California LEGISLATIVE INFORMATION

AB-1467 Health. (2011-2012)

Assembly Bill No. 1467

CHAPTER 23

An act to amend Sections 7575, 12803.3, and 15438 of, to add Section 15438.10 to, and to repeal Section 7582 of, the Government Code, to amend Sections 137, 138.4, 138.6, 152, 1324.8, 1324.24, 100950, 104150, 104160, 104162.1, 104163, 104314, 104315, 104322, 110050, 113717, 116064.2, 123865, 123870, 123875, 124300, 125130, 125205, 125215, 130060, 130316, 130317, 131051, and 131052 of, to add Sections 1324.9, 131019.5, and 131055.1 to, to repeal Sections 135, 136, 138, 150, 151, 116064.1, and 125145 of, and to repeal and add Section 113718 of, the Health and Safety Code, and to amend Sections 4362, 4362.5, 4364, 4364.5, 4366, 4367.5, 4368.5, 5820, 5821, 5822, 5830, 5840, 5845, 5846, 5847, 5848, 5878.1, 5878.3, 5890, 5891, 5892, 5897, 5898, 14046.7, 14091.3, 14105.22, 14134, 14134.1, 14154, 14165, 14166.8, 14166.12, 14166.14, 14166.17, 14166.19, 14169.7, 14169.7.5, 14169.13, 14169.31, 14169.32, 14169.33, 14169.34, 14169.36, 14169.38, 14171, 14182.4, 14182.45, 14183.6, 14204, 14301.1, 14500.5, 15911, 15916, 24000, and 24001 of, to amend and repeal Sections 14085.6, 14085.7, 14085.8, 14085.81, and 14085.9 of, to add Sections 4024.7, 5899, 14089.08, 14089.09, 14166.151, 14166.152, 14166.153, 14166.154, 14166.155, 14459.6, 14459.8, 15911.1, and 15912.1 to, to add Article 2.82 (commencing with Section 14087.98) to Chapter 7 of Part 3 of Division 9 of, and to add and repeal Section 14105.196 of, the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor June 27, 2012. Filed with Secretary of State June 27, 2012.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1467, Committee on Budget. Health.

(1) Under existing law, the Robert W. Crown California Children's Services Act, the State Department of Health Care Services and each county administer the California Children's Services Program (CCS program) for treatment services for persons under 21 years of age diagnosed with severe chronic disease or severe physical limitations, as specified. Existing law generally limits eligibility for CCS program services to persons in families with an annual adjusted gross income of $40,000 or less. Under existing law, the department, or any designated local agency administering the program, is responsible for providing medically necessary occupational and physical therapy, to eligible children, as specified.

Existing law requires school districts, county offices of education, and special education local plan areas to comply with state laws that conform to the federal Individuals with Disabilities Education Act (IDEA), in order that the state may qualify for federal funds available for the education of individuals with exceptional needs. Existing law requires school districts, county offices of education, and special education local plan areas to identify, locate, and assess individuals with exceptional needs and to provide those pupils with a free appropriate public education in the least restrictive environment, and with special education and related services as reflected in an individualized education program (IEP). Existing law requires the Superintendent of Public Instruction to administer the special education provisions of the Education Code and to be responsible for assuring provision of, and supervising, education and related services to individuals with exceptional needs as required pursuant to the federal IDEA.

This bill would require, when a child has an IEP, that all occupational and physical therapy services assessed and determined to be educationally necessary by the IEP team and included in the IEP shall be provided in accordance with the federal IDEA, and not paid for by the CCS program. The bill would require the parents or estate of a child with an IEP to disclose that IEP to the CCS program at the time of application and on revision of the child's IEP. This bill would make conforming changes to procedures applicable to the CCS program's medical therapy unit conference team, when determining a child's eligibility for those therapy services.

Existing law requires that specified assessments and therapy treatment services rendered to a child referred to a local education agency for an assessment or a disabled child or youth with an IEP be exempt from financial eligibility standards and family repayment requirements.

This bill would delete these provisions.

The bill would require the State Department of Education to review regulations to ensure the appropriate implementation of educationally necessary occupational and physical therapy services required by specified provisions of federal law and specified provisions of the bill. The bill would require that specified provisions of the bill be implemented no later than October 1, 2012, and would require the State Department of Health Care Services to report, as provided, specified data relating to the implementation of the bill's provisions.

(2) Existing law transfers the Systems Integration Division of the California Health and Human Services Data Center to the California Health and Human Services Agency and provides that it shall be known as the Office of Systems Integration. Existing law prohibits the California Health and Human Services Agency from placing or transferring information technology projects in the office without further legislation authorizing these activities.

This bill would delete this prohibition.

(3) The California Health Facilities Financing Authority Act authorizes the California Health Facilities Financing Authority to make loans from the continuously appropriated California Health Facilities Financing Authority Fund to participating health institutions for financing or refinancing the acquisition, construction, or remodeling of health facilities. The act defines a health facility to include various specified facilities and facilities operated in conjunction with these facilities. It also defines a participating health institution to mean specified entities authorized by state law to provide or operate a health facility and undertake the financing or refinancing of the construction or acquisition of a project or of working capital, as defined. Existing law authorizes the authority to award grants to any eligible health facility, as defined, for purposes of financing defined projects.

This bill would authorize the authority to award one or more grants that, in the aggregate, do not exceed $1,500,000 to one or more projects designed to demonstrate new or enhanced cost-effective methods of delivering health care services, as specified. This bill would authorize the authority to implement a 2nd grant program to award up to $5,000,000 to eligible recipients, if a demonstration project is successful at developing a new method of delivering certain services. This bill would create the California Health Access Model Program Account in the California Health Facilities Financing Authority Fund, and would transfer up to $6,500,000 from the fund to the account for the purposes of the bill. The bill would require that any moneys remaining in the account as of January 1, 2020, revert to the fund. By expanding the purposes for which a continuously appropriated fund may be used, this bill would make an appropriation.

(4) Existing law establishes the Office of Women's Health within the State Department of Health Care Services. Existing law requires the California Health and Human Services Agency to establish an interagency task force on women's health, as specified. Existing law establishes the Office of Multicultural Health within the State Department of Public Health.

This bill would repeal these provisions and other related provisions and instead establish the Office of Health Equity within the State Department of Public Health. The bill would require the office to perform various duties relating to reducing health and mental health disparities in vulnerable communities, as defined. The bill would require that a deputy director be appointed, as specified, and that an advisory committee be established within the office no later than October 1, 2013. The bill would require that an interagency agreement be established between the State Department of Public Health and the State Department of Health Care Services to outline the process by which the departments will jointly work to advance the mission of the office, including responsibilities, scope of work, and necessary resources. This bill would make conforming and related 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. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law requires that, as a condition of participation in the Medi-Cal program, there be imposed a quality assurance fee on certain

intermediate care facilities. Existing law requires that the fees be deposited into the General Fund and allocated to intermediate care facilities to support their quality improvement efforts, and distributed to each facility based on the number of Medi-Cal patients at the eligible facility. Existing law requires the department to impose a uniform quality assurance fee on each skilled nursing facility, with certain exceptions, in accordance with a prescribed formula and requires that the fees be deposited in the State Treasury. Existing law, the Medi-Cal Long-Term Care Reimbursement Act, requires the department to implement a facility-specific reimbursement ratesetting system for certain skilled nursing facilities. Reimbursement rates for freestanding skilled nursing facilities are funded by a combination of federal funds and moneys collected pursuant to the skilled nursing uniform quality assurance fee.

This bill would instead, beginning August 1, 2013, require the quality assurance fees imposed pursuant to these provisions be deposited into the Long-Term Care Quality Assurance Fund which would be created by this bill.

(6) The State Department of Public Health is required to perform various public health functions, including providing breast and cervical cancer screening and treatment for low-income individuals, providing prostate cancer screening and treatment for low-income and uninsured men, and specified family planning services.

This bill would, commencing July 1, 2012, transfer the duties referenced above to the State Department of Health Care Services.

(7) Existing law, the Sherman Food, Drug, and Cosmetic Law (Sherman Law), requires the department to regulate activities related to food, drugs, devices, and cosmetics and establishes the Food Safety Fund for the deposit of money collected by the department under specified Sherman Law provisions. Money in the Food Safety Fund is available to the department, upon appropriation by the Legislature, to implement specified Sherman Law provisions. The existing California Retail Food Code regulates the health and sanitation standards for retail food facilities and establishes the Retail Food Safety and Defense Fund. Money collected by the department under specified California Retail Food Code provisions is deposited in the fund and used by the department, upon appropriation by the Legislature, to implement the California Retail Food Code.

This bill would eliminate the Retail Food Safety and Defense Fund and require all money deposited into the fund to be transferred to the Food Safety Fund. This bill would expand the purpose of the Food Safety Fund to include carrying out the provisions of the California Retail Food Code.

(8) Existing law requires public swimming pools to be equipped with antientrapment devices or systems that meet ASME/ANSI or ASTM performance standards. Existing law permits the State Department of Public Health to assess an annual fee on public swimming pool owners, collected by the local health department, and deposited into the Recreational Health Fund along with other money collected by the department through enforcement of these provisions. Money in the fund is available to the department, upon appropriation by the Legislature, for the purpose of promoting these public swimming pool provisions.

This bill would instead require public swimming pools to be equipped with antientrapment devices or systems that comply with ANSI/APSP standard 16 and make related changes. This bill would eliminate the Recreational Health Fund and the department's authority to administer or enforce specified public swimming pool provisions.

(9) Existing law requires, after January 1, 2008, that any general acute care hospital building that is determined to be a potential risk of collapse or pose significant loss of life only be used for nonacute care hospital purposes, unless granted an extension as prescribed.

Existing law authorizes, commencing on the date when the State Department of Health Care Services receives specified federal approval for a 2011–12 fiscal year hospital quality assurance fee program that meets a specified condition, the Office of Statewide Health Planning and Development to grant a hospital an additional extension of up to 7 years for a hospital building that it owns or operates if the hospital meets specified milestones. These milestones include a March 31, 2012, deadline for submitting to the office a specified letter of intent and schedule.

This bill would extend until September 30, 2012, the deadline for the above-described milestones for submitting a letter of intent and a schedule.

(10) Existing law requires the Director of Health Care Services to appoint an Advisory Committee on Genetically Handicapped Person's Program. Existing law requires the director to seek advice from the committee when adopting regulations under the Genetically Handicapped Person's Program that would expand the list of genetically handicapping conditions covered by the program and requires approval from the committee when prioritizing funds and services.

This bill would delete the provisions that establish the Advisory Committee on Genetically Handicapped Person's Program. This bill would delete the provisions that authorize the director to expand the list of genetically handicapping conditions covered by the program and that require the director to establish priorities for the use of funds and services. This bill would make conforming changes.

(11) Existing law, the Health Insurance Portability and Accountability Implementation Act of 2001, requires the Office of HIPAA Implementation, established by the Governor's office within the agency, to perform specified activities required for compliance with the federal Health Insurance Portability and Accountability Act. Under existing law, the act will become inoperative and be repealed on January 1, 2013, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date, and all unexpended or unencumbered funds under that act will revert to the General Fund on January 1, 2013.

The bill would extend the act's duration to June 30, 2016, when it would be inoperative and repealed, and all funds under the act that are unexpended or unencumbered as of that date would revert to the General Fund.

(12) Under existing law, the State Department of Mental Health is authorized and required to perform various functions relating to the care and treatment of persons with mental disorders. Existing law requires the Director of Mental Health, with the advice of the Statewide Resources Consultant, as described, to contract with nonprofit community resource agencies to establish regionally based resource centers to provide services for brain-impaired adults.

This bill would transfer the Director of Mental Health's responsibilities with respect to these resource centers to the Director of Health Care Services.

(13) 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, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. Existing law establishes the Mental Health Services Oversight and Accountability Commission (commission) to oversee the administration of various parts of the Mental Health Services Act. The act provides that it may be amended by the Legislature by a 2/3 vote of each house as long as the amendment is consistent with and furthers the intent of the act, and that the Legislature may also clarify procedures and terms of the act by majority vote.

This bill would authorize the commission to assist in providing technical assistance, as specified, and would authorize the commission to work in collaboration with, and in consultation with, various entities in designing a comprehensive joint plan for coordinated evaluation of client outcomes. This bill would require the California Health and Human Services Agency to lead the comprehensive joint plan effort. This bill would transfer various functions of the State Department of Mental Health under the Mental Health Services Act to the State Department of Health Care Services and the Office of Statewide Health Planning and Development. This bill would make various technical and conforming changes to reflect the transfer of those mental health responsibilities. This bill would require all projects included in the innovative programs portion of the county plan to meet specified requirements.

Existing law requires each county mental health program to prepare and submit a 3-year plan that includes specified components.

This bill, in this regard, would require the plan to be a 3-year program and expenditure plan adopted by the county board of supervisors and submitted to the commission, would require annual updates, and would require plans to be certified by the county mental health director and the county auditor-controller, as specified. This bill would require the State Department of Health Care Services to inform the California Mental Health Directors Association and the commission of the methodology used for revenue allocation to the counties. This bill would require the State Department of Health Care Services, in consultation with the commission and the California Mental Health Directors Association, to develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report, as prescribed.

This bill would declare that it clarifies procedures and terms of the Mental Health Services Act.

This bill would require the Governor or the Director of Health Care Services to appoint, subject to confirmation by the Senate, a Deputy Director of Mental Health and Substance Use Disorder Services of the State Department of Health Care Services.

(14) Existing law requires the State Department of Health Care Services to establish and administer, until July 1, 2021, the Medi-Cal Electronic Health Records Incentive Program, for the purposes of providing federal incentive payments to Medi-Cal providers for the implementation and use of electronic records systems. Existing

law prohibits General Fund moneys from being used for this purpose.

This bill would instead provide that no more than $200,000 from the General Fund may be used annually for state administrative costs associated with implementing these provisions.

(15) Existing law establishes the Emergency Services and Supplemental Payments Fund, the Medi-Cal Education Supplemental Payment Fund, the Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund, and the Small and Rural Hospital Supplemental Payments Fund administered by the department from which the department is required to make supplemental payments to certain hospitals based on specified criteria.

This bill would provide that these provisions shall become inoperative on June 30, 2013, and shall be repealed on January 1, 2014.

(16) Existing law authorizes the department to provide health care services to Medi-Cal beneficiaries through various models of managed care, including though a comprehensive program of managed health care plan services for Medi-Cal recipients residing in clearly defined geographical areas. Existing law provides for a schedule of benefits under the Medi-Cal program, which, with some exceptions, includes certain dental services.

This bill would authorize the Director of Health Care Services to enter into contracts with one or more managed health care plans to provide a comprehensive program of managed health care services to Medi-Cal beneficiaries residing in specified counties. This bill would also make enrollment in Medi-Cal managed health care plans mandatory for beneficiaries residing in these counties.

This bill would require the department to establish a list of performance measures to ensure dental health plans meet quality criteria required by the department to be included in dental health contracts entered into between the department and a dental health plan. This bill would require the department to designate an external quality review organization to conduct quality reviews for any dental health plan contracting with the department, as specified. This bill would require the Director of Health Care Services to establish a beneficiary dental exception (BDE) process for Medi-Cal beneficiaries mandatorily enrolled in dental health plans in the County of Sacramento, and would require the department to amend contracts with dental health plans that provide dental services to Medi-Cal beneficiaries who reside in a specified geographic area to meet these additional requirements.

This bill would require the department, by no later than March 15, 2013, and annually thereafter, to provide designated committees of the Legislature a report on dental managed care in the Counties of Sacramento and Los Angeles, and, for reports on the County of Sacramento, data outcomes and findings from the BDE process. This bill would require the Department of Managed Health Care, by no later than January 1, 2013, to provide designated committees of the Legislature with its final report on specified surveys for the dental health plans participating in the Sacramento Geographic Managed Care Program. This bill would authorize the County of Sacramento to establish a stakeholder advisory committee on the delivery of oral health and dental care services, and would require the State Department of Health Care Services to meet periodically with the committee, as specified.

This bill would also require the department to perform specified functions in connection with the Medi-Cal managed care plan default assignment algorithm.

Existing law requires the department to enter into an interagency agreement with the Department of Managed Health Care to conduct financial audits, medical surveys, and a review of the provider networks of the managed care plans participating in a certain demonstration project.

This bill would additionally require the department to enter into the interagency agreement with the Department of Managed Health Care to conduct financial audits, medical surveys, and a review of the provider networks in connection with the expansion of Medi-Cal managed care into rural counties, and to provide consumer assistance to beneficiaries affected by certain provisions.

This bill would make legislative findings and declarations as to the necessity of a special statute for specified counties.

(17) Existing law requires, until January 1, 2013, a hospital that does not have in effect a contract with a Medi-Cal managed care health plan, as defined, that establishes payment amounts for services furnished to a beneficiary enrolled in that plan to accept as payment in full, from all Medi-Cal managed care plans, specified amounts for outpatient services, emergency inpatient services, and poststabilization services following an

emergency admission.

This bill would modify the payment amount a hospital subject to these provisions is required to accept as payment in full from Medi-Cal managed care health plans for emergency inpatient services, and would provide that the payment amounts for both emergency inpatient services and poststabilization services related to an emergency medical condition shall remain in effect only until the department implements a specified payment methodology based on diagnosis-related groups, at which time, the hospital shall accept the payment amount established by that methodology for those services. This bill would extend the operative date of these provisions to July 1, 2013, and would make related changes.

(18) Existing federal law requires the state to provide payment for primary care services furnished in the 2013 and 2014 calendar years by Medi-Cal providers with specified primary specialty designations at a rate not less than 100% of the payment rate that applies to those services and physicians under the Medicare Program.

This bill would, only to the extent that the federal medical assistance percentage is equal to 100% and only until January 1, 2015, implement this requirement for both Medi-Cal fee-for-service and managed care plans.

(19) Existing law provides that reimbursement for clinical laboratory or laboratory services under the Medi-Cal program, as defined, may not exceed 80% of the lowest maximum allowance established by the federal Medicare Program for the same or similar services.

This bill would, upon federal approval, change the rate methodology for clinical laboratory or laboratory services, as specified. This bill would also require that rates for clinical laboratory or laboratory services be reduced by 10% until federal approval is obtained for this new rate methodology.

(20) Existing law requires Medi-Cal beneficiaries to make set copayments for specified services. Existing law, subject to federal approval, revises these copayment rates, expands the services for which copayments are due, and requires the department to reduce the amount of the payment to the provider by the amount of the copayment. Existing law provides, upon federal approval and with certain exceptions, that a provider has no obligation to provide services to a beneficiary who does not pay the copayment at the point of service.

This bill would modify these provisions as they relate to emergency and nonemergency services.

(21) Existing law provides that it is the intent of the Legislature to provide appropriate funding to the counties for the effective administration of the Medi-Cal program, except for specified fiscal years in regard to any cost-of-doing-business adjustment.

This bill would additionally provide that it is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2012–13 fiscal year.

(22) Existing law establishes the continuously appropriated Private Hospital Supplemental Fund and the continuously appropriated Nondesignated Public Hospital Supplemental Fund administered by the California Medical Assistance Commission for the purposes of funding the nonfederal share of specified payments to private and nondesignated hospitals. Existing law also provides for stabilization funding for certain hospitals through October 31, 2010, and requires specified amounts of that funding to be transferred to the Private Hospital Supplemental Fund and the Nondesignated Public Hospital Supplemental Fund. Existing law requires that the California Medical Assistance Commission be dissolved after June 30, 2012, and requires the department to develop a staff transition plan, as specified, that will be included in the 2012–13 Governor's budget. Existing law requires that, upon dissolution of the commission, all powers, duties, and responsibilities of the commission be transferred to the Director of Health Care Services. Existing law provides that upon a determination by the director that a payment system based on diagnosis-related groups, as described, has been developed and implemented, the powers, duties, and responsibilities conferred on the commission and transferred to the director shall no longer be exercised.

This bill, instead, would provide that the powers, duties, and responsibilities conferred on the commission and transferred to the director shall no longer be exercised upon the director's determination, except for those relating to specified stabilization payments and the ability to negotiate and make payments from the Private Hospital Supplemental Fund and the Nondesignated Public Hospital Supplemental Fund. This bill would also modify the criteria a hospital would have to meet to receive distributions from these funds. This bill would also require, notwithstanding any other law, that stabilization funding payable to nondesignated public hospitals and to project year private DSH hospitals that has not been paid or specifically committed for payment prior to January 1, 2012, be transferred to the General Fund, except as specified, and that funds that would otherwise be drawn from the General Fund for stabilization payments to these hospitals be retained in the General Fund.

This bill would delete the requirement that the department develop a staff transition plan and, instead, would implement the transition of staff positions serving the commission to the department. This bill would provide that after the diagnosis-related groups payment system is implemented, the transferred employees will transfer to civil service classifications within the department, as specified.

(23) Existing law establishes the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, which revises hospital supplemental payment methodologies under the Medi-Cal program in order to maximize the use of federal funds consistent with federal Medicaid law and to stabilize the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients. Existing law requires the department to seek a successor 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. Existing law provides that to the extent the provisions under the Medi-Cal Hospital/Uninsured Care Demonstration Project Act do not conflict with the provisions of, or the Special Terms and Conditions of, this demonstration project, the provisions of the Medi-Cal Hospital/Uninsured Care Demonstration Project Act shall apply. Existing law establishes the continuously appropriated Health Care Support Fund, which consists of federal safety net care pool funds claimed and received by the department under the demonstration project and the successor demonstration project. Existing law also establishes the continuously appropriated Public Hospital Investment, Improvement, and Incentive Fund, which consists of moneys that a county, other political subdivision of the state, or other governmental entity in the state elects to transfer to the department for use as the nonfederal share of investment, improvement, and incentive payments to participating designated hospitals and the governmental entities with which they are affiliated.

This bill would, subject to federal approval, modify the inpatient fee-for-service reimbursement methodology for nondesignated public hospitals under the successor demonstration project. This bill would, among other things, provide that beginning with the 2012–13 fiscal year, and if specified conditions are met, nondesignated public hospitals, or governmental entities with which they are affiliated, shall be eligible to receive safety net care pool payments for uncompensated care from the Health Care Support Fund. By revising the purposes for which moneys in the Health Care Support Fund may be expended, this bill would make an appropriation. This bill would also provide that beginning with the 2012–13 fiscal year, subject to federal approval and if specified conditions are met, nondesignated public hospitals may receive delivery system reform incentive pool funding, as specified. This bill would make related changes to the Public Hospital Investment, Improvement, and Incentive Fund provisions. By revising the purposes for which moneys in the Public Hospital Investment, Improvement, and Incentive Fund may be used, this bill would make an appropriation. This bill would also require designated public hospitals to report and certify specified information for each successor demonstration year beginning with the 2012–13 fiscal year.

(24) Existing law, subject to federal approval, imposes a quality assurance fee, as specified, on certain general acute care hospitals for the period of July 1, 2011, through December 31, 2013. Existing law creates the Hospital Quality Assurance Revenue Fund in the State Treasury and requires that the money collected from the quality assurance fee be deposited into the fund. Existing law, subject to federal approval, provides that the moneys in the Hospital Quality Assurance Revenue Fund shall, upon appropriation by the Legislature, be available only for certain purposes, including, among other things, paying for health care coverage for children, as specified, making supplemental payments to private hospitals, and making direct grants in support of health care expenditures to designated and nondesignated public hospitals.

This bill would revise the definition of “federal approval” for the purposes of those provisions and would make conforming changes. This bill would increase the amount previously allocated for health care coverage for children for each subject fiscal quarter during the 2012–13 and 2013–14 fiscal years, and would, for the 2013–14 fiscal year, additionally require that the amount of $21,500,000 previously allocated for grants to designated public hospitals be retained by the state to pay for health care coverage of children, as specified.

(25) Existing law requires the department to audit the amounts paid for services provided to Medi-Cal beneficiaries. Existing law requires the Director of Health Care Services to establish administrative appeal processes to review complaints arising from the findings of an audit. Existing law provides that a specified interest rate shall be assessed on amounts when a provider prevails in an appeal of a disallowed payment that was paid and recovered by the department or when an unrecovered overpayment is due to the department, and in other circumstances.

This bill would modify the applicable interest rate.

(26) Existing law requires the department, pursuant to federal approval of a successor demonstration project, to authorize a local Low Income Health Program (LIHP) to provide health care services to eligible low-income

individuals under certain circumstances.

This bill would modify the provisions relating to the application of rates agreed to between the department and the participating entities with respect to the LIHP year ending June 30, 2012.

(27) Existing law authorizes counties meeting certain criteria to elect to participate in the County Medical Services Program (CMSP), for the purpose of providing specified health services to eligible county residents. Counties that elect to participate in the program may establish a CMSP governing board, responsible for the oversight of the participating counties. Existing law permits a CMSP governing board to apply to operate a local LIHP for the purpose of providing health care services, as specified.

This bill would authorize the Director of Finance to require the Controller to draw warrants against General Fund cash to provide cashflow loans of no more than a total of $100,000,000 in the 2012–13 and 2013–14 fiscal years for CMSP governing board expenses that are associated with a Low Income Health Program operated by the governing board, thereby making an appropriation.

(28) Existing law establishes the Office of AIDS in the State Department of Public Health as the lead agency responsible for coordinating state programs, services, and activities relating to the human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS-related conditions (ARC). Existing federal law, under the federal Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White Act), makes financial assistance available to states and other public and nonprofit entities to provide for the delivery of services to families with HIV.

This bill would require the State Department of Health Care Services, in collaboration with the State Department of Public Health, and in consultation with stakeholders, to develop polices and guidance on the transition of persons diagnosed with HIV/AIDS from programs funded under the federal Ryan White Act to the Low Income Health Program.

(29) Existing law provides for the Health Care Coverage Initiative (HCCI), which is a federal waiver demonstration project established to expand health care coverage to low-income uninsured individuals who are not currently eligible for the Medi-Cal program, the Healthy Families Program, or the Access for Infants and Mothers Program. Existing law requires the department to annually seek authority from the federal Centers for Medicare and Medicaid Services under the Special Terms and Conditions of the successor demonstration project to redirect HCCI funds within the safety net care pool, as defined, that are not fully utilized by the end of a demonstration year, as defined, to the category of uncompensated care to be used by designated public hospitals, on a voluntary basis, for allowable certified public expenditures, as specified.

This bill would modify the conditions under which designated public hospitals may utilize the redirected safety net care pool funds and would modify the provisions relating to disallowances or deferrals that relate to certified public expenditures for uncompensated care incurred by the designated public hospitals under these provisions.

(30) This bill would incorporate additional changes in Section 123870 of the Health and Safety Code proposed in AB 1494 and SB 1034, that would become operative only if either AB 1494 or SB 1034 and this bill are both chaptered and become effective on or before January 1, 2013, and this bill is chaptered last.

(31) 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 Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 7575 of the Government Code is amended to read:

7575. (a) Notwithstanding any other provision of law, all services assessed and determined as educationally necessary by the individualized education program (IEP) team contained in the child's IEP or individualized education plan shall be provided in accordance with the federal Individuals with Disabilities Education Act (IDEA; 20 U.S.C. Sec. 1400 et seq.).

(b) If a child applies to the California Children's Services Program pursuant to Section 123865 or 123875 of the Health and Safety Code, the State Department of Health Care Services shall determine whether the child needs medically necessary occupational therapy or physical therapy. A medical referral to the California Children's Services Program shall be based on a written report from a licensed physician and surgeon who has examined

the pupil. The written report shall include the following:

(1) The diagnosed neuromuscular, musculoskeletal, or physical disabling condition prompting the referral.

(2) The referring physician's treatment goals and objectives.

(3) The basis for determining the recommended treatment goals and objectives, including how these will ameliorate or improve the pupil's diagnosed condition.

(4) The relationship of the medical disability to the pupil's need for special education and related services.

(5) Relevant medical records.

(c) If the child has an IEP pursuant to the federal IDEA, the parents or the estate of the child shall disclose that IEP to the California Children's Services Program at the time of application and on revision of the child's IEP.

(d) The department shall provide the service directly or by contracting with another public agency, qualified individual, or a state-certified nonpublic nonsectarian school or agency.

(e) Local education agencies shall provide necessary space and equipment for the provision of occupational therapy and physical therapy in the most efficient and effective manner.

(f) The department shall also be responsible for providing the services of a home health aide when the local education agency considers a less restrictive placement from home to school for a pupil for whom both of the following conditions exist:

(1) The California Medical Assistance Program provides a life-supporting medical service via a home health agency during the time in which the pupil would be in school or traveling between school and home.

(2) The medical service provided requires that the pupil receive the personal assistance or attention of a nurse, home health aide, parent or guardian, or some other specially trained adult in order to be effectively delivered.

SEC. 2. Section 7582 of the Government Code is repealed.

SEC. 3. Section 12803.3 of the Government Code is amended to read:

12803.3. (a) For purposes of this section, the following definitions shall apply:

(1) "Director" means the Director of the Office of Systems Integration.

(2) "Office" means the Office of Systems Integration.

(3) "Services" means all functions, responsibilities, and services deemed to be functions, responsibilities, and services of the Systems Integration Division, also known as Systems Management Services, of the California Health and Human Services Agency Data Center, as determined by the Secretary of California Health and Human Services.

(b) (1) The Systems Integration Division of the California Health and Human Services Agency Data Center is hereby transferred to the California Health and Human Services Agency and shall be known as the Office of Systems Integration. The Office of Systems Integration shall be the successor to, and is vested with, all of the duties, powers, purposes, responsibilities, and jurisdiction of the Systems Integration Division of the California Health and Human Services Agency Data Center.

(2) Notwithstanding any other law, all services of the Systems Integration Division of the California Health and Human Services Agency Data Center shall become the services of the Office of Systems Integration.

(c) The office shall be under the supervision of a director, known as the Director of the Office of Systems Integration, who shall be appointed by, and serve at the pleasure of, the Secretary of California Health and Human Services.

(d) No contract, lease, license, or any other agreement to which the California Health and Human Services Data Center is a party on the date of the transfer as described in paragraph (1) of subdivision (b) shall be void or voidable by reason of this section, but shall continue in full force and effect. The office shall assume from the California Health and Human Services Data Center all of the rights, obligations, and duties of the Systems Integration Division. This assumption of rights, obligations, and duties shall not affect the rights of the parties to the contract, lease, license, or agreement.

(e) All books, documents, records, and property of the Systems Integration Division shall be in the possession and under the control of the office.

(f) All officers and employees of the Systems Integration Division shall be designated as officers and employees of the agency. The status, position, and rights of any officer or employee shall not be affected by this designation and all officers and employees shall be retained by the agency pursuant to the applicable provisions of the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5), except as to any position that is exempt from civil service.

(g) (1) All contracts, leases, licenses, or any other agreements to which the California Health and Human Services Data Center is a party regarding any of the following are hereby assigned from the California Health and Human Services Data Center to the office:

(A) Statewide Automated Welfare System (SAWS).

(B) Child Welfare Services/Case Management System (CWS/CMS).

(C) Electronic Benefit Transfer (EBT).

(D) Statewide Fingerprinting Imaging System (SFIS).

(E) Case Management Information Payrolling System (CMIPS).

(F) Employment Development Department Unemployment Insurance Modernization (UIMOD) Project.

(2) All other contracts, leases, or agreements necessary or related to the operation of the Systems Integration Division of the California Health and Human Services Data Center are hereby assigned from the California Health and Human Services Data Center to the office.

(h) It is the intent of the Legislature that the transfer of the Systems Integration Division of the California Health and Human Services Agency Data Center pursuant to this section shall be retroactive to the passage and enactment of the Budget Act of 2005 and that existing employees of the Systems Integration Division of the California Health and Human Services Agency Data Center and the newly established Office of Systems Integration shall not be negatively impacted by the reorganization and transfer conducted pursuant to this section.

(i) It is the intent of the Legislature to review fully implemented information technology projects managed by the office to assess the viability of placing the management responsibility for those projects in the respective program department.

(j) On or before April 1, 2006, the Department of Finance shall report to the Chairperson of the Joint Legislative Budget Committee the date that the administration shall conduct an assessment for each of the projects managed by the office. The California Health and Human Services Agency, the California Health and Human Services Agency Data Center, or its successor, the State Department of Social Services, and the office shall provide to the Department of Finance all information and analysis the Department of Finance deems necessary to conduct the assessment required by this section. Each assessment shall consider the costs, benefits, and any associated risks of maintaining the project management responsibility in the office and of moving the project management responsibility to its respective program department.

SEC. 4. Section 15438 of the Government Code is amended to read:

15438. The authority may do any of the following:

(a) Adopt bylaws for the regulation of its affairs and the conduct of its business.

(b) Adopt an official seal.

(c) Sue and be sued in its own name.

(d) Receive and accept from any agency of the United States, any agency of the state, or any municipality, county, or other political subdivision thereof, or from any individual, association, or corporation gifts, grants, or donations of moneys for achieving any of the purposes of this chapter.

(e) Engage the services of private consultants to render professional and technical assistance and advice in carrying out the purposes of this part.

(f) Determine the location and character of any project to be financed under this part, and to acquire, construct, enlarge, remodel, renovate, alter, improve, furnish, equip, fund, finance, own, maintain, manage, repair, operate, lease as lessee or lessor, and regulate the same, to enter into contracts for any or all of those purposes, to enter into contracts for the management and operation of a project or other health facilities owned by the authority, and to designate a participating health institution as its agent to determine the location and character of a project undertaken by that participating health institution under this chapter and as the agent of the authority, to acquire, construct, enlarge, remodel, renovate, alter, improve, furnish, equip, own, maintain, manage, repair, operate, lease as lessee or lessor, and regulate the same, and as the agent of the authority, to enter into contracts for any or all of those purposes, including contracts for the management and operation of that project or other health facilities owned by the authority.

(g) Acquire, directly or by and through a participating health institution as its agent, by purchase solely from funds provided under the authority of this part, or by gift or devise, and to sell, by installment sale or otherwise, any lands, structures, real or personal property, rights, rights-of-way, franchises, easements, and other interests in lands, including lands lying under water and riparian rights, that are located within the state that the authority determines necessary or convenient for the acquisition, construction, or financing of a health facility or the acquisition, construction, financing, or operation of a project, upon the terms and at the prices considered by the authority to be reasonable and that can be agreed upon between the authority and the owner thereof, and to take title thereto in the name of the authority or in the name of a participating health institution as its agent.

(h) Receive and accept from any source loans, contributions, or grants for, or in aid of, the construction, financing, or refinancing of a project or any portion of a project in money, property, labor, or other things of value.

(i) Make secured or unsecured loans to, or purchase secured or unsecured loans of, any participating health institution in connection with the financing of a project or working capital in accordance with an agreement between the authority and the participating health institution. However, no loan to finance a project shall exceed the total cost of the project, as determined by the participating health institution and approved by the authority. Funds for secured loans may be provided from the California Health Facilities Financing Authority Fund pursuant to subdivision (b) of Section 15439 to small or rural health facilities pursuant to authority guidelines.

(j) (1) Make secured or unsecured loans to, or purchase secured or unsecured loans of, any participating health institution in accordance with an agreement between the authority and the participating health institution to refinance indebtedness incurred by that participating health institution or a participating health institution that controls or manages, is controlled or managed by, is under common control or management with, or is affiliated with that participating health institution, in connection with projects undertaken or for health facilities acquired or for working capital.

(2) Make secured or unsecured loans to, or purchase secured or unsecured loans of, any participating health institution in accordance with an agreement between the authority and the participating health institution to refinance indebtedness incurred by that participating health institution or a participating health institution that controls or manages, is controlled or managed by, is under common control or management with, or is affiliated with that participating health institution, payable to the authority or assigned or pledged to authority issued bonds.

(3) Funds for secured loans may be provided from the California Health Facilities Financing Authority Fund pursuant to subdivision (b) of Section 15439 to small or rural health facilities pursuant to authority guidelines.

(k) Mortgage all or any portion of interest of the authority in a project or other health facilities and the property on which that project or other health facilities are located, whether owned or thereafter acquired, including the granting of a security interest in any property, tangible or intangible, and to assign or pledge all or any portion of the interests of the authority in mortgages, deeds of trust, indentures of mortgage or trust, or similar instruments, notes, and security interests in property, tangible or intangible, of participating health institutions to which the authority has made loans, and the revenues therefrom, including payments or income from any thereof owned or held by the authority, for the benefit of the holders of bonds issued to finance the project or health facilities or issued to refund or refinance outstanding indebtedness of participating health institutions as permitted by this part.

(l) Lease to a participating health institution the project being financed or other health facilities conveyed to the authority in connection with that financing, upon the terms and conditions the authority determines proper,

charge and collect rents therefor, terminate the lease upon the failure of the lessee to comply with any of the obligations of the lease, and include in that lease, if desired, provisions granting the lessee options to renew the term of the lease for the period or periods and at the rent, as determined by the authority, purchase any or all of the health facilities or that upon payment of all of the indebtedness incurred by the authority for the financing of that project or health facilities or for refunding outstanding indebtedness of a participating health institution, then the authority may convey any or all of the project or the other health facilities to the lessee or lessees thereof with or without consideration.

(m) Charge and equitably apportion among participating health institutions, the administrative costs and expenses incurred by the authority in the exercise of the powers and duties conferred by this part.

(n) Obtain, or aid in obtaining, from any department or agency of the United States or of the state, any private company, or any insurance or guarantee as to, of, or for the payment or repayment of, interest or principal, or both, or any part thereof, on any loan, lease, or obligation, or any instrument evidencing or securing the loan, lease, or obligation, made or entered into pursuant to this part; and notwithstanding any other provisions of this part, to enter into any agreement, contract, or any other instrument whatsoever with respect to that insurance or guarantee, to accept payment in the manner and form as provided therein in the event of default by a participating health institution, and to assign that insurance or guarantee as security for the authority's bonds.

(o) Enter into any and all agreements or contracts, including agreements for liquidity or credit enhancement, bond exchange agreements, interest rate swaps or hedges, execute any and all instruments, and do and perform any and all acts or things necessary, convenient, or desirable for the purposes of the authority or to carry out any power expressly granted by this part.

