 required to be additionally certified by the mental health plan in
35 the county of original jurisdiction.

36 (3) (A) On or before January 1, 2009, use the standardized
37 items described in paragraph (1) to provide medically necessary
38 specialty mental health services to a foster child placed outside
39 his or her county of original jurisdiction to constitute a complete

1 contract, authorization procedure, and set of documentation
2 standards and forms, so that no additional documents are required.

3 (B) Authorize a county mental health plan to be exempt from
4 subparagraph (A) and have an addendum to a contract,
5 authorization procedure, or set of documentation standards and
6 forms, if the county mental health plan has an externally placed
7 requirement, such as a requirement from a federal integrity
8 agreement, that would affect one of these documents.

9 (4) Following consultation with stakeholders, including, but not
10 limited to, the California Institute for Mental Health, the Child and
11 Family Policy Institute of California, the County Behavioral Health
12 Directors Association of California, the California State
13 Association of Counties, and the California Alliance of Child and
14 Family Services, require the use of the standardized contracts,
15 authorization procedures, and documentation standards and forms
16 as specified in paragraph (1) in the 2008–09 state-county mental
17 health plan contract and each state-county mental health plan
18 contract thereafter.

19 (5) The mental health plan shall complete a standardized
20 contract, as provided in paragraph (1), if a contract is required, or
21 another mechanism of payment if a contract is not required, with
22 a provider or providers of the county’s choice, to deliver approved
23 specialty mental health services for a specified foster child, within
24 30 days of an approved treatment authorization request.

25 (b) The California Health and Human Services Agency shall
26 coordinate the efforts of the department and the State Department
27 of Social Services to do all of the following:

28 (1) Participate with the stakeholders in the activities described
29 in this section.

30 (2) During budget hearings in 2008 and 2009, report to the
31 Legislature regarding the implementation of this section and
32 subdivision (c) of Section 14716.

33 (3) On or before July 1, 2008, establish the following, in
34 consultation with stakeholders, including, but not limited to, the
35 County Behavioral Health Directors Association of California, the
36 California Alliance of Child and Family Services, and the County
37 Welfare Directors Association of California:

38 (A) Informational materials that explain to foster care providers
39 how to arrange for specialty mental health services on behalf of
40 the beneficiary in their care.

1 (B) Informational materials that county child welfare agencies
2 can access relevant to the provision of services to children in their
3 care from the out-of-county local mental health plan that is
4 responsible for providing those services, including, but not limited
5 to, receiving a copy of the child’s treatment plan within 60 days
6 after requesting services.

7 (C) It is the intent of the Legislature to ensure that foster children
8 who are adopted or placed permanently with relative guardians,
9 and who move to a county outside their original county of
10 residence, can access specialty mental health services in a timely
11 manner. It is the intent of the Legislature to enact this section as
12 a temporary means of ensuring access to these services, while the
13 appropriate stakeholders pursue a long-term solution in the form
14 of a change to the Medi-Cal Eligibility Data System that will allow
15 these children to receive specialty mental health services through
16 their new county of residence.

17 ~~SEC. 72.~~

18 *SEC. 59.* Section 14718 of the Welfare and Institutions Code
19 is amended to read:

20 14718. (a) This section shall be limited to specialty mental
21 health services reimbursed to a mental health plan that certifies
22 public expenditures subject to cost settlement or specialty mental
23 health services reimbursed through the department’s fiscal
24 intermediary.

25 (b) The following provisions shall apply to matters related to
26 specialty mental health services provided under the approved
27 Medi-Cal state plan and the Specialty Mental Health Services
28 Waiver, including, but not limited to, reimbursement and claiming
29 procedures, reviews and oversight, and appeal processes for mental
30 health plans (MHPs) and MHP subcontractors.

31 (1) As determined by the department, the MHP shall submit
32 claims for reimbursement to the Medi-Cal program for eligible
33 services.

34 (2) The department may offset the amount of any federal
35 disallowance, audit exception, or overpayment against subsequent
36 claims from the MHP. The department may offset the amount of
37 any state disallowance, or audit exception or overpayment against
38 subsequent claims from the mental health plan, through the
39 2010–11 fiscal year. This offset may be done at any time, after the
40 department has invoiced or otherwise notified the mental health

1 plan about the audit exception, disallowance, or overpayment. The
2 department shall determine the amount that may be withheld from
3 each payment to the mental health plan. The maximum withheld
4 amount shall be 25 percent of each payment as long as the
5 department is able to comply with the federal requirements for
6 repayment of federal financial participation pursuant to Section
7 1903(d)(2) of the federal Social Security Act (42 U.S.C. Sec.
8 1396b(d)(2)). The department may increase the maximum amount
9 when necessary for compliance with federal laws and regulations.

10 (3) (A) Oversight by the department of the MHPs may include
11 client record reviews of Early and Periodic Screening, Diagnosis,
12 and Treatment (EPSDT) specialty mental health services rendered
13 by MHPs and MHP subcontractors under the Medi-Cal specialty
14 mental health services waiver in addition to other audits or reviews
15 that are conducted.

