AMENDED IN SENATE JUNE 14, 2013

AMENDED IN SENATE JUNE 13, 2013

AMENDED IN SENATE JUNE 12, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 82

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

January 10, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This bill would delete these provisions.

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

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

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

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

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

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

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

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

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

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

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

This bill would delete the above-described exception.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The prisoner's name.

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

(3) The date of sentence, if applicable.

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

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

(6) The prisoner's address after release.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The facility is a licensed facility.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Involuntary ambulatory psychiatric patients.

(2) Voluntary ambulatory psychiatric patients.

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

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

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

(d) The regulations shall include provisions for an "open planning" architectural concept.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) For the purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) In compliance with Sections 12693.71 and 12693.72.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Activities programs.

(B) Administrative policies and procedures.

(C) Admissions, including provisions for a mental evaluation.

(D) Discharge planning.

(E) Health records content.
(F) Health records services.
(G) Interdisciplinary treatment teams.
(H) Nursing services.
(I) Patient rights.
(J) Pharmaceutical services.
(K) Program space requirements.
(L) Psychiatrist and clinical psychological services.
(M) Rehabilitation services.
(N) Restraint and seclusion.
(O) Social work services.
(P) Space, supplies, and equipment.
(Q) Staffing standards.
(R) Unusual occurrences.
(S) Use of outside resources, including agreements with general acute care hospitals.
(T) Linguistic access and cultural competence.
(U) Structured outpatient services to be provided under special permit.

(2) The State Department of Health Care Services has the sole authority to grant program flexibility.

(f) Commencing July 1, 2013, the State Department of Health Care Services may adopt regulations regarding psychiatric health facilities that shall include, but not be limited to, all of the following:

(1) Procedures by which the State Department of Health Care Services shall review and may approve the program and facility requesting licensure as a psychiatric health facility as being in compliance with program standards established by the department.

(2) Procedures by which the Director of Health Care Services shall approve, or deny approval of, the program and facility licensed as a psychiatric health facility pursuant to this section.

(3) Provisions for site visits by the State Department of Health Care Services for the purpose of reviewing a facility's compliance with program and facility standards.

(4) Provisions for the State Department of Health Care Services for any administrative proceeding regarding denial, suspension, or revocation of a psychiatric health facility license.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Cease and desist orders.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

My name is _____ .
I am a _____ .
(peace officer, mental health professional)
with _____ .
(name of agency)
You are not under criminal arrest, but I am taking you for examination by mental health professionals at _____ .
_____
(name of facility)
You will be told your rights by the mental health staff.

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

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

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

(1) Name of person detained for evaluation.

(2) Name and position of peace officer or mental health professional taking person into custody.

(3) Date.

(4) Whether advisement was completed.

(5) If not given or completed, the mental health professional at the facility shall either provide the information specified in subdivision (a), or include a statement of good cause, as defined by regulations of the State Department of Health Care Services, which shall be kept with the patient's medical record.

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

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

My name is _____.
My position here is _____.
You are being placed into the psychiatric unit because it is our professional opinion that as a result of mental disorder, you are likely to:
(check applicable)
harm yourself ____
harm someone else ____
be unable to take care of your own
food, clothing, and housing needs ____
We feel this is true because
_____
(herewith a listing of the facts upon which the allegation of dangerous or gravely disabled due to mental disorder is based, including pertinent facts arising from the admission interview.)
You will be held on the ward for a period up to 72 hours.
This does not include weekends or holidays.
Your 72-hour period will begin _____
(day and time.)
During these 72 hours you will be evaluated by the hospital staff, and you may be given treatment, including medications. It is possible for you to be released before the end of the 72 hours. But if the staff decides that you need continued treatment you can be held for a longer period of time. If you are held longer than 72 hours you have the right to a lawyer and a qualified interpreter and a hearing before a judge. If you are unable to pay for the lawyer, then one will be provided free.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

representing the originating county prior to any change of placement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(F) Employment history and current employer recommendations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The program shall include the following components:

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

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

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

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

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

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

(1) Suicide.

(2) Incarcerations.

(3) School failure or dropout.

(4) Unemployment.