(p) Invest any moneys held in reserve or sinking funds or any moneys not required for immediate use or disbursement, at the discretion of the authority, in any obligations authorized by the resolution authorizing the issuance of the bonds secured thereof or authorized by law for the investment of trust funds in the custody of the Treasurer.

(q) Award grants to any eligible clinic pursuant to Section 15438.6.

(r) Award grants to any eligible health facility pursuant to Section 15438.7.

(s) (1) Notwithstanding any other provision of law, provide a working capital loan of up to five million dollars ($5,000,000) to assist in the establishment and operation of the California Health Benefit Exchange (Exchange) established under Section 100500. The authority may require any information it deems necessary and prudent prior to providing a loan to the Exchange and may require any term, condition, security, or repayment provision it deems necessary in the event the authority chooses to provide a loan. Under no circumstances shall the authority be required to provide a loan to the Exchange.

(2) Prior to the authority providing a loan to the Exchange, a majority of the board of the Exchange shall be appointed and shall demonstrate, to the satisfaction of the authority, that the federal planning and establishment grants made available to the Exchange by the United States Secretary of Health and Human Services are insufficient or will not be released in a timely manner to allow the Exchange to meet the necessary requirements of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(3) The Exchange shall repay a loan made under this subdivision no later than June 30, 2016, and shall pay interest at the rate paid on moneys in the Pooled Money Investment Account.

(t) Award grants pursuant to Section 15438.10.

SEC. 5. Section 15438.10 is added to the Government Code, to read:

15438.10. (a) The Legislature finds and declares the following:

(1) Many Californians face serious obstacles in obtaining needed health care services, including, but not limited to, medical, mental health, dental, and preventive services. The obstacles faced by vulnerable populations and communities include existence of complex medical, physical, or social conditions, disabilities, economic disadvantage, and living in remote or underserved areas that make it difficult to access services.

(2) With the recent passage of national health care reform, there is an increased demand for innovative ways to deliver quality health care, including preventive services, to individuals in a cost-effective manner.

(3) There is a need to develop new methods of delivering health services utilizing innovative models that can be

demonstrated to be effective and then replicated throughout California and that bring community-based health care preventive services to individuals where they live or receive education, social, or general health services.

(4) For more than 30 years, the California Health Facilities Financing Authority has provided financial assistance through tax-exempt bonds, low-interest loans, and grants to health facilities in California, assisting in the expansion of the availability of health services and health care facilities throughout the state.

(b) (1) Following the completion of a competitive selection process, the authority may award one or more grants that, in the aggregate, do not exceed one million five hundred thousand dollars ($1,500,000) to one or more projects designed to demonstrate specified new or enhanced cost-effective methods of delivering quality health care services to improve access to quality health care for vulnerable populations or communities, or both, that are effective at enhancing health outcomes and improving access to quality health care and preventive services. These health care services may include, but are not limited to, medical, mental health, or dental services for the diagnosis, care, prevention, and treatment of human illness, or individuals with physical, mental, or developmental disabilities. More than one demonstration project may receive a grant pursuant to this section. It is the intent of the Legislature for a demonstration project that receives a grant to allow patients to receive screenings, diagnosis, or treatment in community settings, including, but not limited to, school-based health centers, adult day care centers, and residential care facilities for the elderly, or for individuals with mental illness or developmental disabilities.

(2) A grant awarded pursuant to this subdivision may be allocated in increments to a demonstration project over multiple years to ensure the demonstration project's ability to complete its work, as determined by the authority. Prior to the initial allocation of funds pursuant to this subdivision, the administrators of the demonstration project shall provide evidence that the demonstration project has or will have additional funds sufficient to ensure completion of the demonstration project. If the authority allocates a grant in increments, each subsequent year's allocation shall be provided to the demonstration project only upon submission of research that shows that the project is progressing toward the identification of a high-quality and cost-effective delivery model that improves health outcomes and access to quality health care and preventive services for vulnerable populations or communities, and can be replicated throughout the state in community settings.

(3) Except for a health facility that qualifies as a "small and rural hospital" pursuant to Section 124840 of the Health and Safety Code, a health facility that has received tax-exempt bond financing from the authority shall not be eligible to receive funds awarded for a demonstration project. Such a health facility may participate as an uncompensated partner or member of a collaborative effort that is awarded a demonstration project grant. A health facility that participates in a demonstration project that receives funds pursuant to this section may not claim the funding provided by the authority toward meeting its community benefit and charity care obligations.

(4) Funds provided to a demonstration project pursuant to this subdivision may be used to supplement, but not to supplant, existing financial and resource commitments of the grantee or grantees or any other member of a collaborative effort that has been awarded a demonstration project grant.

(c) (1) If a demonstration project that receives a grant pursuant to subdivision (b) is successful at developing a new method of delivering high-quality and cost-effective health care services in community settings that result in increased access to quality health care and preventive services or improved health care outcomes for vulnerable populations or communities, or both, then beginning as early as the second year after the initial allocation of moneys provided pursuant to subdivision (b), the authority may implement a second grant program that awards not more than five million dollars ($5,000,000), in the aggregate, to eligible recipients as defined by the authority, to replicate in additional California communities the model developed by a demonstration project that received a grant pursuant to subdivision (b). Prior to the implementation of this second grant program, the authority shall prepare and provide a report to the Legislature and the Governor on the outcomes of the demonstration project. The report shall be made in accordance with Section 9795.

(2) If the authority implements the second grant program, the authority shall also report annually, beginning with the first year of implementation of the second grant program, to the Legislature and the Governor regarding the program, including, but not limited to, the total amount of grants issued pursuant to this subdivision, the amount of each grant issued, and a description of each project awarded funding for replication of the model.

(3) Grants under this subdivision may be utilized for eligible costs, as defined in subdivision (c) of Section 15432, including equipment, information technology, and working capital, as defined in subdivision (h) of Section 15432.

(4) The authority may adopt regulations relating to the grant program authorized pursuant to this subdivision, including regulations that define eligible recipients, eligible costs, and minimum and maximum grant amounts.

(d) (1) The authority shall prepare and provide a report to the Legislature and the Governor by January 1, 2014, on the outcomes of the demonstration grant program, including, but not limited to, the following:

(A) The total amount of grants issued.

(B) The amount of each grant issued.

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

(D) A description of each project awarded funding.

(E) A description of project outcomes that demonstrate cost-effective delivery of health care services in community settings, that result in improved access to quality health care or improved health care outcomes.

(2) A report submitted pursuant to this subdivision shall be submitted in compliance with Section 9795.

(e) There is hereby created the California Health Access Model Program Account in the California Health Facilities Financing Authority Fund. All moneys in the account are hereby continuously appropriated to the authority for carrying out the purposes of this section. An amount of up to six million five hundred thousand dollars ($6,500,000) shall be transferred from funds in the California Health Facilities Financing Authority Fund that are not impressed with a trust for other purposes into the California Health Access Model Program Account for the purpose of issuing grants pursuant to this section. Any moneys remaining in the California Health Access Model Program Account on January 1, 2020, shall revert as of that date to the California Health Facilities Financing Authority Fund.

(f) Any recipient of a grant provided pursuant to subdivision (b) shall adhere to all applicable laws relating to scope of practice, licensure, staffing, and building codes.

SEC. 6. Section 135 of the Health and Safety Code is repealed.

SEC. 7. Section 136 of the Health and Safety Code is repealed.

SEC. 8. Section 137 of the Health and Safety Code is amended to read:

137. (a) The State Department of Public Health shall develop a coordinated state strategy for addressing the health-related needs of women, including implementation of goals and objectives for women's health.

(b) The approved programmatic costs associated with this strategy shall be the responsibility of the State Department of Public Health unless otherwise provided by law.

SEC. 9. Section 138 of the Health and Safety Code is repealed.

SEC. 10. Section 138.4 of the Health and Safety Code is amended to read:

138.4. (a) The State Department of Public Health shall place priority on providing information to consumers, patients, and health care providers regarding women's gynecological cancers, including signs and symptoms, risk factors, the benefits of early detection through appropriate diagnostic testing, and treatment options.

(b) In exercising the powers under this section, the State Department of Public Health shall consult with appropriate health care professionals and providers, consumers, and patients, or organizations representing them.

(c) The duties of the State Department of Public Health pursuant to this section are contingent upon the receipt of funds appropriated for this purpose.

(d) The State Department of Public Health may adopt any regulations necessary and appropriate for the implementation of this section.

SEC. 11. Section 138.6 of the Health and Safety Code is amended to read:

138.6. (a) The State Department of Public Health shall include in any literature that it produces regarding breast cancer information that shall include, but not be limited to, all of the following:

(1) Summarized information on risk factors for breast cancer in younger women, including, but not limited to, information on the increased risk associated with a family history of the disease.

(2) Summarized information regarding detection alternatives to mammography that may be available and more effective for at-risk women between the ages of 25 and 40 years.

(3) Information on Internet Web sites of relevant organizations, government agencies, and research institutions where information on mammography alternatives may be obtained.

(b) The information required by subdivision (a) shall be produced consistent with the department's protocols and procedures regarding the production and dissemination of information on breast cancer, including, but not limited to, the following factors:

(1) Restrictions imposed by space limitation on materials currently produced and distributed by the department.

(2) Future regular production and replacement schedules.

(3) Translation standards governing the number of languages and literacy levels.

(4) The nature, content, and purpose of the material into which this new information will be incorporated.

(c) It is the intent of the Legislature that subdivisions (a) and (b) apply to information that is distributed by any branch of the department, including, but not limited to, the Cancer Detection Section and the Office of Health Equity.

SEC. 12. Section 150 of the Health and Safety Code is repealed.

SEC. 13. Section 151 of the Health and Safety Code is repealed.

SEC. 14. Section 152 of the Health and Safety Code is amended to read:

152. (a) The State Department of Public Health Office of Health Equity shall do all of the following:

(1) Perform strategic planning to develop departmentwide plans for implementation of goals and objectives to close the gaps in health status and access to care among the state's diverse racial and ethnic communities, women, persons with disabilities, and the lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) communities.

(2) Conduct departmental policy analysis on specific issues related to multicultural health.

(3) Coordinate projects funded by the state that are related to improving the effectiveness of services to ethnic and racial communities, women, and the LGBTQQ communities.

(4) Identify the unnecessary duplication of services and future service needs.

(5) Communicate and disseminate information and perform a liaison function within the department and to providers of health, social, educational, and support services to racial and ethnic communities, women, persons with disabilities, and the LGBTQQ communities. The department shall consult regularly with representatives from diverse racial and ethnic communities, women, persons with disabilities, and the LGBTQQ communities, including health providers, advocates, and consumers.

(6) Perform internal staff training, an internal assessment of cultural competency, and training of health care professionals to ensure more linguistically and culturally competent care.

(7) Serve as a resource for ensuring that programs collect and keep data and information regarding ethnic and racial health statistics, including those statistics described in reports released by Healthy People 2020, and information based on sexual orientation, gender identity, and gender expression, strategies and programs that address multicultural health issues, including, but not limited to, infant and maternal mortality, cancer, cardiovascular disease, diabetes, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), child and adult immunization, osteoporosis, menopause, and full reproductive health, asthma, unintentional and intentional injury, and obesity, as well as issues that impact the health of racial and ethnic communities, women, and the LGBTQQ communities, including substance abuse, mental health, housing, teenage pregnancy, environmental disparities, immigrant and migrant health, and health insurance and delivery systems.

(8) Encourage innovative responses by public and private entities that are attempting to address multicultural health issues.

(9) Provide technical assistance to counties, other public entities, and private entities seeking to obtain funds for initiatives in multicultural health, including identification of funding sources and assistance with writing grants.

(b) Notwithstanding Section 10231.5 of the Government Code, the State Department of Public Health shall biennially prepare and submit a report to the Legislature on the status of the activities required by this chapter. This report shall be included in the report required under paragraph (1) of subdivision (d) of Section 131019.5.

SEC. 15. Section 1324.8 of the Health and Safety Code is amended to read:

1324.8. (a) The quality assurance fee assessed and collected pursuant to this article shall be deposited in the General Fund.

(b) Notwithstanding subdivision (a), commencing August 1, 2013, the quality assurance fee assessed and collected pursuant to this article shall be deposited in the Long-Term Care Quality Assurance Fund established pursuant to Section 1324.9.

SEC. 16. Section 1324.9 is added to the Health and Safety Code, 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).

SEC. 17. Section 1324.24 of the Health and Safety Code is amended to read:

1324.24. (a) The quality assurance fee assessed and collected pursuant to this article shall be deposited in the State Treasury.

(b) Notwithstanding subdivision (a), commencing August 1, 2013, the quality assurance fee assessed and collected pursuant to this article shall be deposited in the Long-Term Care Quality Assurance Fund established pursuant to Section 1324.9.

SEC. 18. Section 100950 of the Health and Safety Code is amended to read:

100950. The department shall administer this part, Section 100295, and Chapter 3 (commencing with Section 101175) of Part 3 and shall adopt necessary regulations. These regulations shall be adopted only after consultation with and approval by the California Conference of Local Health Officers. Approval of these regulations shall be by majority vote of those present at an official session.

SEC. 19. Section 104150 of the Health and Safety Code is amended to read:

104150. (a) A provider or entity that participates in the grant made to the department by the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program established under Title XV of the federal Public Health Service Act (42 U.S.C. Sec. 300k et seq.) in accordance with requirements of Section 1504 of that act (42 U.S.C. Sec. 300n) may only render screening services under the grant to an individual if the provider or entity determines that the individual's family income does not exceed 200 percent of the federal poverty level.

(b) The department shall provide for breast cancer and cervical cancer screening services under the grant at the level of funding budgeted from state and other resources during the fiscal year in which the Legislature has appropriated funds to the department for this purpose. These screening services shall not be deemed to be an

entitlement.

(c) To implement the federal breast and cervical cancer early detection program specified in this section, the department may contract, to the extent permitted by Section 19130 of the Government Code, with public and private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary. However, the Medi-Cal program's fiscal intermediary shall only be utilized if services provided under the program are specifically identified and reimbursed in a manner that does not claim federal financial reimbursement. Any contracts with, and the utilization of, the Medi-Cal program's fiscal intermediary shall not be subject to Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code. Contracts to implement the federal breast and cervical cancer early detection program entered into by the department with entities other than the Medi-Cal program's fiscal intermediary shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

(d) The department shall enter into an interagency agreement with the State Department of Health Care Services to transfer that portion of the grant made to the department by the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program established under Title XV of the federal Public Health Service Act (42 U.S.C. Sec. 300k et seq.) to the State Department of Health Care Services. The department shall have no other liability to the State Department of Health Care Services under this article.

SEC. 20. Section 104160 of the Health and Safety Code is amended to read:

104160. (a) The State Department of Health Care Services shall develop and maintain the Breast and Cervical Cancer Treatment Program to expand and ensure quality breast and cervical cancer treatment for low-income uninsured and underinsured individuals who are diagnosed with breast or cervical cancer.

(b) To implement the program, the State Department of Health Care Services may contract with public or private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary, only if services provided under the program are specifically identified and reimbursed in a manner that does not claim federal financial reimbursement. The utilization of the Medi-Cal program's fiscal intermediary shall not be subject to Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code. Contracts to implement the program entered into by the State Department of Health Care Services with entities other than the Medi-Cal program's fiscal intermediary shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

SEC. 21. Section 104162.1 of the Health and Safety Code is amended to read:

104162.1. When an individual is underinsured, as defined in subdivision (g) of Section 104161, the State Department of Health Care Services shall be the payer of second resort for treatment services. To the extent necessary for the individual to obtain treatment services under any health care insurance listed in paragraph (2), (3), or (4) of subdivision (f) of Section 104161, the State Department of Health Care Services may do the following:

(a) Pay for the individual's breast or cervical cancer copayments, premiums, and deductible.

(b) Provide only treatment services not otherwise covered by any health care insurance listed in paragraph (2), (3), or (4) of subdivision (f) of Section 104161.

SEC. 22. Section 104163 of the Health and Safety Code is amended to read:

104163. The State Department of Health Care Services shall provide for breast cancer and cervical cancer treatment services pursuant to this article at the level of funding budgeted from state and other resources during the fiscal year in which the Legislature has appropriated funds to the department for this purpose. These treatment services shall not be deemed to be an entitlement.

SEC. 23. Section 104314 of the Health and Safety Code is amended to read:

104314. (a) The Prostate Cancer Fund is hereby established in the State Treasury. It is the intent of the Legislature that the fund be funded by an annual appropriation, when funds are available, in the Budget Act.

(b) The moneys in the Prostate Cancer Fund shall be expended by the State Department of Health Care Services, upon appropriation by the Legislature, for the purpose of the Prostate Cancer Screening Program

established by Section 104315.

(c) For the purposes of this chapter, “department” means the State Department of Health Care Services.

SEC. 24. Section 104315 of the Health and Safety Code is amended to read:

104315. (a) The Prostate Cancer Screening Program shall be established in the State Department of Health Care Services.

(b) The program shall apply to both of the following:

(1) Uninsured men 50 years of age and older.

(2) Uninsured men between 40 and 50 years of age who are at high risk for prostate cancer, upon the advice of a physician or upon the request of the patient.

(c) For purposes of this chapter, “uninsured” means not covered by any of the following:

(1) Medi-Cal.

(2) Medicare.

(3) A health care service plan contract or policy of disability insurance that covers screening for prostate cancer for men 50 years of age and older, and for men between 40 and 50 years of age who are at high risk for prostate cancer upon the advice of a physician or upon the request of the patient.

(4) Any other form of health care coverage that covers screening for prostate cancer for men 50 years of age and older, and for men between 40 and 50 years of age who are at high risk for prostate cancer upon the advice of a physician or upon the request of the patient.

(d) The program shall include all of the following:

(1) Screening of men for prostate cancer as an early detection health care measure.

(2) After screening, medical referral of screened men and services necessary for definitive diagnosis.

(3) If a positive diagnosis is made, then assistance and advocacy shall be provided to help the person obtain necessary treatment.

(4) Outreach and health education activities to ensure that uninsured men are aware of and appropriately utilize the services provided by the program.

(e) Any entity funded by the program shall coordinate with other local providers of prostate cancer screening, diagnostic, followup, education, and advocacy services to avoid duplication of effort. Any entity funded by the program shall comply with any applicable state and federal standards regarding prostate cancer screening.

(f) Administrative costs of the department shall not exceed 10 percent of the funds allocated to the program. Indirect costs of the entities funded by this program shall not exceed 12 percent. The department shall define “indirect costs” in accordance with applicable state and federal law.

(g) Any entity funded by the program shall collect data and maintain records that are determined by the department to be necessary to facilitate the state department’s ability to monitor and evaluate the effectiveness of the entities and the program. Commencing with the program’s second year of operation, and notwithstanding Section 10231.5 of the Government Code, the department shall submit an annual report to the Legislature and any other appropriate entity. The report shall describe the activities and effectiveness of the program and shall include, but not be limited to, the following types of information regarding those served by the program:

(1) The number.

(2) The ethnic, geographic, and age breakdown.

(3) The stages of presentation.

(4) The diagnostic and treatment status.

(h) The department or any entity funded by the program shall collect personal and medical information necessary to administer the program from any individual applying for services under the program. The

information shall be confidential and shall not be disclosed other than for purposes directly connected with the administration of the program or except as otherwise provided by law or pursuant to prior written consent of the subject of the information.

(i) The department or any entity funded by the program may disclose the confidential information to medical personnel and fiscal intermediaries of the state to the extent necessary to administer the program, and to other state public health agencies or medical researchers if the confidential information is necessary to carry out the duties of those agencies or researchers in the investigation, control, or surveillance of prostate cancer.

(j) The department shall adopt regulations to implement the Prostate Cancer Screening Program in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(k) This section shall not be implemented unless and until funds are appropriated for this purpose in the annual Budget Act.

(l) To implement the Prostate Cancer Screening Program, the department may contract, to the extent permitted by Section 19130 of the Government Code, with public and private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary. However, the Medi-Cal program's fiscal intermediary shall only be utilized if services provided under the program are specifically identified and reimbursed in a manner that does not claim federal financial reimbursement. Any contracts with, and the utilization of, the Medi-Cal program's fiscal intermediary shall not be subject to Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code. Contracts to implement the Prostate Cancer Screening Program entered into by the department with entities other than the Medi-Cal program's fiscal intermediary shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

SEC. 25. Section 104322 of the Health and Safety Code is amended to read:

104322. (a) (1) The State Department of Health Care Services shall develop and implement a program to provide quality prostate cancer treatment for low-income and uninsured men.

(2) The State Department of Health Care Services shall award one or more contracts to provide prostate cancer treatment through private or public nonprofit organizations, including, but not limited to, community-based organizations, local health care providers, the University of California medical centers, and the Charles R. Drew University of Medicine and Science, an affiliate of the David Geffen School of Medicine at the University of California at Los Angeles. Contracts awarded, subsequent to the effective date of the amendments to this section made during the 2005 portion of the 2005–06 Regular Session, pursuant to this paragraph shall be consistent with both of the following:

(A) Eighty-seven percent of the total contract funding shall be used for direct patient care.

(B) No less than 70 percent of the total contract funding shall be expended on direct patient care treatment costs, which shall be defined as funding to fee-for-service providers for Medi-Cal eligible services.

(3) The contracts described in paragraph (2) shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code. Commencing July 1, 2006, those contracts shall be entered into on a competitive bid basis.

(4) It is the intent of the Legislature to support the prostate cancer treatment program provided for pursuant to this section, and that the program be cost-effective and maximize the number of men served for the amount of funds appropriated. It is further the intent of the Legislature to ensure that the program has an adequate health care provider network to facilitate reasonable access to treatment.

(b) Treatment provided under this chapter shall be provided to uninsured and underinsured men with incomes at or below 200 percent of the federal poverty level. Covered services shall be limited to prostate cancer treatment and prostate cancer-related services. Eligible men shall be enrolled in a 12-month treatment regimen.

(c) The State Department of Health Care Services shall contract for prostate cancer treatment services only at the level of funding budgeted from state and other sources during a fiscal year in which the Legislature has appropriated funds to the department for this purpose.

(d) Notwithstanding subdivision (a) of Section 2.00 of the Budget Act of 2003 and any other provision of law, commencing with the 2003–04 fiscal year and for each fiscal year thereafter, any amount appropriated to the

State Department of Health Care Services for the prostate cancer treatment program implemented pursuant to this chapter shall be made available, for purposes of that program, for encumbrance for one fiscal year beyond the year of appropriation and for expenditure for two fiscal years beyond the year of encumbrance.

SEC. 26. Section 110050 of the Health and Safety Code is amended to read:

110050. The Food Safety Fund is hereby created as a special fund in the State Treasury. All moneys collected by the department under subdivision (c) of Section 110466 and Sections 110470, 110471, 110485, 111130, and 113717, and under Article 7 (commencing with Section 110810) of Chapter 5 shall be deposited in the fund, for use by the department, upon appropriation by the Legislature, for the purposes of providing funds necessary to carry out and implement the inspection provisions of this part relating to food, licensing, inspection, enforcement, and other provisions of Article 12 (commencing with Section 111070) relating to water, the provisions relating to education and training in the prevention of microbial contamination pursuant to Section 110485, and the registration provisions of Article 7 (commencing with Section 110810) of Chapter 5, and to carry out and implement the provisions of the California Retail Food Code (Part 7 (commencing with Section 113700) of Division 104).

SEC. 27. Section 113717 of the Health and Safety Code is amended to read:

113717. (a) Any person requesting the department to undertake any activity pursuant to paragraph (5) of subdivision (c) of Section 113871, Section 114417, paragraph (2) of subdivision (b) of Section 114419, and Section 114419.3 shall pay the department's costs incurred in undertaking the activity. The department's services shall be assessed at the current hourly cost-recovery rate, and it shall be entitled to recover any other costs reasonably and actually incurred in performing those activities, including, but not limited to, the costs of additional inspection and laboratory testing. For purposes of this section, the department's hourly rate shall be adjusted annually in accordance with Section 100425.

(b) The department shall provide to the person paying the required fee a statement, invoice, or similar document that describes in reasonable detail the costs paid.

(c) For purposes of this section only, the term "person" does not include any city, county, city and county, or other political subdivision of the state or local government.

SEC. 28. Section 113718 of the Health and Safety Code is repealed.

SEC. 29. Section 113718 is added to the Health and Safety Code, to read:

113718. Notwithstanding Section 16350 of the Government Code, all moneys deposited in the Retail Food Safety and Defense Fund shall be transferred to the Food Safety Fund for appropriation and expenditure as specified by Section 110050.

SEC. 30. Section 116064.1 of the Health and Safety Code is repealed.

SEC. 31. Section 116064.2 of the Health and Safety Code is amended to read:

116064.2. (a) As used in this section, the following words have the following meanings:

(1) "ASME/ANSI performance standard" means a standard that is accredited by the American National Standards Institute and published by the American Society of Mechanical Engineers.

(2) "ASTM performance standard" means a standard that is developed and published by ASTM International.

(3) "Main drain" means a submerged suction outlet typically located at the bottom of a swimming pool that conducts water to a recirculating pump.

(4) "Public swimming pool" means an outdoor or indoor structure, whether in-ground or above-ground, intended for swimming or recreational bathing, including a swimming pool, hot tub, spa, or nonportable wading pool, that is any of the following:

(A) Open to the public generally, whether for a fee or free of charge.

(B) Open exclusively to members of an organization and their guests, residents of a multiunit apartment building, apartment complex, residential real estate development, or other multifamily residential area, or

patrons of a hotel or other public accommodations facility.

(C) Located on the premises of an athletic club, or public or private school.

(5) “Qualified individual” means a contractor who holds a current valid license issued by the State of California or a professional engineer licensed in the State of California who has experience working on public swimming pools.

(6) “Safety vacuum release system” means a vacuum release system that ceases operation of the pump, reverses the circulation flow, or otherwise provides a vacuum release at a suction outlet when a blockage is detected.

(7) “Skimmer equalizer line” means a suction outlet located below the waterline and connected to the body of a skimmer that prevents air from being drawn into the pump if the water level drops below the skimmer weir. However, a skimmer equalizer line is not a main drain.

(8) “Unblockable drain” means a drain of any size and shape that a human body cannot sufficiently block to create a suction entrapment hazard.

(b) Subject to subdivision (e), every public swimming pool shall be equipped with antientrapment devices or systems that comply with the ANSI/APSP-16 2011 standard as in effect on December 31, 2011.

(c) Subject to subdivisions (d) and (e), every public swimming pool with a single main drain that is not an unblockable drain shall be equipped with at least one or more of the following devices or systems that are designed to prevent physical entrapment by pool drains:

(1) A safety vacuum release system that has been tested by a nationally recognized testing laboratory and found to conform to ASME/ANSI performance standard A112.19.17, as in effect on December 31, 2009, or ASTM performance standard F2387, as in effect on December 31, 2009.

(2) A suction-limiting vent system with a tamper-resistant atmospheric opening, provided that it conforms to any applicable ASME/ANSI or ASTM performance standard.

(3) A gravity drainage system that utilizes a collector tank, provided that it conforms to any applicable ASME/ANSI or ASTM performance standard.

(4) An automatic pump shut-off system tested by a department-approved independent third party and found to conform to any applicable ASME/ANSI or ASTM performance standard.

(5) Any other system that is deemed, in accordance with federal law, to be equally effective as, or more effective than, the systems described in paragraph (1) at preventing or eliminating the risk of injury or death associated with pool drainage systems.

(d) Every public swimming pool constructed on or after January 1, 2010, shall have at least two main drains per pump that are hydraulically balanced and symmetrically plumbed through one or more “T” fittings, and that are separated by a distance of at least three feet in any dimension between the drains. A public swimming pool constructed on or after January 1, 2010, that meets the requirements of this subdivision, shall be exempt from the requirements of subdivision (c).

(e) A public swimming pool constructed prior to January 1, 2010, shall be retrofitted to comply with subdivisions (b) and (c) by no later than July 1, 2010, except that no further retrofitting is required for a public swimming pool that completed a retrofit between December 19, 2007, and January 1, 2010, that complied with the Virginia Graeme Baker Pool and Spa Safety Act (15 U.S.C. Sec. 8001 et seq.) as in effect on the date of issue of the construction permit, or for a nonportable wading pool that completed a retrofit prior to January 1, 2010, that complied with state law on the date of issue of the construction permit. A public swimming pool owner who meets the exception described in this subdivision shall do one of the following prior to September 30, 2010:

(1) File the form issued by the department pursuant to subdivision (f), as otherwise provided in subdivision (h).

(2) (A) File a signed statement attesting that the required work has been completed.

(B) Provide a document containing the name and license number of the qualified individual who completed the required work.

(C) Provide either a copy of the final building permit, if required by the local agency, or a copy of one of the

following documents if no permit was required:

(i) A document that describes the modification in a manner that provides sufficient information to document the work that was done to comply with federal law.

(ii) A copy of the final paid invoice. The amount paid for the services may be omitted or redacted from the final invoice prior to submission.

(f) Prior to March 31, 2010, the department shall issue a form for use by an owner of a public swimming pool to indicate compliance with this section. The department shall consult with county health officers and directors of departments of environmental health in developing the form and shall post the form on the department's Internet Web site. The form shall be completed by the owner of a public swimming pool prior to filing the form with the appropriate city, county, or city and county department of environmental health. The form shall include, but not be limited to, the following information:

(1) A statement of whether the pool operates with a single or split main drain.

(2) Identification of the type of antientrapment devices or systems that have been installed pursuant to subdivision (b) and the date or dates of installation.

(3) Identification of the type of devices or systems designed to prevent physical entrapment that have been installed pursuant to subdivision (c) in a public swimming pool with a single main drain that is not an unblockable drain and the date or dates of installation or the reason why the requirement is not applicable.

(4) A signature and license number of a qualified individual who certifies that the factual information provided on the form in response to paragraphs (1) to (3), inclusive, is true to the best of his or her knowledge.

(g) A qualified individual who improperly certifies information pursuant to paragraph (4) of subdivision (f) shall be subject to potential disciplinary action at the discretion of the licensing authority.

(h) Except as provided in subdivision (e), each public swimming pool owner shall file a completed copy of the form issued by the department pursuant to this section with the city, county, or city and county department of environmental health in the city, county, or city and county in which the swimming pool is located. The form shall be filed within 30 days following the completion of the swimming pool construction or installation required pursuant to this section or, if the construction or installation is completed prior to the date that the department issues the form pursuant to this section, within 30 days of the date that the department issues the form. The public swimming pool owner or operator shall not make a false statement, representation, certification, record, report, or otherwise falsify information that he or she is required to file or maintain pursuant to this section.

(i) In enforcing this section, health officers and directors of city, county, or city and county departments of environmental health shall consider documentation filed on or with the form issued pursuant to this section by the owner of a public swimming pool as evidence of compliance with this section. A city, county, or city and county department of environmental health may verify the accuracy of the information filed on or with the form.

(j) To the extent that the requirements for public wading pools imposed by Section 116064 conflict with this section, the requirements of this section shall prevail.

(k) The department shall have no authority to take any enforcement action against any person for violation of this section and has no responsibility to administer or enforce the provisions of this section.

SEC. 32. Section 123865 of the Health and Safety Code is amended to read:

123865. (a) Whenever the parents or estate of a handicapped child is wholly or partly unable to furnish for the child necessary services, the parents or guardian may apply to the agency of the county that has been designated by the board of supervisors of the county of residence under the terms of Section 123850 to administer the provisions for handicapped children. Residence shall be determined in accordance with Sections 243 and 244 of the Government Code.

(b) If the child has an individualized education program (IEP) pursuant to the federal Individuals with Disabilities Education Act (IDEA; 20 U.S.C. Sec. 1400 et seq.), that IEP shall be disclosed to the California Children's Services Program by the parents or the estate of the handicapped child at the time of application provided for in subdivision (a) and on revision of the child's IEP.

SEC. 33. Section 123870 of the Health and Safety Code is amended to read:

123870. (a) The State Department of Health Care Services 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. 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 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 CCS 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 physical development would be impeded without the services. All occupational and physical therapy services assessed and determined to be educationally necessary by the individualized education program (IEP) team and included in the child's IEP developed pursuant to the provisions of the federal Individuals with Disabilities Education Act (IDEA; 20 U.S.C. Sec. 1400 et seq.), shall be provided in accordance with the provisions of that federal act and shall not be paid for by the CCS program.

(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 CCS 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 in accordance with the federal IDEA 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.

SEC. 33.5. Section 123870 of the Health and Safety Code is amended to read:

123870. (a) The State Department of Health Care Services 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, the financial documentation required to establish eligibility for the Medi-Cal program 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, or enrolled in the Medi-Cal program pursuant to Section 14005.26 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 CCS 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 physical development would be impeded without the services. All occupational and physical therapy services assessed and determined to be educationally necessary by the individualized education program (IEP) team and included in the child's IEP developed pursuant to the provisions of the federal Individuals with Disabilities Education Act (IDEA; 20 U.S.C. Sec. 1400 et seq.), shall be provided in accordance with the provisions of that federal act and shall not be paid for by the CCS program.

(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 CCS 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 in accordance with the federal IDEA 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.

SEC. 34. Section 123875 of the Health and Safety Code is amended to read:

123875. A handicapped child, as defined in Section 123830, who applies to the California Children's Services Program in accordance with Section 123865, shall be determined to be eligible for therapy services when the California Children's Services Program's medical therapy unit conference team finds that the child needs medically necessary occupational or physical therapy. If the California Children's Services medical consultant disagrees with the determination of eligibility by the California Children's Services medical therapy unit conference team, the medical consultant shall communicate with the conference team to ask for further justification of its determination, and shall weigh the conference team's arguments in support of its decision in reaching his or her own determination.

This section shall not change eligibility criteria for the California Children's Services programs as described in Sections 123830 and 123860.

This section shall not apply to children diagnosed as specific learning disabled, unless they otherwise meet the eligibility criteria of the California Children's Services.

SEC. 35. Section 124300 of the Health and Safety Code is amended to read:

124300. Within any county where 10 percent or more of the population, as determined by the Population Research Unit of the Department of Finance, speaks any one language other than English as its native language, every local health department shall make copies of circulars and pamphlets relating to family planning that are made available to the public also available in the other language.

The State Department of Health Care Services, upon request, shall make a translation available in other than English those family planning informational materials normally distributed to the general public.

SEC. 36. Section 125130 of the Health and Safety Code is amended to read:

125130. The Director of Health Care Services shall establish and administer a program for the medical care of persons with genetically handicapping conditions, including cystic fibrosis, hemophilia, sickle cell disease, Huntington's disease, Friedreich's Ataxia, Joseph's disease, Von Hippel-Landau syndrome, and the following hereditary metabolic disorders: phenylketonuria, homocystinuria, branched chain amino acidurias, disorders of propionate and methylmalonate metabolism, urea cycle disorders, hereditary orotic aciduria, Wilson's Disease, galactosemia, disorders of lactate and pyruvate metabolism, tyrosinemia, hyperornithinemia, and other genetic organic acidemias that require specialized treatment or service available from only a limited number of program-approved sources.

The program shall also provide access to social support services, that may help ameliorate the physical, psychological, and economic problems attendant to genetically handicapping conditions, in order that the genetically handicapped person may function at an optimal level commensurate with the degree of impairment.

The medical and social support services may be obtained through physicians and surgeons, genetically handicapped person's program specialized centers, and other providers that qualify pursuant to the regulations of the department to provide the services. "Medical care," as used in this section, is limited to noncustodial medical and support services.

The director shall adopt regulations that are necessary for the implementation of this article.

SEC. 37. Section 125145 of the Health and Safety Code is repealed.

SEC. 38. Section 125205 of the Health and Safety Code is amended to read:

125205. The department and the State Department of Social Services shall, after consultation with the Genetically Handicapped Persons Program of the department and consumer organizations representing persons with chronic and degenerative conditions, as defined in Section 125210, compile a list of long-term care resources that serve adults with chronic and degenerative conditions, as defined. The list of resources shall include those that have already been identified by the Genetically Handicapped Persons Program as serving persons with Huntington's disease, Joseph's disease, and Friedrich's ataxia, and shall include those that have already been identified by consumer organizations representing persons with chronic and degenerative conditions. The list of resources shall include, but not be limited to, the following:

(a) Public and private skilled nursing facilities and intermediate care facilities.

(b) Public and private community residential care facilities.

(c) Public and private out-of-home long-term care resources such as day activity programs, and in-home support service programs. Nothing in this section shall require the State Department of Health Care Services to undertake a survey of long-term care facilities or programs in the state for the purposes of carrying out the requirements of this section.

The information shall be made available to the public, upon request, through the Genetically Handicapped Persons Program of the department.

SEC. 39. Section 125215 of the Health and Safety Code is amended to read:

125215. The department and the State Department of Social Services shall review regulations that currently provide disincentives to providers of in-home and out-of-home long-term care resources, as defined in Section 125205, to accept and serve persons with chronic and degenerative disorders. The review shall be conducted with assistance and input from the Genetically Handicapped Persons Program of the department. These departments shall provide a list of those regulations to the Legislature by September 1, 1982. The regulations subject to review shall be those regulations that do the following:

(a) Affect the admission of patients to state-licensed skilled nursing facilities, intermediate care facilities, and community residential care facilities.

(b) Affect the staffing ratios necessary to care for persons with chronic and degenerative conditions, as defined, within those facilities.

(c) Affect the likelihood of facilities, or of day care programs and in-home support service programs, to refuse the admission of persons with chronic and degenerative conditions, solely on the basis of anticipated jeopardy to their licensing, or on the basis of anticipated liability to the facilities arising from instances where a person's degenerative condition, by its own clinical merits, results in medical complications that are, in fact, entirely unrelated to the quality of care provided by the facility or program.

SEC. 40. Section 130060 of the Health and Safety Code is amended to read:

130060. (a) (1) After January 1, 2008, any general acute care hospital building that is determined to be a potential risk of collapse or pose significant loss of life shall only be used for nonacute care hospital purposes. A delay in this deadline may be granted by the office upon a demonstration by the owner that compliance will result in a loss of health care capacity that may not be provided by other general acute care hospitals within a reasonable proximity. In its request for an extension of the deadline, a hospital shall state why the hospital is unable to comply with the January 1, 2008, deadline requirement.