16 (B) The department may contract with an independent,
17 nongovernmental entity to conduct client record reviews. The
18 contract awarded in connection with this section shall be on a
19 competitive bid basis, pursuant to the Department of General
20 Services contracting requirements, and shall meet both of the
21 following additional requirements:

22 (i) Require the entity awarded the contract to comply with all
23 federal and state privacy laws, including, but not limited to, the
24 federal Health Insurance Portability and Accountability Act
25 (HIPAA; 42 U.S.C. Sec. 1320d et seq.) and its implementing
26 regulations, the Confidentiality of Medical Information Act (Part
27 2.6 (commencing with Section 56) of Division 1 of the Civil Code),
28 and Section 1798.81.5 of the Civil Code. The entity shall be subject
29 to existing penalties for violation of these laws.

30 (ii) Prohibit the entity awarded the contract from using or
31 disclosing client records or client information for a purpose other
32 than the one for which the record was given.

33 (iii) Prohibit the entity awarded the contract from selling client
34 records or client information.

35 (C) For purposes of this paragraph, the following terms shall
36 have the following meanings:

37 (i) “Client record” means a medical record, chart, or similar
38 file, as well as other documents containing information regarding
39 an individual recipient of services, including, but not limited to,
40 clinical information, dates and times of services, and other

1 information relevant to the individual and services provided and
2 that evidences compliance with legal requirements for Medi-Cal
3 reimbursement.

4 (ii) “Client record review” means examination of the client
5 record for a selected individual recipient for the purpose of
6 confirming the existence of documents that verify compliance with
7 legal requirements for claims submitted for Medi-Cal
8 reimbursement.

9 (D) The department shall recover overpayments of federal
10 financial participation from MHPs within the timeframes required
11 by federal law and regulation for repayment to the federal Centers
12 for Medicare and Medicaid Services.

13 (4) (A) The department, in consultation with mental health
14 stakeholders, the County Behavioral Health Directors Association
15 of California, and MHP subcontractor representatives, shall provide
16 an appeals process that specifies a progressive process for
17 resolution of disputes about claims or recoupments relating to
18 specialty mental health services under the Medi-Cal specialty
19 mental health services waiver.

20 (B) The department shall provide MHPs and MHP
21 subcontractors the opportunity to directly appeal findings in
22 accordance with procedures that are similar to those described in
23 Article 1.5 (commencing with Section 51016) of Chapter 3 of
24 Subdivision 1 of Division 3 of Title 22 of the California Code of
25 Regulations, until new regulations for a progressive appeals process
26 are promulgated. When an MHP subcontractor initiates an appeal,
27 it shall give notice to the MHP. The department shall propose a
28 rulemaking package consistent with the department’s appeals
29 process that is in effect on July 1, 2012, by no later than the end
30 of the 2013–14 fiscal year. The reference in this subparagraph to
31 the procedures described in Article 1.5 (commencing with Section
32 51016) of Chapter 3 of Subdivision 1 of Division 3 of Title 22 of
33 the California Code of Regulations, shall only apply to those
34 appeals addressed in this subparagraph.

35 (C) The department shall develop regulations as necessary to
36 implement this paragraph.

37 (5) The department shall conduct oversight of utilization controls
38 as specified in Section 14133. The MHP shall include a
39 requirement in any subcontracts that all inpatient subcontractors
40 maintain necessary licensing and certification. MHPs shall require

1 that services delivered by licensed staff are within their scope of
2 practice. Nothing in this chapter shall prohibit the MHPs from
3 establishing standards that are in addition to the federal and state
4 requirements, provided that these standards do not violate federal
5 and state requirements and guidelines.

6 (6) (A) Subject to federal approval and consistent with state
7 requirements, the MHP may negotiate rates with providers of
8 specialty mental health services.

9 (B) Any excess in the distribution of funds over the expenditures
10 for services by the mental health plan shall be spent for the
11 provision of specialty mental health services and related
12 administrative costs.

13 (7) Nothing in this chapter shall limit the MHP from being
14 reimbursed appropriate federal financial participation for any
15 qualified services. To receive federal financial participation, the
16 mental health plan shall certify its public expenditures for specialty
17 mental health services to the department.

18 (8) Notwithstanding Section 14115, claims for federal
19 reimbursement for service pursuant to this chapter shall be
20 submitted by MHPs within the timeframes required by federal
21 Medicaid requirements and the approved Medicaid state plan and
22 waivers.

23 (9) The MHP shall use the fiscal intermediary of the Medi-Cal
24 program of the State Department of Health Care Services for the
25 processing of claims for inpatient psychiatric hospital services
26 rendered in fee-for-service Medi-Cal hospitals. The department
27 shall request the Controller to offset the distribution of funds to
28 the counties from the Mental Health Subaccount, the Mental Health
29 Equity Subaccount, or the Vehicle License Collection Account of
30 the Local Revenue Fund, or funds from the Mental Health Account
31 or the Behavioral Health Subaccount of the Local Revenue Fund
32 2011 for the nonfederal financial participation share for these
33 claims.