(5) Prolonged suffering.

(6) Homelessness.

(7) Removal of children from their homes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding any authority expressly granted to any officer or employee of state government.

(5) Enter into contracts.

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

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

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

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

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

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

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

SEC. 50. Section 5846 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) The amount billed.

(B) The charge to the general public.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Acupuncture services.

(C) Audiology services and speech therapy services.

(D) Chiropractic services.

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

(F) Podiatric services.

(G) Psychology services.

(H) Incontinence creams and washes.

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

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

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

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

(ii) Amalgam and composite restorations.

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

(iv) Anterior root canal therapy.

(v) Complete dentures, including immediate dentures.

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

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

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

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

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

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

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

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

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

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the provisions of this section by means of all-county letters, provider bulletins, or similar instructions, without taking further regulatory action.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Placing the individual's health, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
(B) Serious impairment to bodily functions.
(C) Serious dysfunction of any bodily organ or part.

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

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

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

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

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

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

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

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

(D) Any woman receiving perinatal care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Serious impairment to bodily functions.

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

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

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

(B) Serious impairment to bodily functions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) High quality and accessible EPSDT mental health services for eligible children and youth, consistent with federal law.

(B) Information that improves practice at the individual, program, and system levels.

(C) Minimization of costs by building upon existing resources to the fullest extent possible.

(D) Reliable data that are collected and analyzed in a timely fashion.

(3) At a minimum, the plan for a performance outcome system for EPSDT mental health services shall consider evidence-based models for performance outcome systems, such as the Child and Adolescent Needs and Strengths (CANS), federal requirements, including the review by the External Quality Review Organization (EQRO), and, timelines for implementation at the provider, county, and state levels.

(c) The State Department of Health Care Services shall provide the performance outcomes system plan, including milestones and timelines, for EPSDT mental health services described in subdivision (a) to all fiscal committees and appropriate policy committees of the Legislature no later than October 1, 2013.

(d) The State Department of Health Care Services shall propose how to implement the performance outcomes system plan for EPSDT mental health services described in subdivision (a) no later than January 10, 2014.

(e) Commencing no later than February 1, 2014, the department shall convene a stakeholder advisory committee comprised of advocates for and representatives of, child and youth clients, family members, managed care health plans, providers, counties, and the Legislature. The committee shall develop methods to routinely measure, assess, and communicate program information regarding informing, identifying, screening, assessing, referring, and linking Medi-Cal eligible beneficiaries to mental health services and supports. The committee shall also review health plan screenings for mental health illness, health plan referrals to Medi-Cal fee-for-service providers, and health plan referrals to county mental health plans, among others. The committee shall make recommendations to the department regarding performance and outcome measures that will contribute to improving timely access to appropriate care for Medi-Cal eligible beneficiaries.

(1) The department shall incorporate into the performance outcomes system established pursuant to this section the screenings and referrals described in this subdivision, including milestones

and timelines, and shall provide an updated performance outcomes system plan to all fiscal committees and the appropriate policy committees of the Legislature no later than October 1, 2014.

(2) The department shall propose how to implement the updated performance systems outcome plan described in paragraph (1) no later than January 10, 2015.

SEC. 68. Part 3.3 (commencing with Section 15800) is added to Division 9 of the Welfare and Institutions Code, to read:

PART 3.3. HEALTH CARE COVERAGE ASSISTANCE

Chapter 1. General Provisions

15800. (a) (1) Commencing October 1, 2013, the State Department of Health Care Services shall administer the AIM-Linked Infants Program to address the health care needs of children formerly covered pursuant to clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the Insurance Code. The department is vested with the same powers, purposes, responsibilities, and jurisdiction exercised by the Managed Risk Medical Insurance Board as they relate to those children. Nothing in this paragraph shall be construed to alter, diminish, or supersede the authority of the Managed Risk Medical Insurance Board to exercise the same powers, purposes, responsibilities, and jurisdiction within the Healthy Families Program established under Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(2) The department may, before October 1, 2013, conduct transition activities necessary to ensure the efficient transfer of the program identified in subdivision (a) and populations served by that program.