(2) Prior to granting an extension of the January 1, 2008, deadline pursuant to this section, the office shall do all of the following:

(A) Provide public notice of a hospital's request for an extension of the deadline. The notice, at a minimum, shall be posted on the office's Internet Web site, and shall include the facility's name and identification number, the status of the request, and the beginning and ending dates of the comment period, and shall advise the public of the opportunity to submit public comments pursuant to subparagraph (C). The office shall also provide notice of all requests for the deadline extension directly to interested parties upon request of the interested parties.

(B) Provide copies of extension requests to interested parties within 10 working days to allow interested parties to review and provide comment within the 45-day comment period. The copies shall include those records that are available to the public pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section

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

(C) Allow the public to submit written comments on the extension proposal for a period of not less than 45 days from the date of the public notice.

(b) (1) It is the intent of the Legislature, in enacting this subdivision, to facilitate the process of having more hospital buildings in substantial compliance with this chapter and to take nonconforming general acute care hospital inpatient buildings out of service more quickly.

(2) The functional contiguous grouping of hospital buildings of a general acute care hospital, each of which provides, as the primary source, one or more of the hospital's eight basic services as specified in subdivision (a) of Section 1250, may receive a five-year extension of the January 1, 2008, deadline specified in subdivision (a) of this section pursuant to this subdivision for both structural and nonstructural requirements. A functional contiguous grouping refers to buildings containing one or more basic hospital services that are either attached or connected in a way that is acceptable to the State Department of Health Care Services. These buildings may be either on the existing site or a new site.

(3) To receive the five-year extension, a single building containing all of the basic services or at least one building within the contiguous grouping of hospital buildings shall have obtained a building permit prior to 1973 and this building shall be evaluated and classified as a nonconforming, Structural Performance Category-1 (SPC-1) building. The classification shall be submitted to and accepted by the Office of Statewide Health Planning and Development. The identified hospital building shall be exempt from the requirement in subdivision (a) until January 1, 2013, if the hospital agrees that the basic service or services that were provided in that building shall be provided, on or before January 1, 2013, as follows:

(A) Moved into an existing conforming Structural Performance Category-3 (SPC-3), Structural Performance Category-4 (SPC-4), or Structural Performance Category-5 (SPC-5) and Non-Structural Performance Category-4 (NPC-4) or Non-Structural Performance Category-5 (NPC-5) building.

(B) Relocated to a newly built compliant SPC-5 and NPC-4 or NPC-5 building.

(C) Continued in the building if the building is retrofitted to a SPC-5 and NPC-4 or NPC-5 building.

(4) A five-year extension is also provided to a post-1973 building if the hospital owner informs the Office of Statewide Health Planning and Development that the building is classified as SPC-1, SPC-3, or SPC-4 and will be closed to general acute care inpatient service use by January 1, 2013. The basic services in the building shall be relocated into a SPC-5 and NPC-4 or NPC-5 building by January 1, 2013.

(5) SPC-1 buildings, other than the building identified in paragraph (3) or (4), in the contiguous grouping of hospital buildings shall also be exempt from the requirement in subdivision (a) until January 1, 2013. However, on or before January 1, 2013, at a minimum, each of these buildings shall be retrofitted to a SPC-2 and NPC-3 building, or no longer be used for general acute care hospital inpatient services.

(c) On or before March 1, 2001, the office shall establish a schedule of interim work progress deadlines that hospitals shall be required to meet to be eligible for the extension specified in subdivision (b). To receive this extension, the hospital building or buildings shall meet the year 2002 nonstructural requirements.

(d) A hospital building that is eligible for an extension pursuant to this section shall meet the January 1, 2030, nonstructural and structural deadline requirements if the building is to be used for general acute care inpatient services after January 1, 2030.

(e) Upon compliance with subdivision (b), the hospital shall be issued a written notice of compliance by the office. The office shall send a written notice of violation to hospital owners that fail to comply with this section. The office shall make copies of these notices available on its Internet Web site.

(f) (1) A hospital that has received an extension of the January 1, 2008, deadline pursuant to subdivision (a) or (b) may request an additional extension of up to two years for a hospital building that it owns or operates and that meets the criteria specified in paragraph (2), (3), or (5).

(2) The office may grant the additional extension if the hospital building subject to the extension meets all of the following criteria:

(A) The hospital building is under construction at the time of the request for extension under this subdivision and the purpose of the construction is to meet the requirements of subdivision (a) to allow the use of the

building as a general acute care hospital building after the extension deadline granted by the office pursuant to subdivision (a) or (b).

(B) The hospital building plans were submitted to the office and were deemed ready for review by the office at least four years prior to the applicable deadline for the building. The hospital shall indicate, upon submission of its plans, the SPC-1 building or buildings that will be retrofitted or replaced to meet the requirements of this section as a result of the project.

(C) The hospital received a building permit for the construction described in subparagraph (A) at least two years prior to the applicable deadline for the building.

(D) The hospital submitted a construction timeline at least two years prior to the applicable deadline for the building demonstrating the hospital's intent to meet the applicable deadline. The timeline shall include all of the following:

(i) The projected construction start date.

(ii) The projected construction completion date.

(iii) Identification of the contractor.

(E) The hospital is making reasonable progress toward meeting the timeline set forth in subparagraph (D), but factors beyond the hospital's control make it impossible for the hospital to meet the deadline.

(3) The office may grant the additional extension if the hospital building subject to the extension meets all of the following criteria:

(A) The hospital building is owned by a health care district that has, as owner, received the extension of the January 1, 2008, deadline, but where the hospital is operated by an unaffiliated third-party lessee pursuant to a facility lease that extends at least through December 31, 2009. The district shall file a declaration with the office with a request for an extension stating that, as of the date of the filing, the district has lacked, and continues to lack, unrestricted access to the subject hospital building for seismic planning purposes during the term of the lease, and that the district is under contract with the county to maintain hospital services when the hospital comes under district control. The office shall not grant the extension if an unaffiliated third-party lessee will operate the hospital beyond December 31, 2010.

(B) The hospital building plans were submitted to the office and were deemed ready for review by the office at least four years prior to the applicable deadline for the building. The hospital shall indicate, upon submission of its plans, the SPC-1 building or buildings that will be retrofitted or replaced to meet the requirements of this section as a result of the project.

(C) The hospital received a building permit for the construction described in subparagraph (B) by December 31, 2011.

(D) The hospital submitted, by December 31, 2011, a construction timeline for the building demonstrating the hospital's intent and ability to meet the deadline of December 31, 2014. The timeline shall include all of the following:

(i) The projected construction start date.

(ii) The projected construction completion date.

(iii) Identification of the contractor.

(E) The hospital building is under construction at the time of the request for the extension, the purpose of the construction is to meet the requirements of subdivision (a) to allow the use of the building as a general acute care hospital building after the extension deadline granted by the office pursuant to subdivision (a) or (b), and the hospital is making reasonable progress toward meeting the timeline set forth in subparagraph (D).

(F) The hospital granted an extension pursuant to this paragraph shall submit an additional status report to the office, equivalent to that required by subdivision (c) of Section 130061, no later than June 30, 2013.

(4) An extension granted pursuant to paragraph (3) shall be applicable only to the health care district applicant and its affiliated hospital while the hospital is operated by the district or an entity under the control of the district.

(5) The office may grant the additional extension if the hospital building subject to the extension meets all of the following criteria:

(A) The hospital owner submitted to the office, prior to June 30, 2009, a request for review using current computer modeling utilized by the office and based upon software developed by the Federal Emergency Management Agency, referred to as Hazards US, and the building was deemed SPC-1 after that review.

(B) The hospital building plans for the building are submitted to the office and deemed ready for review by the office prior to July 1, 2010. The hospital shall indicate, upon submission of its plans, the SPC-1 building or buildings that shall be retrofitted or replaced to meet the requirements of this section as a result of the project.

(C) The hospital receives a building permit from the office for the construction described in subparagraph (B) prior to January 1, 2012.

(D) The hospital submits, prior to January 1, 2012, a construction timeline for the building demonstrating the hospital's intent and ability to meet the applicable deadline. The timeline shall include all of the following:

(i) The projected construction start date.

(ii) The projected construction completion date.

(iii) Identification of the contractor.

(E) The hospital building is under construction at the time of the request for the extension, the purpose of the construction is to meet the requirements of subdivision (a) to allow the use of the building as a general acute care hospital building after the extension deadline granted by the office pursuant to subdivision (a) or (b), and the hospital is making reasonable progress toward meeting the timeline set forth in subparagraph (D).

(F) The hospital owner completes construction such that the hospital meets all criteria to enable the office to issue a certificate of occupancy by the applicable deadline for the building.

(6) A hospital denied an extension pursuant to this subdivision may appeal the denial to the Hospital Building Safety Board.

(7) The office may revoke an extension granted pursuant to this subdivision for any hospital building where the work of construction is abandoned or suspended for a period of at least one year, unless the hospital demonstrates in a public document that the abandonment or suspension was caused by factors beyond its control.

(g) (1) Notwithstanding subdivisions (a), (b), (c), and (f), and Sections 130061.5 and 130064, a hospital that has received an extension of the January 1, 2008, deadline pursuant to subdivision (a) or (b) also may request an additional extension of up to seven years for a hospital building that it owns or operates. The office may grant the extension subject to the hospital meeting the milestones set forth in paragraph (2).

(2) The hospital building subject to the extension shall meet all of the following milestones, unless the hospital building is reclassified as SPC-2 or higher as a result of its Hazards US score:

(A) The hospital owner submits to the office, no later than September 30, 2012, a letter of intent stating whether it intends to rebuild, replace, or retrofit the building, or remove all general acute care beds and services from the building, and the amount of time necessary to complete the construction.

(B) The hospital owner submits to the office, no later than September 30, 2012, a schedule detailing why the requested extension is necessary, and specifically how the hospital intends to meet the requested deadline.

(C) The hospital owner submits to the office, no later than September 30, 2012, an application ready for review seeking structural reassessment of each of its SPC-1 buildings using current computer modeling based upon software developed by FEMA, referred to as Hazards US.

(D) The hospital owner submits to the office, no later than January 1, 2015, plans ready for review consistent with the letter of intent submitted pursuant to subparagraph (A) and the schedule submitted pursuant to subparagraph (B).

(E) The hospital owner submits a financial report to the office at the time the plans are submitted pursuant to subparagraph (D). The report shall demonstrate the hospital owner's financial capacity to implement the construction plans submitted pursuant to subparagraph (D).

(F) The hospital owner receives a building permit consistent with the letter of intent submitted pursuant to subparagraph (A) and the schedule submitted pursuant to subparagraph (B), no later than July 1, 2018.

(3) To evaluate public safety and determine whether to grant an extension of the deadline, the office shall consider the structural integrity of the hospital's SPC-1 buildings based on its Hazards US scores, community access to essential hospital services, and the hospital owner's financial capacity to meet the deadline as determined by either a bond rating of BBB or below or the financial report on the hospital owner's financial capacity submitted pursuant to subparagraph (E) of paragraph (2). The criteria contained in this paragraph shall be considered by the office in its determination of the length of an extension or whether an extension should be granted.

(4) The extension or subsequent adjustments granted pursuant to this subdivision may not exceed the amount of time that is reasonably necessary to complete the construction specified in paragraph (2).

(5) If the circumstances underlying the request for extension submitted to the office pursuant to paragraph (2) change, the hospital owner shall notify the office as soon as practicable, but in no event later than six months after the hospital owner discovered the change of circumstances. The office may adjust the length of the extension granted pursuant to paragraphs (2) and (3) as necessary, but in no event longer than the period specified in paragraph (1).

(6) A hospital denied an extension pursuant to this subdivision may appeal the denial to the Hospital Building Safety Board.

(7) The office may revoke an extension granted pursuant to this subdivision for any hospital building when it is determined that any information submitted pursuant to this section was falsified, or if the hospital failed to meet a milestone set forth in paragraph (2), or where the work of construction is abandoned or suspended for a period of at least six months, unless the hospital demonstrates in a publicly available document that the abandonment or suspension was caused by factors beyond its control.

(8) Regulatory submissions made by the office to the California Building Standards Commission to implement this section shall be deemed to be emergency regulations and shall be adopted as emergency regulations.

(9) The hospital owner that applies for an extension pursuant to this subdivision shall pay the office an additional fee, to be determined by the office, sufficient to cover the additional reasonable costs incurred by the office for maintaining the additional reporting requirements established under this section, including, but not limited to, the costs of reviewing and verifying the extension documentation submitted pursuant to this subdivision. This additional fee shall not include any cost for review of the plans or other duties related to receiving a building or occupancy permit.

(10) This subdivision shall become operative on the date that the State Department of Health Care Services receives all necessary federal approvals for a 2011–12 fiscal year hospital quality assurance fee program that includes three hundred twenty million dollars ($320,000,000) in fee revenue to pay for health care coverage for children, which is made available as a result of the legislative enactment of a 2011–12 fiscal year hospital quality assurance fee program.

SEC. 41. Section 130316 of the Health and Safety Code is amended to read:

130316. Any funds appropriated for the purpose of this division that remain unexpended or unencumbered on June 30, 2016, shall revert to the General Fund on that date unless a statute that is enacted before June 30, 2016, extends the provisions of this division.

SEC. 42. Section 130317 of the Health and Safety Code is amended to read:

130317. This division shall become inoperative on June 30, 2016, and as of that date is repealed, unless a later enacted statute, that is enacted before June 30, 2016, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 43. Section 131019.5 is added to the Health and Safety Code, to read:

131019.5. (a) For purposes of this section, the following definitions shall apply:

(1) "Determinants of equity" means social, economic, geographic, political, and physical environmental

conditions that lead to the creation of a fair and just society.

(2) “Health equity” means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

(3) “Health and mental health disparities” means differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors.

(4) “Health and mental health inequities” means disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair.

(5) “Vulnerable communities” include, but are not limited to, women, racial or ethnic groups, low-income individuals and families, individuals who are incarcerated and those who have been incarcerated, individuals with disabilities, individuals with mental health conditions, children, youth and young adults, seniors, immigrants and refugees, individuals who are limited-English proficient (LEP), and lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) communities, or combinations of these populations.

(6) “Vulnerable places” means places or communities with inequities in the social, economic, educational, or physical environment or environmental health and that have insufficient resources or capacity to protect and promote the health and well-being of their residents.

(b) The State Department of Public Health shall establish an Office of Health Equity for the purposes of aligning state resources, decisionmaking, and programs to accomplish all of the following:

(1) Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically isolated communities.

(2) Work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health.

(3) Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services.

(4) Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and inequities.

(c) The duties of the Office of Health Equity shall include all of the following:

(1) Conducting policy analysis and developing strategic policies and plans regarding specific issues affecting vulnerable communities and vulnerable places to increase positive health and mental health outcomes for vulnerable communities and decrease health and mental health disparities and inequities. The policies and plans shall also include strategies to address social and environmental inequities and improve health and mental health. The office shall assist other departments in their missions to increase access to services and supports and improve quality of care for vulnerable communities.

(2) Establishing a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities and inequities. The strategies and recommendations developed shall take into account the needs of vulnerable communities to ensure strategies are developed throughout the state to eliminate health and mental health disparities and inequities. This plan shall be developed in collaboration with the Health in All Policies Task Force. This plan shall establish goals and benchmarks for specific strategies in order to measure and track disparities and the effectiveness of these strategies. This plan shall be updated periodically, but not less than every two years, to keep abreast of data trends, best practices, promising practices, and to more effectively focus and direct necessary resources to mitigate and eliminate disparities and inequities. This plan shall be included in the report required under paragraph (1) of subdivision (d). The Office of Health Equity shall seek input from the public on the plan through an inclusive public stakeholder process.

(3) Building upon and informing the work of the Health in All Policies Task Force in working with state agencies and departments to consider health in appropriate and relevant aspects of public policy development to ensure the implementation of goals and objectives that close the gap in health status. The Office of Health Equity shall work collaboratively with the Health in All Policies Task Force to assist state agencies and departments in developing policies, systems, programs, and environmental change strategies that have population health

impacts in all of the following ways, within the resources made available:

(A) Develop intervention programs with targeted approaches to address health and mental health inequities and disparities.

(B) Prioritize building cross-sectoral partnerships within and across departments and agencies to change policies and practices to advance health equity.

(C) Work with the advisory committee established pursuant to subdivision (f) and through stakeholder meetings to provide a forum to identify and address the complexities of health and mental health inequities and disparities and the need for multiple, interrelated, and multisectoral strategies.

(D) Provide technical assistance to state and local agencies and departments with regard to building organizational capacity, staff training, and facilitating communication to facilitate strategies to reduce health and mental health disparities.

(E) Highlight and share evidence-based, evidence-informed, and community-based practices for reducing health and mental health disparities and inequities.

(F) Work with local public health departments, county mental health or behavioral health departments, local social services, and mental health agencies, and other local agencies that address key health determinants, including, but not limited to, housing, transportation, planning, education, parks, and economic development. The Office of Health Equity shall seek to link local efforts with statewide efforts.

(4) Consult with community-based organizations and local governmental agencies to ensure that community perspectives and input are included in policies and any strategic plans, recommendations, and implementation activities.

(5) Assist in coordinating projects funded by the state that pertain to increasing the health and mental health status of vulnerable communities.

(6) Provide consultation and technical assistance to state departments and other state and local agencies charged with providing or purchasing state-funded health and mental health care, in their respective missions to identify, analyze, and report disparities and to identify strategies to address health and mental health disparities.

(7) Provide information and assistance to state and local departments in coordinating projects within and across state departments that improve the effectiveness of public health and mental health services to vulnerable communities and that address community environments to promote health. This information shall identify unnecessary duplication of services.

(8) Communicate and disseminate information within the department and with other state departments to assist in developing strategies to improve the health and mental health status of persons in vulnerable communities and to share strategies that address the social and environmental determinants of health.

(9) Provide consultation and assistance to public and private entities that are attempting to create innovative responses to improve the health and mental health status of vulnerable communities.

(10) Seek additional resources, including in-kind assistance, federal funding, and foundation support.

(d) In identifying and developing recommendations for strategic plans, the Office of Health Equity shall, at a minimum, do all of the following:

(1) Conduct demographic analyses on health and mental health disparities and inequities. The report shall include, to the extent feasible, an analysis of the underlying conditions that contribute to health and well-being. The first report shall be due July 1, 2014. This information shall be updated periodically, but not less than every two years, and made available through public dissemination, including posting on the department's Internet Web site. The report shall be developed using primary and secondary sources of demographic information available to the office, including the work and data collected by the Health in All Policies Task Force. Primary sources of demographic information shall be collected contingent on the receipt of state, federal, or private funds for this purpose.

(2) Based on the availability of data, including valid data made available from secondary sources, the report described in paragraph (1) shall address the following key factors as they relate to health and mental health disparities and inequities:

(A) Income security such as living wage, earned income tax credit, and paid leave.

(B) Food security and nutrition such as food stamp eligibility and enrollment, assessments of food access, and rates of access to unhealthy food and beverages.

(C) Child development, education, and literacy rates, including opportunities for early childhood development and parenting support, rates of graduation compared to dropout rates, college attainment, and adult literacy.

(D) Housing, including access to affordable, safe, and healthy housing, housing near parks and with access to healthy foods, and housing that incorporates universal design and visitability features.

(E) Environmental quality, including exposure to toxins in the air, water, and soil.

(F) Accessible built environments that promote health and safety, including mixed-used land, active transportation such as improved pedestrian, bicycle, and automobile safety, parks and green space, and healthy school siting.

(G) Health care, including accessible disease management programs, access to affordable, quality health and behavioral health care, assessment of the health care workforce, and workforce diversity.

(H) Prevention efforts, including community-based education and availability of preventive services.

(I) Assessing ongoing discrimination and minority stressors against individuals and groups in vulnerable communities based upon race, gender, gender identity, gender expression, ethnicity, marital status, language, sexual orientation, disability, and other factors, such as discrimination that is based upon bias and negative attitudes of health professionals and providers.

(J) Neighborhood safety and collective efficacy, including rates of violence, increases or decreases in community cohesion, and collaborative efforts to improve the health and well-being of the community.

(K) The efforts of the Health in All Policies Task Force, including monitoring and identifying efforts to include health and equity in all sectors.

(L) Culturally appropriate and competent services and training in all sectors, including training to eliminate bias, discrimination, and mistreatment of persons in vulnerable communities.

(M) Linguistically appropriate and competent services and training in all sectors, including the availability of information in alternative formats such as large font, braille, and American Sign Language.

(N) Accessible, affordable, and appropriate mental health services.

(3) Consult regularly with representatives of vulnerable communities, including diverse racial, ethnic, cultural, and LGBTQQ communities, women's health advocates, mental health advocates, health and mental health providers, community-based organizations and advocates, academic institutions, local public health departments, local government entities, and low-income and vulnerable consumers.

(4) Consult regularly with the advisory committee established by subdivision (f) for input and updates on the policy recommendations, strategic plans, and status of cross-sectoral work.

(e) The Office of Health Equity shall be organized as follows:

(1) A Deputy Director shall be appointed by the Governor or the State Public Health Officer, and is subject to confirmation by the Senate. The salary for the Deputy Director shall be fixed in accordance with state law.

(2) The Deputy Director of the Office of Health Equity shall report to the State Public Health Officer and shall work closely with the Director of Health Care Services to ensure compliance with the requirements of the office's strategic plans, policies, and implementation activities.

(f) The Office of Health Equity shall establish an advisory committee to advance the goals of the office and to actively participate in decisionmaking. The advisory committee shall be composed of representatives from applicable state agencies and departments, local health departments, community-based organizations working to advance health and mental health equity, vulnerable communities, and stakeholder communities that represent the diverse demographics of the state. The chair of the advisory committee shall be a representative from a nonstate entity. The advisory committee shall be established by no later than October 1, 2013, and shall meet, at a minimum, on a quarterly basis. Subcommittees of this advisory committee may be formed as determined by the chair.

(g) An interagency agreement shall be established between the State Department of Public Health and the State Department of Health Care Services to outline the process by which the departments will jointly work to advance the mission of the Office of Health Equity, including responsibilities, scope of work, and necessary resources.

SEC. 44. Section 131051 of the Health and Safety Code is amended to read:

131051. The duties, powers, functions, jurisdiction, and responsibilities transferred to the State Department of Public Health shall, pursuant to the act that added this section, include all of the following previously performed by the former State Department of Health Services:

(a) Under the jurisdiction of the Deputy Director for Prevention Services:

(1) The Office of AIDS, including but not limited to:

(A) The AIDS Drug Assistance Program (Chapter 6 (commencing with Section 120950) of Part 4 of Division 105).

(B) The AIDS Early Intervention Program (Chapter 4 (commencing with Section 120900) of Part 4 of Division 105).

(C) The CARE Services Program, provided for pursuant to the federal Ryan White CARE Act, 42 U.S.C. Section 300ff.

(D) The CARE/Health Insurance Premium Payment Program (federal Ryan White CARE Act, 42 U.S.C. Sec. 300ff).

(E) The Housing Opportunities for Persons with AIDS Program (Section 100119).

(F) The Residential AIDS Licensed Facilities Program (former Section 100119; Chapter 2 (commencing with Section 120815) of Part 4 of Division 105).

(G) The AIDS Case Management Program (federal Ryan White CARE Act, 42 U.S.C. Sec. 300ff; Chapter 2 (commencing with Section 120815) of Part 4 of Division 105).

(H) The AIDS Medi-Cal Waiver Program (former Section 100119; 42 U.S.C. Sec. 1396n(c)).

(I) The Bridge Project (former Section 100119).

(J) The HIV Therapeutic Monitoring Program (Chapter 16 (commencing with Section 121345) of Part 4 of Division 105).

(K) The Learning Immune Function Enhancement program (former Section 100119).

(L) The San Ysidro Prevention Project (Section 113019).

(M) The California Statewide Treatment Education Program (former Section 100119).

(N) The HIV Counseling and Testing Program (Section 113019).

(O) The Neighborhood Intervention Geared Toward High-Risk Testing program (former Section 100119).

(P) The Perinatal Transmission Prevention Project (Section 113019).

(Q) The California AIDS Clearinghouse (Section 113019).

(R) The California Disclosure Assistance and Partner Services/Partner Counseling and Referral Services (Section 113019).

(S) The African-American HIV Initiative (Section 113019; Chapter 13.7 (commencing with Section 120290) of Part 4 of Division 105).

(T) The Injection Drug User HIV Testing Utilizing Hepatitis C Testing High-Risk Initiative (Section 113019).

(U) The Prevention with Positives High-Risk Initiative (Section 113019).

(V) The Statewide Technical Assistance Initiatives (Section 113019).

(W) The HIV/AIDS Case Registry (Sections 113019, 120125, and 120130).

(2) The Office of Binational Border Health, including, but not limited to, all of the following:

(A) The California-Mexico Health Initiative (Part 3 (commencing with Section 475) of Division 1).

(B) The Early Warning Infectious Disease Surveillance Program (Chapter 2 (commencing with Section 1250) of Division 2; Chapter 2 (commencing with Section 120130) of Part 1 of Division 105).

(3) The Division of Communicable Disease Control, including, but not limited to, all of the following:

(A) The Infant Botulism Treatment and Prevention Program (Article 2.5 (commencing with Section 123700) of Chapter 3 of Part 2 of Division 106).

(B) The Sexually Transmitted Disease Control Program (Part 3 (commencing with Section 120500) of Division 105).

(C) The Infectious Disease Program (Chapter 2 (commencing with Section 120130) of Part 1 of Division 105).

(D) The Bioterrorism Epidemiology Program.

(E) The Vector Borne Disease (Part 11 (commencing with Section 116100) of Division 104).

(F) The Tuberculosis Control Program (Part 5 (commencing with Section 121350) of Division 105).

(G) The Microbial Diseases Laboratory (Chapter 2 (commencing with Section 100250) of Division 101).

(H) The Viral and Rickettsial Disease Laboratory (Chapter 2 (commencing with Section 100250) of Division 101).

(I) The West Nile Human Surveillance Program (Chapter 2 (commencing with Section 116110) of Part 11 of Division 104).

(J) The Immunization Program (Part 2 (commencing with Section 120325) of Division 105).

(K) The Vaccines for Children Program (Part 2 (commencing with Section 120325) of Division 105).

(4) The Division of Chronic Disease and Injury Control, including, but not limited to, all of the following:

(A) The IMPACT Prostate Cancer Treatment Program (Chapter 7 (commencing with Section 104322) of Part 1 of Division 103), until June 30, 2012. Commencing July 1, 2012, the duties, powers, functions, jurisdiction, and responsibilities of the State Department of Public Health regarding this program are hereby with the State Department of Health Care Services.

(B) The Every Woman Counts program (Breast and Cervical Cancer Screening Program) (Article 1.3 (commencing with Section 104150) of Chapter 2 of Part 1 of Division 103; Section 30461.6 of the Revenue and Taxation Code), until June 30, 2012. Commencing July 1, 2012, the duties, powers, functions, jurisdiction, and responsibilities of the State Department of Public Health regarding this program are hereby with the State Department of Health Care Services.

(C) The Well-Integrated Screening and Evaluation for Women Across the Nation Demonstration Project (Article 1.3 (commencing with Section 104150) of Chapter 2 of Part 1 of Division 103).

(D) The California Nutrition Network (Chapter 2 (commencing with Section 104575) of Part 3 of Division 103).

(E) The Cancer Research Program (Article 2 (commencing with Section 104175) of Chapter 2 of Part 1 of Division 103).

(F) The Translational Cancer Research and Technology Transfer Program (Article 2 (commencing with Section 104175) of Chapter 2 of Part 1 of Division 103).

(G) The Ken Maddy California Cancer Registry (Chapter 2 (commencing with Section 103875) of Part 2 of Division 102).

(H) The California Osteoporosis Prevention and Education Program (Chapter 1 (commencing with Section 125700) of Part 8 of Division 106).

(I) The Preventive Health Care for the Aging Program (Part 4 (commencing with Section 104900) of Division

103).

(J) The California Arthritis Prevention Program (former Section 100185).

(K) The Office of Oral Health (Chapter 3 (commencing with Section 104750) of Part 3 of Division 103).

(L) The Children's Dental Disease Prevention Program (Article 3 (commencing with Section 104770) of Chapter 3 of Part 3 of Division 103).

(M) The Community Water Fluoridation Program (Article 3.5 (commencing with Section 116409) of Chapter 4 of Part 12 of Division 104).

(N) The California Asthma Public Health Initiative (Chapter 6.5 (commencing with Section 104316) of Part 1 of Division 103).

(O) The California Obesity Prevention Initiative (Chapter 2 (commencing with Section 104575) of Part 3 of Division 103).

(P) The School Health Connections program (Chapter 2 (commencing with Section 104575) of Part 3 of Division 103).

(Q) The California Project LEAN (Chapter 2 (commencing with Section 104575) of Part 3 of Division 103).

(R) The California Center for Physical Activity (Section 131085).

(S) The California Diabetes Program (Section 131085).

(T) The Preventive Medicine Residency Program (Section 131090).

(U) The California Epidemiologic Investigation Service (Article 4 (commencing with Section 100325) of Chapter 2 of Part 1 of Division 101).

(V) The Continuing Professional Education Program (Section 131090).

(W) The Injury Surveillance and Epidemiology Program (Part 2 (commencing with Section 104325) of Division 103).

(X) The State and Local Injury Control Program (Chapter 1 (commencing with Section 104325) of Part 2 of Division 103).

(Y) The Office on Disability and Health (former Section 100185).

(Z) The Alzheimer's Disease Program (Article 4 (commencing with Section 125275) of Chapter 2 of Part 5 of Division 106).

(AA) The California Tobacco Control Program (Chapter 1 (commencing with Section 104350) of Part 3 of Division 103).

(5) The Division of Drinking Water and Environmental Management, including, but not limited to, all of the following:

(A) The Medical Waste Management Program (Part 14 (commencing with Section 117600) of Division 104).

(B) The Department of Defense Oversight Program (Radiologic Guidance and Approvals) (Part 9 (commencing with Section 114650) of Division 104).

(C) The Nuclear Emergency Response Program (Part 9 (commencing with Section 114650) of Division 104).

(D) The Institutions Program (Environmental Surveys) (Article 5 (commencing with Section 116025) of Chapter 5 of Part 10 of Division 104).

(E) The Drinking Water Field Management program (Chapter 4 (commencing with Section 116270) of Part 12 of Division 104).

(F) The Environmental Health Specialist Registration Program (Article 1 (commencing with Section 106600) of Chapter 4 of Part 1 of Division 104).

(G) The Sanitation and Radiation Laboratory (Article 2 (commencing with Section 100250) of Chapter 2 of Part

1 of Division 101); Chapter 4 (commencing with Section 116270) of Part 12 of Division 104).

(H) The Radon Program (Chapter 7 (commencing with Section 105400) of Part 5 of Division 103; Chapter 4 (commencing with Section 116270) of Part 12, and Article 2 (commencing with Section 106750) of Chapter 4 of Part 1, of Division 104).

(I) The Shellfish Sanitation Program (Chapter 5 (commencing with Section 112150) of Part 6 of Division 104).

(J) The Ocean Beach Safety Programs (Article 2 (commencing with Section 115875) of Chapter 5 of Part 10 of Division 104).

(K) The Bioterrorism Planning and Response for Drinking Water, Medical Waste, and Environmental Health program (Article 6 (commencing with Section 101315) of Chapter 3 of Part 3 of Division 101).

(L) The Safe Drinking Water State Revolving Fund (Chapter 4.5 (commencing with Section 116760) of Part 12 of Division 104).

(M) The Drinking Water Technical Programs (Chapter 4 (commencing with Section 16270) of Part 12 of Division 104; Chapter 4.5 (commencing with Section 116760) of Part 12 of Division 104; Article 3 (commencing with Section 106875) of Chapter 4 of Part 1 of Division 104; Chapter 5 (commencing with Section 116775) of Part 12 of Division 104; Chapter 5 (commencing with Section 115825) of Part 10 of Division 104; Chapter 7 (commencing with Section 13500) of Division 7 of the Water Code; Section 13411 of the Water Code).

(N) The Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002 (Proposition 50) (Division 26.5 (commencing with Section 79500) of the Water Code).

(6) The Division of Environmental and Occupational Disease Control, including, but not limited to, all of the following:

(A) The California Birth Defect Monitoring Program (Chapter 1 (commencing with Section 103825) of Part 2 of Division 102).

(B) The Childhood Lead Poisoning Prevention Program (Chapter 5 (commencing with Section 105275) of Part 5 of Division 103; Article 7 (commencing with Section 124125) of Chapter 3 of Part 2 of Division 106).

(C) The Lead Related Construction Program (Chapter 4 (commencing with Section 105250) of Part 5 of Division 103).

(D) The Epidemiology Studies Laboratory (Sections 25416, former Section 100170, Section 100325, and Section 104324.25).

(E) The Center for Autism and Developmental Disabilities Research and Epidemiology (former Section 100170).

(F) The Cancer Cluster/Environmental Investigations (former Section 100170).

(G) The Toxic Mold Program (Chapter 18 (commencing with Section 26100) of Division 20).

(H) The Federal Agency for Toxic Substances and Disease Registry Health Assessments, Education and Investigations program (former Section 100170).

(I) The Fish Contamination Outreach and Education program (former Section 100170).

(J) The Air Pollution and Cardiovascular Disease in the California Teachers Study Cohort Project (former Section 100170).

(K) The Delta Watershed Fish Project (outreach, education, and training to reduce exposures to mercury in fish) (former Section 100170).

(L) The Environmental Health Laboratory (former Section 100170; Article 2 (commencing with Section 100250) of Chapter 2 of Part 1 of Division 101).

(M) The Indoor Air Quality program (Chapter 7 (commencing with Section 105400) of Part 5 of Division 103).

(N) The Outdoor Air Quality program (Section 60.9 of the Labor Code).

(O) The Laboratory Response Network for Chemical Terrorism program (former Section 100170; Article 2 (commencing with Section 100250) of Chapter 2 of Part 1 of Division 101).

(P) The Air Quality and Human Monitoring Support Program (former Section 100170).

(Q) The Hazard Evaluation System and Information Service Program (Article 1 (commencing with Section 105175) of Chapter 2 of Part 5 of Division 103; Section 147.2 of the Labor Code).

(R) The Occupational Health Surveillance and Evaluation Program (Article 1 (commencing with Section 105175) of Chapter 2 of Part 5 of Division 103).

(S) The Occupational Lead Poisoning Prevention Program (Article 2 (commencing with Section 105185) of Chapter 2 of Part 5 of Division 103).

(T) The Occupational Blood Lead Registry (Article 2 (commencing with Section 105185) of Chapter 2 of Part 5 of Division 103).

(7) The Division of Food, Drug and Radiation Safety, including, but not limited to, all of the following:

(A) The Drug Licensing Program (Article 6 (commencing with Section 111615) of Chapter 6 of Part 5 of Division 104).

(B) The Consumer Product Safety Program (Part 3 (commencing with Section 108100) of Division 104).

(C) The Export Program (Article 2 (commencing with Section 110190) of Chapter 2 of Part 5 of Division 104).

(D) The Food Safety Inspection Program (Part 5 (commencing with Section 109875) and Part 6 (commencing with Section 111940) of Division 104).

(E) The Foodborne Illness and Tampering Emergency Response Program (Part 5 (commencing with Section 109875) of Division 104).

(F) The Retail Food Safety Program (Part 7 (commencing with Section 113700) of Division 104).

(G) The Food Safety Industry Education and Training Program (pursuant to Section 110485).

(H) The Medical Device Licensing Program (Article 6 (commencing with Section 111615) of Chapter 6 of Part 5 of Division 104).

(I) The Medical Device Safety Program (Part 5 (commencing with Section 109875) of Division 104).

(J) The Stop Tobacco Access to Kids Enforcement Program (STAKE) (Division 8.5 (commencing with Section 22950) of the Business and Professions Code).

(K) The Food and Drug Laboratory (Chapter 2 (commencing with Section 100250) of Division 101).

(L) The Drug Safety Program (Part 4 (commencing with Section 109250) and Part 5 (commencing with Section 109875) of Division 104).

(M) The General Food Safety Program (Part 5 (commencing with Section 109875) and Part 6 (commencing with Section 111940) of Division 104).

(N) The Food Testing Program (Chapter 2 (commencing with Section 100250) of Division 101).

(O) The Forensic Alcohol Testing Program (Article 2 (commencing with Section 100700) of Chapter 4 of Part 1 of Division 101).

(P) The Methadone Laboratory Regulating Program (Article 2 (commencing with Section 11839.23) of Chapter 10 of Part 2 of Division 10.5).

(Q) The Radiologic Health Program (Part 9 (commencing with Section 114650) of Division 104).

(R) The Mammography Program (Chapter 6 (commencing with Section 114840) of Part 9 of Division 104).

(S) The Radioactive Materials Licensing and Inspection Program (Chapter 8 (commencing with Section 114960) of Part 9 of Division 104).

(T) The Radiological Technologist Certification Program (Article 5 (commencing with Section 106955) of Part 1, and Article 3 (commencing with Section 114855) of Chapter 6 of Part 9 of Division 104).

(U) The Radioactive Waste Tracking Program (Chapter 8 (commencing with Section 114960) of Part 9 of

Division 104).

(V) The Radioactive Waste Minimization Program (Chapter 8 (commencing with Section 114960) of Part 9 of Division 104).

(W) The Low Level Radioactive Waste Management, Treatment and Disposal Program (Chapter 8 (commencing with Section 114960) of Part 9 of Division 104).

(X) The Statewide Environmental Radiation Monitoring Program (pursuant to Section 114755).

(Y) The Department of Energy Oversight Program (Part 9 (commencing with Section 114650) of Division 104).

(Z) The X-Ray Machine Inspection and Registration and Mammography Quality Standards Act Inspection Program (Article 5 (commencing with Section 106955) of Part 1, and Article 3 (commencing with Section 114855) of Chapter 6 of Part 9 of Division 104).