34 (c) Counties may set aside funds for self-insurance, audit
35 settlement, and statewide program risk pools. The counties shall
36 assume all responsibility and liability for appropriate administration
37 of the funds. Special consideration may be given to small counties
38 with a population of less than 200,000. This subdivision shall not
39 make the state or department liable for mismanagement or loss of
40 funds by the entity designated by counties under this subdivision.

1 (d) The department shall consult with the County Behavioral
2 Health Directors Association of California in February and
3 September of each year to obtain data and methodology necessary
4 to forecast future fiscal trends in the provision of specialty mental
5 health services provided under the Medi-Cal specialty mental
6 health services waiver, to estimate yearly specialty mental health
7 services related costs, and to estimate the annual amount of federal
8 funding participation to reimburse costs of specialty mental health
9 services provided under the Medi-Cal specialty mental health
10 services waiver. This shall include a separate presentation of the
11 data and methodology necessary to forecast future fiscal trends in
12 the provision of Early Periodic Screening, Diagnosis, and
13 Treatment specialty mental health services provided under the
14 Medi-Cal specialty mental health services waiver, to estimate
15 annual EPSDT specialty mental health services related costs, and
16 to estimate the annual amount of EPSDT specialty mental health
17 services provided under the state Medi-Cal specialty mental health
18 services waiver, including federal funding participation to
19 reimburse costs of EPSDT.

20 (e) When seeking federal approval for any federal Medicaid
21 state plan amendment or waiver associated with Medi-Cal specialty
22 mental health services, the department shall consult with staff of
23 the Legislature, counties, providers, and other stakeholders in the
24 development of the state plan amendment or waiver.

25 (f) This section shall become operative on July 1, 2012.

26 ~~SEC. 73.~~

27 *SEC. 60.* Section 14725 of the Welfare and Institutions Code
28 is amended to read:

29 14725. (a) The State Department of Health Care Services shall
30 develop a quality assurance program to govern the delivery of
31 Medi-Cal specialty mental health services, in order to ensure
32 quality patient care based on community standards of practice.

33 (b) The department shall issue standards and guidelines for local
34 quality assurance activities. These standards and guidelines shall
35 be reviewed and revised in consultation with the County Behavioral
36 Health Directors Association of California, as well as other
37 stakeholders from the mental health community, including, but
38 not limited to, individuals who receive services, family members,
39 providers, mental health advocacy groups, and other interested

1 parties. The standards and guidelines shall be based on federal
2 Medicaid requirements.

3 (c) The standards and guidelines developed by the department
4 shall reflect the special problems that small rural counties have in
5 undertaking comprehensive quality assurance systems.

6 ~~SEC. 74.~~

7 *SEC. 61.* Section 15204.8 of the Welfare and Institutions Code
8 is amended to read:

9 15204.8. (a) The Legislature may appropriate annually in the
10 Budget Act funds to support services provided pursuant to Sections
11 11325.7 and 11325.8.

12 (b) Funds appropriated pursuant to subdivision (a) shall be
13 allocated to the counties separately and shall be available for
14 expenditure by the counties for services provided during the budget
15 year. A county may move funds between the two accounts during
16 the budget year for expenditure if necessary to meet the particular
17 circumstances in the county. Any unexpended funds may be
18 retained by each county for expenditure for the same purposes
19 during the succeeding fiscal year. By November 20, 1998, each
20 county shall report to the department on the use of these funds.

21 (c) Beginning January 10, 1999, the Department of Finance
22 shall report annually to the Legislature on the extent to which funds
23 available under subdivision (a) have not been spent and may
24 reallocate the unexpended balances so as to better meet the need
25 for services.

26 (d) No later than September 1, 2001, the department in
27 consultation with relevant stakeholders, which may include the
28 County Welfare Directors Association and the County Behavioral
29 Health Directors Association of California, shall develop the
30 allocation methodology for these funds, including the specific
31 components to be considered in allocating the funds.

32 ~~SEC. 75.~~

33 *SEC. 62.* Section 15847.7 of the Welfare and Institutions Code
34 is amended to read:

35 15847.7. (a) For purposes of Sections 15847, 15847.3, and
36 15847.5, “group health coverage” includes any health care service
37 plan, self-insured employee welfare benefit plan, or disability
38 insurance providing medical or hospital benefits.

39 (b) This section shall become operative on July 1, 2014.

1 ~~SEC. 76. No reimbursement is required by this act pursuant to~~
2 ~~Section 6 of Article XIII B of the California Constitution because~~
3 ~~the only costs that may be incurred by a local agency or school~~
4 ~~district will be incurred because this act creates a new crime or~~
5 ~~infraction, eliminates a crime or infraction, or changes the penalty~~
6 ~~for a crime or infraction, within the meaning of Section 17556 of~~
7 ~~the Government Code, or changes the definition of a crime within~~
8 ~~the meaning of Section 6 of Article XIII B of the California~~
9 ~~Constitution.~~

O