(b) The department shall seek any federal waivers, approvals, and state plan amendments necessary to implement this part. This part shall only be implemented to the extent that necessary federal approvals are obtained and federal financial participation is available for eligible programs and services.

15801. The terms of all regulations and orders adopted by the Managed Risk Medical Insurance Board in effect immediately preceding October 1, 2013, that relate to the operation of the program and to the children transferred by the act that added this

section and are not rendered legally unenforceable by the act that added this section shall be fully enforceable by the State Department of Health Care Services within the AIM-Linked Infants Program unless and until the department adopts regulations for the AIM-Linked Infants Program. Nothing in this section shall be construed to alter, diminish, or supersede the authority of the Managed Risk Medical Insurance Board to interpret, enforce, maintain, or amend the same regulations for purposes of the Healthy Families Program established under Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

15802. (a) The State Department of Health Care Services may issue rules and regulations to carry out the purposes of this part.

(b) Notwithstanding subdivision (a) or Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory actions, may implement, interpret, or make specific this part and amend or repeal regulations and orders adopted by the Managed Risk Medical Insurance Board as provided in Section 15801 by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action during the transition of the programs to the department. Thereafter, the adoption and readoption of regulations to implement, interpret, or make specific this part shall be deemed to be an emergency that calls for immediate action to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is exempted from the requirement that it describe facts showing the need for immediate action. The regulations shall become effective immediately upon filing with the Secretary of State.

15803. (a) To implement this part and clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the Insurance Code, the State Department of Health Care Services may contract with public or private entities, including the Managed Risk Medical Insurance Board, which administers the Access for Infants and Mothers Program pursuant to Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code. Contracts entered into under this part may be on a noncompetitive bid basis and shall be exempt from the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code.

(3) Review or approval of contracts by the Department of General Services.

(b) During the transition of the programs to the department, the department shall also be exempt from the review or approval of feasibility study reports and the requirements of Sections 4819.35 to 4819.37, inclusive, and 4920 to 4928, inclusive, of the State Administrative Manual.

15804. On October 1, 2013, or when the State Department of Health Care Services has implemented Chapter 2 (commencing with Section 15850), whichever occurs later, the Managed Risk Medical Insurance Board shall cease to provide coverage to the children transferred to the AIM-Linked Infants Program, pursuant to Section 15800.

15805. (a) The Managed Risk Medical Insurance Board shall provide the State Department of Health Care Services any data, information, or record concerning the Healthy Families Program or the Access for Infants and Mothers Program as are necessary to implement this part and clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the Insurance Code.

(b) Notwithstanding any other law, all of the following shall apply:

(1) The term "data, information, or record" shall include, but is not limited to, personal information as defined in Section 1798.3 of the Civil Code.

(2) Any data, information, or record shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of the Government Code) and any other law, to the same extent that it was exempt from disclosure or privileged prior to the provision of the data, information, or record to the department.

(3) The provision of any data, information, or record to the department shall not constitute a waiver of any evidentiary privilege or exemption from disclosure.

(4) The department shall keep all data, information, or records provided by the Managed Risk Medical Insurance Board confidential to the full extent permitted by law, including, but not limited to, the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of the Government Code), and consistent with the Managed Risk Medical Insurance Board's contractual obligations to keep data, information, or records confidential.

Chapter 2. AIM-Linked Infants Program

15810. This chapter shall be known, and may be cited, as the AIM-Linked Infants Program.

15811. The definitions contained in this section govern the construction of this chapter, unless the context requires otherwise.

(a) "AIM-linked infant" means any infant born to a woman whose enrollment in the Access for Infants and Mothers Program under Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code begins after June 30, 2004.

(b) "Department" means the State Department of Health Care Services.

(c) "Program" means the AIM-Linked Infants Program.

(d) "Subscriber" means an individual who is eligible for and enrolled in the program.

(e) "Subscriber contribution" means the cost to the subscriber to participate in the program.

15822. Health care services under the program shall include, but are not limited to, all of the following:

(a) Preventive, screening, diagnostic, and treatment services furnished directly by a licensed clinic, either onsite or by formal written contract, on a case-managed basis, to patients who remain less than 24 hours at the clinic for an illness or injury, advice, counseling, outreach, and translation as needed.