(8) The Deputy Director for Laboratory Science, including, but not limited to, all of the following:

(A) The Environmental Laboratory Accreditation Program (Article 3 (commencing with Section 100825) of Chapter 4 of Part 1 of Division 101).

(B) The Laboratory Central Services Program (Article 2 (commencing with Section 100250) of Chapter 2 of Part 1 of Division 101).

(C) The National Laboratory Training Network (Section 131085).

(D) The Laboratory Field Services program (Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code).

(b) Under the jurisdiction of the Deputy Director for Licensing and Certification:

(1) The General Acute Care Hospitals Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(2) The Acute Psychiatric Hospitals Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(3) The Special Hospitals Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(4) The Chemical Dependency Recovery Hospitals Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(5) The Skilled Nursing Facilities Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(6) The Intermediate Care Facilities Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(7) The Intermediate Care Facilities-Developmentally Disabled Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(8) The Intermediate Care Facilities-Developmentally Disabled-Habilitative Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(9) The Intermediate Care Facility-Developmentally Disabled-Nursing Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(10) The Home Health Agencies Licensing Program (Chapter 8 (commencing with Section 1725) of Division 2).

(11) The Referral Agencies Licensing Program (Chapter 2.3 (commencing with Section 1400) of Division 2).

(12) The Adult Day Health Centers Licensing Program (Chapter 3.3 (commencing with Section 1570) of Division 2).

(13) The Congregate Living Health Facilities (Chapter 2 (commencing with Section 1250) of Division 2).

(14) The Psychology Clinics Licensing Program (Chapter 1 (commencing with Section 1200) of Division 2).

(15) The Primary Clinics—Community and Free Licensing Program (Chapter 1 (commencing with Section 1200)

of Division 2).

(16) The Specialty Clinics—Rehab Clinics Licensing Program (Chapter 1 (commencing with Section 1200) of Division 2).

(17) The Dialysis Clinics Licensing Program (Chapter 1 (commencing with Section 1200) of Division 2).

(18) The Pediatric Day Health/Respite Care Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(19) The Alternative Birthing Centers Licensing Program (Chapter 1 (commencing with Section 1200) of Division 2).

(20) The Hospice Licensing Program (Chapter 2 (commencing with Section 1339.30) of Division 2).

(21) The Correctional Treatment Centers Licensing Program (Chapter 2 (commencing with Section 1250) of Division 2).

(22) The Medicare/Medi-Cal Certification Program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(23) The Nursing Home Administrator Professional Certification Program (Chapter 2.35 (commencing with Section 1416) of Division 2).

(24) The Certified Nursing Assistants Professional Certification Program (Chapter 2 (commencing with Section 1337) of Division 2).

(25) The Home Health Aides Professional Certification Program (Chapter 8 (commencing with Section 1725) of Division 2).

(26) The Hemodialysis Technicians Professional Certification Program (Chapter 3 (commencing with Section 1247) of Division 2 of the Business and Professions Code; Chapter 10 (commencing with Section 1794) of Division 2).

(27) The Criminal Background Clearance Program (Chapter 2 (commencing with Section 1337), Chapter 3 (commencing with Section 1520), Chapter 3.01 (commencing with Section 1569.15), Chapter 3.4 (commencing with Section 1496.80) of Division 2, and Chapter 4 (commencing with Section 11150) of Division 8).

(c) Under the jurisdiction of the Deputy Director for Health Information and Strategic Planning:

(1) The Refugee Health Program (Subpart G of Part 400 of Title 45 of the Code of Federal Regulations).

(2) The Office of County Health Services (Article 5 (commencing with Section 101300) of Chapter 3 of Part 3 of Division 101; Part 4.7 (commencing with Section 16900) of Division 9 of the Welfare and Institutions Code).

(3) The Medically Indigent Services Program (Article 5 (commencing with Section 101300) of Chapter 3 of Part 3 of Division 101).

(4) The Office of Vital Records (Part 1 (commencing with Section 102100) of Division 102).

(5) The Office of Health Information and Research (Article 1 (commencing with Section 102175) of Chapter 2 of Part 1 of Division 102; Section 128730).

(6) The Local Public Health Services Program (Article 5 (commencing with Section 101300) of Chapter 3 of Part 3 of Division 101).

(7) The Center for Health Statistics (Part 1 (commencing with Section 102100) of Division 102; Section 128730).

(8) The Medical Marijuana Program (Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 of the Health and Safety Code).

(d) Under the jurisdiction of the Deputy Director for Primary Care and Family Health:

(1) The Maternal, Child and Adolescent Health program (Part 2 (commencing with Section 123225) of Division 106).

(2) The Adolescent Family Life Program (Article 1 (commencing with Section 124175) of Chapter 4 of Part 2 of Division 106).

(3) The Advanced Practice Nurse Training program (Part 2 (commencing with Section 123225) of Division 106).

(4) The Black Infant Health Program (Part 2 (commencing with Section 123225) of Division 106).

(5) The Breastfeeding Program (Article 3 (commencing with Section 123360) of Chapter 1 of Part 2 of Division 6).

(6) The California Diabetes and Pregnancy Program (Part 2 (commencing with Section 123225) of Division 106).

(7) The California Initiative to Improve Adolescent Health (Part 2 (commencing with Section 123225) of Division 106).

(8) The Childhood Injury Prevention Program (Article 4 (commencing with Section 100325) of Chapter 2 of Division 101).

(9) The Comprehensive Perinatal Services Program (Article 3 (commencing with Section 123475) of Chapter 2 of Part 2; Section 14134.5 of the Welfare and Institutions Code).

(10) The Fetal and Infant Mortality Review Program (Article 1 (commencing with Section 123650) of Chapter 3 of Part 2 of Division 106).

(11) The Human Stem Cell Research Program (Chapter 3 (commencing with Section 125290.10) of Part 5 of Division 106; Chapter 1 (commencing with Section 125300) of Part 5.5 of Division 106).

(12) The Local Health Department Maternal, Child and Adolescent Health Program (Section 123255).

(13) The Maternal Mortality Review Program (Article 4 (commencing with Section 100325) of Chapter 2 of Division 101).

(14) The Oral Health Program (Part 2 (commencing with Section 123225) of Division 106).

(15) The Preconception Health and Health Care Initiative (Part 2 (commencing with Section 123225) of Division 106).

(16) The Regional Perinatal Programs of California (Article 4 (commencing with Section 123550) of Chapter 2 of Part 2 of Division 106).

(17) The Perinatal Dispatch Centers Outreach and Education Program (Article 4 (commencing with Section 123750) of Chapter 3 of Part 2 of Division 106).

(18) The State Early Childhood Comprehensive Services program (Part 2 (commencing with Section 123225) of Division 106).

(19) The Sudden Infant Death Syndrome Program (Article 3 (commencing with Section 123725) of Chapter 3 of Part 2 of Division 106).

(20) The Youth Pilot Program (Chapter 12.85 (commencing with Section 18987) of Part 6 of Division 9 of the Welfare and Institutions Code).

(21) The Office of Family Planning (Chapter 8.5 (commencing with Section 14500) of Part 3 of Division 9 of the Welfare and Institutions Code; Division 24 (commencing with Section 24000) of the Welfare and Institutions Code), until June 30, 2012. Commencing July 1, 2012, the duties, powers, functions, jurisdiction, and responsibilities of the State Department of Public Health regarding this office are hereby with the State Department of Health Care Services.

(22) The Community Challenge Grant Program (Section 14504.1 of the Welfare and Institutions Code, and Chapter 14 (commencing with Section 18993) of Part 6 of Division 9 of the Welfare and Institutions Code).

(23) The Information and Education Program (Section 14504.3 of the Welfare and Institutions Code).

(24) The Family PACT Program (subdivision (aa) of Section 14132 and Section 24005 of the Welfare and Institutions Code), until June 30, 2012. Commencing July 1, 2012, the duties, powers, functions, jurisdiction, and responsibilities of the State Department of Public Health regarding this program are hereby with the State Department of Health Care Services.

(25) The Male Involvement Program (Section 14504 of the Welfare and Institutions Code).

(26) The TeenSMART Outreach Program (Section 14504.2 of the Welfare and Institutions Code).

(27) The Battered Women Shelter Program (Chapter 6 (commencing with Section 124250) of Part 2 of Division 106).

(28) The Women, Infants and Children Program (Article 1 (commencing with Section 123275) of Chapter 1 of Part 2 of Division 106).

(29) The WIC Supplemental Nutrition Program (Article 1 (commencing with Section 123275) of Chapter 1 of Part 2 of Division 106).

(30) The Farmers Market Nutrition Program (Section 123279).

(31) Genetic Disease Program (Chapter 1 (commencing with Section 124975) of Part 5 of Division 106).

(32) The Newborn Screening Program (Chapter 1 (commencing with Section 124975) of Part 5 of Division 106).

(33) The Prenatal Screening Program (Chapter 1 (commencing with Section 124975) of Part 5 of Division 106).

SEC. 45. Section 131052 of the Health and Safety Code is amended to read:

131052. In implementing the transfer of jurisdiction pursuant to this article, the State Department of Public Health succeeds to and is vested with all the statutory duties, powers, purposes, responsibilities, and jurisdiction of the former State Department of Health Services as they relate to public health as provided for or referred to in all of the following provisions of law:

(1) Sections 550, 555, 650, 680, 1241, 1658, 2221.1, 2248.5, 2249, 2259, 2259.5, 2541.3, 2585, 2728, 3527, 4017, 4027, 4037, 4191, 19059.5, 19120, 22950, 22973.2, and 22974.8 of the Business and Professions Code.

(2) Sections 56.17, 1812.508, and 1812.543 of the Civil Code.

(3) Sections 8286, 8803, 17613, 32064, 32065, 32066, 32241, 49030, 49405, 49414, 49423.5, 49452.6, 49460, 49464, 49565, 49565.8, 49531.1, 56836.165, and 76403 of the Education Code.

(4) Sections 405, 6021, 6026, 18963, 30852, 41302, and 78486 of the Food and Agricultural Code.

(5) Sections 307, 355, 422, 7572, 7574, 8706, 8817, and 8909 of the Family Code.

(6) Sections 217.6, 1507, 1786, 4011, 5671, 5674, 5700, 5701, 5701.5, 7715, and 15700 of the Fish and Game Code.

(7) Sections 855, 51010, and 551017.1 of the Government Code. For purposes of subdivision (s) of Section 6254 of the Government Code, the term “State Department of Health Services” is hereby deemed to refer to the State Department of Public Health.

(8) (A) Sections 475, 1180.6, 1418.1, 1422.1, 1428.2, 1457, 1505, 1507.1, 1507.5, 1570.7, 1599.2, 1599.60, 1599.75, 1599.87, 2002, 2804, 11362.7, 11776, 11839.21, 11839.23, 11839.24, 11839.25, 11839.26, 11839.27, 11839.28, 11839.29, 11839.30, 11839.31, 11839.32, 11839.33, 11839.34, 17920.10, 17961, 18897.2, 24185, 24186, 24187, 24275, 26101, 26122, 26134, 26155, 26200, and 26203.

(B) Chapters 1, 2, 2.05, 2.3, 2.35, 2.4, 3.3, 3.9, 3.93, 3.95, 4, 4.1, 4.5, 5, 6, 6.5, 8, 8.3, 8.5, 8.6, 9, and 11 of Division 2.

(C) Articles 2 and 4 of Chapter 2, Chapter 3, and Chapter 4 of Part 1, Part 2 and Part 3 of Division 101.

(D) Division 102, including Sections 102230 and 102231.

(E) Division 103, including Sections 104145, 104181, 104182, 104182.5, 104187, 104191, 104192, 104193, 104316, 104317, 104318, 104319, 104320, 104321, 104324.2, 104324.25, 104350, 105191, 105251, 105255, 105280, 105340, and 105430.

(F) Division 104, including Sections 106615, 106675, 106770, 108115, 108855, 109282, 109910, 109915, 112155, 112500, 112650, 113355, 114460, 114475, 114650, 114710, 114850, 114855, 114985, 115061, 115261, 115340, 115736, 115880, 115885, 115915, 116064, 116183, 116270, 116365.5, 116366, 116375,

116610, 116751, 116760.20, 116825, 117100, 117924, and 119300.

(G) Division 105, including Sections 120262, 120381, 120395, 120440, 120480, 120956, 120966, 121155, 121285, 121340, 121349.1, 121480, 122410, and 122420.

(H) Part 1, Part 2 excluding Articles 5, 5.5, 6, and 6.5 of Chapter 3, Part 3 and Part 5 excluding Articles 1 and 2 of Chapter 2, Part 7, and Part 8 of Division 106.

(9) Sections 799.03, 10123.35, 10123.5, 10123.55, 10123.10, 10123.184, and 11520 of the Insurance Code.

(10) Sections 50.8, 142.3, 144.5, 144.7, 147.2, 4600.6, 6307.1, 6359, 6712, 9009, and 9022 of the Labor Code.

(11) Sections 4018.1, 5008.1, 7501, 7502, 7510, 7511, 7515, 7518, 7530, 7550, 7553, 7575, 7576, 11010, 11174.34, and 13990 of the Penal Code.

(12) Section 4806 of the Probate Code.

(13) Sections 15027, 25912, 28004, 30950, 41781.1, 42830, 43210, 43308, 44103, and 71081 of the Public Resources Code.

(14) Section 10405 of the Public Contract Code.

(15) Sections 883, 1507, and 7718 of the Public Utilities Code.

(16) Sections 18833, 18838, 18845.2, 18846.2, 18847.2, 18863, 30461.6, 43010.1, and 43011.1 of the Revenue and Taxation Code.

(17) Section 11020 of the Unemployment Insurance Code.

(18) Sections 22511.55, 23158, 27366, and 33000 of the Vehicle Code.

(19) Sections 5326.9, 5328, 5328.15, 14132, 16902, and 16909, and Division 24 of the Welfare and Institutions Code. Payment for services provided under the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program pursuant to subdivision (aa) of Section 14132 and Division 24 shall be made through the State Department of Health Care Services. The State Department of Public Health and the State Department of Health Care Services may enter into an interagency agreement for the administration of those payments. This paragraph, to the extent that it applies to the Family PACT Waiver Program, shall become inoperative on June 30, 2012.

(20) Sections 13176, 13177.5, 13178, 13193, 13390, 13392, 13392.5, 13393.5, 13395.5, 13396.7, 13521, 13522, 13523, 13528, 13529, 13529.2, 13550, 13552.4, 13552.8, 13553, 13553.1, 13554, 13554.2, 13816, 13819, 13820, 13823, 13824, 13825, 13827, 13830, 13834, 13835, 13836, 13837, 13858, 13861, 13862, 13864, 13868, 13868.1, 13868.3, 13868.5, 13882, 13885, 13886, 13887, 13891, 13892, 13895.1, 13895.6, 13895.9, 13896, 13896.3, 13896.4, 13896.5, 13897, 13897.4, 13897.5, 13897.6, 13898, 14011, 14012, 14015, 14016, 14017, 14019, 14022, 14025, 14026, 14027, and 14029 of the Water Code.

SEC. 46. Section 131055.1 is added to the Health and Safety Code, to read:

131055.1. (a) Notwithstanding Section 131050, commencing on July 1, 2012, the State Department of Health Care Services shall succeed to and be vested with all the duties, powers, purposes, functions, responsibilities, and jurisdiction of the State Department of Public Health as they relate to the Breast and Cervical Cancer Screening Program pursuant to Article 1.3 (commencing with Section 104150) of Chapter 1, the Breast and Cervical Cancer Treatment Program pursuant to Article 1.5 (commencing with Section 104160) of Chapter 1, the Prostate Cancer Screening Program pursuant to Chapter 6 (commencing with Section 104310), the IMPACT Prostate Cancer Treatment Program pursuant to Chapter 7 (commencing with Section 104322) of Part 1 of Division 103, translation services pursuant to Part 3 (commencing with Section 124300) of Division 106, the Office of Family Planning pursuant to Chapter 8.5 (commencing with Section 14500) of Part 3 of Division 9 of the Welfare and Institutions Code, excluding the Personal Responsibility Education Federal Grant Program, the Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to subdivision (aa) of Section 14132, and the State-Only Family Planning Program pursuant to Division 24 (commencing with Section 24000) of the Welfare and Institutions Code.

(b) Commencing July 1, 2012, any reference to the State Department of Public Health with regard to the Breast

and Cervical Cancer Screening Program pursuant to Article 1.3 (commencing with Section 104150) of Chapter 1, the Breast and Cervical Cancer Treatment Program pursuant to Article 1.5 (commencing with Section 104160) of Chapter 1, the Prostate Cancer Screening Program pursuant to Chapter 6 (commencing with Section 104310), the IMPACT Prostate Cancer Treatment Program pursuant to Chapter 7 (commencing with Section 104322) of Part 1 of Division 103, translation services pursuant to Part 3 (commencing with Section 124300) of Division 106, the Office of Family Planning pursuant to Chapter 8.5 (commencing with Section 14500) of Part 3 of Division 9 of the Welfare and Institutions Code, excluding the Personal Responsibility Education Federal Grant Program, the Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to subdivision (aa) of Section 14132, or the State-Only Family Planning Program pursuant to Division 24 (commencing with Section 24000) of the Welfare and Institutions Code, shall refer to the State Department of Health Care Services.

(c) All regulations and orders adopted by the State Department of Public Health and any of its predecessors in effect prior to July 1, 2012, shall remain in effect and shall be fully enforceable unless and until readopted, amended, or repealed, or until they expire by their own terms. Any action by or against the State Department of Public Health and any of its predecessors pertaining to matters vested in the State Department of Health Care Services by this act shall not abate but shall continue in the name of the State Department of Health Care Services, and the State Department of Health Care Services shall be substituted for the State Department of Public Health and any of its predecessors by the court wherein the action is pending. The substitution shall not in any way affect the rights of the parties to the action.

(d) Commencing July 1, 2012, the unexpended balance of all funds available for use by the State Department of Public Health or any of its predecessors in carrying out any functions transferred to the State Department of Health Care Services shall be available for use by the State Department of Health Care Services.

(e) Commencing July 1, 2012, all books, documents, records, and property of the State Department of Public Health pertaining to functions transferred to the State Department of Health Care Services shall be transferred to the State Department of Health Care Services.

(f) Commencing July 1, 2012, positions filled by appointment by the Governor in the State Department of Public Health whose principal assignment was to perform functions transferred to the State Department of Health Care Services shall be transferred to the State Department of Health Care Services. Individuals in positions transferred pursuant to this subdivision shall serve at the pleasure of the Governor. Salaries of positions transferred shall remain at the level established pursuant to law unless otherwise provided.

(g) Commencing July 1, 2012, every officer and employee of the State Department of Public Health who is performing a function transferred to the State Department of Health Care Services and who is serving in the state civil service, other than as a temporary employee, shall be transferred to the State Department of Health Care Services pursuant to the provisions of Section 19050.9 of the Government Code. The status, position, and rights of any officer or employee of the State Department of Public Health shall not be affected by the transfer and shall be retained by the person as an officer or employee of the State Department of Health Care Services, as applicable, pursuant to the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government Code), except for a position that is exempt from civil service.

(h) No contract, lease, license, or any other agreement to which the State Department of Public Health is a party shall be void or voidable by reason of this act, but shall continue in full force and effect, with State Department of Health Care Services assuming all of the rights, obligations, liabilities, and duties of the State Department of Public Health as relates to the duties, powers, purposes, responsibilities, and jurisdiction vested by this section in the State Department of Health Care Services. The assumption by the State Department of Health Care Services shall not in any way affect the rights of the parties to any contract, lease, license, or agreement.

SEC. 47. Section 4024.7 is added to the Welfare and Institutions Code, to read:

4024.7. The Governor or the Director of Health Care Services shall appoint, subject to confirmation by the Senate, a Deputy Director of Mental Health and Substance Use Disorder Services of the State Department of Health Care Services. The salary for the deputy director shall be fixed in accordance with law.

SEC. 48. Section 4362 of the Welfare and Institutions Code is amended to read:

4362. The Legislature finds all of the following:

(a) That state public policy discriminates against adults with brain damage or degenerative brain disease, such

as Alzheimer's disease. This damage or disease is referred to as "brain impairments" in this chapter.

(b) That the Legislature has declared state public policy and accepted responsibility to ensure that persons under the age of 18 years who are developmentally disabled pursuant to Division 4.5 (commencing with Section 4500), receive services necessary to meet their needs, which are often similar to those of persons who suffer from brain impairments.

(c) That persons over the age of 18 who sustain brain impairment have a variety of program and service needs for which there is no clearly defined, ultimate responsibility vested in any single state agency and for which there are currently a number of different programs attempting to meet their needs.

(d) That the lack of clearly defined ultimate responsibility has resulted in severe financial liability and physical and mental strain on brain-impaired persons, their families, and caregivers.

(e) That terminology and nomenclature used to describe brain impairments are varied and confusing, in part because of different medical diagnoses and professional opinions, as well as differences in terminology used by the various funding sources for programs and services. Uniformity is required in order to ensure that appropriate programs and services are available throughout the state to serve these persons.

(f) That the term "brain damage" covers a wide range of organic and neurological disorders, and that these disorders, as identified below, are not necessarily to be construed as mental illnesses. These disorders include, but are not limited to, all of the following:

(1) Progressive, degenerative, and dementing illnesses, including, but not limited to, presenile and senile dementias, Alzheimer's disease, multiinfarct disease, Pick's disease, and Kreutzfeldt-Jakob's disease.

(2) Degenerative diseases of the central nervous system that can lead to dementia or severe brain impairment, including, but not limited to, epilepsy, multiple sclerosis, Parkinson's disease, amyotrophic lateral sclerosis (ALS), and hereditary diseases such as Huntington's disease.

(3) Permanent damage caused by cerebrovascular accidents more commonly referred to as "strokes," including, but not limited to, cerebral hemorrhage, aneurysm, and embolism.

(4) Posttraumatic, postanoxic, and postinfectious damage caused by incidents, including, but not limited to, coma, accidental skull and closed head injuries, loss of oxygen (anoxia), and infections such as encephalitis, herpes simplex, and tuberculosis.

(5) Permanent brain damage or temporary or progressive dementia as a result of tumors (neoplasm), hydrocephalus, abscesses, seizures, substance toxicity, and other disorders.

(g) That brain damage frequently results in functional impairments that adversely affect personality, behavior, and ability to perform daily activities. These impairments cause dependency on others for care and decisionmaking. The manifestations of brain damage include impairments of memory, cognitive ability, orientation, judgment, emotional response, and social inhibition. Brain damage can strike anyone regardless of age, race, sex, occupation, or economic status.

(h) That Family Survival Project for Brain-Damaged Adults of San Francisco, a three-year pilot project established pursuant to former Chapter 4 (commencing with Section 4330), has demonstrated that the most successful, cost-effective service model is one which allows a nonprofit community agency to provide a full array of support services to families that have a member who suffers from a brain impairment. This agency provides direct services, coordinates existing resources, and assists in the development of new programs and services on a regional basis.

(i) That respite care services provide a combination of time-limited, in-home, and out-of-home services that significantly decrease the stress of family members and increase their ability to maintain a brain-impaired person at home at less cost than other alternatives. This ability is further increased when complemented by case planning, care training, and other support services for family members.

(j) That providing services to brain-impaired adults, and to their families and caregivers, requires the coordinated services of many state departments and community agencies to ensure that no gaps occur in communication, in the availability of programs, or in the provision of services.

SEC. 49. Section 4362.5 of the Welfare and Institutions Code is amended to read:

4362.5. As used in this chapter:

(a) "Brain damage," "degenerative brain diseases," and "brain impairment" mean significant destruction of brain tissue with resultant loss of brain function. Examples of causes of the impairments are Alzheimer's disease, stroke, traumatic brain injury, and other impairments described in subdivision (f) of Section 4330.

(b) "Brain-impaired adult" means a person whose brain impairment has occurred after the age of 18.

(c) "Respite care" means substitute care or supervision in support of the caregiver for the purposes of providing relief from the stresses of constant care provision and so as to enable the caregiver to pursue a normal routine and responsibilities. Respite care may be provided in the home or in an out-of-home setting, such as day care centers or short-term placements in inpatient facilities.

(d) "Family member" means any relative or court-appointed guardian or conservator who is responsible for the care of a brain-impaired adult.

(e) "Caregiver" means any unpaid family member or individual who assumes responsibility for the care of a brain-impaired adult.

(f) "Director" means the Director of Health Care Services.

SEC. 50. Section 4364 of the Welfare and Institutions Code is amended to read:

4364. The Statewide Resources Consultant shall do all of the following:

(a) Serve as the centralized information and technical assistance clearinghouse for brain-impaired adults, their families, caregivers, service professionals and agencies, and volunteer organizations, and in this capacity may assist organizations that serve families with adults with Huntington's disease and Alzheimer's disease by reviewing data collected by those organizations in their efforts to determine the means of providing high-quality appropriate care in health facilities and other out-of-home placements; and shall disseminate information, including, but not limited to, the results of research and activities conducted pursuant to its responsibilities set forth in this chapter as determined by the director, and which may include forwarding quality of care and related information to appropriate state departments for consideration.

(b) Work closely and coordinate with organizations serving brain-impaired adults, their families, and caregivers in order to ensure, consistent with requirements for quality of services as may be established by the director, that the greatest number of persons are served and that the optimal number of organizations participate.

(c) Develop and conduct training that is appropriate for a variety of persons, including, but not limited to, all of the following:

(1) Families.

(2) Caregivers and service professionals involved with brain-impaired adults.

(3) Advocacy and self-help family and caregiver support organizations.

(4) Educational institutions.

(d) Provide other training services, including, but not limited to, reviewing proposed training curricula regarding the health, psychological, and caregiving aspects of individuals with brain damage as defined in subdivision (f) of Section 4362. The proposed curricula may be submitted by providers or statewide associations representing individuals with brain damage, their families, or caregivers.

(e) Provide service and program development consultation to resource centers and to identify funding sources that are available.

(f) Assist the appropriate state agencies in identifying and securing increased federal financial participation and third-party reimbursement, including, but not limited to, Title XVIII (42 U.S.C. Sec. 1395 and following) and Title XIX (42 U.S.C. Sec. 1396 and following) of the federal Social Security Act.

(g) Conduct public social policy research based upon the recommendations of the director.

(h) Assist the director, as the director may require, in conducting directly, or through contract, research in brain damage epidemiology and data collection, and in developing a uniform terminology and nomenclature.

(i) Assist the director in establishing criteria for, and in selecting resource centers and in designing a methodology for, the consistent assessment of resources and needs within the geographic areas to be serviced by the resource centers.

(j) Conduct conferences, as required by the director, for families, caregivers, service providers, advocacy organizations, educational institutions, business associations, community groups, and the general public, in order to enhance the quality and availability of high-quality, low-cost care and treatment of brain-impaired adults.

(k) Make recommendations, after consultation with appropriate state department representatives, to the director and the Secretary of California Health and Human Services for a comprehensive statewide policy to support and strengthen family caregivers, including the provision of respite and other support services, in order to implement more fully this chapter. The Statewide Resources Consultant shall coordinate its recommendations to assist the California Health and Human Services Agency to prepare its report on long-term care programs pursuant to Chapter 1.5 (commencing with Section 100145) of Part 1 of Division 101 of the Health and Safety Code.

(l) Conduct an inventory and submit an analysis of California's publicly funded programs serving family caregivers of older persons and functionally impaired adults.

SEC. 51. Section 4364.5 of the Welfare and Institutions Code is amended to read:

4364.5. The Statewide Resources Consultant, pursuant to Section 4364, shall do the following:

(a) Develop respite care training materials, with consultation by other appropriate organizations including the California Association of Homes for the Aging, and under the direction of the director, for distribution to all resource centers established under this chapter.

(b) Provide the respite care training materials described in subdivision (a) to other appropriate state entities for distribution to their respective services and programs.

(c) Pursuant to the requirements of Section 4365.5, report on the utilization of the respite care training materials, developed pursuant to subdivision (a), by all the resource centers for the period ending December 31, 1990, only, and make recommendations for the future use of these materials.

SEC. 52. Section 4366 of the Welfare and Institutions Code is amended to read:

4366. Resource centers shall serve all of the following functions:

(a) Provide directly or assist families in securing information, advice, and referral services, legal services and financial consultation, planning and problem-solving consultation, family support services, and respite care services, as specified in Section 4338.

(b) Provide centralized access to information about, and referrals to, local, state, and federal services and programs in order to assure a comprehensive approach for brain-impaired adults, their families, and caregivers. Nothing in this chapter shall prohibit access to services through other organizations which provide similar programs and services to brain-impaired adults and their families, nor shall other organizations be prevented from providing these programs and services.

(c) Assist in the identification and documentation of service needs and the development of necessary programs and services to meet the needs of brain-impaired adults in the geographic area.

(d) Cooperate with the Statewide Resources Consultant and the director in any activities which they deem necessary for the proper implementation of this chapter.

(e) Work closely and coordinate with organizations serving brain-impaired adults, their families, and caregivers in order to ensure, consistent with requirements for quality of services as may be established by the director, that the greatest number of persons are served and that the optimal number of organizations participate.

SEC. 53. Section 4367.5 of the Welfare and Institutions Code is amended to read:

4367.5. The director shall establish criteria for client eligibility, including financial liability, pursuant to Section 4368. However, persons eligible for services provided by regional centers or the State Department of

Developmental Services are not eligible for services provided under this chapter. Income shall not be the sole basis for client eligibility. The director shall assume responsibility for the coordination of existing funds and services for brain-impaired adults, and for the purchase of respite care, as defined in subdivision (c) of Section 4362.5, with other departments that may serve brain-impaired adults, including the Department of Rehabilitation, the State Department of Social Services, the State Department of Developmental Services, the Department of Aging, the Office of Statewide Health Planning and Development, and the State Department of Alcohol and Drug Programs.

SEC. 54. Section 4368.5 of the Welfare and Institutions Code is amended to read:

4368.5. In considering total service funds available for the project, the director shall utilize funding available from appropriate state departments, including, but not limited to: the State Department of Social Services, the Department of Rehabilitation, the California Department of Aging, and the State Department of Alcohol and Drug Programs. The director in conjunction with the Statewide Resources Consultant shall coordinate his or her activities with the implementation of the Torres-Felando Long-Term Care Reform Act (Chapter 1453, Statutes of 1982) in order to further the goal of obtaining comprehensive, coordinated public policy and to maximize the availability of funding for programs and services for persons with brain impairments.

SEC. 55. Section 5820 of the Welfare and Institutions Code is amended to read:

5820. (a) It is the intent of this part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

(b) Each county mental health program shall submit to the Office of Statewide Health Planning and Development a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. For purposes of this part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.

(c) The Office of Statewide Health Planning and Development, in coordination with the California Mental Health Planning Council, shall identify the total statewide needs for each professional and other occupational category utilizing county needs assessment information and develop a five-year education and training development plan.

(d) Development of the first five-year plan shall commence upon enactment of the initiative. Subsequent plans shall be adopted every five years, with the next five-year plan due as of April 1, 2014.

(e) Each five-year plan shall be reviewed and approved by the California Mental Health Planning Council.

SEC. 56. Section 5821 of the Welfare and Institutions Code is amended to read:

5821. (a) The California Mental Health Planning Council shall advise the Office of Statewide Health Planning and Development on education and training policy development and provide oversight for education and training plan development.

(b) The Office of Statewide Health Planning and Development shall work with the California Mental Health Planning Council and the State Department of Health Care Services so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

SEC. 57. Section 5822 of the Welfare and Institutions Code is amended to read:

5822. The Office of Statewide Health Planning and Development shall include in the five-year plan:

(a) Expansion plans for the capacity of postsecondary education to meet the needs of identified mental health occupational shortages.

(b) Expansion plans for the forgiveness and scholarship programs offered in return for a commitment to employment in California's public mental health system and make loan forgiveness programs available to current employees of the mental health system who want to obtain Associate of Arts, Bachelor of Arts, master's

degrees, or doctoral degrees.

(c) Creation of a stipend program modeled after the federal Title IV-E program for persons enrolled in academic institutions who want to be employed in the mental health system.

(d) Establishment of regional partnerships between the mental health system and the educational system to expand outreach to multicultural communities, increase the diversity of the mental health workforce, to reduce the stigma associated with mental illness, and to promote the use of web-based technologies, and distance learning techniques.

(e) Strategies to recruit high school students for mental health occupations, increasing the prevalence of mental health occupations in high school career development programs such as health science academies, adult schools, and regional occupation centers and programs, and increasing the number of human service academies.

(f) Curriculum to train and retrain staff to provide services in accordance with the provisions and principles of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division.

(g) Promotion of the employment of mental health consumers and family members in the mental health system.

(h) Promotion of the meaningful inclusion of mental health consumers and family members and incorporating their viewpoint and experiences in the training and education programs in subdivisions (a) through (f).

(i) Promotion of meaningful inclusion of diverse, racial, and ethnic community members who are underrepresented in the mental health provider network.

(j) Promotion of the inclusion of cultural competency in the training and education programs in subdivisions (a) through (f).

SEC. 58. Section 5830 of the Welfare and Institutions Code is amended to read:

5830. County mental health programs shall develop plans for innovative programs to be funded pursuant to paragraph (6) of subdivision (a) of Section 5892.

(a) The innovative programs shall have the following purposes:

(1) To increase access to underserved groups.

(2) To increase the quality of services, including better outcomes.

(3) To promote interagency collaboration.

(4) To increase access to services.

(b) All projects included in the innovative program portion of the county plan shall meet the following requirements:

(1) Address one of the following purposes as its primary purpose:

(A) Increase access to underserved groups.

(B) Increase the quality of services, including measurable outcomes.

(C) Promote interagency and community collaboration.

(D) Increase access to services.

(2) Support innovative approaches by doing one of the following:

(A) Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention.

(B) Making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.

(C) Introducing a new application to the mental health system of a promising community-driven practice or an

approach that has been successful in nonmental health contexts or settings.

(c) An innovative project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges, including, but not limited to, any of the following:

(1) Administrative, governance, and organizational practices, processes, or procedures.

(2) Advocacy.

(3) Education and training for service providers, including nontraditional mental health practitioners.

(4) Outreach, capacity building, and community development.

(5) System development.

(6) Public education efforts.

(7) Research.

(8) Services and interventions, including prevention, early intervention, and treatment.

(d) If an innovative project has proven to be successful and a county chooses to continue it, the project workplan shall transition to another category of funding as appropriate.

(e) County mental health programs shall expend funds for their innovation programs upon approval by the Mental Health Services Oversight and Accountability Commission.

SEC. 59. 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 guidelines 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. 60. 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.

(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. 61. Section 5846 of the Welfare and Institutions Code is amended to read:

5846. (a) The commission shall issue guidelines for 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, no later than 180 days before the fiscal year for which the funds will apply.

(b) 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.

(c) 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. 62. Section 5847 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

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

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults, and seniors that it is currently serving pursuant to Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act, 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, during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

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

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

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

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

(e) Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800) for adults and seniors, Part 3.2 (commencing with Section 5830) for innovative programs, Part 3.6 (commencing with Section 5840) for prevention and early intervention programs, and Part 4 (commencing with Section 5850) for services for children, and updates to the plans developed pursuant to this section. Each expenditure update shall indicate the number of children, adults, and seniors to be served pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

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

SEC. 63. Section 5848 of the Welfare and Institutions Code is amended to read:

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

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure plan

or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.

(c) The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) funded by the Mental Health Services Fund and established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the California Mental Health Directors Association.

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

SEC. 64. Section 5878.1 of the Welfare and Institutions Code is amended to read:

5878.1. (a) It is the intent of this article to establish programs that ensure services will be provided to severely mentally ill children as defined in Section 5878.2 and that they be part of the children's system of care established pursuant to this part. It is the intent of this act that services provided under this chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and his or her family.

(b) Nothing in this act shall be construed to authorize any services to be provided to a minor without the consent of the child's parent or legal guardian beyond those already authorized by existing statute.

SEC. 65. Section 5878.3 of the Welfare and Institutions Code is amended to read:

5878.3. (a) Subject to the availability of funds as determined pursuant to Part 4.5 (commencing with Section 5890) of this division, county mental health programs shall offer services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. Other entitlement programs include but are not limited to mental health services available pursuant to Medi-Cal, child welfare, and special education programs. The funding shall cover only those portions of care that cannot be paid for with public or private insurance, other mental health funds or other entitlement programs.

(b) Funding shall be at sufficient levels to ensure that counties can provide each child served all of the necessary services set forth in the applicable treatment plan developed in accordance with this part, including services where appropriate and necessary to prevent an out of home placement, such as services pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9.

(c) The State Department of Health Care Services shall contract with county mental health programs for the provision of services under this article in the manner set forth in Section 5897.

SEC. 66. Section 5890 of the Welfare and Institutions Code is amended to read:

5890. (a) The Mental Health Services Fund is hereby created in the State Treasury. The fund shall be administered by the state. Notwithstanding Section 13340 of the Government Code, all moneys in the fund are, except as provided in subdivision (d) of Section 5892, continuously appropriated, without regard to fiscal years, for the purpose of funding the following programs and other related activities as designated by other provisions of this division:

(1) Part 3 (commencing with Section 5800), the Adult and Older Adult System of Care Act.

(2) Part 3.2 (commencing with Section 5830), Innovative Programs.

(3) Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs.

(4) Part 4 (commencing with Section 5850), the Children's Mental Health Services Act.

(b) Nothing in the establishment of this fund, nor any other provisions of the act establishing it or the programs funded shall be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for mental health services, including those services required under Section 1374.72 of the

Health and Safety Code and Section 10144.5 of the Insurance Code, related to mental health parity. Nothing in this act shall be construed to modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing these obligations of plans and insurance policies.

(c) Nothing in this act shall be construed to modify or reduce the existing authority or responsibility of the State Department of Health Care Services.

(d) The State Department of Health Care Services shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care.

(e) Share of costs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division, shall be determined in accordance with the Uniform Method for Determining Ability to Pay applicable to other publicly funded mental health services, unless this Uniform Method is replaced by another method of determining co-payments, in which case the new method applicable to other mental health services shall be applicable to services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.