(b) Physician services.

(c) Emergency first aid, perinatal, obstetric, radiology, laboratory, and nutrition services.

(d) Services of advanced practice nurses or mid-level practitioners who are authorized to perform any of the services listed in this section within the scope of their licensure.

(e) All services and benefits set forth in Chapter 7 (commencing with Section 14000) of Part 3.

15824. To the extent permitted by federal law, services for individuals eligible under this chapter shall be provided, at the department's discretion and to the extent the department determines the selected delivery system is cost effective, through the Medi-Cal fee-for-service or managed care delivery system, or both.

15826. The department shall administer the program and may do all of the following:

(a) Determine eligibility criteria for the program. These criteria shall include the requirements set forth in Section 15832.

(b) Determine the eligibility of AIM-linked infants.

(c) Determine when subscribers are covered and the extent and scope of coverage.

(d) Determine subscriber contribution amounts schedules. Subscriber contributions shall not be greater than those applicable on March 23, 2010, for infants enrolled pursuant to clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the Insurance Code.

(e) Provide coverage through Medi-Cal delivery systems and contract for the administration of the program and the enrollment of subscribers. Any contract entered into pursuant to this chapter shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The department shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on projected and actual subscriber enrollments in a total amount not to exceed the amount appropriated for the program.

(f) Authorize expenditures to pay program expenses that exceed subscriber contributions, and to administer the program as necessary.

(g) Develop a promotional component of the program to make Californians aware of the program and the opportunity that it presents.

(h) (1) Issue rules and regulations as necessary to administer the program.

(2) During the 2011–12 to 2014–15 fiscal years, inclusive, the adoption and readoption of regulations pursuant to this chapter shall be deemed to be an emergency that calls for immediate action

to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that the department describe facts showing the need for immediate action.

(i) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this chapter.

15828. The department shall coordinate with other state agencies, as appropriate, to help ensure continuity of health care services.

15830. (a) The department may contract with a variety of health plans and types of health care service delivery systems in order to offer subscribers a choice of plans, providers, and types of service delivery.

(b) Participating health plans contracting with the department pursuant to this chapter shall provide benefits or coverage to subscribers only as determined by the department pursuant to subdivision (b) of Section 15826.

15832. To be eligible to participate in the program, a person shall meet all of the following requirements:

(a) (1) Be a child under two years of age who is delivered by a mother enrolled in the program under Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code. Except as stated in this section, these infants shall be automatically enrolled in the program.

(2) For the applicable month, not be enrolled in employer-sponsored health care coverage, or have been enrolled in that health care coverage in the prior three months or enrolled in full-scope Medi-Cal without a share of cost. Exceptions may be identified in regulations or other guidance and shall, at minimum, include all exceptions applicable to the Healthy Families Program on and after March 23, 2010.

(3) Be subject to subscriber contributions as determined by the department. The subscriber contributions shall not be greater than those applicable on March 23, 2010, for infants enrolled in the Healthy Families Program pursuant to clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the Insurance Code.

(b) For AIM-linked infants identified in subdivision (a), all of the following shall apply:

(1) Enrollment shall cover the first 12 months of the infant's life unless he or she is eligible for Medi-Cal benefits under Section 14005.26. If the infant is eligible under Section 14005.26, he or she shall be automatically enrolled in the Medi-Cal program on that basis.

(2) (A) At the end of the 12 months, as a condition of continued eligibility, the subscriber shall provide income information. The infant shall be disenrolled from the program if the annual household income exceeds 300 percent of the federal poverty level, or if the infant is eligible for full-scope Medi-Cal with no share of cost.

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

(3) At the end of their first and second year in the program, infants shall be screened for eligibility for the Medi-Cal program.

(c) If at any time the director determines that the eligibility criteria established under this chapter for the program may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act, the director may alter the eligibility criteria to the extent necessary for the state to receive that federal financial participation.

15834. A person shall not be eligible for covered services under the program if those services are covered through private health care coverage arrangements at the time of eligibility.