SEC. 67. Section 5891 of the Welfare and Institutions Code is amended to read:

5891. (a) The funding established pursuant to this act shall be utilized to expand mental health services. Except as provided in subdivision (j) of Section 5892 due to the state's fiscal crisis, these funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund or from the Local Revenue Fund 2011 in the State Treasury, and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Section 5892. These funds may not be used to pay for any other program. These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Section 5892.

(b) Notwithstanding subdivision (a), the Controller may use the funds created pursuant to this part for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Any such loan shall be repaid from the General Fund with interest computed at 110 percent of the Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund. This subdivision does not authorize any transfer that would interfere with the carrying out of the object for which these funds were created.

(c) Commencing July 1, 2012, on or before the 15th day of each month, pursuant to a methodology provided by the State Department of Health Care Services, the Controller shall distribute to each Local Mental Health Service Fund established by counties pursuant to subdivision (f) of Section 5892, all unexpended and unreserved funds on deposit as of the last day of the prior month in the Mental Health Services Fund, established pursuant to Section 5890, for the provision of programs and other related activities set forth in Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850).

(d) Counties shall base their expenditures on the county mental health program's three-year program and expenditure plan or annual update, as required by Section 5847. Nothing in this subdivision shall affect subdivision (a) or (b).

SEC. 68. Section 5892 of the Welfare and Institutions Code is amended to read:

5892. (a) In order to promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services Fund as follows:

(1) In 2005–06, 2006–07, and in 2007–08 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.

(2) In 2005–06, 2006–07 and in 2007–08 10 percent for capital facilities and technological needs distributed to

counties in accordance with a formula developed in consultation with the California Mental Health Directors Association to implement plans developed pursuant to Section 5847.

(3) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840) of this division.

(4) The expenditure for prevention and early intervention may be increased in any county in which the department determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850), for the children's system of care and Part 3 (commencing with Section 5800), for the adult and older adult system of care.

(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division, shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.

(b) In any year after 2007–08, programs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.

(d) Prior to making the allocations pursuant to subdivisions (a), (b), and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 3.5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. The amount of funds available for the purposes of this subdivision in any fiscal year shall be subject to appropriation in the annual Budget Act.

(e) In 2004–05 funds shall be allocated as follows:

(1) Forty-five percent for education and training pursuant to Part 3.1 (commencing with Section 5820) of this division.

(2) Forty-five percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).

(3) Five percent for local planning in the manner specified in subdivision (c).

(4) Five percent for state implementation in the manner specified in subdivision (d).

(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years, provided however, that funds for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the fund.

(i) If there are still additional revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the commission's adopted plan which furthers the purposes of this act.

(j) For the 2011–12 fiscal year, General Fund revenues will be insufficient to fully fund many existing mental health programs, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and mental health services provided for special education pupils. In order to adequately fund those programs for the 2011–12 fiscal year and avoid deeper reductions in programs that serve individuals with severe mental illness and the most vulnerable, medically needy citizens of the state, prior to distribution of funds under paragraphs (1) to (6), inclusive, of subdivision (a), effective July 1, 2011, moneys shall be allocated from the Mental Health Services Fund to the counties as follows:

(1) Commencing July 1, 2011, one hundred eighty-three million six hundred thousand dollars ($183,600,000) of the funds available as of July 1, 2011, in the Mental Health Services Fund, shall be allocated in a manner consistent with subdivision (c) of Section 5778 and based on a formula determined by the state in consultation with the California Mental Health Directors Association to meet the fiscal year 2011–12 General Fund obligation for Medi-Cal Specialty Mental Health Managed Care.

(2) Upon completion of the allocation in paragraph (1), the Controller shall distribute to counties ninety-eight million five hundred eighty-six thousand dollars ($98,586,000) from the Mental Health Services Fund for mental health services for special education pupils based on a formula determined by the state in consultation with the California Mental Health Directors Association.

(3) Upon completion of the allocation in paragraph (2), the Controller shall distribute to counties 50 percent of their 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, not to exceed four hundred eighty-eight million dollars ($488,000,000). This allocation shall commence beginning August 1, 2011.

(4) Upon completion of the allocation in paragraph (3), and as revenues are deposited into the Mental Health Services Fund, the Controller shall distribute five hundred seventy-nine million dollars ($579,000,000) from the Mental Health Services Fund to counties to meet the General Fund obligation for EPSDT for fiscal year 2011–12. These revenues shall be distributed to counties on a quarterly basis and based on a formula determined by the state in consultation with the California Mental Health Directors Association. These funds shall not be subject to reconciliation or cost settlement.

(5) The Controller shall distribute to counties the remaining 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, beginning no later than April 30, 2012. These remaining allocations shall be made on a monthly basis.

(6) The total one-time allocation from the Mental Health Services Fund for EPSDT, Medi-Cal Specialty Mental Health Managed Care, and mental health services provided to special education pupils as referenced shall not exceed eight hundred sixty-two million dollars ($862,000,000). Any revenues deposited in the Mental Health Services Fund in fiscal year 2011–12 that exceed this obligation shall be distributed to counties for remaining fiscal year 2011–12 Mental Health Services Act component allocations, consistent with Sections 5847 and 5891.

(k) Subdivision (j) shall not be subject to repayment.

(l) Subdivision (j) shall become inoperative on July 1, 2012.

SEC. 69. Section 5897 of the Welfare and Institutions Code is amended to read:

5897. (a) Notwithstanding any other provision of state law, the State Department of Health Care Services shall implement the mental health services provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. As used herein a county mental health program includes a city receiving funds pursuant to Section 5701.5.

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of such mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through the annual county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2 of Division 5.

(d) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific timeline to achieve improvements.

(e) Contracts awarded by the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with Section 5800), Part 3.1 (commencing with Section 5820), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and Part 4.5 (commencing with Section 5890) of this division, may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to such contracts.

(f) For purposes of Section 5775, the allocation of funds pursuant to Section 5892 which are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the State Department of Health Care Services of the anticipated county matching funds needed for community mental health programs.

SEC. 70. Section 5898 of the Welfare and Institutions Code is amended to read:

5898. The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission, shall develop regulations, as necessary, for the State Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, or designated state and local agencies to implement this act. Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments.

SEC. 71. Section 5899 is added to the Welfare and Institutions Code, to read:

5899. (a) The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission and the California Mental Health Directors Association, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report. This report shall be submitted electronically to the department and to the Mental Health Services Oversight and Accountability Commission.

(b) The purpose of the Annual Mental Health Services Act Revenue and Expenditure Report is as follows:

(1) Identify the expenditures of Mental Health Services Act (MHSA) funds that were distributed to each county.

(2) Quantify the amount of additional funds generated for the mental health system as a result of the MHSA.

(3) Identify unexpended funds, and interest earned on MHSA funds.

(4) Determine reversion amounts, if applicable, from prior fiscal year distributions.

(c) This report is intended to provide information that allows for the evaluation of all of the following:

(1) Children's systems of care.

(2) Prevention and early intervention strategies.

(3) Innovative projects.

(4) Workforce education and training.

(5) Adults and older adults systems of care.

(6) Capital facilities and technology needs.

SEC. 72. Section 14046.7 of the Welfare and Institutions Code is amended to read:

14046.7. (a) General Fund moneys shall not be used for the purposes of this article.

(b) Notwithstanding subdivision (a), no more than two hundred thousand dollars ($200,000) from the General Fund may be used annually for state administrative costs associated with implementing this article.

SEC. 73. Section 14085.6 of the Welfare and Institutions Code is amended to read:

14085.6. (a) Except as stated in subdivision (g), each hospital contracting to provide services under this article that meets the criteria contained in the state Medicaid plan for disproportionate share hospital status shall be eligible to negotiate with the commission for distributions from the Emergency Services and Supplemental Payments Fund, which is hereby created. All distributions from the fund shall be pursuant to this section.

(b) (1) To the extent permitted by federal law, the department shall administer the fund in accordance with this section.

(2) The money in this fund shall be available for expenditure by the department for the purposes of this section, subject to approval through the regular budget process.

(c) The fund shall include all of the following:

(1) Subject to subdivision (l), all public funds transferred by public agencies to the department for deposit in the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws. These transfers shall constitute local government financial participation in Medi-Cal as permitted under Section 1902(a)(2) of the federal Social Security Act (Title 42 U.S.C. Sec. 1396a(a)(2)) and other applicable federal Medicaid laws.

(2) Subject to subdivision (l), all private donated funds transferred by private individuals or entities for deposit in the fund as permitted under applicable federal Medicaid laws.

(3) Any amounts appropriated to the fund by the Legislature.

(4) Interest that accrues on amounts in the fund.

(5) Moneys appropriated to the fund, or appropriated for poison control center grants and transferred to the fund, pursuant to the annual Budget Act.

(d) Amounts in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section.

(e) Distributions from the fund shall be supplemental to any and all other amounts that hospitals would have received under the contracting program, and under the state Medicaid plan, including contract rate increases and supplemental payments and payment adjustments under distribution programs relating to disproportionate share hospitals.

(f) Distributions from the fund shall not serve as the state's payment adjustment program under Section 1923 of the federal Social Security Act (42 U.S.C. Sec. 1396r-4). To the extent permitted by federal law, and except as otherwise provided in this section, distributions from the fund shall not be subject to requirements contained in or related to Section 1923 of the federal Social Security Act (42 U.S.C. Sec. 1396r-4). Distributions from the fund shall be supplemental contract payments and may be structured on any federally permissible basis, as negotiated between the commission and the hospital.

(g) In order to qualify for distributions from the fund, a hospital shall meet all of the following criteria:

(1) Be a contracting hospital under this article.

(2) Satisfy the state Medicaid plan criteria referred to in subdivision (a).

(3) Be one of the following:

(A) A licensed provider of basic emergency services as described in Sections 70411 and following of Title 22 of the California Code of Regulations.

(B) A licensed provider of comprehensive emergency medical services as defined in Sections 70451 and following of Title 22 of the California Code of Regulations.

(C) A children's hospital as defined in Section 14087.21 that satisfies subparagraph (A) or (B) or that jointly provides basic or comprehensive emergency services in conjunction with another licensed hospital.

(D) A hospital owned and operated by a public agency that operates two or more hospitals that qualify under subparagraph (A) or (B) with respect to the particular state fiscal year.

(E) A hospital designated by the National Cancer Institute as a comprehensive or clinical cancer research center that primarily treats acutely ill cancer patients and that is exempt from the federal Medicare prospective payment system pursuant to Section 1886(d)(1)(B)(v) of the federal Social Security Act (42 U.S.C. Sec. 1395ww(d)(1)(B)(v)).

(4) Be able to demonstrate a purpose for additional funding under the selective provider contracting program including proposals relating to emergency services and other health care services, including infrequent yet high-cost services, such as anti-AB human antitoxin treatment for infant botulism (human botulinum immune globulin (HBIG), commonly referred to as "Baby-BIG"), that are made available, or will be made available, to Medi-Cal beneficiaries.

(h) (1) The department shall seek federal financial participation for expenditures made from the fund to the full extent permitted by federal law.

(2) The department shall promptly seek any necessary federal approvals regarding this section.

(i) Any funds remaining in the fund at the end of a fiscal year shall be carried forward for use in following fiscal years.

(j) For purposes of this section, "fund" means the Emergency Services and Supplemental Payments Fund.

(k) (1) Any public agency transferring amounts to the fund, as specified in paragraph (1) of subdivision (c), may for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public funds or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(2) Notwithstanding paragraph (1), a public agency may transfer to the fund only those moneys that have a source that will qualify for federal financial participation under the provisions of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or other applicable federal Medicaid laws.

(l) Public funds transferred pursuant to paragraph (1) of subdivision (c), and private donated funds transferred pursuant to paragraph (2) of subdivision (c), shall be deposited into the fund, and expended pursuant to this section. The director may accept only those funds that are certified by the transferring entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contributions and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and may return any funds transferred in error.

(m) The department may adopt emergency regulations, if necessary, for the purposes of this section.

(n) The state shall be held harmless from any federal disallowance resulting from this section. A hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the implementation of this section with respect to that hospital. The state may recoup that federal disallowance from the hospital in any manner authorized by law or contract.

(o) This section shall become inoperative on June 30, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 74. Section 14085.7 of the Welfare and Institutions Code is amended to read:

14085.7. (a) The Medi-Cal Medical Education Supplemental Payment Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to, and under the administrative control of, the department for the purposes specified in this section. Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) All public moneys transferred by public agencies to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

(2) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal Medicaid laws.

(3) Any amounts appropriated to the fund by the Legislature.

(4) Any interest that accrues on amounts in the fund.

(b) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(c) The department shall have the discretion to accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal matching funds to the full extent permitted by law. The department shall accept only those funds that are certified by the transferring or donating entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable, and may return any funds transferred or donated in error.

(d) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under subdivision (e). Distributions from the fund shall be supplemental to any other amounts that hospitals receive under the contracting program.

(e) For purposes of recognizing medical education costs incurred for services rendered to Medi-Cal beneficiaries, payments from this fund shall be negotiated between the California Medical Assistance Commission and hospitals contracting under this article that meet the definition of university teaching hospitals or major (nonuniversity) teaching hospitals as set forth on page 51 and as listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping." Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(f) The state shall be held harmless from any federal disallowance resulting from this section. A hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the implementation of this section with respect to that hospital. The state may recoup any federal disallowance from the hospital.

(g) This section shall become inoperative on June 30, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 75. Section 14085.8 of the Welfare and Institutions Code is amended to read:

14085.8. (a) The Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund is hereby created in the State Treasury.

(b) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to, and under the administrative control of, the department for the purposes specified in this section.

(c) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) All public moneys transferred by public agencies to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

(2) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal Medicaid laws.

(3) Any amounts appropriated to the fund by the Legislature.

(4) Any interest that accrues on amounts in the fund.

(d) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(e) The department may accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal matching funds to the full extent permitted by law. The department shall accept only those funds that are certified by the transferring or donating entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable, and may return any funds transferred or donated in error.

(f) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under subdivision (g). Distributions from the fund shall be supplemental to any other amounts that hospitals receive under the contracting program.

(g) (1) For purposes of recognizing medical education costs incurred for services rendered to Medi-Cal beneficiaries, contracts for payments from the fund may, at the discretion of the California Medical Assistance Commission, be negotiated between the commission and hospitals contracting under this article that are defined as either of the following:

(A) A large teaching emphasis hospital, as set forth on page 51 and listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," and meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(B) A children's hospital pursuant to Section 10727 and meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(2) Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(h) The state shall be held harmless from any federal disallowance resulting from this section. A hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the implementation of this section with respect to that hospital. The state may recoup any federal disallowance from the hospital.

(i) This section shall become inoperative on June 30, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 76. Section 14085.81 of the Welfare and Institutions Code is amended to read:

14085.81. (a) Notwithstanding the requirement in subparagraph (A) of paragraph (1) of subdivision (g) of Section 14085.8 that a hospital must be listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," any hospital whose license pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code was consolidated during the 1999 calendar year with a large teaching emphasis hospital that is listed on page 57 of the above described report shall be eligible to negotiate payments pursuant to paragraph (1) of subdivision (g) of Section 14085.8. All other requirements of Section 14085.8 shall continue to apply.

(b) This section shall become inoperative on June 30, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 77. Section 14085.9 of the Welfare and Institutions Code is amended to read:

14085.9. (a) Except as provided in subdivision (g), each hospital contracting to provide services under this article that meets the criteria contained in the state Medicaid plan for disproportionate share hospital status shall be eligible to negotiate with the commission for distributions from the Small and Rural Hospital Supplemental Payments Fund, which is hereby created and, notwithstanding Section 13340 of the Government Code, is continuously appropriated for the purposes specified in this section. All distributions from the fund shall be pursuant to this section.

(b) (1) To the extent permitted by federal law, the department shall administer the fund in accordance with this section.

(2) The money in this fund shall be available for expenditure by the department for the purposes of this section, subject to approval through the regular budget process.

(c) The fund shall include all of the following:

(1) Subject to subdivision (l), all public funds transferred by public agencies to the department for deposit in the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws. These transfers shall constitute local government financial participation in Medi-Cal as permitted under Section 1902(a)(2) of the federal Social Security Act (Title 42 U.S.C. Sec. 1396a(a)(2)) and other applicable federal Medicaid laws.

(2) Subject to subdivision (l), all private donated funds transferred by private individuals or entities for deposit in the fund as permitted under applicable federal Medicaid laws.

(3) Any amounts appropriated to the fund by the Legislature.

(4) Interest that accrues on amounts in the fund.

(d) Amounts in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section.

(e) Distributions from the fund shall be supplemental to any and all other amounts that hospitals would have received under the contracting program, and under the state Medicaid plan, including contract rate increases and supplemental payments and payment adjustments under distribution programs relating to disproportionate share hospitals.

(f) Distributions from the fund shall not serve as the state's payment adjustment program under Section 1923 of the federal Social Security Act (42 U.S.C. Sec. 1396r-4). To the extent permitted by federal law, and except as otherwise provided in this section, distributions from the fund shall not be subject to requirements contained in or related to Section 1923 of the federal Social Security Act (42 U.S.C. Sec. 1396r-4). Distributions from the fund shall be supplemental contract payments and may be structured on any federally permissible basis, as negotiated between the commission and the hospital.

(g) In order to qualify for distributions from the fund, a hospital shall meet all of the following criteria:

(1) Be a contracting hospital under this article.

(2) Satisfy the state Medicaid plan criteria referred to in subdivision (a).

(3) Be a small and rural hospital as defined in Section 124840 of the Health and Safety Code.

(4) Be a licensed provider of standby emergency services as described in Section 70649 and following of Title 22 of the California Code of Regulations.

(5) Be able to demonstrate a purpose for additional funding under the selective provider contracting program with proposals relating to health care services that are made available, or will be made available, to Medi-Cal beneficiaries.

(6) Be determined by the California Medical Assistance Commission to be a hospital that provides an important community service that otherwise would not be provided in the community.

(h) (1) The department shall seek federal financial participation for expenditures made from the fund to the full extent permitted by federal law.

(2) The department shall promptly seek any necessary federal approvals regarding this section.

(i) Any funds remaining in the fund at the end of a fiscal year shall be carried forward for use in following fiscal years.

(j) For purposes of this section, "fund" means the Small and Rural Hospital Supplemental Payments Fund.

(k) (1) Any public agency transferring amounts to the fund, as specified in paragraph (1) of subdivision (c), may for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public funds or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(2) Notwithstanding paragraph (1), a public agency may transfer to the fund only those moneys that have a source that will qualify for federal financial participation under the provisions of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or other applicable federal Medicaid laws.

(l) Public funds transferred pursuant to paragraph (1) of subdivision (c), and private donated funds transferred pursuant to paragraph (2) of subdivision (c), shall be deposited into the fund, and expended pursuant to this section. The director may accept only those funds that are certified by the transferring entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contributions and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and may return any funds transferred in error.

(m) The department may adopt emergency regulations for the purposes of this section.

(n) The state shall be held harmless from any federal disallowance resulting from this section. A hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the implementation of this section with respect to that hospital. The state may recoup that federal disallowance from the hospital in any manner authorized by law or contract.

(o) This section shall become inoperative on June 30, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 78. Article 2.82 (commencing with Section 14087.98) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 2.82. Managed Health Care Expansion into Rural Counties

14087.98. (a) The purpose of this article is to provide a comprehensive program of managed health care plan services to Medi-Cal recipients residing in the following counties that currently receive Medi-Cal services on a fee-for-service basis: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc, Nevada, Mono, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.

(b) The director may enter into exclusive or nonexclusive contracts on a bid or negotiated basis with one or more managed health care plans to provide a comprehensive program of managed health care plan services to Medi-Cal recipients residing in the counties described in subdivision (a). The director shall give special consideration to managed health care plans that meet all of the following:

(1) Have demonstrated experience in effectively serving Medi-Cal beneficiaries, including diverse populations.

(2) Have demonstrated experience in effectively partnering with public and traditional safety net health care providers.

(3) Have demonstrated experience in working with local stakeholders, including consumers, providers, advocates, and county officials, in plan oversight and in delivery of care.

(4) Have the lowest administrative costs.

(5) Show support from local county officials as demonstrated by an action of the county board of supervisors.

(6) Show recent successful experience with expansion of managed care to a rural area.

(7) Offer a quality improvement program for primary care providers.

(c) Contracts entered into or amended pursuant to this section shall be exempt from the provisions of Chapter 2

(commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code.

(d) The managed health care plans that the department contracts with under this article shall comply with the requirements of Section 14087.48 and meet all of the following:

(1) Have Medi-Cal managed health care plan contract experience, or evidence of the ability to meet these contracting requirements.

(2) Be in good financial standing and meet licensure requirements under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), if applicable.

(3) Meet quality measures, which may include Medi-Cal and Medicare Healthcare Effectiveness Data and Information Set measures and other quality measures determined or developed by the department and the federal Centers for Medicare and Medicaid Services.

(e) The managed health care plans that the department contracts with under this article shall provide Medi-Cal beneficiaries with information about enrollment rights and options, plan benefits and rules, and care plan elements so that beneficiaries have the ability to make informed choices. This information shall be delivered in a format and language accessible to beneficiaries. The managed health care plans shall provide access to providers in compliance with applicable state and federal laws, including, but not limited to, physical accessibility and the provision of health plan information in alternative formats.

(f) The department shall conduct a stakeholder process including relevant stakeholders to ensure that beneficiaries, health care providers, and managed health care plans have an opportunity to provide input into the delivery model for these counties and to help ensure smooth care transitions for beneficiaries.

(g) Enrollment in a Medi-Cal managed health care plan or plans under this article shall be mandatory in order to receive services under Medi-Cal, except as otherwise provided by law.

(h) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship if his or her treating provider is a primary care provider or clinic contracting with the managed health care plan, has the available capacity, and agrees to continue to treat that beneficiary or eligible applicant. The managed health care plans shall comply with continuity of care requirements in Section 1373.96 of the Health and Safety Code.

(i) (1) 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 and amend regulations and orders adopted by the department by means of plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action, until the time 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.

(2) 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 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.

(3) 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.

(j) The cost of any program established under this section shall not exceed the total amount that the department estimates it would pay for all services and requirements within the same geographic area under the fee-for-service Medi-Cal program.

(k) The department shall have exclusive authority to set the rates, terms, and conditions of managed health care plan contracts and contract amendments under this article. The director may include in the contract a provision for quality assurance withholding from the plan payment, to be paid only if quality measures identified in the plan contract are met.

(l) The department shall provide the fiscal and appropriate policy committees of the Legislature with quarterly updates, commencing January 1, 2014, and ending January 1, 2016, regarding the expansion of Medi-Cal managed care into the new counties authorized pursuant to this section. These updates shall include, but not be limited to, continuity of care requests, grievance and appeal rates, and utilization reports for the new counties.

(m) The department shall seek all necessary federal approvals to allow for federal financial participation in expenditures under this article. This article shall not be implemented until all necessary federal approvals have been obtained.

(n) This section shall be implemented only to the extent federal financial participation or funding is available.

(o) Notwithstanding subdivision (q) of Section 6254 of the Government Code, a contract or contract amendments executed by both parties after the effective date of the act adding this subdivision shall be considered a public record for purposes of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and shall be disclosed upon request. This subdivision applies to contracts that reveal the department's rates of payment for health care services, the rates themselves, and rate manuals.

(p) To implement this section, the department may contract with public or private entities. Contracts or amendments entered into under this section may be on an exclusive or nonexclusive basis and 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.

SEC. 79. Section 14089.08 is added to the Welfare and Institutions Code, to read:

14089.08. (a) Sacramento County may establish a stakeholder advisory committee to provide input on the delivery of oral health and dental care services, including prevention and education services, dental managed care, and fee-for-service Denti-Cal. The advisory committee shall include, but not be limited to, local nonprofit organizations, representatives from the First Five Sacramento Commission, representatives and members of the local dental society, local health and human services representatives, representatives of Medi-Cal dental managed care plans, Medi-Cal enrollees, and other interested individuals. The advisory committee may meet on a monthly basis.

(b) The advisory committee may submit written input to the State Department of Health Care Services or the Sacramento County Board of Supervisors, as applicable, regarding policies that improve the delivery of oral health and dental services in Sacramento under the Medi-Cal program or county-administered health care system.

(c) The State Department of Health Care Services shall meet periodically, but at least on a quarterly basis, with the advisory committee to facilitate communication, dissemination of information, and improvements in the provision of oral health and dental care services under the Medi-Cal program in the County of Sacramento. The dissemination of information shall include data reported from performance measures and benchmarks used by the department.

(d) The advisory committee may meet periodically, but at least twice annually, with the Sacramento County Department of Health and Human Services advisory committee established pursuant to Section 14089.07.

(e) No state General Fund moneys shall be used to fund advisory committee costs or to fund any related administrative costs incurred by the county.

SEC. 80. Section 14089.09 is added to the Welfare and Institutions Code, to read:

14089.09. (a) It is the intent of the Legislature to improve access to oral health and dental care services provided to Medi-Cal beneficiaries enrolled in dental health managed care plans in the Counties of Sacramento and Los Angeles through implementation of performance contracting to ensure dental health plans meet quality criteria and timely access to dental care, as contained in Section 14459.6, and implementation of a beneficiary dental

exception process for Medi-Cal beneficiaries in the County of Sacramento to access dental care through fee-for-service Denti-Cal when applicable.

(b) (1) The Director of Health Care Services shall exercise his or her authority under Section 14131.15 to establish a beneficiary dental exception (BDE) process, as described in paragraph (2), for Medi-Cal beneficiaries mandatorily enrolled in dental health plans in the County of Sacramento. The BDE process shall be implemented no later than July 1, 2012, and shall be in effect for as long as mandatory enrollment for dental care is in effect in the County of Sacramento. The department shall consult with the advisory committee established pursuant to Section 14089.08 regarding potential modifications to the BDE process. For purposes of emergency access to dental care issues, the department shall establish specific processes under the BDE to accommodate for these issues.

(2) The BDE shall be available to Medi-Cal dental managed care beneficiaries in the County of Sacramento who are unable to secure access to services through their managed care plan, in accordance with applicable contractual timeframes and in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code). The BDE shall allow a beneficiary to opt-out of Medi-Cal dental managed care and move into fee-for-service Denti-Cal where the beneficiary may select his or her own dental provider on an ongoing basis. The beneficiary shall remain in fee-for-service Denti-Cal until the time he or she chooses to opt in to a dental managed care arrangement.

(3) Beneficiaries shall be notified of the BDE option, which shall include the process for access to emergency visits, through a letter from the department detailing the process, directions on how to fill out the BDE form, and where to access the BDE form. A hard copy of the BDE form shall accompany the letter from the department. The BDE form, directions on how to fill out the BDE form, and a description of the process shall also be posted on the department's Internet Web site for easy access by beneficiaries and the public. The department shall also notify and inform dental managed care plans of the BDE process and its operation.

(4) Upon receipt of the BDE form, the department shall have no more than three business days to contact the beneficiary. The department shall, within five business days from the date of contact with the beneficiary, work with the beneficiary and the dental plan to schedule an appointment within the applicable contractual timeframes and in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(A) If an appointment is not available, the department shall approve and process the BDE and move the beneficiary into fee-for-service Denti-Cal.

(B) If an appointment is available, the beneficiary shall receive from the department a followup telephone call after the appointment to assess how the visit went and to determine if there is a need for any additional followup.

(5) Based on the followup as identified in subparagraph (B) of paragraph (4), to the extent no additional access issues to contractually required services are identified, the BDE shall be closed and the beneficiary shall remain in the selected dental plan.

(c) The department shall take all necessary steps to implement the BDE process as described in this section and shall, monthly, publicly report on the department's Internet Web site the number of individuals requesting the BDE and the specific outcome of each request, including, but not limited to, summary data on the types of visits subject to the BDE process, the services provided, description of timely access to care, the delivery system in which services were provided, beneficiary satisfaction, and the department's perspective of the outcome. The information provided on the department's Internet Web site shall be deidentified in accordance with the Health Insurance Portability and Availability Act of 1996 (HIPAA), including Section 164.514 of Title 45 of the Code of Federal Regulations, and shall not contain any personally indentifiable information according to the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code).

(d) The department shall consult with stakeholders in the development of the BDE form and related materials.

SEC. 81. Section 14091.3 of the Welfare and Institutions Code is amended to read:

14091.3. (a) For purposes of this section, the following definitions shall apply:

(1) "Medi-Cal managed care plan contracts" means those contracts entered into with the department by any individual, organization, or entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8

(commencing with Section 14087.5), or Article 2.91 (commencing with Section 14089) of this chapter, or Article 1 (commencing with Section 14200) or Article 7 (commencing with Section 14490) of Chapter 8, or Chapter 8.75 (commencing with Section 14591).

(2) “Medi-Cal managed care health plan” means an individual, organization, or entity operating under a Medi-Cal managed care plan contract with the department under this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591).

(b) The department shall take all appropriate steps to amend the Medicaid State Plan, if necessary, to carry out this section. This section shall be implemented only to the extent that federal financial participation is available.

(c) (1) Any hospital that does not have in effect a contract with a Medi-Cal managed care health plan, as defined in paragraph (2) of subdivision (a), that establishes payment amounts for services furnished to a beneficiary enrolled in that plan shall accept as payment in full, from all these plans, the following amounts:

(A) For outpatient services, the Medi-Cal fee-for-service (FFS) payment amounts.

(B) For emergency inpatient services, the average per diem contract rate specified in paragraph (2) of subdivision (b) of Section 14166.245, except that the payment amount shall not be reduced by 5 percent, until July 1, 2013, and thereafter, the average contract rate specified in Section 1396u-2(b)(2) of Title 42 of the United States Code. For the purposes of this subparagraph, this payment amount shall apply to all hospitals, including hospitals that contract with the department under the Medi-Cal Selective Provider Contracting Program described in Article 2.6 (commencing with Section 14081), and small and rural hospitals specified in Section 124840 of the Health and Safety Code.

(C) For poststabilization services following an emergency admission, payment amounts shall be consistent with Section 438.114(e) of Title 42 of the Code of Federal Regulations. This paragraph shall only be implemented to the extent that contract amendment language providing for these payments is approved by CMS. For purposes of this subparagraph, this payment amount shall apply to all hospitals, including hospitals that contract with the department under the Medi-Cal Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081).

(2) The rates established in paragraph (1) for emergency inpatient services and poststabilization services shall remain in effect only until the department implements the payment methodology based on diagnosis-related groups pursuant to Section 14105.28.

(3) Upon implementation of the payment methodology based on diagnosis-related groups pursuant to Section 14105.28, any hospital described in paragraph (1) shall accept as payment in full for inpatient hospital services, including both emergency inpatient services and poststabilization services related to an emergency medical condition, the payment amount established pursuant to the methodology developed under Section 14105.28.

(d) Medi-Cal managed care health plans that, pursuant to the department’s encouragement in All Plan Letter 07003, have been paying out-of-network hospitals the most recent California Medical Assistance Commission regional average per diem rate as a temporary rate for purposes of Section 1932(b)(2)(D) of the federal Social Security Act (SSA), which became effective January 1, 2007, shall make reconciliations and adjustments for all hospital payments made since January 1, 2007, based upon rates published by the department pursuant to Section 1932(b)(2)(D) of the SSA and effective January 1, 2007, to June 30, 2008, inclusive, and, if applicable, provide supplemental payments to hospitals as necessary to make payments that conform with Section 1932(b)(2)(D) of the SSA. In order to provide managed care health plans with 60 working days to make any necessary supplemental payments to hospitals prior to these payments becoming subject to the payment of interest, Section 1300.71 of Title 28 of the California Code of Regulations shall not apply to these supplemental payments until 30 working days following the publication by the department of the rates.

(e) (1) The department shall provide a written report to the policy and fiscal committees of the Legislature on October 1, 2009, and May 1, 2010, on the implementation and impact made by this section, including the impact of these changes on access to hospitals by managed care enrollees and on contracting between hospitals and managed care health plans, including the increase or decrease in the number of these contracts.

(2) Not later than August 1, 2010, the department shall report to the Legislature on the implementation of this section. The report shall include, but not be limited to, information and analyses addressing managed care enrollee access to hospital services, the impact of this section on managed care health plan capitation rates, the impact of this section on the extent of contracting between managed care health plans and hospitals, and fiscal impact on the state.

(3) For the purposes of preparing the status reports and the final evaluation report required pursuant to this subdivision, Medi-Cal managed care health plans shall provide the department with all data and documentation, including contracts with providers, including hospitals, as deemed necessary by the department to evaluate the impact of the implementation of this section. In order to ensure the confidentiality of managed care health plan proprietary information, and thereby enable the department to have access to all of the data necessary to provide the Legislature with accurate and meaningful information regarding the impact of this section, all information and documentation provided to the department pursuant to this section shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(f) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (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 and applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action. Prior to issuing any letter or similar instrument authorized pursuant to this section, the department shall notify and consult with stakeholders, including advocates, providers, and beneficiaries.

(g) This section shall become inoperative on July 1, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 82. Section 14105.196 is added to the Welfare and Institutions Code, to read:

14105.196. (a) It is the intent of the Legislature to comply with the provisions of the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and temporarily increase reimbursement to certain primary care providers at the same levels as Medicare rates for the 2013 and 2014 calendar years for specified services.

(b) (1) Notwithstanding any other law, to the extent required by federal law and regulations, beginning January 1, 2013, through and including December 31, 2014, payments for primary care services provided by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine shall not be less than 100 percent of the payment rate that applies to those services and physicians as established by the Medicare Program, for both fee-for-service and managed care plans.

(2) Notwithstanding any other law, to the extent required by federal law and regulations, beginning January 1, 2013, through and including December 31, 2014, the payments for primary care services implemented pursuant to this section shall be exempt from the payment reductions under Sections 14105.191 and 14105.192.

(c) For purposes of this section, “primary care services” and “primary specialty” means the services and primary specialties defined in Section 1202 of the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152; 42 U.S.C. Sec. 1396a(a)(13)(C)) and related federal regulations.

(d) Notwithstanding any other law, effective on or after January 1, 2013, the payment increase implemented pursuant to this section shall apply to managed care health plans that contract with the department pursuant to Chapter 8.75 (commencing with Section 14591) and to contracts with the Senior Care Action Network and the AIDS Healthcare Foundation, and to the extent that the services are provided through any of these contracts, payments shall be increased by the actuarial equivalent amount of the payment increases pursuant to contract amendments or change orders effective on or after January 1, 2013.

(e) 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, clarify, make specific, and define the provisions of this section by means of provider bulletins or similar instructions, without taking regulatory action.

(f) Notwithstanding paragraph (1) of subdivision (b), if a final judicial determination is made by any state or federal court that is not appealed, in any action by any party, or a final determination is made by the administrator of the federal Centers for Medicare and Medicaid Services, that any payments pursuant to this section are invalid, unlawful, or contrary to any provision of federal law or regulations, or of state law, this section shall become inoperative.

(g) (1) The director shall implement the increased payments for primary care services and primary specialties provided for in this section only to the extent that the federal medical assistance percentage is equal to 100

percent.

(2) In assessing whether federal financial participation is available, the director shall determine whether the 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.

(3) To the extent that the director determines that the payments do not comply with applicable federal Medicaid requirements, the director shall retain the discretion not to implement the changes and may revise the payments as necessary to comply with the federal Medicaid requirements.

(h) This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.

SEC. 83. 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, may 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 payment rates for clinical laboratory or laboratory services that are comparable to the payment amounts received from other payers for 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 the rate methodology developed for clinical laboratories or laboratory services pursuant to this subdivision.

(B) In addition to subparagraph (a), 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 12 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 services.

(4) 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.

(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 laboratory services, laboratory service providers shall submit data reports within six months of the date the act that added this paragraph becomes effective and annually thereafter. The data provided shall be based on the previous calendar year and shall specify the provider's usual and customary payments, reflecting Medi-Cal, other state Medicaid programs, private insurance, and Medicare payment data, minus discounts and rebates.

(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 laboratory services, excluding significant deviations of cost or volume factors and with consideration to geographical areas.

(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 rate setting 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. 84. Section 14134 of the Welfare and Institutions Code, as amended by Chapter 3 of the Statutes of 2011, 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) 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.

(10) 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 the act that added this subdivision.

SEC. 85. Section 14134 of the Welfare and Institutions Code, as added by Chapter 3 of the Statutes of 2011, 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 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.

(i) 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.

(j) (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. 86. Section 14134.1 of the Welfare and Institutions Code is amended to read:

14134.1. (a) Except as provided in paragraph (2) of subdivision (a) of Section 14134, no provider under this chapter may deny care or services to an individual eligible for care or services under this chapter because of the individual's inability to pay a copayment, as defined in Section 14134. The requirements of this section shall not extinguish the liability of the individual to whom the care or services were furnished for payment of the copayment.

(b) 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, without taking further regulatory action.

(c) This section shall become inoperative to the extent, and on the implementation date for, copayments as stated in the declaration executed by the director pursuant to Section 14134 as added by Section 101.5 of the

act that added this subdivision.

SEC. 87. Section 14154 of the Welfare and Institutions Code is amended to read:

14154. (a) (1) The department shall establish and maintain a plan whereby costs for county administration of the determination of eligibility for benefits under this chapter will be effectively controlled within the amounts annually appropriated for that administration. The plan, to be known as the County Administrative Cost Control Plan, shall establish standards and performance criteria, including workload, productivity, and support services standards, to which counties shall adhere. The plan shall include standards for controlling eligibility determination costs that are incurred by performing eligibility determinations at county hospitals, or that are incurred due to the outstationing of any other eligibility function. Except as provided in Section 14154.15, reimbursement to a county for outstationed eligibility functions shall be based solely on productivity standards applied to that county's welfare department office.

(2) (A) The plan shall delineate both of the following:

(i) The process for determining county administration base costs, which include salaries and benefits, support costs, and staff development.

(ii) The process for determining funding for caseload changes, cost-of-living adjustments, and program and other changes.

(B) The annual county budget survey document utilized under the plan shall be constructed to enable the counties to provide sufficient detail to the department to support their budget requests.