15836. (a) If a subscriber is dissatisfied with any action, or failure to act, that has occurred in connection with eligibility or covered services under this chapter, the subscriber may appeal to the department and shall be accorded an opportunity for a fair hearing. Hearings may be conducted pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(b) The department may place a lien on compensation or benefits that are recovered or recoverable by a subscriber for whom benefits have been provided under a policy or plan issued under this chapter from any party or parties responsible for the compensation or benefits.

15838. (a) A provider who is furnished documentation of a subscriber's enrollment in the program shall not seek reimbursement or attempt to obtain payment for any covered services provided to that subscriber other than from the participating health plan or insurer covering the subscriber or from the department.

(b) Subdivision (a) shall not apply to any copayment required by the department under this chapter for the covered services provided to the subscriber.

(c) For purposes of this chapter, "provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services and includes as that term is defined in subdivision (o) of Section 14043.1.

15840. (a) At a minimum, coverage provided pursuant to this chapter shall be provided to eligible AIM-linked infants less than two years of age.

(b) Coverage provided pursuant to this chapter shall include, at a minimum, those services required to be provided by health care service plans approved by the Secretary of Health and Human Services as a federally qualified health care service plan pursuant to Section 417.101 of Title 42 of the Code of Federal Regulations.

(c) Medically necessary prescription drugs shall be a required benefit in the coverage provided pursuant to this chapter.

15842. Notwithstanding any other law, for a subscriber who is determined by the California Children's Services Program to be eligible for benefits under the program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, a provider shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. Providers shall refer a child whom they reasonably suspect of having a medical condition that is eligible for services under the California

Children's Services Program to the California Children's Services Program. The California Children's Services Program shall provide case management and authorization of services if the child is found to be medically eligible for the California Children's Services Program. Diagnosis and treatment services that are authorized by the California Children's Services Program shall be performed by paneled providers for that program and approved special care centers of that program in accordance with treatment plans approved by the California Children's Services Program. All other services provided under this chapter shall be available to the subscriber.

15844. A child enrolled in the program under this chapter who has a medical condition that is eligible for services pursuant to the California Children's Services Program, and whose family is not financially eligible for the California Children's Services Program, shall have the medically necessary treatment services for his or her California Children's Services Program eligible medical condition authorized and paid for by the California Children's Services Program. County expenditures for the payment of services for the child shall be waived and these expenditures shall be paid for by the state from Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.) funds and state general funds.

15846. The department shall encourage all providers who provide services under the program to have viable protocols for screening and referring children needing supplemental services outside of the scope of the screening, preventive, and medically necessary and therapeutic services covered by the contract to public programs providing such supplemental services for which they may be eligible, as well as for coordination of care between the provider and the public programs. The public programs for which providers may be required to develop screening, referral, and care coordination protocols may include the California Children's Services Program, the regional centers, county mental health programs, programs administered by the Department of Alcohol and Drug Programs or its successor agency or agencies, and programs administered by local education agencies.

SEC. 69. Section 15911 of the Welfare and Institutions Code is amended to read:

15911. (a) Funding for each LIHP shall be based on all of the following:

(1) The amount of funding that the participating entity voluntarily provides for the nonfederal share of LIHP expenditures.

(2) For a LIHP that had in operation a Health Care Coverage Initiative program under Part 3.5 (commencing with Section 15900) as of November 1, 2010, and elects to continue funding the program, the amount of funds requested to ensure that eligible enrollees continue to receive health care services for persons enrolled in the Health Care Coverage Initiative program as of November 1, 2010.

(3) Any limitations imposed by the Special Terms and Conditions of the demonstration project.

(4) The total allocations requested by participating entities for Health Care Coverage Initiative eligible individuals.

(5) Whether funding under this part would result in the reduction of other payments under the demonstration project.

(b) Nothing in this part shall be construed to require a political subdivision of the state to participate in a LIHP as set forth in this part, and those local funds expended or transferred for the nonfederal share of LIHP expenditures under this part shall be considered voluntary contributions for purposes of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), as amended by the federal Patient Protection and Affordable Care Act.

(c) No state General Fund moneys shall be used to fund LIHP services, nor to fund any related administrative costs incurred by counties or any other political subdivision of the state.

(d) Subject to the Special Terms and Conditions of the demonstration project, if a participating entity elects to fund the nonfederal share of a LIHP, the nonfederal funding and payments to the LIHP shall be provided through one of the following mechanisms, at the options of the participating entity:

(1) On a quarterly basis, the participating entity shall transfer to the department for deposit in the LIHP Fund established for the participating counties and pursuant to subparagraph (A), the amount necessary to meet the nonfederal share of estimated payments to the LIHP for the next quarter under subdivision (g) Section 15910.3.

(A) The LIHP Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, all moneys in the fund shall be continuously appropriated to the department for the purposes specified in this part. The fund shall contain all moneys deposited into the fund in accordance with this paragraph.

(B) The department shall obtain the related federal financial participation and pay the rates established under Section 15910.3, provided that the intergovernmental transfer is transferred in accordance with the deadlines imposed under the Medi-Cal Checkwrite Schedule, no later than the next available warrant release date. This payment shall be a nondiscretionary obligation of the department, enforceable under a writ of mandate pursuant to Section 1085 of the Code of Civil Procedure. Participating entities may request expedited processing within seven business days of the transfer as made available by the Controller's office, provided that the participating entity prepay the department for the additional administrative costs associated with the expedited processing.

(C) Total quarterly payment amounts shall be determined in accordance with estimates of the number of enrollees in each rate category, subject to annual reconciliation to final enrollment data.

(2) If a participating entity operates its LIHP through a contract with another entity, the participating entity may pay the operating entity based on the per enrollee rates established under Section 15910.3 on a quarterly basis in accordance with estimates of the number of enrollees in each rate category, subject to annual reconciliation to final enrollment data.

(A) (i) On a quarterly basis, the participating entity shall certify the expenditures made under this paragraph and submit the report of certified public expenditures to the department.

(ii) The department shall report the certified public expenditures of a participating entity under this paragraph on the next available quarterly report as necessary to obtain federal financial participation for the expenditures. The total amount of federal financial participation associated with the participating entity's expenditures under this paragraph shall be reimbursed to the participating entity.

(B) At the option of the participating entity, the LIHP may be reimbursed on a cost basis in accordance with the methodology

applied to Health Care Coverage Initiative programs established under Part 3.5 (commencing with Section 15900) including interim quarterly payments.

(e) Notwithstanding Section 15910.3 and subdivision (d) of this section, if the participating entity cannot reach an agreement with the department as to the appropriate rate to be paid under Section 15910.3, at the option of the participating entity, the LIHP shall be reimbursed on a cost basis in accordance with the methodology applied to Health Care Coverage Initiative programs established under Part 3.5 (commencing with Section 15900), including interim quarterly payments. If the participating entity and the department reach an agreement as to the appropriate rate, the rate shall be applied no earlier than the first day of the LIHP year in which the parties agree to the rate.

(f) If authorized under the Special Terms and Conditions of the demonstration project, pending the department's development of rates in accordance with Section 15910.3, the department shall make interim quarterly payments to approved LIHPs for expenditures based on estimated costs submitted for rate setting.

(g) Participating entities that operate a LIHP directly or through contract with another entity shall be entitled to any federal financial participation available for administrative expenditures incurred in the operation of the Medi-Cal program or the demonstration project, including, but not limited to, outreach, screening and enrollment, program development, data collection, reporting and quality monitoring, and contract administration, but only to the extent that the expenditures are allowable under federal law and only to the extent the expenditures are not taken into account in the determination of the per enrollee rates under Section 15910.3.

(h) On and after January 1, 2014, the state shall implement comprehensive health care reform for the populations targeted by the LIHP in compliance with federal health care reform law, regulation, and policy, including the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and subsequent amendments.

(i) Subject to the Special Terms and Conditions of the demonstration project, a participating entity may elect to include, in collaboration with the department, as the nonfederal share of LIHP expenditures, voluntary intergovernmental transfers or

certified public expenditures of another governmental entity, as long as the intergovernmental transfer or certified public expenditure is consistent with federal law.