(3) The plan shall be part of a single state plan, jointly developed by the department and the State Department of Social Services, in conjunction with the counties, for administrative cost control for the California Work Opportunity and Responsibility to Kids (CalWORKs), CalFresh, and Medical Assistance (Medi-Cal) programs. Allocations shall be made to each county and shall be limited by and determined based upon the County Administrative Cost Control Plan. In administering the plan to control county administrative costs, the department shall not allocate state funds to cover county cost overruns that result from county failure to meet requirements of the plan. The department and the State Department of Social Services shall budget, administer, and allocate state funds for county administration in a uniform and consistent manner.

(4) The department and county welfare departments shall develop procedures to ensure the data clarity, consistency, and reliability of information contained in the county budget survey document submitted by counties to the department. These procedures shall include the format of the county budget survey document and process, data submittal and its documentation, and the use of the county budget survey documents for the development of determining county administration costs. Communication between the department and the county welfare departments shall be ongoing as needed regarding the content of the county budget surveys and any potential issues to ensure the information is complete and well understood by involved parties. Any changes developed pursuant to this section shall be incorporated within the state's annual budget process by no later than the 2011–12 fiscal year.

(5) The department shall provide a clear narrative description along with fiscal detail in the Medi-Cal estimate package, submitted to the Legislature in January and May of each year, of each component of the county administrative funding for the Medi-Cal program. This shall describe how the information obtained from the county budget survey documents was utilized and, where applicable, modified and the rationale for the changes.

(6) Notwithstanding any other provision of law, the department shall develop and implement, in consultation with county program and fiscal representatives, a new budgeting methodology for Medi-Cal county administrative costs. The new budgeting methodology shall be used to reimburse counties for eligibility determinations for applicants and beneficiaries, including one-time eligibility processing and ongoing case maintenance.

(A) The budgeting methodology shall include, but is not limited to, identification of the costs of eligibility determinations for applicants, and the costs of eligibility redeterminations and case maintenance activities for recipients, for different groupings of cases. The groupings of cases shall be based on variations in time and resources needed to conduct eligibility determinations. The calculation of time and resources shall be based on the following factors: complexity of eligibility rules, ongoing eligibility requirements, and other factors as determined appropriate by the department.

(B) The new budgeting methodology shall be clearly described, state the necessary data elements to be

collected from the counties, and establish the timeframes for counties to provide the data to the state.

(C) The department may develop a process for counties to phase in the requirements of the new budgeting methodology.

(D) To the extent a county does not submit the requested data pursuant to subparagraph (B), the new budgeting methodology may include a process to use peer-based proxy costs in developing the county budget.

(E) The department shall provide the new budgeting methodology to the legislative fiscal committees by March 1, 2012, and may include the methodology in the May Medi-Cal Local Assistance Estimate, beginning with the May 2012 estimate, for the 2012–13 fiscal year and each fiscal year thereafter.

(F) To the extent that the funding for the county budgets developed pursuant to the new budget methodology is not fully appropriated in any given fiscal year, the department, with input from the counties, shall identify and consider options to align funding and workload responsibilities.

(b) Nothing in this section, Section 15204.5, or Section 18906 shall be construed so as to limit the administrative or budgetary responsibilities of the department in a manner that would violate Section 14100.1, and thereby jeopardize federal financial participation under the Medi-Cal program.

(c) (1) The Legislature finds and declares that in order for counties to do the work that is expected of them, it is necessary that they receive adequate funding, including adjustments for reasonable annual cost-of-doing-business increases. The Legislature further finds and declares that linking appropriate funding for county Medi-Cal administrative operations, including annual cost-of-doing-business adjustments, with performance standards will give counties the incentive to meet the performance standards and enable them to continue to do the work they do on behalf of the state. It is therefore the Legislature's intent to provide appropriate funding to the counties for the effective administration of the Medi-Cal program at the local level to ensure that counties can reasonably meet the purposes of the performance measures as contained in this section.

(2) It is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2008–09, 2009–10, 2010–11, 2011–12, and 2012–13 fiscal years.

(d) The department is responsible for the Medi-Cal program in accordance with state and federal law. A county shall determine Medi-Cal eligibility in accordance with state and federal law. If in the course of its duties the department becomes aware of accuracy problems in any county, the department shall, within available resources, provide training and technical assistance as appropriate. Nothing in this section shall be interpreted to eliminate any remedy otherwise available to the department to enforce accurate county administration of the program. In administering the Medi-Cal eligibility process, each county shall meet the following performance standards each fiscal year:

(1) Complete eligibility determinations as follows:

(A) Ninety percent of the general applications without applicant errors and are complete shall be completed within 45 days.

(B) Ninety percent of the applications for Medi-Cal based on disability shall be completed within 90 days, excluding delays by the state.

(2) (A) The department shall establish best-practice guidelines for expedited enrollment of newborns into the Medi-Cal program, preferably with the goal of enrolling newborns within 10 days after the county is informed of the birth. The department, in consultation with counties and other stakeholders, shall work to develop a process for expediting enrollment for all newborns, including those born to mothers receiving CalWORKs assistance.

(B) Upon the development and implementation of the best-practice guidelines and expedited processes, the department and the counties may develop an expedited enrollment timeframe for newborns that is separate from the standards for all other applications, to the extent that the timeframe is consistent with these guidelines and processes.

(3) Perform timely annual redeterminations, as follows:

(A) Ninety percent of the annual redetermination forms shall be mailed to the recipient by the anniversary date.

(B) Ninety percent of the annual redeterminations shall be completed within 60 days of the recipient's annual redetermination date for those redeterminations based on forms that are complete and have been returned to the county by the recipient in a timely manner.

(C) Ninety percent of those annual redeterminations where the redetermination form has not been returned to the county by the recipient shall be completed by sending a notice of action to the recipient within 45 days after the date the form was due to the county.

(D) When a child is determined by the county to change from no share of cost to a share of cost and the child meets the eligibility criteria for the Healthy Families Program established under Section 12693.98 of the Insurance Code, the child shall be placed in the Medi-Cal-to-Healthy Families Bridge Benefits Program, and these cases shall be processed as follows:

(i) Ninety percent of the families of these children shall be sent a notice informing them of the Healthy Families Program within five working days from the determination of a share of cost.

(ii) Ninety percent of all annual redetermination forms for these children shall be sent to the Healthy Families Program within five working days from the determination of a share of cost if the parent has given consent to send this information to the Healthy Families Program.

(iii) Ninety percent of the families of these children placed in the Medi-Cal-to-Healthy Families Bridge Benefits Program who have not consented to sending the child's annual redetermination form to the Healthy Families Program shall be sent a request, within five working days of the determination of a share of cost, to consent to send the information to the Healthy Families Program.

(E) Subparagraph (D) shall not be implemented until 60 days after the Medi-Cal and Joint Medi-Cal and Healthy Families applications and the Medi-Cal redetermination forms are revised to allow the parent of a child to consent to forward the child's information to the Healthy Families Program.

(e) The department shall develop procedures in collaboration with the counties and stakeholder groups for determining county review cycles, sampling methodology and procedures, and data reporting.

(f) On January 1 of each year, each applicable county, as determined by the department, shall report to the department on the county's results in meeting the performance standards specified in this section. The report shall be subject to verification by the department. County reports shall be provided to the public upon written request.

(g) If the department finds that a county is not in compliance with one or more of the standards set forth in this section, the county shall, within 60 days, submit a corrective action plan to the department for approval. The corrective action plan shall, at a minimum, include steps that the county shall take to improve its performance on the standard or standards with which the county is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the county in order to avoid a sanction.

(h) (1) If a county does not meet the performance standards for completing eligibility determinations and redeterminations as specified in this section, the department may, at its sole discretion, reduce the allocation of funds to that county in the following year by 2 percent. Any funds so reduced may be restored by the department if, in the determination of the department, sufficient improvement has been made by the county in meeting the performance standards during the year for which the funds were reduced. If the county continues not to meet the performance standards, the department may reduce the allocation by an additional 2 percent for each year thereafter in which sufficient improvement has not been made to meet the performance standards.

(2) No reduction of the allocation of funds to a county shall be imposed pursuant to this subdivision for failure to meet performance standards during any period of time in which the cost-of-doing-business increase is suspended.

(i) The department shall develop procedures, in collaboration with the counties and stakeholders, for developing instructions for the performance standards established under subparagraph (D) of paragraph (3) of subdivision (d), no later than September 1, 2005.

(j) No later than September 1, 2005, the department shall issue a revised annual redetermination form to allow a parent to indicate parental consent to forward the annual redetermination form to the Healthy Families Program if the child is determined to have a share of cost.

(k) The department, in coordination with the Managed Risk Medical Insurance Board, shall streamline the method of providing the Healthy Families Program with information necessary to determine Healthy Families eligibility for a child who is receiving services under the Medi-Cal-to-Healthy Families Bridge Benefits Program.

(l) 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 and any applicable federal waivers and state plan amendments by means of all-county letters or similar instructions.

SEC. 88. Section 14165 of the Welfare and Institutions Code is amended to read:

14165. (a) There is hereby created in the Governor's office the California Medical Assistance Commission, for the purpose of contracting with health care delivery systems for the provision of health care services to recipients under the California Medical Assistance program.

(b) Notwithstanding any other provision of law, the commission created pursuant to subdivision (a) shall continue through June 30, 2012, after which, it shall be dissolved and the term of any commissioner serving at that time shall end.

(1) Upon dissolution of the commission, all powers, duties, and responsibilities of the commission shall be transferred to the Director of Health Care Services. These powers, duties, and responsibilities shall include, but are not limited to, those exercised in the operation of the selective provider contracting program pursuant to Article 2.6 (commencing with Section 14081).

(2) (A) On July 1, 2012, notwithstanding any other law, employees of the California Medical Assistance Commission as of June 30, 2012, excluding commissioners, shall transfer to the State Department of Health Care Services.

(B) Employees who transfer pursuant to subparagraph (A) shall be subject to the same conditions of employment under the department as they were under the California Medical Assistance Commission, including retention of their exempt status, until the diagnosis-related groups payment system described in Section 14105.28 replaces the contract-based payment system described in this article.

(C) (i) Notwithstanding any other law or rule, persons employed by the department who transferred to the department pursuant to subparagraph (A) shall be eligible to apply for civil service examinations. Persons receiving passing scores shall have their names placed on lists resulting from these examinations, or otherwise gain eligibility for appointment. In evaluating minimum qualifications, related California Medical Assistance Commission experience shall be considered state civil service experience in a class deemed comparable by the State Personnel Board, based on the duties and responsibilities assigned.

(ii) On the date the diagnosis-related groups payment system described in Section 14105.28 replaces the contract-based system described in this article, employees who transferred to the department pursuant to subparagraph (A) shall transfer to civil service classifications within the department for which they are eligible.

(3) Upon a determination by the Director of Health Care Services that a payment system based on diagnosis-related groups as described in Section 14105.28 that is sufficient to replace the contract-based payment system described in this article has been developed and implemented, the powers, duties, and responsibilities conferred on the commission and transferred to the Director of Health Care Services shall no longer be exercised, excluding both of the following:

(A) Stabilization payments made or committed from Sections 14166.14 and 14166.19 for services rendered prior to the director's determination pursuant to this paragraph.

(B) The ability to negotiate and make payments from the Private Hospital Supplemental Fund, established pursuant to Section 14166.12, and the Nondesignated Public Hospital Supplemental Fund, established pursuant to Section 14166.17.

(4) Protections afforded to the negotiations and contracts of the commission by the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) shall be applicable to the negotiations and contracts conducted or entered into pursuant to this section by the State Department of Health Care Services.

(c) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, or any other provision of law, the State Department of Health Care Services may implement and administer this section by means of provider bulletins or other similar instructions, without taking regulatory action. The authority to implement this section as set forth in this subdivision shall include the authority to give notice by provider bulletin or other similar instruction of a

determination made pursuant to paragraph (3) of subdivision (b) and to modify or supersede existing regulations in Title 22 of the California Code of Regulations that conflict with implementation of this section.

SEC. 89. Section 14166.8 of the Welfare and Institutions Code is amended to read:

14166.8. (a) Within five months after the end of each project year or successor demonstration year, each of the designated public hospitals shall submit to the department all of the following reports:

(1) The hospital's Medicare cost report for the project year or successor demonstration year.

(2) Other cost reporting and statistical data necessary for the determination of amounts due the hospital under the demonstration project or successor demonstration project, as requested by the department.

(b) For each project year or successor demonstration year, the reports shall identify all of the following:

(1) The costs incurred in providing inpatient hospital services to Medi-Cal beneficiaries on a fee-for-service basis and physician and nonphysician practitioner services costs, as identified in subdivision (e) of Section 14166.4.

(2) The amount of uncompensated costs incurred in providing hospital services to Medi-Cal beneficiaries, including managed care enrollees.

(3) The costs incurred in providing hospital services to uninsured individuals.

(4) (A) Discharge data, commencing with successor demonstration year 6, and retrospectively for prior periods as necessary to establish interim payment determinations, for the following patient categories:

(i) Uninsured patients.

(ii) Low Income Health Program patients.

(iii) Medi-Cal patients, excluding discharges for which Medicare payments were received.

(B) The department shall consult with the designated public hospitals regarding a methodology for adjusting prior period discharge data to reflect the projected number of discharges relating to Low Income Health Program patients for the period at issue.

(c) (1) Each designated public hospital, or governmental entity with which it is affiliated, that operates nonhospital clinics or provides physician, nonphysician practitioner, or other health care services that are not identified as hospital services under the Special Terms and Conditions for the demonstration project and successor demonstration project, may report and certify all, or a portion, of the uncompensated Medi-Cal and uninsured costs of the services furnished.

(2) Notwithstanding paragraph (1), beginning with the 2012–13 fiscal year, and for each successor demonstration year thereafter, each designated public hospital, or governmental entity with which it is affiliated, that operates nonhospital clinics or provides physician, nonphysician practitioner, or other health care services that are not identified as hospital services under the Special Terms and Conditions for the successor demonstration project, shall report and certify all of the uncompensated uninsured costs of the services furnished that meet the requirements of subdivisions (d) and (e).

(3) The amount of these uncompensated costs to be claimed by the department shall be determined by the department in consultation with the governmental entity so as to optimize the level of claimable federal Medicaid funding.

(d) Reports submitted under this section shall include all allowable costs.

(e) The appropriate public official shall certify to all of the following:

(1) The accuracy of the reports required under this section.

(2) That the expenditures to meet the reported costs comply with Section 433.51 of Title 42 of the Code of Federal Regulations.

(3) That the sources of funds used to make the expenditures certified under this section do not include impermissible provider taxes or donations as defined under Section 1396b(w) of Title 42 of the United States Code or other federal funds. For this purpose, federal funds do not include delivery system reform incentive pool payments, patient care revenue received as payment for services rendered under programs such as designated

state health programs, the Low Income Health Program, Medicare, or Medicaid.

(f) The certification of public expenditures made pursuant to this section shall be based on a schedule established by the department. The director may require the designated public hospitals to submit quarterly estimates of anticipated expenditures, if these estimates are necessary to obtain interim payments of federal Medicaid funds. All reported expenditures shall be subject to reconciliation to allowable costs, as determined in accordance with applicable implementing documents for the demonstration project and successor demonstration project.

(g) Subject to the determination made under paragraph (3) of subdivision (c), the director shall seek Medicaid federal financial participation for all certified public expenditures reported by the designated public hospitals and recognized under the demonstration project and successor demonstration project, to the extent consistent with Section 14166.9.

(h) Governmental or public entities other than those that operate a designated public hospital may, at the request of a governmental or public entity, certify uncompensated Medi-Cal and uninsured costs in accordance with this section, subject to the department's discretion and prior approval of the federal Centers for Medicare and Medicaid Services.

(i) The timeframes for data submission and reporting periods may be adjusted as necessary with respect to the 2010–11 project year through October 31, 2010, and successor demonstration years 6 and 10.

SEC. 90. Section 14166.12 of the Welfare and Institutions Code is amended to read:

14166.12. (a) The California Medical Assistance Commission shall negotiate payment amounts, in accordance with the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081), from the Private Hospital Supplemental Fund established pursuant to subdivision (b) for distribution to private hospitals that satisfy the criteria of subdivision (s). Pursuant to Section 14165, on and after July 1, 2012, the Director of Health Care Services shall exercise the discretion granted to the California Medical Assistance Commission.

(b) The Private Hospital Supplemental Fund is hereby established in the State Treasury. For purposes of this section, "fund" means the Private Hospital Supplemental Fund.

(c) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department for the purposes specified in this section.

(d) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) One hundred eighteen million four hundred thousand dollars ($118,400,000), which shall be transferred annually from General Fund amounts appropriated in the annual Budget Act for the Medi-Cal program, except as follows:

(A) For the 2008–09 fiscal year, this amount shall be reduced by thirteen million six hundred thousand dollars ($13,600,000) and by an amount equal to one-half of the difference between eighteen million three hundred thousand dollars ($18,300,000) and the amount of any reduction in the additional payments for distressed hospitals calculated pursuant to subparagraph (B) of paragraph (3) of subdivision (b) of Section 14166.20.

(B) For the 2012–13 fiscal year, this amount shall be reduced by seventeen million five hundred thousand dollars ($17,500,000).

(C) For the 2013–14 fiscal year, this amount shall be reduced by eight million seven hundred fifty thousand dollars ($8,750,000).

(2) Any additional moneys appropriated to the fund.

(3) All stabilization funding transferred to the fund pursuant to paragraph (2) of subdivision (a) of Section 14166.14.

(4) Any moneys that any county, other political subdivision of the state, or other governmental entity in the state may elect to transfer to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

(5) All private moneys donated by private individuals or entities to the department for deposit in the fund as

permitted under applicable federal Medicaid laws.

(6) Any interest that accrues on amounts in the fund.

(e) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(f) The department may accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal financial participation to the full extent permitted by law. With respect to funds transferred or donated from private individuals or entities, the department shall accept only those funds that are certified by the transferring or donating entity that qualify for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable. The department may return any funds transferred or donated in error.

(g) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section.

(h) Any funds remaining in the fund at the end of a fiscal year shall be carried forward for use in the following fiscal year.

(i) Moneys shall be allocated from the fund by the department and shall be applied to obtain federal financial participation in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section. Distributions from the fund shall be supplemental to any other Medi-Cal reimbursement received by the hospitals, including amounts that hospitals receive under the selective provider contracting program (Article 2.6 (commencing with Section 14081)), and shall not affect provider rates paid under the selective provider contracting program.

(j) Each private hospital that was a private hospital during the 2002–03 fiscal year, received payments for the 2002–03 fiscal year from any of the prior supplemental funds, and, during the project year, satisfies the criteria in subdivision (s) to be eligible to negotiate for distributions under any of those sections, shall receive no less from the Private Hospital Supplemental Fund for the project year than 100 percent of the amount the hospital received from the prior supplemental funds for the 2002–03 fiscal year. Each private hospital described in this subdivision shall be eligible for additional payments from the fund pursuant to subdivision (k).

(k) All amounts that are in the fund for a project year in excess of the amount necessary to make the payments under subdivision (j) shall be available for negotiation by the California Medical Assistance Commission, along with corresponding federal financial participation, for supplemental payments to private hospitals, which for the project year satisfy the criteria under subdivision (s) to be eligible to negotiate for distributions under any of those sections, and paid for services rendered during the project year pursuant to the selective provider contracting program established under Article 2.6 (commencing with Section 14081).

(l) The amount of any stabilization funding transferred to the fund, or the amount of intergovernmental transfers deposited to the fund pursuant to subdivision (o), together with the associated federal reimbursement, with respect to a particular project year, may, in the discretion of the California Medical Assistance Commission, until its dissolution on June 30, 2012, be paid for services furnished in the same project year regardless of when the stabilization funds or intergovernmental transfer funds, and the associated federal reimbursement, become available, provided the payment is consistent with other applicable federal or state law requirements and does not result in a hospital exceeding any applicable reimbursement limitations. On and after July 1, 2012, the Director of Health Care Services shall exercise the discretion granted to the California Medical Assistance Commission by this subdivision.

(m) The department shall pay amounts due to a private hospital from the fund for a project year, with the exception of stabilization funding, in up to four installment payments, unless otherwise provided in the hospital's contract negotiated with the California Medical Assistance Commission, except that hospitals that are not described in subdivision (j) shall not receive the first installment payment. The first payment shall be made as soon as practicable after the issuance of the tentative disproportionate share hospital list for the project year, and in no event later than January 1 of the project year. The second and subsequent payments shall be made after the issuance of the final disproportionate hospital list for the project year, and shall be made only to hospitals that are on the final disproportionate share hospital list for the project year. The second payment shall be made by February 1 of the project year or as soon as practicable after the issuance of the final

disproportionate share hospital list for the project year. The third payment, if scheduled, shall be made by April 1 of the project year. The fourth payment, if scheduled, shall be made by June 30 of the project year. This subdivision does not apply to hospitals that are scheduled to receive payments from the fund because they meet the criteria under paragraph (2) of subdivision (s) and do not meet the criteria under paragraph (1), (3), or (4) of subdivision (s), which shall be paid in accordance with the applicable contract or contract amendment negotiated by the California Medical Assistance Commission.

(n) The department shall pay stabilization funding transferred to the fund in amounts negotiated by the California Medical Assistance Commission and shall pay the scheduled payments in accordance with the applicable contract or contract amendment.

(o) Payments to private hospitals that are eligible to receive payments pursuant to subdivision (s) may be made using funds transferred from governmental entities to the state, at the option of the governmental entity. Any payments funded by intergovernmental transfers shall remain with the private hospital and shall not be transferred back to any unit of government. An amount equal to 25 percent of the amount of any intergovernmental transfer made in the project year that results in a supplemental payment made for the same project year to a project year private DSH hospital designated by the governmental entity that made the intergovernmental transfer shall be deposited in the fund for distribution as determined by the California Medical Assistance Commission. An amount equal to 75 percent shall be deposited in the fund and distributed to the private hospitals designated by the governmental entity.

(p) A private hospital that receives payment pursuant to this section for a particular project year shall not submit a notice for the termination of its participation in the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081) until the later of the following dates:

(1) On or after December 31 of the next project year.

(2) The date specified in the hospital's contract, if applicable.

(q) (1) For the 2007–08, 2008–09, and 2009–10 project years, the County of Los Angeles shall make intergovernmental transfers to the state to fund the nonfederal share of increased Medi-Cal payments to those private hospitals that serve the South Los Angeles population formerly served by Los Angeles County Martin Luther King, Jr.-Harbor Hospital. The intergovernmental transfers required under this subdivision shall be funded by county tax revenues and shall total five million dollars ($5,000,000) per project year, except that, in the event that the director determines that any amount is due to the County of Los Angeles under the demonstration project for services rendered during the portion of a project year during which Los Angeles County Martin Luther King, Jr.-Harbor Hospital was operational, the amount of intergovernmental transfers required under this subdivision shall be reduced by a percentage determined by reducing 100 percent by the percentage reduction in Los Angeles County Martin Luther King, Jr.-Harbor Hospital's baseline, as determined under subdivision (c) of Section 14166.5 for that project year.

(2) Notwithstanding subdivision (o), an amount equal to 100 percent of the county's intergovernmental transfers under this subdivision shall be deposited in the fund and, within 30 days after receipt of the intergovernmental transfer, shall be distributed, together with related federal financial participation, to the private hospitals designated by the county in the amounts designated by the county. The director shall disregard amounts received pursuant to this subdivision in calculating the OBRA 1993 payment limitation, as defined in paragraph (24) of subdivision (a) of Section 14105.98, for purposes of determining the amount of disproportionate share hospital replacement payments due a private hospital under Section 14166.11.

(r) (1) The reductions in supplemental payments under this section that result from the reductions in the amounts transferred from the General Fund to the Private Hospital Supplemental Fund for the 2012–13 and 2013–14 fiscal years under subparagraphs (B) and (C) of paragraph (1) of subdivision (d) shall be allocated equally in the aggregate between children's hospitals eligible for supplemental payments under this section and other hospitals eligible for supplemental payments under this section. When negotiating payment amounts to a hospital under this section for the 2012–13 and 2013–14 fiscal years, the California Medical Assistance Commission, or its successor agency, shall identify both a payment amount that would have been made absent the funding reductions in subparagraphs (B) and (C) of paragraph (1) of subdivision (d) and the payment amount that will be made taking into account the funding reductions under subparagraphs (B) and (C) of paragraph (1) of subdivision (d). For purposes of this subdivision, "children's hospital" shall have the meaning set forth in paragraph (13) of subdivision (a) of Section 14105.98.

(2) This subdivision shall not preclude the department from including some or all of the reductions under this

section within the payments made under a new diagnosis-related group payment methodology for the 2012–13 fiscal year or the 2013–14 fiscal year. In the event the department includes some or all of the amounts, including reductions, within the payments made under a new diagnosis-related group payment methodology for the 2012–13 fiscal year or the 2013–14 fiscal year, the department, in implementing the reductions in paragraph (1) of subdivision (d), shall, to the extent feasible, utilize the allocation specified in paragraph (1).

(s) In order for a hospital to receive distributions pursuant to this section, the hospital shall satisfy the eligibility criteria in paragraph (1), (2), (3), or (4) of this subdivision.

(1) The hospital meets all of the following criteria:

(A) The hospital is contracting under this article.

(B) The hospital meets the criteria contained in the Medicaid State Plan for disproportionate share hospital status.

(C) The hospital is one of the following:

(i) A licensed provider of basic emergency services as described in Section 70411 of Title 22 of the California Code of Regulations.

(ii) A licensed provider of comprehensive emergency medical services as defined in Section 70451 of Title 22 of the California Code of Regulations.

(iii) A children's hospital, as defined in Section 14087.21, that satisfies clause (i) or (ii), or that jointly provides basic or comprehensive emergency services in conjunction with another licensed hospital.

(iv) A hospital owned and operated by a public agency that operates two or more hospitals that qualify under subparagraph (A) or (B) with respect to the particular state fiscal year.

(v) A hospital designated by the National Cancer Institute as a comprehensive or clinical cancer research center that primarily treats acutely ill cancer patients and that is exempt from the federal Medicare prospective payment system pursuant to Section 1886(d)(1)(B)(v) of the federal Social Security Act (42 U.S.C. Sec. 1395ww(d)(1)(B)(v)).

(D) The hospital is able to demonstrate a purpose for additional funding under the selective provider contracting program including proposals relating to emergency services and other health care services, including infrequent yet high-cost services, such as anti-AB human antitoxin treatment for infant botulism (human botulinum immune globulin (HBIG), commonly referred to as "Baby-BIG"), that are made available, or will be made available, to Medi-Cal beneficiaries.

(2) The hospital is contracting under this article and meets the definition of a university teaching hospital or major, nonuniversity, teaching hospital as set forth on page 51 and as listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping." Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(3) The hospital is contracting under this article, and meets the definition of any of the following:

(A) A large teaching emphasis hospital, as set forth on page 51 and listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," and also meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(B) A children's hospital pursuant to Section 10727, and also meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(C) Notwithstanding the requirement in subparagraph (A) that a hospital must be listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," any hospital whose license pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code was consolidated during the 1999 calendar year with a large teaching emphasis hospital that is listed on page 57 of the above-described report shall be eligible. All other requirements of paragraph (3) shall continue to apply.

(4) The hospital meets all of the following criteria:

(A) The hospital is contracting under this article.

(B) The hospital satisfies the Medicaid State Plan criteria for disproportionate share hospital status.

(C) The hospital is a small and rural hospital as defined in Section 124840 of the Health and Safety Code.

(D) The hospital is a licensed provider of standby emergency services as described in Section 70649 of Title 22 of the California Code of Regulations.

(E) The hospital is able to demonstrate a purpose for additional funding under the selective provider contracting program with proposals relating to health care services that are made available, or will be made available, to Medi-Cal beneficiaries.

(F) The hospital is determined by the California Medical Assistance Commission to be a hospital that provides an important community service that otherwise would not be provided in the community.

SEC. 91. Section 14166.14 of the Welfare and Institutions Code is amended to read:

14166.14. The amount of any stabilization funding payable to the project year private DSH hospitals under Section 14166.20 for a project year, which amount shall not include the amount of stabilization funding paid or payable to hospitals prior to the computation of the stabilization funding under Section 14166.20, plus any amount payable to project year private DSH hospitals under paragraph (1) of subdivision (b) of Section 14166.21, shall be allocated as follows:

(a) (1) To fund any shortfall due under Section 14166.11.

(2) An amount shall be transferred to the Private Hospital Supplemental Fund established pursuant to Section 14166.12, as may be necessary so that the amount for the Private Hospital Supplemental Fund for the project year, including all funds previously transferred to, or deposited in, the Private Hospital Supplemental Fund for the project year, is not less than the Private Hospital Supplemental Fund base amount determined pursuant to subdivision (j) of Section 14166.12.

(3) The amounts paid or transferred under paragraphs (1) and (2) shall be reduced pro rata if there is not sufficient funding described under paragraphs (1) and (2).

(b) Of the stabilization funding remaining, after allocations pursuant to subdivision (a), that are payable to project year private DSH hospitals, 66.4 percent shall be allocated and distributed among those hospitals pro rata based on the amounts determined in accordance with Section 14166.11, and 33.6 percent shall be transferred to the Private Hospital Supplemental Fund.

(c) (1) Notwithstanding any other law, the stabilization funding payable to project year private DSH hospitals under Section 14166.20 for a project year as determined under this section that has not been paid, or specifically committed for payment, to hospitals prior to January 1, 2012, may be utilized by the director to make payments to hospitals that received underpayments pursuant to Section 14166.11 due to improper peer group classifications for the 2005–06 and 2006–07 payment adjustment years.

(2) The balance after payments made pursuant to paragraph (1), if any, of the stabilization funding payable to project year private DSH hospitals under Section 14166.20 shall not be paid to the project year private DSH hospitals pursuant to Section 14166.20. The funds that would otherwise be paid from the Private Hospital Supplemental Fund shall be transferred to the General Fund, and funds that would otherwise be drawn from the General Fund for payments to the private DSH hospitals pursuant to Section 14166.20 shall be retained in the General Fund.

SEC. 92. Section 14166.151 is added to the Welfare and Institutions Code, to read:

14166.151. (a) It is the intent of the Legislature to reform the inpatient fee-for-service reimbursement methodology for nondesignated public hospitals based on their public structure in order to provide new opportunities for nondesignated public hospitals to receive reimbursement under the successor demonstration project for care provided to the uninsured and to receive new incentive payments for achievement related to delivery system reform.

(b) Subject to subdivision (c), beginning with services provided on or after July 1, 2012, fee-for-service payments to nondesignated public hospitals for inpatient services shall be governed by this subdivision. Each nondesignated public hospital shall receive as payment for inpatient hospital services provided to Medi-Cal beneficiaries during any successor demonstration year, the federal financial participation claimed by the department based on the hospital's allowable costs incurred in providing those services, subject to all of the following:

(1) Nondesignated public hospitals shall comply with the requirements of Section 14166.152. The payments authorized in this section shall be subject to audit and a final reconciliation where an overpayment to the nondesignated public hospital shall result in a collection of the overpayment and an underpayment to the nondesignated public hospital shall result in a corrective payment.

(2) (A) Nondesignated public hospitals shall be eligible to receive safety net care pool payments for uncompensated care costs to the extent that additional federal funding is made available pursuant to the Special Terms and Conditions for the safety net care pool uncompensated care limit of the successor demonstration project and if they comply with the requirements set forth in Section 14166.154.

(B) The amount of funds that may be claimed pursuant to subparagraph (A) shall not exceed the additional federal funding made available under the safety net care pool for nondesignated public hospital uncompensated care costs, and shall not reduce the amounts of federal funding for safety net care pool uncompensated care costs that would otherwise be made available to designated public hospitals in the absence of this paragraph, including the amounts available under the Special Terms and Conditions in effect as of April 1, 2012, and amounts available pursuant to Section 15916.

(C) (i) Notwithstanding subparagraph (B), if the designated public hospitals do not have sufficient certified public expenditures to claim the full amount of federal funding made available to the designated public hospitals as referenced in subparagraph (B), including consideration of the potential for the designated public hospitals to have sufficient certified public expenditures in a subsequent year, the department may authorize the funding to be claimed by the nondesignated public hospitals.

(ii) The department may determine whether designated public hospitals do not have sufficient certified public expenditures to claim the full amount of federal funding pursuant to clause (i) no sooner than after the submission of the cost reporting information required pursuant to Section 14166.8 for the applicable successor demonstration year.

(iii) If the department makes the determination identified in clause (ii) based on as-filed cost reporting information submitted prior to a final audit, the department shall make the determination in consultation with the designated public hospitals and shall apply an audit cushion of at least 5 percent to the as-filed cost information. If the department makes the determination identified in clause (ii) based on audited cost reporting information, no audit cushion shall be applied.

(3) (A) Nondesignated public hospitals shall be eligible to receive delivery system reform incentive pool payments to the extent additional federal funding is made available for this purpose under the delivery system reform incentive pool in the successor demonstration project and if the nondesignated public hospitals comply with the delivery system reform incentive pool funding requirements set forth in Section 14166.155.

(B) The amount of funds that may be received shall not exceed the additional federal funding made available for delivery system reform incentive pool payments to nondesignated public hospitals, and shall not reduce the amounts that would otherwise be made available to designated public hospitals in the absence of this paragraph, including the amounts that designated public hospitals would be eligible to receive under their delivery system reform incentive pool plans approved as of January 1, 2012.

(C) Notwithstanding subparagraph (B), if the designated public hospitals are unable to claim the full amount of federal funding made available to the designated public hospitals pursuant to Section 14166.77 and the Special Terms and Conditions, including through reallocations made pursuant to paragraph (3) of subdivision (a) of Section 14166.77 as authorized by the Special Terms and Conditions, and the unused amount of federal funding made available to the designated public hospitals cannot be used in a later demonstration year, the department may authorize such unused funding to be made available to the nondesignated public hospitals.

(c) (1) (A) The reimbursement methodology developed pursuant to subdivision (b) shall be effective beginning July 1, 2012. If all necessary federal approvals have not been received by July 1, 2012, then the effective date shall be retroactive to July 1, 2012. Between July 1, 2012, and when all necessary federal approvals have been received, any payments made pursuant to any methodology replaced by subdivision (b) shall be deemed as interim payments subject to offsetting and recoupment against payments made under subdivision (b) pursuant to Section 51047 of Title 22 of the California Code of Regulations.

(B) Subject to paragraph (2), beginning January 1, 2014, the reimbursement methodology developed pursuant to subdivision (b), which shall be in effect July 1, 2012, through and including December 31, 2013, shall continue for those nondesignated public hospitals that certify voluntary participation as described in clause (i), if the director executes a declaration on or before December 31, 2013, certifying all of the following:

(i) The governmental entities that own or operate a nondesignated public hospital, or hospitals, have provided certifications of voluntary participation in the reimbursement methodology pursuant to subdivision (b).

(ii) Any necessary federal approvals have been obtained.

(iii) Continuation of the reimbursement methodology for those nondesignated public hospitals certifying voluntary participation would be cost beneficial to the state.

(2) On December 31, 2013, if one or more of the nondesignated public hospitals subject to the reimbursement methodology described in subdivision (b) have not provided written certification of voluntariness described in clause (i) of subparagraph (B) of paragraph (1), or if the director determines, for any reason, that the reimbursement methodology described in subdivision (b) cannot be implemented on or after January 1, 2014, then the director shall execute a declaration certifying that the reimbursement methodology described in subdivision (b) cannot continue to be implemented for all or one or more of the nondesignated public hospitals, in which case subdivision (e) shall be implemented on January 1, 2014.

(d) Upon implementation of subparagraph (A) of paragraph (1) of subdivision (c), implementation of the laws and regulations listed in paragraphs (1) to (4), inclusive, shall be suspended with respect to fee-for-service payments to all nondesignated public hospitals for inpatient services through and including December 31, 2013. Implementation of the laws and regulations listed in paragraphs (1) to (4), inclusive, shall also be suspended with respect to fee-for-service payments to nondesignated public hospitals that certify voluntary participation if a declaration is executed pursuant to subparagraph (B) of paragraph (1) of subdivision (c), beginning on January 1, 2014, and until the expiration of the successor demonstration project.

(1) The Nondesignated Public Hospital Medi-Cal Rate Stabilization Act in Article 5.17 (commencing with Section 14165.55).

(2) The inpatient fee-for-service per diem rate authorized in Article 2.6 (commencing with Section 14081).

(3) The reimbursement methodology for fee-for-service inpatient services in Sections 14105 and 14105.15, and Article 7.5 (commencing with Section 51536) of Title 22 of the California Code of Regulations.

(4) Section 14166.17.

(e) Subject to the conditions in paragraph (2) of subdivision (c), on January 1, 2014, the percentage of each intergovernmental transfer amount retained pursuant to subdivision (j) of Section 14165.57 shall be increased to 20 percent to reimburse the department, or transferred to the General Fund, for the administrative costs of operating the Nondesignated Public Hospital Intergovernmental Transfer Program and for the benefit of the Medi-Cal program.

(f) This section and Sections 14166.152, 14166.153, 14166.154, and 14166.155 shall become operative on the date all necessary federal approvals have been obtained to implement all of these sections.

SEC. 93. Section 14166.152 is added to the Welfare and Institutions Code, to read:

14166.152. (a) Pursuant to subdivision (b) of Section 14166.151, and notwithstanding any other law, fee-for-service payments to nondesignated public hospitals for inpatient services to Medi-Cal beneficiaries shall be governed by this section. The hospitals' allowable costs shall be determined, certified, and claimed in accordance with Section 14166.153. The Medicaid federal financial participation received by the state for the certified public expenditures of the hospital, or the governmental entity with which the hospital is affiliated, for inpatient hospital services rendered to Medi-Cal beneficiaries shall be paid to the hospital.