(j) Participation in the LIHP under this part is voluntary on the part of the eligible entity for purposes of all applicable federal laws. As part of its voluntary participation under this article, the participating entity shall agree to reimburse the state for the nonfederal share of state staffing and administrative costs directly attributable to the cost of administering that LIHP, including, but not limited to, the state administrative costs related to certified public expenditures and intergovernmental transfers. This section shall be implemented only to the extent federal financial participation is not jeopardized.

SEC. 70. (a) The State Department of Health Care Services shall accept contributions by private foundations in the amount of at least fourteen million dollars ($14,000,000) for the purpose of this section and shall immediately seek an equal amount of federal matching funds.

(b) Entities and persons that are eligible for Medi-Cal in-person enrollment assistance payments of fifty-eight dollars ($58) per approved Medi-Cal application and payment processing costs shall be those trained and eligible for in-person enrollment assistance payments by the California Health Benefit Exchange. The payments may be made by the State Department of Health Care Services or through the California Health Benefit Exchange in-person assistance payment system.

(c) Enrollment assistance payments shall be made only for Medi-Cal applicants newly eligible for coverage pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), or those who have not been enrolled in the Medi-Cal program during the previous 12 months prior to making the application.

(d) The commencement of enrollment assistance payments shall be consistent with those of the California Health Benefit Exchange.

(e) The State Department of Health Care Services or the California Health Benefit Exchange shall provide monthly and cumulative payment updates and number of persons enrolled through in-person assistance payments on its Internet Web site.

SEC. 71. (a) (1) The State Department of Health Care Services shall accept funding from private foundations in the amount of at least $12.5 million to provide allocations for the management and funding of Medi-Cal outreach and enrollment plans specific to the provisions contained in this section.

(2) The department shall seek necessary federal approval for purposes of obtaining federal funding for activities conducted under this section.

(3) Notwithstanding any other law, and in a manner that the Director of Health Care Services shall provide, the department may make allocations to fund Medi-Cal outreach and enrollment activities as described in this section.

(b) (1) Funds appropriated by the Legislature to the department for the purposes of this section shall be made available to selected counties, counties acting jointly, and the County Medical Services Program Governing Board pursuant to Section 16809 of the Welfare and Institutions Code.

(2) Selected counties, counties acting jointly, and the County Medical Services Program Governing Board may partner with community-based organizations as applicable to conduct outreach and enrollment to the target population as contained in subdivision (d).

(3) The director may, at his or her discretion, also give consideration to community-based organizations in an area or region of the state if a county, or counties acting jointly do not seek an allocation or funds are made available.

(4) For purposes of this section only, "county" shall be defined as county, city and county, a consortium of counties serving a region consisting of more than one county, the County Medical Services Program Governing Board, or a health authority.

(c) (1) The allocations shall be apportioned geographically, by the entities identified in subdivision (b), according to the estimated number of persons who are eligible but not enrolled in Medi-Cal and who will be newly Medi-Cal eligible as of January 1, 2014.

(2) The department may determine the number of allocations and the application process. The director may consult or obtain technical assistance from private foundations in implementation of the application and allocation process.

(3) The department shall coordinate and partner with the California Health Benefit Exchange on certified application assister

and outreach, enrollment, and marketing activities related to the federal Patient Protection and Affordable Care Act.

(d) Notwithstanding any other law, the department shall develop selection criteria to allocate funds for the Medi-Cal outreach and enrollment activities with special emphasis targeting all of the following populations:

(1) Persons with mental health disorder needs.

(2) Persons with substance use disorder needs.

(3) Persons who are homeless.

(4) Young men of color.

(5) Persons who are in county jail, in state prison, on state parole, on county probation, or under postrelease community supervision.

(6) Families of mixed-immigration status.

(7) Persons with limited English proficiency.

(e) (1) The funds allocated under this section shall be used only for the Medi-Cal outreach and enrollment activities and may supplement, but shall not supplant, existing local, state, and foundation funding of county outreach and enrollment activities.

(2) Notwithstanding Section 10744 of the Welfare and Institutions Code, the department may recoup or withhold all or part of an allocation for failure to comply with any requirements or standards set forth by the department for the purposes of this section.

(f) The department shall begin the payment for the outreach and enrollment allocation program no later than February 1, 2014.

(g) Under the terms of the approved allocation for the outreach and enrollment program, funded entities under this section shall not receive payment for in-person assister payments for assisting potential Medi-Cal enrollees.

(h) The department shall require progress reports, in a manner as determined by the department, from those receiving allocations under this section.

(i) To the extent federal funding is received for the services specified in this section, reimbursements for costs incurred under the approved allocations shall be made in compliance with federal law.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this

section by means of all-county letters, provider bulletins, or similar instructions.

(k) The department may use a portion of the private foundation funding pursuant to paragraph (a) to carry out the activities under this section.

SEC. 72. Commencing no later than August 1, 2013, the State Department of Health Care Services shall convene a series of stakeholder meetings to receive input from clients, family members, providers, counties, and representatives of the Legislature concerning the development of the Behavioral Health Services Plan, as required by paragraph 25.d of the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Medicaid Demonstration.

SEC. 73. Given the uncertainty within which persons diagnosed with HIV/AIDS from federal Ryan White HIV/AIDS Treatment Extension Act of 2009 funded programs may transition to Medi-Cal or other health insurance coverage, the State Department of Public Health shall report to the Joint Legislative Budget Committee by October 1, 2013, on whether any of the projections or assumptions used to develop the AIDS Drug Assistance Program (ADAP) estimated budget for the Budget Act of 2013 may result in an inability of ADAP to provide services to ADAP eligible clients. If the State Department of Public Health determines, before October 1, 2013, that ADAP is unable to provide services to ADAP eligible clients, the State Department of Public Health shall provide notification to the Joint Legislative Budget Committee within 15 calendar days of making this determination.

SEC. 74. By October 1, 2013, the State Department of Public Health shall submit to the fiscal and appropriate policy committees of the Legislature a report describing how it plans to address the findings and recommendations described in its "Zero-Based Budgeting Review" report dated May 14, 2013, regarding the Infant Botulism Treatment and Prevention Program (BabyBIG program).

SEC. 75. As part of the Governor's annual budget release to the Legislature in January and May, the State Department of Health Care Services shall identify as a separate policy change within the Medi-Cal Local Assistance Estimate, the projected General Fund savings attributable to the receipt of enhanced federal funding for Medi-Cal eligibles, subject to the use of Modified Adjusted Gross

Income as the basis for their income eligibility, who were previously calculated as being currently eligible and for whom the state received only a 50 percent federal matching assistant payment. The identified savings shall be attributed to the receipt of enhanced federal funding under Title XIX of the federal Social Security Act. The State Department of Health Care Services shall confer with applicable fiscal and policy staff of the Legislature by no later than October 1, 2013, regarding the potential content and attributes of the information provided in this policy change. This separate policy change format shall be provided through 2019–20.

SEC. 76. Notwithstanding any other law, the balance of Item 4150-001-0890 of the Budget Act of 2012 is reappropriated to the Department of Managed Health Care for the purposes of continuing operation of consumer assistance programs to help uninsured individuals obtain health care coverage pursuant to the terms of the federal Consumer Assistance Program Grant. These funds shall be available for encumbrance and expenditure until June 30, 2014.

SEC. 77. The adoption and readoption of regulations implementing portions of this act by the Managed Risk Medical Insurance Board shall be deemed an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

SEC. 78. The Legislature finds and declares that Section 2 of this act, which amends Section 6254 to the Government Code, and Section 68 of this act, which adds Part 3.3 (commencing with Section 15800) to Division 9 of the Welfare and Institution Code, impose a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

(a) In order to ensure that the State Department of Health Care Services is not constrained in exercising its fiduciary powers and obligations to negotiate on behalf of the public as it implements the provisions of Part 3.3 (commencing with Section 15800) of Division 9 of the Welfare and Institutions Code, the limitations

on the public's right of access imposed by Section 2 of this act are necessary.

(b) To ensure the continued confidentiality of otherwise privileged or confidential information, the limitations on the public's right of access imposed by Section 68 of this act are necessary.

SEC. 79. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

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