(b) With respect to each successor demonstration year, each of the nondesignated public hospitals shall receive an interim payment for each day of inpatient hospital services rendered to Medi-Cal beneficiaries based upon claims filed by the hospital in accordance with the claiming process set forth in Division 3 (commencing with Section 50000) of Title 22 of the California Code of Regulations. The interim per diem payment amount shall be based on estimated costs, which shall be derived from statistical data from the following sources and which shall be multiplied by the federal medical assistance percentage:

(1) For allowable costs reflected in the Medicare cost report, the cost report most recently audited by the hospital's Medicare fiscal intermediary adjusted by a trend factor to reflect increased costs, as approved by the federal Centers for Medicare and Medicaid Services for the successor demonstration project.

(2) For allowable costs not reflected in the Medicare cost report, each hospital shall provide hospital-specific

cost data requested by the department. The department shall adjust the data by a trend factor as necessary to reflect project year allowable costs.

(c) Until the department commences making payments pursuant to subdivision (b), the department may continue to make fee-for-service per diem payments to the nondesignated public hospitals pursuant to the selective provider contracting program in accordance with Article 2.6 (commencing with Section 14081), for services rendered on and after July 1, 2012. Per diem payments shall be adjusted retroactively to the amounts determined under the payment methodology prescribed in this section.

(d) No later than April 1 following the end of the relevant reporting period for the successor demonstration year, the department shall undertake an interim reconciliation of payments made pursuant to subdivisions (a) to (c), inclusive, based on Medicare and other cost and statistical data submitted by the hospital for the year and shall adjust payments to the hospital accordingly.

(e) (1) The nondesignated public hospitals shall receive supplemental reimbursement for the costs incurred for physician and nonphysician practitioner services provided to Medi-Cal beneficiaries who are patients of the hospital, to the extent that those services are not claimed as inpatient hospital services by the hospital and the costs of those services are not otherwise recognized under subdivision (a).

(2) Expenditures made by the nondesignated public hospital, or a governmental entity with which it is affiliated, for the services identified in paragraph (1) shall be reduced by any payments received pursuant to Article 7 (commencing with Section 51501) of Title 22 of the California Code of Regulations. The remainder shall be certified by the appropriate public official and claimed by the department in accordance with Section 14166.153. These expenditures may include any of the following:

(A) Compensation to physicians or nonphysician practitioners pursuant to contracts with the nondesignated public hospital.

(B) Salaries and related costs for employed physicians and nonphysician practitioners.

(C) The costs of interns, residents, and related teaching physician and supervision costs.

(D) Administrative costs associated with the services described in subparagraphs (A) to (C), inclusive, including billing costs.

(3) Nondesignated public hospitals shall receive federal financial participation based on the expenditures identified and certified in paragraph (2).

(4) The federal financial participation received by the department for the certified public expenditures identified in paragraph (2) shall be paid to the nondesignated public hospital, or a governmental entity with which it is affiliated.

(5) Supplemental reimbursement under this subdivision may be distributed as part of the interim payments under subdivision (b), on a per-visit basis, on a per-procedure basis, or on any other federally permissible basis.

(6) The department shall submit for federal approval, by September 30, 2012, a proposed amendment to the Medi-Cal state plan to implement this subdivision, retroactive to July 1, 2012, to the extent permitted by the federal Centers for Medicare and Medicaid Services. If necessary to obtain federal approval, the department may limit the application of this subdivision to costs determined allowable by the federal Centers for Medicare and Medicaid Services. If federal approval is not obtained, this subdivision shall not be implemented.

(f) This section shall become operative as provided in subdivision (f) of Section 14166.151.

SEC. 94. Section 14166.153 is added to the Welfare and Institutions Code, to read:

14166.153. (a) Beginning in the 2012–13 fiscal year, within five months after the end of a successor demonstration year, each of the nondesignated public hospitals shall submit to the department all of the following reports:

(1) The hospital's Medicare cost report for the project year or successor demonstration year.

(2) Other cost reporting and statistical data necessary for the determination of amounts due the hospital under the demonstration project or successor demonstration project, as requested by the department.

(b) For each project year or successor demonstration year, the reports shall identify all of the following:

(1) To the extent applicable, the costs incurred in providing inpatient hospital services to Medi-Cal beneficiaries on a fee-for-service basis and physician and nonphysician practitioner services costs, as identified in subdivision (e) of Section 14166.152.

(2) The costs incurred in providing hospital services to uninsured individuals.

(c) Each nondesignated public hospital, or governmental entity with which it is affiliated, that operates nonhospital clinics or provides physician, nonphysician practitioner, or other health care services that are not identified as hospital services under the Special Terms and Conditions for the demonstration project and successor demonstration project, shall report and certify all of the uncompensated Medi-Cal and uninsured costs of the services furnished. The amount of these uncompensated costs to be claimed by the department shall be determined by the department in consultation with the governmental entity so as to optimize the level of claimable federal Medicaid reimbursement.

(d) Reports submitted under this section shall include all allowable costs.

(e) The appropriate public official shall certify to all of the following:

(1) The accuracy of the reports required under this section.

(2) That the expenditures to meet the reported costs comply with Section 433.51 of Title 42 of the Code of Federal Regulations.

(3) That the sources of funds used to make the expenditures certified under this section do not include impermissible provider taxes or donations as defined under Section 1396b(w) of Title 42 of the United States Code or other federal funds. For this purpose, federal funds do not include delivery system reform incentive pool payments or patient care revenue received as payment for services rendered under programs such as nondesignated state health programs, the Low Income Health Program, Medicare, or Medicaid.

(f) The certification of public expenditures made pursuant to this section shall be based on a schedule established by the department in accordance with federal requirements.

(1) The director may require the nondesignated public hospitals to submit quarterly estimates of anticipated expenditures, if these estimates are necessary to obtain interim payments of federal Medicaid funds.

(2) All reported expenditures shall be subject to reconciliation to allowable costs, as determined in accordance with applicable implementing documents for the demonstration project and successor demonstration project.

(g) The director shall seek Medicaid federal financial participation for all certified public expenditures reported by the nondesignated public hospitals and recognized under the successor demonstration project.

(h) The timeframes for data submission and reporting periods may be adjusted as necessary in accordance with federal requirements.

(i) This section shall become operative as provided in subdivision (f) of Section 14166.151.

SEC. 95. Section 14166.154 is added to the Welfare and Institutions Code, to read:

14166.154. (a) (1) Beginning in the 2012–13 fiscal year, if the reimbursement methodology in subdivision (b) of Section 14166.151 is in effect and federal approval is obtained for an amendment to the successor demonstration project that was submitted pursuant to subdivision (d), then, with respect to each successor demonstration year, nondesignated public hospitals, or governmental entities with which they are affiliated, shall be eligible to receive safety net care pool payments for uncompensated care from the Health Care Support Fund established pursuant to Section 14166.21. Safety net care pool payments for uncompensated care shall be allocated to nondesignated public hospitals as follows:

(A) The department shall determine the maximum amount of safety net care pool payments for uncompensated care that is available to nondesignated public hospitals for the successor demonstration year pursuant to paragraph (2) of subdivision (b) of Section 14166.151. This determination shall be made solely with respect to allowable uncompensated care costs incurred by nondesignated public hospitals and reported pursuant to Section 14166.153.

(B) The department shall establish, in consultation with the nondesignated public hospitals, an allocation methodology to determine the amount of safety net care pool payments to be made to each hospital. The

allocation methodology shall be implemented when the director issues a declaration stating that the methodology complies with all applicable federal requirements for federal financial participation.

(2) A safety net care pool payment amount may be paid to a nondesignated public hospital, or governmental entity with which it is affiliated, pursuant to this section independent of the amount of uncompensated Medi-Cal and uninsured costs that is certified as public expenditures pursuant to Section 14166.153, provided that, in accordance with the Special Terms and Conditions for the successor demonstration project, the recipient hospital does not return any portion of the funds received to any unit of government, excluding amounts recovered by the state or federal government.

(3) In establishing the amount to be paid to each nondesignated public hospital under this subdivision, the department shall minimize to the extent possible the redistribution of federal funds that are based on certified public expenditures as described in paragraph (2).

(b) Each nondesignated public hospital, or governmental entity with which it is affiliated, shall receive the amount established pursuant to subdivision (a) in quarterly interim payments during the successor demonstration year. The determination of the interim payments shall be made on an interim basis prior to the start of each successor demonstration year. The department shall use the same cost and statistical data that is used in determining the interim payments for Medi-Cal inpatient hospital services under Section 14166.152.

(c) (1) No later than April 1 following the end of the relevant reporting period for the successor demonstration year, the department shall undertake an interim reconciliation of the payment amount established pursuant to subdivision (a) for each nondesignated public hospital using Medicare and other cost, payment, and statistical data submitted by the hospital for the successor demonstration year, and shall adjust payments to the hospital accordingly.

(2) The final payment to a nondesignated public hospital, for purposes of subdivision (b) and paragraph (1) of this subdivision, shall be subject to final audits of all applicable Medicare and other cost, payment, discharge, and statistical data for the successor demonstration year.

(d) The department shall submit for federal approval a proposed amendment to the successor demonstration project to implement this section.

(e) This section shall become operative as provided in subdivision (f) of Section 14166.151.

SEC. 96. Section 14166.155 is added to the Welfare and Institutions Code, to read:

14166.155. (a) (1) Beginning in the 2012–13 fiscal year, if the reimbursement methodology in subdivision (b) of Section 14166.151 is in effect and federal approval is obtained for an amendment to the successor demonstration project that was submitted pursuant to subdivision (c), then nondesignated public hospitals may receive payments pursuant to this section. The amount of delivery system reform incentive pool funding, consisting of both the federal and nonfederal share of payments, that is made available to each nondesignated public hospital system in the aggregate for the term of the successor demonstration project shall be based initially on the delivery system reform proposals that are submitted by the nondesignated public hospitals to the department for review and submission to the federal Centers for Medicare and Medicaid Services for final approval. The initial percentages of delivery system reform incentive pool funding among the nondesignated public hospitals for each successor demonstration year shall be determined based on the annual components as contained in the approved proposals.

(2) The actual receipt of funds shall be conditioned on the nondesignated public hospital's progress toward, and achievement of, the specified milestones and other metrics established in its approved delivery system reform incentive pool proposal. A nondesignated public hospital may carry forward available incentive pool funding associated with milestones and metrics from one year to a subsequent period as authorized by the Special Terms and Conditions and the final delivery system reform incentive pool protocol.

(3) The department may reallocate the incentive pool funding available under this section pursuant to conditions specified, and as authorized by, the Special Terms and Conditions and the final delivery system reform incentive pool protocol.

(b) Each nondesignated public hospital shall be individually responsible for progress toward, and achievement of, milestones and other metrics in its proposal, as well as other applicable requirements specified in the Special Terms and Conditions and the final delivery system reform incentive pool protocol, in order to receive its specified allocation of incentive pool funding under this section.

(1) The nondesignated public hospital shall submit semiannual reports and requests for payment to the department by March 31 and the September 30 following the end of the second and fourth quarters of the successor demonstration year, or comply with any other process as approved by the federal Centers for Medicare and Medicaid Services.

(2) Within 14 days after the semiannual report due date, the nondesignated public hospital system or its affiliated governmental entity shall make an intergovernmental transfer of funds equal to the nonfederal share that is necessary to claim the federal funding for the pool payment related to the achievement or progress metric that is certified. The intergovernmental transfers shall be deposited into the Public Hospital Investment, Improvement, and Incentive Fund, established pursuant to Section 14182.4.

(3) The department shall claim the federal funding and pay both the nonfederal and federal shares of the incentive payment to the nondesignated public hospital system or other affiliated governmental provider, as applicable. If the intergovernmental transfer is made within the appropriate 14-day timeframe, the incentive payment shall be disbursed within seven days with the expedited payment process as approved by the federal Centers for Medicare and Medicaid Services, otherwise the payment shall be disbursed within 20 days of when the transfer is made.

(4) The nondesignated public hospital system or other affiliated governmental provider is responsible for any fee or cost required to implement the expedited payment process in accordance with Section 8422.1 of the State Administrative Manual.

(c) The department shall submit for federal approval an amendment to the successor demonstration project to implement this section.

(d) In the event of a conflict between any provision of this section and the Special Terms and Conditions for the successor demonstration project and the final delivery system reform incentive pool protocol, the Special Terms and Conditions and the final delivery system reform incentive pool protocol shall control.

(e) This section shall become operative as provided in subdivision (f) of Section 14166.151.

SEC. 97. Section 14166.17 of the Welfare and Institutions Code is amended to read:

14166.17. (a) The California Medical Assistance Commission shall negotiate payment amounts in accordance with the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081) from the Nondesignated Public Hospital Supplemental Fund established pursuant to subdivision (b) for distribution to nondesignated public hospitals that satisfy the criteria of subdivision (o). Pursuant to Section 14165, on and after July 1, 2012, the Director of Health Care Services shall exercise the discretion granted to the California Medical Assistance Commission.

(b) The Nondesignated Public Hospital Supplemental Fund is hereby established in the State Treasury. For purposes of this section, “fund” means the Nondesignated Public Hospital Supplemental Fund.

(c) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department for the purposes specified in this section.

(d) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) One million nine hundred thousand dollars ($1,900,000), which shall be transferred annually from General Fund amounts appropriated in the annual Budget Act for the fund.

(2) Any additional moneys appropriated to the fund.

(3) All stabilization funding transferred to the fund.

(4) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal Medicaid laws.

(5) Any interest that accrues on amounts in the fund.

(e) The department may accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal financial participation to the full extent permitted by law. With respect to funds transferred or donated from private individuals or entities, the department shall accept only those funds that are certified by the transferring or donating entity as

qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable. The department may return any funds transferred or donated in error.

(f) Moneys in the funds shall be used as the source for the nonfederal share of payments to hospitals under this section.

(g) Any funds remaining in the fund at the end of a fiscal year shall be carried forward for use in the following fiscal year.

(h) Moneys shall be allocated from the fund by the department and shall be applied to obtain federal financial participation in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section. Distributions from the fund shall be supplemental to any other Medi-Cal reimbursement received by the hospitals, including amounts that hospitals receive under the selective provider contracts negotiated under Article 2.6 (commencing with Section 14081), and shall not affect provider rates paid under the selective provider contracting program.

(i) Each nondesignated public hospital that was a nondesignated public hospital during the 2002–03 fiscal year, received payments for the 2002–03 fiscal year from any of the prior supplemental funds, and, during the project year satisfies the criteria in subdivision (o) to be eligible to negotiate for distributions under any of those sections shall receive no less from the Nondesignated Public Hospital Supplemental Fund for the project year than 100 percent of the amount the hospital received from the prior supplemental funds for the 2002–03 fiscal year, minus the total amount of intergovernmental transfers made by or on behalf of the hospital pursuant to subdivision (o) for the same fiscal year. Each hospital described in this subdivision shall be eligible for additional payments from the fund pursuant to subdivision (j).

(j) All amounts that are in the fund for a project year in excess of the amount necessary to make the payments under subdivision (i) shall be available for negotiation by the California Medical Assistance Commission, along with corresponding federal financial participation, for supplemental payments to nondesignated public hospitals that for the project year satisfy the criteria under subdivision (o) to be eligible to negotiate for distributions under any of those sections, and paid for services rendered during the project year pursuant to the selective provider contracting program under Article 2.6 (commencing with Section 14081).

(k) The amount of any stabilization funding transferred to the fund with respect to a project year may in the discretion of the California Medical Assistance Commission, until its dissolution on June 30, 2012, to be paid for services furnished in the same project year regardless of when the stabilization funds become available, provided the payment is consistent with other applicable federal or state legal requirements and does not result in a hospital exceeding any applicable reimbursement limitations. On and after July 1, 2012, the Director of Health Care Services shall exercise the discretion granted to the California Medical Assistance Commission by this subdivision.

(l) The department shall pay amounts due to a nondesignated hospital from the fund for a project year, with the exception of stabilization funding, in up to four installment payments, unless otherwise provided in the hospital's contract negotiated with the California Medical Assistance Commission, except that hospitals that are not described in subdivision (i) shall not receive the first installment payment. The first payment shall be made as soon as practicable after the issuance of the tentative disproportionate share hospital list for the project year, and in no event later than January 1 of the project year. The second and subsequent payments shall be made after the issuance of the final disproportionate hospital list for the project year, and shall be made only to hospitals that are on the final disproportionate share hospital list for the project year. The second payment shall be made by February 1 of the project year or as soon as practicable after the issuance of the final disproportionate share hospital list for the project year. The third payment, if scheduled, shall be made by April 1 of the project year. The fourth payment, if scheduled, shall be made by June 30 of the project year. This subdivision does not apply to hospitals that are scheduled to receive payments from the fund because they meet the criteria under paragraph (2) of subdivision (o) but do not meet the criteria under paragraph (1), (3), or (4) of subdivision (o).

(m) The department shall pay stabilization funding transferred to the fund in amounts negotiated by the California Medical Assistance Commission and paid in accordance with the applicable contract or contract amendment.

(n) A nondesignated public hospital that receives payment pursuant to this section for a particular project year shall not submit a notice for the termination of its participation in the selective provider contracting program

established pursuant to Article 2.6 (commencing with Section 14081) until the later of the following dates:

(1) On or after December 31 of the next project year.

(2) The date specified in the hospital's contract, if applicable.

(o) In order for a hospital to receive distributions pursuant to this section, the hospital shall satisfy the eligibility criteria in paragraph (1), (2), (3), or (4) of this subdivision.

(1) The hospital meets all of the following criteria:

(A) The hospital is contracting under this article.

(B) The hospital meets the criteria contained in the Medicaid State Plan for disproportionate share hospital status.

(C) The hospital is one of the following:

(i) A licensed provider of basic emergency services as described in Section 70411 of Title 22 of the California Code of Regulations.

(ii) A licensed provider of comprehensive emergency medical services as defined in Section 70451 of Title 22 of the California Code of Regulations.

(iii) A children's hospital, as defined in Section 14087.21, that satisfies clause (i) or (ii), or that jointly provides basic or comprehensive emergency services in conjunction with another licensed hospital.

(iv) A hospital owned and operated by a public agency that operates two or more hospitals that qualify under subparagraph (A) or (B) with respect to the particular state fiscal year.

(v) A hospital designated by the National Cancer Institute as a comprehensive or clinical cancer research center that primarily treats acutely ill cancer patients and that is exempt from the federal Medicare prospective payment system pursuant to Section 1886(d)(1)(B)(v) of the federal Social Security Act (42 U.S.C. Sec. 1395ww(d)(1)(B)(v)).

(D) (1) The hospital is able to demonstrate a purpose for additional funding under the selective provider contracting program including proposals relating to emergency services and other health care services, including infrequent yet high-cost services, such as anti-AB human antitoxin treatment for infant botulism (human botulinum immune globulin (HBIG), commonly referred to as "Baby-BIG"), that are made available, or will be made available, to Medi-Cal beneficiaries.

(2) The hospital is contracting under this article and meets the definition of a university teaching hospital or major, nonuniversity, teaching hospital as set forth on page 51 and as listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping." Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(3) The hospital is contracting under this article and meets the definition of any of the following:

(A) A large teaching emphasis hospital, as set forth on page 51 and listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," and also meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(B) A children's hospital pursuant to Section 10727, and also meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(C) Notwithstanding the requirement in subparagraph (A) of paragraph (3) that a hospital must be listed on page 57 of the department's report dated May 1991, entitled "Hospital Peer Grouping," any hospital whose license pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code was consolidated during the 1999 calendar year with a large teaching emphasis hospital that is listed on page 57 of the above-described report shall be eligible. All other requirements of paragraph (3) shall continue to apply.

(4) The hospital meets all of the following criteria:

(A) The hospital is contracting under this article.

(B) The hospital satisfies the Medicaid State Plan criteria for disproportionate share hospital status.

(C) The hospital is a small and rural hospital as defined in Section 124840 of the Health and Safety Code.

(D) The hospital is a licensed provider of standby emergency services as described in Section 70649 of Title 22 of the California Code of Regulations.

(E) The hospital is able to demonstrate a purpose for additional funding under the selective provider contracting program with proposals relating to health care services that are made available, or will be made available, to Medi-Cal beneficiaries.

(F) The hospital is determined by the California Medical Assistance Commission to be a hospital that provides an important community service that otherwise would not be provided in the community.

SEC. 98. Section 14166.19 of the Welfare and Institutions Code is amended to read:

14166.19. The amount of any stabilization funding payable to the nondesignated public hospitals under paragraph (4) of subdivision (b) of Section 14166.20 for a project year, which amount shall not include the amount of stabilization funding paid or payable to hospitals prior to the computation of the stabilization funding under Section 14166.20, shall be allocated in the following priority:

(a) An amount shall be transferred to the Nondesignated Public Hospital Supplemental Fund, as may be necessary so that the amount for the Nondesignated Public Hospital Supplemental Fund for the project year, including all funds previously transferred to, or deposited in, the Nondesignated Public Hospital Supplemental Fund for the project year, is not less than one million nine hundred thousand dollars ($1,900,000).

(b) Of the remaining stabilization funding payable to nondesignated public hospitals, 75 percent shall be allocated, distributed, and paid in accordance with Section 14166.16, and 25 percent shall be transferred to the Nondesignated Public Hospital Supplemental Fund.

(c) Notwithstanding any other law, the amount of any stabilization funding payable to nondesignated public hospitals under Section 14166.20 for a project year as determined under this section that has not been paid, or specifically committed for payment, to nondesignated public hospitals before January 1, 2012, shall not be paid pursuant to Section 14166.20. The funds that would otherwise be paid from the Nondesignated Public Hospital Supplemental Fund shall be transferred to the General Fund, and funds that would otherwise be drawn from the General Fund for payments to the nondesignated public hospitals pursuant to Section 14166.20 shall be retained in the General Fund.

SEC. 99. Section 14169.7 of the Welfare and Institutions Code is amended to read:

14169.7. (a) (1) Designated public hospitals shall be paid direct grants in support of health care expenditures, which shall not constitute Medi-Cal payments, and which shall be funded by the quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31). The aggregate amount of the grants to designated public hospitals shall be fifty million dollars ($50,000,000) for the 2011–12 fiscal year, forty-three million dollars ($43,000,000) for the 2012–13 fiscal year, and twenty-one million five hundred thousand dollars ($21,500,000) for the 2013–14 fiscal year. The director shall allocate the amounts specified in this paragraph pursuant to paragraph (2).

(2) For the 2011–12 fiscal year, the director shall allocate the fifty million dollars ($50,000,000) identified in paragraph (1) among the designated public hospitals pursuant to a methodology developed in consultation with the designated public hospitals. For the 2012–13 fiscal year, the director shall allocate the forty-three million dollars ($43,000,000) identified in paragraph (1) among the designated public hospitals pursuant to a methodology developed in consultation with the designated public hospitals. For the 2013–14 fiscal year, the state shall retain the twenty-one million five hundred thousand dollars ($21,500,000) identified in paragraph (1) to pay for health care coverage for children in addition to the amounts identified in Section 14169.33.

(b) Nondesignated public hospitals shall be paid direct grants in support of health care expenditures, and shall be funded by the quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31). The aggregate amount of the grants to nondesignated public hospitals for each subject fiscal year shall be ten million dollars ($10,000,000), except that for the 2013–14 subject fiscal year, the aggregate amount of the grants shall be five million dollars ($5,000,000). The director shall allocate the amounts specified in this subdivision among the nondesignated public hospitals pursuant to a methodology developed in consultation with the nondesignated public hospitals.

SEC. 100. Section 14169.7.5 of the Welfare and Institutions Code is amended to read:

14169.7.5. (a) The Low Income Health Program MCE Out-of-Network Emergency Care Services Fund is hereby established in the State Treasury. The moneys in the fund shall, upon appropriation by the Legislature to the department, be used solely for the purposes specified in this section. Notwithstanding Section 16305.7 of the Government Code, any and all interest and dividends earned on money in the fund shall be used exclusively for the purposes of this section.

(b) The fund shall consist of the following:

(1) Funds transferred from governmental entities, at the option of the governmental entity, to the state for deposit into the fund in an aggregate amount of twenty million dollars ($20,000,000) per subject fiscal year, except that for the 2013–14 subject fiscal year, the aggregate amount of the transfer shall be ten million dollars ($10,000,000).

(2) Proceeds of the quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31) that, subject to paragraph (1) of subdivision (a) of Section 14169.36, are transferred from the Hospital Quality Assurance Revenue Fund and deposited into the fund in an aggregate amount of seventy-five million dollars ($75,000,000) per subject fiscal year, except that for the 2013–14 subject fiscal year, the aggregate amount of the proceeds of the quality assurance fee deposited into the fund shall be thirty-seven million five hundred thousand dollars ($37,500,000).

(c) Any amounts of the quality assurance fee deposited to the fund in excess of the funds required to implement this section shall be returned to the Hospital Quality Assurance Revenue Fund.

(d) Any amounts deposited to the fund as described in paragraph (1) of subdivision (b) that are in excess of the funds required to implement this section shall be returned to the transferring entity.

(e) Consistent with the Special Terms and Conditions for the California's Bridge to Reform Section 1115(a) Medicaid Demonstration (11-W-00193/9), moneys in the fund shall be used with respect to Low Income Health Programs (LIHPs) operating pursuant to Part 3.6 (commencing with Section 15909) as the source for the nonfederal share of expenditures for coverage for the Medi-Cal coverage expansion (MCE) population of medically necessary hospital emergency services for emergency medical conditions and required poststabilization care furnished by private hospitals and nondesignated public hospitals that are outside the LIHP coverage network, subject to the following:

(1) Moneys in the fund shall only be used to fund the nonfederal share of supplemental payments made to private hospital and nondesignated public hospital out-of-network emergency care services providers by the LIHP for the MCE population in accordance with this section.

(2) Supplemental payments under this section shall supplement but shall not supplant amounts that would have been paid absent the provisions of this section.

(f) Moneys in the fund shall be allocated with respect to each subject fiscal year as follows:

(1) Within 60 days after the last day of each subject fiscal year, each LIHP shall report utilization data to the department on approved hospital emergency services for emergency medical conditions and required poststabilization care, in accordance with Paragraph 63.f.ii of the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration (11-W-00193/9), provided to MCE enrollees by out-of-network private hospitals and nondesignated public hospitals during that year. The reported data shall be as specified by the department, and shall include the number of emergency room encounters and the number of inpatient hospital days.

(2) The department shall, in consultation with the hospital community, determine the amount of funding for the nonfederal share of supplemental payments available for each reported emergency room encounter or inpatient day by dividing the total funds available by the total number of inpatient days or emergency visits in accordance with subparagraphs (A) and (B).

(A) Seventy percent of the moneys in the fund shall be allocated for the nonfederal share of supplemental payments to private hospitals and nondesignated public hospitals for approved out-of-network inpatient hospital emergency and poststabilization care, in accordance with Paragraph 63.f.ii of the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration (11-W-00193/9).

(B) Thirty percent of the available funds shall be allocated for the nonfederal share of supplemental payments to

private hospitals and nondesignated public hospitals for approved out-of-network hospital emergency room services (excluding emergency room visits, in accordance with Paragraph 63.f.ii of the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration (11-W-00193/9), that resulted in an approved out-of-network inpatient hospital stay), provided that for any emergency room visit that results in a hospital stay for which a supplemental payment is available under subparagraph (A), no supplemental payment shall be available under this subparagraph.

(C) The allocations and total available fund amount shall be adjusted as necessary so as to be consistent with the requirement in paragraph (1) of subdivision (g).

(g) (1) The department shall obtain federal financial participation for moneys in the fund to the full extent permitted by federal law. Moneys shall be allocated from the fund by the department to be matched by federal funds in accordance with the Special Terms and Conditions for the Medicaid Demonstration, or pursuant to other federal approvals or waivers as necessary.

(2) The department shall disburse moneys from the fund to the LIHPs in accordance with the calculations in subdivision (f) within 60 days after completing the calculations. The moneys shall be distributed to the LIHPs solely for purposes of funding the nonfederal portion of the supplemental out-of-network amounts determined for each service in subdivision (f) to out-of-network hospital emergency care services providers.

(3) The LIHPs shall make the supplemental payments described in paragraph (2) within 30 days of receiving the nonfederal share from the department.

(h) It is the intent of the Legislature that for each subject fiscal year, the first twenty million dollars ($20,000,000), or, for subject fiscal year 2013–14, the first ten million dollars ($10,000,000), of the nonfederal share for the emergency hospital services payments are funded with intergovernmental transfers described in paragraph (1) of subdivision (b).

(i) This section shall be implemented only if, and to the extent that, both of the following conditions exist:

(1) All necessary federal approvals have been obtained for the implementation of this section and federal financial participation is available.

(2) The ability of the department to maximize federal funding is not jeopardized.

(j) In designing and implementing the program for supplemental payments created under this section, the director shall have discretion, after consultation with the hospital community and the LIHPs, to modify timelines and to make modifications to the operational requirements of this section, but only to the extent necessary to secure federal approval or to ensure successful operation of the program and to effectuate the intent of this section.

(k) Notwithstanding any other provision of this article or Article 5.229 (commencing with Section 14169.31), federal disapproval of the program developed pursuant to the requirements of this section shall not affect the implementation of the remainder of this article or Article 5.229 (commencing with Section 14169.31).

SEC. 101. Section 14169.13 of the Welfare and Institutions Code is amended to read:

14169.13. (a) The director shall do all of the following:

(1) Promptly submit any state plan amendment or waiver request that may be necessary to implement this article.

(2) Promptly seek federal approvals or waivers as may be necessary to implement this article and to obtain federal financial participation to the maximum extent possible for the payments under this article.

(3) Amend the contracts between the managed health care plans and the department as necessary to incorporate the provisions of Sections 14169.5 and 14169.6 and promptly seek all necessary federal approvals of those amendments. The department shall pursue amendments to the contracts as soon as possible after the effective date of this article and Article 5.229 (commencing with Section 14169.31), and shall not wait for federal approval of this article or Article 5.229 (commencing with Section 14169.31) prior to pursuing amendments to the contracts. The amendments to the contracts shall, among other provisions, set forth an agreement to increase capitation payments to managed health care plans under Section 14169.5 and increase payments to hospitals under Section 14169.6 in a manner that relates back to July 1, 2011, or as soon thereafter as possible, conditioned on obtaining all federal approvals necessary for federal financial participation

for the increased capitation payments to the managed health care plans.

(b) In implementing this article, the department may utilize the services of the Medi-Cal fiscal intermediary through a change order to the fiscal intermediary contract to administer this program, consistent with the requirements of Sections 14104.6, 14104.7, 14104.8, and 14104.9. Contracts entered into for purposes of implementing this article or Article 5.229 (commencing with Section 14169.31) shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

(c) This article shall become inoperative if either of the following occurs:

(1) In the event, and on the effective date, of a final judicial determination made by any court of appellate jurisdiction or a final determination by the federal Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services that Section 14169.2, Section 14169.3, or any provision of Section 14166.115 cannot be implemented.

(2) In the event both of the following conditions exist:

(A) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2013, the implementation of Section 14169.2, Section 14169.3, or the quality assurance fee established pursuant to Article 5.229 (commencing with Section 14169.31).

(B) Section 14169.2, Section 14169.3, or Article 5.229 (commencing with Section 14169.31) cannot be modified by the department pursuant to subdivision (e) of Section 14169.33 in order to meet the requirements of federal law or to obtain federal approval.

(d) If this article becomes inoperative pursuant to paragraph (1) of subdivision (c) and the determination applies to any period or periods of time prior to the effective date of the determination, the department shall have authority to recoup all payments made pursuant to this article during that period or those periods of time.

(e) In the event any hospital, or any party on behalf of a hospital, shall initiate a case or proceeding in any state or federal court in which the hospital seeks any relief of any sort whatsoever, including, but not limited to, monetary relief, injunctive relief, declaratory relief, or a writ, based in whole or in part on a contention that any or all of this article or Article 5.229 (commencing with Section 14169.31) is unlawful and may not be lawfully implemented, both of the following shall apply:

(1) Payments shall not be made to the hospital pursuant to this article until the case or proceeding is finally resolved, including the final disposition of all appeals.

(2) Any amount computed to be payable to the hospital pursuant to this section for a project year shall be withheld by the department and shall be paid to the hospital only after the case or proceeding is finally resolved, including the final disposition of all appeals.

(f) Subject to Section 14169.34, no payment shall be made under this article until all necessary federal approvals for the payment and for the fee provisions in Article 5.229 (commencing with Section 14169.31) have been obtained and the fee has been imposed and collected. Notwithstanding any other provision of law, payments under this article shall be made only to the extent that the fee established in Article 5.229 (commencing with Section 14169.31) is collected and available to cover the nonfederal share of the payments.

(g) A hospital's receipt of payments under this article for services rendered prior to the effective date of this article is conditioned on the hospital's continued participation in Medi-Cal for at least 30 days after the effective date of this article.

(h) All payments made by the department to hospitals, managed health care plans, and mental health plans under this article shall be made only from the following:

(1) The quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31) and due and payable on or before December 31, 2013, along with any interest or other investment income thereon.

(2) Federal reimbursement and any other related federal funds.

SEC. 102. Section 14169.31 of the Welfare and Institutions Code is amended to read:

14169.31. For the purposes of this article, the following definitions shall apply:

(a) (1) "Aggregate quality assurance fee" means, with respect to a hospital that is not a prepaid health plan

hospital, the sum of all of the following:

(A) The annual fee-for-service days for an individual hospital multiplied by the fee-for-service per diem quality assurance fee rate.

(B) The annual managed care days for an individual hospital multiplied by the managed care per diem quality assurance fee rate.

(C) The annual Medi-Cal days for an individual hospital multiplied by the Medi-Cal per diem quality assurance fee rate.

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

(A) The annual fee-for-service days for an individual hospital multiplied by the fee-for-service per diem quality assurance fee rate.

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

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

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

(3) “Aggregate quality assurance fee after the application of the fee percentage” means the aggregate quality assurance fee multiplied by the fee percentage for each subject fiscal year.

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

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

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

(e) “Converted hospital” shall mean a hospital described in subdivision (b) of Section 14169.1.

(f) “Days data source” means the hospital’s Annual Financial Disclosure Report filed with the Office of Statewide Health Planning and Development as of May 5, 2011, for its fiscal year ending during 2009.

(g) “Designated public hospital” shall have the meaning given in subdivision (d) of Section 14166.1 as of January 1, 2011.

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

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

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

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

(2) With the exception of a hospital that is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, a hospital that is a hospital designated as a specialty hospital in the hospital’s Office of Statewide Health Planning and Development Hospital Annual Financial Disclosure Report for the hospital’s fiscal year ending in the 2009 calendar year.

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

(4) A small and rural hospital as specified in Section 124840 of the Health and Safety Code designated as that in the hospital’s Office of Statewide Health Planning and Development Hospital Annual Financial Disclosure Report for the hospital’s fiscal year ending in the 2009 calendar year.

(i) “Federal approval” means the approval by the federal government of both the quality assurance fee established pursuant to this article and the supplemental payments to private hospitals described in Sections 14169.2 and 14169.3.

(j) (1) “Fee-for-service per diem quality assurance fee rate” means a fixed daily fee on fee-for-service days.

(2) The fee-for-service per diem quality assurance fee rate shall be three hundred nine dollars and eighty-six cents ($309.86) per day.

(3) Upon federal approval or conditional federal approval described in Section 14169.34, the director shall determine the fee-for-service per diem quality assurance fee rate based on the funds required to make the payments specified in Article 5.228 (commencing with Section 14169.1), in consultation with the hospital community.

(k) “Fee-for-service days” means inpatient hospital days where the service type is reported as “acute care,” “psychiatric care,” and “rehabilitation care,” and the payer category is reported as “Medicare traditional,” “county indigent programs-traditional,” “other third parties-traditional,” “other indigent,” and “other payers,” for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(l) “Fee percentage” means a fraction, expressed as a percentage, the numerator of which is the amount of payments for each subject fiscal year under Sections 14169.2, 14169.3, 14169.5, and 14169.7.5, for which federal financial participation is available and the denominator of which is four billion eight hundred ninety-seven million eight hundred sixty-six thousand nine hundred thirty-seven dollars ($4,897,866,937).

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

(n) “Hospital community” means any hospital industry organization or system that represents hospitals.

(o) “Managed care days” means inpatient hospital days where the service type is reported as “acute care,” “psychiatric care,” and “rehabilitation care,” and the payer category is reported as “Medicare managed care,” “county indigent programs-managed care,” and “other third parties-managed care,” for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(p) “Managed care per diem quality assurance fee rate” means a fixed fee on managed care days of eighty-six dollars and forty cents ($86.40) per day.

(q) “Medi-Cal days” means inpatient hospital days where the service type is reported as “acute care,” “psychiatric care,” and “rehabilitation care,” and the payer category is reported as “Medi-Cal traditional” and “Medi-Cal managed care,” for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(r) “Medi-Cal fee-for-service days” means inpatient hospital days where the service type is reported as “acute care,” “psychiatric care,” and “rehabilitation care,” and the payer category is reported as “Medi-Cal traditional” for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

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

(t) “Medi-Cal per diem quality assurance fee rate” means a fixed fee on Medi-Cal days of three hundred eighty-three dollars and twenty cents ($383.20) per day.

(u) “New hospital” means a hospital operation, business, or facility functioning under current or prior ownership as a private hospital that does not have a days data source or a hospital that has a days data source in whole, or in part, from a previous operator where there is an outstanding monetary liability owed to the state in connection with the Medi-Cal program and the new operator did not assume liability for the outstanding monetary obligation.

(v) “Nondesignated public hospital” means either of the following:

(1) A public hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not

designated as a specialty hospital in the hospital's Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2009, and satisfies the definition in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(2) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2009, is operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(w) "Prepaid health plan hospital" means a hospital owned by a nonprofit public benefit corporation that shares a common board of directors with a nonprofit health care service plan.

(x) "Prepaid health plan hospital managed care per diem quality assurance fee rate" means a fixed fee on non-Medi-Cal managed care days for prepaid health plan hospitals of forty-eight dollars and thirty-eight cents ($48.38) per day.

(y) "Prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate" means a fixed fee on Medi-Cal managed care days for prepaid health plan hospitals of two hundred fourteen dollars and fifty-nine cents ($214.59) per day.

(z) "Prior fiscal year data" means any data taken from sources that the department determines are the most accurate and reliable at the time the determination is made, or may be calculated from the most recent audited data using appropriate update factors. The data may be from prior fiscal years, current fiscal years, or projections of future fiscal years.

(aa) "Private hospital" means a hospital that meets all of the following conditions:

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

(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2009.

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

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

(ab) "Program period" means the period from July 1, 2011, to December 31, 2013, inclusive.

(ac) "Subject fiscal quarter" means a state fiscal quarter during the program period.

(ad) "Subject fiscal year" means a state fiscal year that ends after July 1, 2011, and begins before January 1, 2014.

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

SEC. 103. Section 14169.32 of the Welfare and Institutions Code is amended to read:

14169.32. (a) There shall be imposed on each general acute care hospital that is not an exempt facility a quality assurance fee, provided that a quality assurance fee under this article shall not be imposed on a converted hospital.

(b) The quality assurance fee shall be computed starting on July 1, 2011, and continue through and including December 31, 2013.

(c) Subject to Section 14169.34, upon receipt of federal approval, the following shall become operative:

(1) Within 10 business days following receipt of the notice of federal approval from the federal government, the department shall send notice to each hospital subject to the quality assurance fee, and publish on its Internet

Web site, the following information:

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

(B) The fee percentage for each subject fiscal year.

(2) The notice to each hospital subject to the quality assurance fee shall also state the following:

(A) The aggregate quality assurance fee after the application of the fee percentage for each subject fiscal year.

(B) The aggregate quality assurance fee.

(C) The amount of each payment due from the hospital with respect to the aggregate quality assurance fee.

(D) The date on which each payment is due.

(3) The hospitals shall pay the aggregate quality assurance fee in 10 equal installments. The department shall establish the date that each installment is due, provided that the first installment shall be due no earlier than 20 days following the department sending the notice pursuant to paragraph (1), and the installments shall be paid at least one month apart, but if possible, the installments shall be paid on a quarterly basis.

(4) Notwithstanding paragraph (3), the amount of each hospital's aggregate quality assurance fee after the application of the fee percentage that has not been paid by the hospital before December 15, 2013, pursuant to paragraph (3), shall be paid by the hospital no later than December 15, 2013.

(d) The quality assurance fee, as paid pursuant to this section, shall be paid by each hospital subject to the fee to the department for deposit in the Hospital Quality Assurance Revenue Fund. Deposits may be accepted at any time and will be credited toward the program period.

(e) This section shall become inoperative if the federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before July 1, 2014, the implementation of the quality assurance fee pursuant to this article or the supplemental payments to private hospitals described in Sections 14169.2 and 14169.3, and either or both provisions cannot be modified by the department pursuant to subdivision (d) of Section 14169.33 in order to meet the requirements of federal law or to obtain federal approval.

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

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

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

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

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

(j) The department shall work in consultation with the hospital community to implement this article and Article 5.228 (commencing with Section 14169.1).

(k) This subdivision creates a contractually enforceable promise on behalf of the state to use the proceeds of the quality assurance fee, including any federal matching funds, solely and exclusively for the purposes set forth in

this article as they existed on the effective date of this article, to limit the amount of the proceeds of the quality assurance fee to be used to pay for the health care coverage of children to the amounts specified in this article, to limit any payments for the department's costs of administration to the amounts set forth in this article on the effective date of this article, to maintain and continue prior reimbursement levels as set forth in Section 14169.12 on the effective date of that article, and to otherwise comply with all its obligations set forth in Article 5.228 (commencing with Section 14169.1) and this article provided that amendments that arise from, or have as a basis, a decision, advice, or determination by the federal Centers for Medicare and Medicaid Services relating to federal approval of the quality assurance fee or the payments set forth in this article or Article 5.228 (commencing with Section 14169.1) shall control for the purposes of this subdivision.

(l) (1) Effective January 1, 2014, the rates payable to hospitals and managed health care plans under Medi-Cal shall be the rates then payable without the supplemental and increased capitation payments set forth in Article 5.228 (commencing with Section 14169.1).

(2) The supplemental payments and other payments under Article 5.228 (commencing with Section 14169.1) shall be regarded as quality assurance payments, the implementation or suspension of which does not affect a determination of the adequacy of any rates under federal law.

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

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

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

(4) If fee payments are remitted to the department after the date determined by the department to be the final date for calculating the final supplemental payments under this article and Article 5.228 (commencing with Section 14169.1), the fee payments shall be retained in the fund for purposes of funding supplemental payments supported by a hospital quality assurance fee program implemented under subsequent legislation, provided, however, that if supplemental payments are not implemented under subsequent legislation, then those fee payments shall be deposited in the Distressed Hospital Fund.

(5) If during the implementation of this article, fee payments that were due under Article 5.21 (commencing with Section 14167.1) and Article 5.22 (commencing with Section 14167.31), or Article 5.226 (commencing with Section 14168.1) and Article 5.227 (commencing with Section 14168.31), are remitted to the department under a payment plan or for any other reason, and the final date for calculating the final supplemental payments under those articles has passed, then those fee payments shall be deposited in the fund to support the uses established by this article.

SEC. 104. Section 14169.33 of the Welfare and Institutions Code is amended to read:

14169.33. (a) (1) All fees required to be paid to the state pursuant to this article shall be paid in the form of remittances payable to the department.

(2) The department shall directly transmit the fee payments to the Treasurer to be deposited in the Hospital Quality Assurance Revenue Fund, created pursuant to Section 14167.35. Notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on deposits in the fund from the proceeds of the fee assessed pursuant to this article shall be retained in the fund for purposes specified in subdivision (b).

(b) Notwithstanding subdivision (c) of Section 14167.35 and subdivision (b) of Section 14168.33, all funds from the proceeds of the fee assessed pursuant to this article in the Hospital Quality Assurance Revenue Fund, together with any interest and dividends earned on money in the fund, shall, upon appropriation by the Legislature, continue to be used exclusively to enhance federal financial participation for hospital services under the Medi-Cal program, to provide additional reimbursement to, and to support quality improvement efforts of, hospitals, and to minimize uncompensated care provided by hospitals to uninsured patients, as well as to pay for the state's administrative costs and to provide funding for children's health coverage, in the following order

of priority:

(1) To pay for the department's staffing and administrative costs directly attributable to implementing Article 5.228 (commencing with Section 14169.1) and this article, not to exceed two million five hundred thousand dollars ($2,500,000) for the program period.

(2) To pay for the health care coverage for children in the amount of eighty-five million dollars ($85,000,000) for each subject fiscal quarter during the 2011–12 subject fiscal year, in the amount of one hundred thirty-four million two hundred fifty thousand dollars ($134,250,000) for each subject fiscal quarter during the 2012–13 subject fiscal year, and in the amount of one hundred forty-four million two hundred fifty thousand dollars ($144,250,000) for each subject fiscal quarter during the 2013–14 subject fiscal year.

(3) To make increased capitation payments to managed health care plans pursuant to Article 5.228 (commencing with Section 14169.1).

(4) To reimburse the General Fund for the increase in the overall compensation to a private hospital that is attributable to its change in status from contract hospital to noncontract hospital, pursuant to subdivision (a) of Section 14169.10.

(5) To make increased payments or grants to hospitals pursuant to Article 5.228 (commencing with Section 14169.1).

(6) To make increased payments to mental health plans pursuant to Article 5.228 (commencing with Section 14169.1).

(7) To make supplemental payments for out-of-network emergency and poststabilization services provided by private hospitals and nondesignated public hospitals to Medi-Cal expansion enrollees in the Low Income Health Program in the amount of thirty-seven million five hundred thousand dollars ($37,500,000) for each fiscal quarter pursuant to Section 14169.7.5.

(c) Any amounts of the quality assurance fee collected in excess of the funds required to implement subdivision (b), including any funds recovered under subdivision (d) of Section 14169.13 or subdivision (e) of Section 14169.38, shall be refunded to general acute care hospitals, pro rata with the amount of quality assurance fee paid by the hospital, subject to the limitations of federal law. If federal rules prohibit the refund described in this subdivision, the excess funds shall be deposited in the Distressed Hospital Fund to be used for the purposes described in Section 14166.23, and shall be supplemental to and not supplant existing funds.

(d) Any methodology or other provision specified in Article 5.228 (commencing with Section 14169.1) or this article may be modified by the department, in consultation with the hospital community, to the extent necessary to meet the requirements of federal law or regulations to obtain federal approval or to enhance the probability that federal approval can be obtained, provided the modifications do not violate the spirit and intent of Article 5.228 (commencing with Section 14169.1) or this article and are not inconsistent with the conditions of implementation set forth in Section 14169.40.

(e) The department, in consultation with the hospital community, shall make adjustments, as necessary, to the amounts calculated pursuant to Section 14169.32 in order to ensure compliance with the federal requirements set forth in Section 433.68 of Title 42 of the Code of Federal Regulations or elsewhere in federal law.

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

(g) 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 this article or Article 5.228 (commencing with Section 14169.1) by means of provider bulletins, all plan letters, or other similar instruction, without taking regulatory action. The department shall also provide notification to the Joint Legislative Budget Committee and to the appropriate policy and fiscal committees of the Legislature within five working days when the above-described action is taken in order to inform the Legislature that the action is being implemented.

SEC. 105. Section 14169.34 of the Welfare and Institutions Code is amended to read:

14169.34. (a) Notwithstanding any other provision of this article or Article 5.228 (commencing with Section 14169.1) requiring federal approvals, the department may impose and collect the quality assurance fee and may make payments under this article and Article 5.228 (commencing with Section 14169.1), including increased capitation payments, based upon receiving a letter from the federal Centers for Medicare and Medicaid Services or the United States Department of Health and Human Services that indicates likely federal approval, but only if and to the extent that the letter is sufficient as set forth in subdivision (b).

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

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

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

(c) Nothing in this section shall be construed as modifying the requirement under Section 14169.13 that payments shall be made only to the extent a sufficient amount of funds collected as the quality assurance fee are available to cover the nonfederal share of those payments.

(d) Upon notice from the federal government that final federal approval for the fee model under this article or for the supplemental payments to private hospitals under Section 14169.2 or 14169.3 has been denied, any fees collected pursuant to this section shall be refunded and any payments made pursuant to this article or Article 5.228 (commencing with Section 14169.1) shall be recouped, including, but not limited to, supplemental payments, increased capitation payments, payments to hospitals by health care plans resulting from the increased capitation payments, increased payments to mental health plans, and payments for the health care coverage of children. To the extent fees were paid by a hospital that also received payments under this section, the payments may first be recouped from fees that would otherwise be refunded to the hospital prior to the use of any other recoupment method allowed under law.

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

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

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

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

(g) The department may draw against the Hospital Quality Assurance Revenue Fund for all administrative costs associated with implementation under this article or Article 5.228 (commencing with Section 14169.1).

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

SEC. 106. Section 14169.36 of the Welfare and Institutions Code is amended to read:

14169.36. (a) Upon receipt of a letter that indicates likely federal approval that the director determines is sufficient for implementation under Section 14169.34, or upon the receipt of federal approval, the following shall occur:

(1) To the maximum extent possible, and consistent with the availability of funds in the Hospital Quality Assurance Revenue Fund, the department shall make all of the payments under Sections 14169.2, 14169.3, 14169.5, 14169.7, and 14169.7.5, including, but not limited to, supplemental payments and increased capitation payments, prior to January 1, 2014, except that the increased capitation payments under Section 14169.5 shall not be made until federal approval is obtained for these payments.

(2) The department shall make supplemental payments to hospitals under Article 5.228 (commencing with Section 14169.1) consistent with the timeframe described in Section 14169.11 or a modified timeline developed pursuant to Section 14169.35.

(b) Notwithstanding any other provision of this article or Article 5.228 (commencing with Section 14169.1), if the director determines, on or after December 15, 2013, that there are insufficient funds available in the Hospital Quality Assurance Revenue Fund to make all scheduled payments under Article 5.228 (commencing with Section 14169.1) before January 1, 2014, he or she shall consult with representatives of the hospital community to develop an acceptable plan for making additional payments to hospitals and managed health care plans to maximize the use of delinquent fee payments or other deposits or interest projected to become available in the fund after December 15, 2013, but before June 15, 2014.

(c) Nothing in this section shall require the department to continue to make payments under Article 5.228 (commencing with Section 14169.1) if, after the consultation required under subdivision (b), the director determines in the exercise of his or her sole discretion that a workable plan for the continued payments cannot be developed.

(d) Subdivisions (b) and (c) shall be implemented only if and to the extent federal financial participation is available for continued supplemental payments and to providers and continued increased capitation payments to managed health care plans.

(e) If any payment or payments made pursuant to this section are found to be inconsistent with federal law, the department shall recoup the payments by means of withholding or any other available remedy.

(f) Nothing in this section shall be read as affecting the department's ongoing authority to continue, after December 31, 2013, to collect quality assurance fees imposed on or before December 31, 2013.

SEC. 107. Section 14169.38 of the Welfare and Institutions Code is amended to read:

14169.38. (a) This article shall be implemented only as long as all of the following conditions are met:

(1) Subject to Section 14169.33, the quality assurance fee is established in a manner that is fundamentally consistent with this article.

(2) The quality assurance fee, including any interest on the fee after collection by the department, is deposited in a segregated fund apart from the General Fund.

(3) The proceeds of the quality assurance fee, including any interest and related federal reimbursement, may only be used for the purposes set forth in this article.

(b) No hospital shall be required to pay the quality assurance fee to the department unless and until the state receives and maintains federal approval.

(c) Hospitals shall be required to pay the quality assurance fee to the department as set forth in this article only as long as all of the following conditions are met:

(1) The federal Centers for Medicare and Medicaid Services allows the use of the quality assurance fee as set forth in this article in accordance with federal approval.

(2) Article 5.228 (commencing with Section 14169.1) is enacted and remains in effect and hospitals are reimbursed the increased rates for services during the program period, as defined in Section 14169.1.

(3) The full amount of the quality assurance fee assessed and collected pursuant to this article remains available only for the purposes specified in this article.

(d) This article shall become inoperative if either of the following occurs:

(1) In the event, and on the effective date, of a final judicial determination made by any court of appellate jurisdiction or a final determination by the United States Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services that the quality assurance fee established pursuant to this article or any provision of Section 14166.115 cannot be implemented.

(2) In the event both of the following conditions exist:

(A) The federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before January 1, 2014, the implementation of Sections 14169.2 and 14169.3 or this article.

(B) Section 14169.2, Section 14169.3, or this article cannot be modified by the department pursuant to subdivision (d) of Section 14169.33 in order to meet the requirements of federal law or to obtain federal

approval.

(e) If this article becomes inoperative pursuant to paragraph (1) of subdivision (d) and the determination applies to any period or periods of time prior to the effective date of the determination, the department may recoup all payments made pursuant to Article 5.228 (commencing with Section 14169.1) during that period or those periods of time.

(f) (1) In the event that all necessary final federal approvals are not received as described and anticipated under this article or Article 5.228 (commencing with Section 14169.1), the director shall have the discretion and authority to develop procedures for recoupment from managed health care plans, and from hospitals under contract with managed health care plans, of any amounts received pursuant to this article or Article 5.228 (commencing with Section 14169.1).

(2) Any procedure instituted pursuant to this subdivision shall be developed in consultation with representatives from managed health care plans and representatives of the hospital community.

(3) Any procedure instituted pursuant to this subdivision shall be in addition to all other remedies made available under the law, pursuant to contracts between the department and the managed health care plans, or pursuant to contracts between the managed health care plans and the hospitals.

SEC. 108. Section 14171 of the Welfare and Institutions Code is amended to read:

14171. (a) The director shall establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination made pursuant to Sections 10722 and 14170 and for final settlements, including, in the case of hospitals, the application of Sections 51536, 51537, and 51539 of Title 22 of the California Code of Regulations. All these processes shall be established by regulation, pursuant to, and consistent with, Section 100171 of the Health and Safety Code.

(b) Different administrative appeal processes may be established by the director for grievances or complaints arising from the determinations of a tentative or final settlement based on audit or examination findings made by or on behalf of the department pursuant to Sections 10722 and 14170. However, consistent with existing practice, no administrative appeal shall be available for tentative settlement of cost reports.

(c) The administrative appeal process established by the director for tentative settlements, including, in the case of hospitals, the application of Sections 51536, 51537, and 51539 of Title 22 of the California Code of Regulations shall be an informal process which, however, guarantees a provider the right to present any grievance or complaint to the department in writing. Any subsequent hearings shall be conducted in an informal manner and shall be held at the discretion of the department.

(d) The time limitations in subdivisions (e) and (f) for the impartial hearing and the final decisions are mandatory. If the department fails to conduct the hearing or to adopt a final decision thereon within the time limitations provided in subdivisions (e) and (f), the amount of any overpayment which is ultimately determined by the department to be due shall be reduced by 10 percent for each 30-day period, or portion thereof, that the hearing or the decision, or both, are delayed beyond the time limitations provided in subdivisions (e) and (f). However, the time period shall be extended by either of the following:

(1) Delay caused by a provider.

(2) Extensions of time granted a provider at its sole request or at the joint request of the provider and the department.

(e) (1) The administrative appeal process established by the director shall commence with an informal conference with the provider, a representative of the department, and the administrative law judge. The informal conference shall be conducted no later than 90 days after the filing of a timely and specific statement of disputed issues by the provider. The administrative law judge, when appropriate, may assign the administrative appeal to an informal level of review where efforts could be made to resolve facts and issues in dispute in a fair and equitable manner, subject to the requirements of state and federal law. The review conducted at this informal level shall be completed no later than 180 days after the filing of a timely and specific statement of disputed issues by the provider.

(2) Nothing in this subdivision shall prohibit the provider from presenting any unresolved grievances or complaints at an impartial hearing pursuant to subdivision (a). The impartial hearing shall be conducted no later than 300 days after the filing of a timely and specific statement of disputed issues by the provider.

(3) (A) Subject to subdivision (f), a final decision in a noninstitutional provider appeal shall be adopted within 180 days after the closure of the record of the impartial hearing, and a final decision in an institutional provider appeal shall be adopted within 300 days after the closure of the record of the impartial hearing.

(B) The department shall mail a copy of the adopted decision to all parties within 30 days of the date of adoption of the decision.

(f) In the event the director intends to modify a proposed decision, on or before the 180th day following the closure of the record of the hearing for noninstitutional providers or the 300th day following the closure of the record of the hearing for institutional providers, the director shall provide written notice of his or her intention to the parties and shall afford the parties an opportunity to present written argument. Following this notice, on or before the 240th day following the closure of the record of the hearing for noninstitutional providers or the 420th day following closure of the record of the hearing for institutional providers, or within that additional time period as is granted pursuant to the sole request of a provider or at the joint request of the provider and the department, the director shall issue a final decision.

(g) In the event recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of a disallowed payment shall be entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7 percent per annum, whichever is higher, commencing on the date the appeal is formally accepted by the department or the date payment is received by the department, whichever is later.

(h) Except as provided in subdivision (i), commencing 60 days after issuance of the first statement of account status or demand for repayment resulting from an audit or examination made pursuant to Sections 10722 and 14170, interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund during the month the first statement of account status or demand for repayment was issued, or simple interest at the rate of 7 percent per annum, whichever is higher, shall be assessed against any unrecovered overpayment due to the department.

(i) (1) Commencing on the day following the last day of the period covered by an audit or examination made pursuant to Sections 10722 and 14170, interest at the rate established under Section 19269 of the Revenue and Taxation Code which is in effect on the date of the commencement of that interest shall be assessed against any unrecovered overpayment due to the department by providers of durable medical equipment or incontinence supplies.

(2) Interest which accrues under this subdivision for recoupment of an overpayment based on the lack of medical necessity for a previously approved claim shall commence to accrue on the date of written demand by the department.

(j) The final decision of the director shall be reviewable in accordance with Section 1094.5 of the Code of Civil Procedure within six months of the issuance of the director's final decision.

SEC. 109. Section 14182.4 of the Welfare and Institutions Code is amended to read:

14182.4. (a) To the extent authorized under a federal waiver or demonstration project described in Section 14180 that is approved by the federal Centers for Medicare and Medicaid Services, the department shall establish a program of investment, improvement, and incentive payments for designated public hospitals and, to the extent federal approval is obtained pursuant to subdivision (c) of Section 14166.155, for nondesignated public hospitals to encourage and incentivize delivery system transformation and innovation in preparation for the implementation of federal health care reform.

(b) The Public Hospital Investment, Improvement, and Incentive Fund is hereby established in the State Treasury. Notwithstanding Section 13340 of the Government Code, moneys in the fund shall be continuously appropriated, without regard to fiscal years, to the department for the purposes specified in this section.

(c) The fund shall consist of any moneys that a county, other political subdivision of the state, or other governmental entity in the state that may elect to transfer to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

(d) Moneys in the fund shall be used as the source for the nonfederal share of investment, improvement, and incentive payments as authorized under a federal waiver or demonstration project to participating designated public hospitals and, to the extent federal approval is obtained pursuant to subdivision (c) of Section

14166.155, to nondesignated public hospitals, defined in subdivisions (d) and (f) of Section 14166.1 respectively, and the governmental entities with which they are affiliated, that provide the intergovernmental transfers for deposit into the fund.

(e) The department shall obtain federal financial participation for moneys in the fund to the full extent permitted by law. Moneys shall be allocated from the fund by the department and used as the nonfederal share for claiming federal funds in accordance with the Special Terms and Conditions of the waiver or demonstration project and Sections 14166.77 and 14166.155, to the extent federal approval is obtained pursuant to subdivision (c) of Section 14166.151, as applicable. The moneys disbursed from the fund, and all associated federal financial participation, shall be distributed only to the designated public hospitals and the governmental entities with which they are affiliated, and to the extent federal approval is obtained pursuant to subdivision (c) of Section 14166.155, to nondesignated public hospitals as described in subdivision (a) and the governmental entities with which they are affiliated.

(f) Participation under this section is voluntary on the part of the county or other political subdivision for purposes of all applicable federal laws. As part of its voluntary participation in the nonfederal share of payments under this section, the county or other political subdivision agrees to reimburse the state for the nonfederal share of state staffing or administrative costs directly attributable to implementation of this section. This section shall be implemented only to the extent federal financial participation is not jeopardized.

(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may clarify, interpret, or implement the provisions of this section by means of provider bulletins or similar instructions. The department shall notify the fiscal and appropriate policy committees of the Legislature of its intent to issue instructions under this section at least five days in advance of the issuance.

SEC. 110. Section 14182.45 of the Welfare and Institutions Code is amended to read:

14182.45. (a) In consultation with the designated public hospitals, as defined in subdivision (d) of Section 14166.1, and to the extent it does not impede the ability of the designated public hospitals to meet the requirements and conditions for delivery system reform incentive payments authorized under Sections 14166.77 and 14182.4, the state may provide for milestone incentive payments to private disproportionate share hospitals and nondesignated public disproportionate share hospitals to create incentives for improvement activities towards, and achievement of, delivery system transformation. The milestone incentive payments to private disproportionate share hospitals and nondesignated public disproportionate share hospitals shall be structured in accordance with the requirements and conditions for delivery system reform incentive payments set forth in the Special Terms and Conditions and as approved by the federal Centers for Medicare and Medicaid Services. Incentive payments may be funded by voluntary intergovernmental transfers made by the designated public hospitals and nondesignated public hospitals. All incentive pool funding, including any potential private and nondesignated public hospital subpools, shall be limited to the total amount of incentive pool funding allowed for delivery system reform incentive payments as set forth in the Special Terms and Conditions.

(b) Upon federal approval of the reimbursement methodology in subdivision (b) of Section 14166.151, this section shall become inoperative.

SEC. 111. Section 14183.6 of the Welfare and Institutions Code is amended to read:

14183.6. The department shall enter into an interagency agreement with the Department of Managed Health Care to have the Department of Managed Health Care, on behalf of the department, conduct financial audits, medical surveys, and a review of the provider networks of the managed care health plans participating in the demonstration project and the Medi-Cal managed care expansion into rural counties, and to provide consumer assistance to beneficiaries affected by Sections 14182.16 and 14182.17. The interagency agreement shall be updated, as necessary, on an annual basis in order to maintain functional clarity regarding the roles and responsibilities of these core activities. The department shall not delegate its authority under this division to the Department of Managed Health Care.

SEC. 112. Section 14204 of the Welfare and Institutions Code is amended to read:

14204. (a) Pursuant to the provisions of this chapter, the department may contract with one or more prepaid health plans in order to provide the benefits authorized under this chapter and Chapter 7 (commencing with Section 14000) of this part. The department may contract with one or more children's hospitals on an exclusive

basis for a specified population in a specified geographic area. Contracts entered into pursuant to this chapter may be awarded on a bid or nonbid basis.

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

(c) The department shall amend contracts with dental health plans in effect on the date the act that added this subdivision and Section 14459.6 become effective to provide Medi-Cal dental services authorized under this chapter and Chapter 7 (commencing with Section 14000) to Medi-Cal beneficiaries who reside in a specified geographic area to meet the requirements of Sections 14089.09 and 14459.6.

SEC. 113. Section 14301.1 of the Welfare and Institutions Code is amended to read:

14301.1. (a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health-plan- and county-specific rates. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

(1) Health-plan-specific encounter and claims data.

(2) Supplemental utilization and cost data submitted by the health plans.

(3) Fee-for-service data for the underlying county of operation or other appropriate counties as deemed necessary by the department.

(4) Department of Managed Health Care financial statement data specific to Medi-Cal operations.

(5) Other demographic factors, such as age, gender, or diagnostic-based risk adjustments, as the department deems appropriate.

(b) To the extent that the department is unable to obtain sufficient actual plan data, it may substitute plan model, similar plan, or county-specific fee-for-service data.

(c) The department shall develop rates that include administrative costs, and may apply different administrative costs with respect to separate aid code groups.

(d) The department shall develop rates that shall include, but are not limited to, assumptions for underwriting, return on investment, risk, contingencies, changes in policy, and a detailed review of health plan financial statements to validate and reconcile costs for use in developing rates.

(e) The department may develop rates that pay plans based on performance incentives, including quality indicators, access to care, and data submission.

(f) The department may develop and adopt condition-specific payment rates for health conditions, including, but not limited to, childbirth delivery.

(g) (1) Prior to finalizing Medi-Cal managed care capitation rates, the department shall provide health plans with information on how the rates were developed, including rate sheets for that specific health plan, and provide the plans with the opportunity to provide additional supplemental information.

(2) For contracts entered into between the department and any entity pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7, the department, by June 30 of each year, or, if the budget has not passed by that date, no later than five working days after the budget is signed, shall provide preliminary rates for the upcoming fiscal year.

(h) For the purposes of developing capitation rates through implementation of this ratesetting methodology, Medi-Cal managed care health plans shall provide the department with financial and utilization data in a form and substance as deemed necessary by the department to establish rates. This data shall be considered proprietary and shall be exempt from disclosure as official information pursuant to subdivision (k) of Section 6254 of the Government Code as contained in the California Public Records Act (Division 7 (commencing with

Section 6250) of Title 1 of the Government Code).

(i) The department shall report, upon request, to the fiscal and policy committees of the respective houses of the Legislature regarding implementation of this section.

(j) Prior to October 1, 2011, the risk-adjusted countywide capitation rate shall comprise no more than 20 percent of the total capitation rate paid to each Medi-Cal managed care plan.

(k) (1) It is the intent of the Legislature to preserve the policy goal to support and strengthen traditional safety net providers who treat high volumes of uninsured and Medi-Cal patients when Medi-Cal enrollees are defaulted into Medi-Cal managed care plans.

(2) As the department adds additional factors, such as managed care plan costs, to the Medi-Cal managed care plan default assignment algorithm, it shall consult with the Auto Assignment Performance Incentive Program stakeholder workgroup to develop cost factor disregards related to intergovernmental transfers and required wraparound payments that support safety net providers.

SEC. 114. Section 14459.6 is added to the Welfare and Institutions Code, to read:

14459.6. (a) The department shall establish a list of performance measures to ensure dental health plans meet quality criteria required by the department. The list shall specify the benchmarks used by the department to determine whether and the extent to which a dental health plan meets each performance measure. Commencing January 1, 2013, and quarterly thereafter, the list of performance measures established by the department along with each plan's performance shall be posted on the department's Internet Web site. The Department of Managed Health Care and the advisory committee established pursuant to Section 14089.08 shall have access to all performance measures and benchmarks used by the department as described in this section.

(1) The performance measures established by the department shall include, but not be limited to, all of the following: provider network adequacy, overall utilization of dental services, annual dental visits, use of preventive dental services, use of dental treatment services, use of examinations and oral health evaluations, sealant to restoration ratio, filling to preventive services ratio, treatment to caries prevention ratio, use of dental sealants, use of diagnostic services, and survey of member satisfaction with plans and providers.

(2) The survey of member satisfaction with plans and providers shall be the same dental version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as used by the Healthy Families Program.

(3) The department shall notify dental health plans at least 30 days prior to the implementation date of these performance measures.

(4) The department shall include the initial list of performance measures and benchmarks in any dental health contracts entered into between the department and a dental health plan pursuant to Section 14204.

(5) The department shall update performance measures and benchmarks and establish additional performance measures and benchmarks in accordance with all of the following:

(A) The department shall consider performance measures and benchmarks established by other states, the federal government, and national organizations developing dental program performance and quality measures.

(B) The department shall notify dental health plans at least 30 days prior to the implementation date of updates or changes to performance measures and benchmarks. The department shall also post these updates or changes on its Internet Web site at least 30 days prior to implementation in order to provide transparency to the public.

(C) To ensure that the dental health needs of Medi-Cal beneficiaries are met, the department shall, when evaluating performance measures and benchmarks for retention on, addition to, or deletion from the list, consider all of the following criteria:

(i) Monthly, quarterly, annual, and multiyear Medi-Cal dental managed care trended data.

(ii) County and statewide Medi-Cal dental fee-for-service performance and quality ratings.

(iii) Other state and national dental program performance and quality measures.

(iv) Other state and national performance ratings.

(b) In establishing and updating the performance measures and benchmarks, the department shall consult the advisory committee established pursuant to Section 14089.08, as well as dental health plan representatives and other stakeholders, including representatives from counties, local dental societies, nonprofit entities, legal aid entities, and other interested parties.

(c) In evaluating a dental health plan's ability to meet the criteria established through the performance measures and benchmarks, the department shall select specific performance measures from those established by the department in subdivision (a) as the basis for establishing financial or other incentives or disincentives, including, but not limited to, bonuses, payment withholds, and adjustments to beneficiary assignment to plan algorithms. These incentives and disincentives shall be included in the dental health plan contracts.

(d) (1) The department shall designate an external quality review organization (EQRO) that shall conduct external quality reviews for any dental health plan contracting with the department pursuant to Section 14204.

(2) As determined by the department, but at least annually, dental health plans shall arrange for an external quality of care review with the EQRO designated by the department that evaluates the dental health plan's performance in meeting the performance measures established in this section. Dental health plans shall cooperate with and assist the EQRO in this review. The Department of Managed Health Care shall have direct access to all external quality of care review information upon request to the department.

(3) An external quality of care review shall include, but not be limited to, all of the following: performance on the selected performance measures and benchmarks established and updated by the department, the CAHPS member or consumer satisfaction survey referenced in paragraph (2) of subdivision (a), reporting systems, and methodologies for calculating performance measures. An external quality of care review that includes all of the above components shall be paid for by the dental health plan and posted online annually, or at any other frequency specified by the department, on the department's Internet Web site.

(e) All marketing methods and activities to be used by dental plans shall comply with subdivision (b) of Section 10850, Sections 14407.1, 14408, 14409, 14410, and 14411, and Title 22 of the California Code of Regulations, including Sections 53880 and 53881. Each dental plan shall submit its marketing plan to the department for review and approval.

(f) Each dental plan shall submit its member services procedures, beneficiary informational materials, and any updates to those procedures or materials to the department for review and approval. The department shall ensure that member services procedures and beneficiary informational materials are clear and provide timely and fair processes for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits.

(g) Each dental plan shall submit its provider compensation agreements to the department for review and approval.

(h) The department shall post to its Internet Web site a copy of all final reports completed by the Department of Managed Health Care regarding dental managed care plans.

SEC. 115. Section 14459.8 is added to the Welfare and Institutions Code, to read:

14459.8. (a) By no later than March 15, 2013, with annual updates thereafter, the department shall provide the fiscal and appropriate policy committees of the Legislature with either a comprehensive report or separate reports on dental managed care in the Counties of Sacramento and Los Angeles. This report shall articulate specific changes and improvements implemented to increase Medi-Cal beneficiary access to preventive services and dental treatment, the utilization of services, and beneficiary satisfaction. Key measures, outcomes, and department findings pertaining to participating dental managed care plans and provider networks shall also be included.

(b) Any report provided pursuant to subdivision (a) on the County of Sacramento shall also provide data regarding the outcomes and findings from the beneficiary dental exception (BDE) process implemented by the department pursuant to Section 14089.09, including the consideration of voluntary enrollment in the County of Sacramento as compared to the existing mandatory enrollment.

(c) The department may seek foundation funding or federal grant funding to facilitate data analysis and reporting as applicable for this purpose.

SEC. 116. Section 14500.5 of the Welfare and Institutions Code is amended to read:

14500.5. (a) It is the intent of the Legislature that family planning includes, but is not limited to, an effective means to improve reproductive health by disease prevention and treatment, to reduce the incidence of unintended pregnancies, and to reduce the demand for abortions. It is the intent of the Legislature that no family planning shall be expended other than for the services enumerated in this chapter. It is also the intent of the Legislature that no funds received pursuant to this chapter be used for abortions or services ancillary to abortions.

(b) For purposes of this chapter, the following definitions shall apply:

(1) "Family planning" means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, natural family planning, abstinence methods, and the management of infertility. Family planning services include preconceptional counseling, maternal and fetal health counseling, and general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, and other services as described in Section 14503, except for abortions and services ancillary to abortions as prohibited in Section 14509. Family planning does not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care which is not incident to the diagnosis of a pregnancy, except as otherwise provided for in this chapter.

(2) "Abortion as a method of family planning" means the deliberate choice of abortion over other methods to limit the number, gender, and spacing of children, including, but not limited to, contraception, abstinence, and natural family planning methods.

(3) "Department" means the State Department of Health Care Services.

(4) "Director" means the Director of Health Care Services.

(5) "Grantee" means an agency, institution, or organization approved by the department to provide family planning services pursuant to this chapter.

SEC. 117. 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) (1) 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, except that for the LIHP year ending June 30, 2012, the rate may apply as early as July 1, 2011, without regard to the date of the agreement between the participating entity and the department.

(2) (A) The department finds and declares all of the following:

(i) The department, in consultation with a number of the LIHPs, has proposed LIHP capitation rates for federal approval.

(ii) There is some concern that federal approval of the proposed rates will not be received, and implementing contracts may not be signed, before June 30, 2012.

(iii) The amendments made to this subdivision by the act that added this clause would allow the federally approved capitation rates to apply to the LIHP year, which is July 1, 2011, to June 30, 2012, inclusive, even if federal approval and the necessary contract amendments are not finalized until after June 30, 2012.

(B) Therefore, it is the intent of the Legislature in amending this subdivision to allow the LIHP capitation rates to apply for the 2011–12 fiscal year even if final agreements on the capitation rates are delayed while awaiting

federal approval and are not finalized until after June 30, 2012.

(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. 118. Section 15911.1 is added to the Welfare and Institutions Code, to read:

15911.1. Upon the order of the Director of Finance, the Controller shall draw warrants against General Fund cash to provide cashflow loans as follows:

(a) The Director of Finance may approve cashflow loans of no more than a total of one hundred million dollars ($100,000,000) in the 2012–13 and 2013–14 fiscal years for County Medical Services Program governing board expenses that are associated with a Low Income Health Program operated by the governing board pursuant to this part.

(b) The terms and conditions of any cashflow loan provided pursuant to this section shall be subject to approval by the Director of Finance. Interest shall be charged at the rate earned by moneys in the Pooled Money Investment Account.

(c) The Department of Finance shall notify the Legislature within 15 days of authorizing a cashflow loan pursuant to this section, unless prior notification of the cashflow loan was included when the Medi-Cal estimates were submitted pursuant to Section 14100.5.

(d) Any cashflow loans made pursuant to this section shall be short term and shall not constitute General Fund expenditures. These loans and the repayment of these loans shall not affect the General Fund reserve.

SEC. 119. Section 15912.1 is added to the Welfare and Institutions Code, to read:

15912.1. (a) The department, in collaboration with the State Department of Public Health, shall develop policies and guidance on the transition of persons diagnosed with HIV/AIDS from federal Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White Act) funded programs, pursuant to Section 131019 of the Health and Safety Code, to the Low Income Health Program (LIHP) pursuant to Part 3.6 (commencing with Section 15909). These policies and guidance shall be provided to local LIHPs, federal Ryan White Act providers, and to persons receiving services pursuant to the federal Ryan White Act, as applicable. Guidance shall include, but not be limited to, operational processes and procedures supporting the transition of persons receiving services

pursuant to the federal Ryan White Act in order to minimize disruption of access to and availability of care and services.

(b) The department, in collaboration with the State Department of Public Health, shall consult with stakeholders, including administrators, advocates, providers, and persons receiving services pursuant to the federal Ryan White Act, to obtain advice in forming the policy decisions regarding the transition of persons receiving services pursuant to the federal Ryan White Act to the local LIHPs.

SEC. 120. Section 15916 of the Welfare and Institutions Code is amended to read:

15916. (a) It is the intent of the Legislature that the State Department of Health Care Services and all other departments take all appropriate steps to fully maximize and claim all available expenditures for Designated State Health Programs listed in the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration under the safety net care pool (SNCP) for an applicable demonstration year.

(b) For the purposes of this section, the following definitions apply:

(1) "California's Bridge to Reform Section 1115(a) Demonstration" means the Section 1115(a) Medicaid demonstration project, No. 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services (CMS), effective for the period of November 1, 2010, through October 31, 2015.

(2) "Demonstration year" means a specific period of time during California's Bridge to Reform Section 1115(a) Wavier as identified in the Special Terms and Conditions. "Demonstration year" may be denominated in yearly increments, which correspond with the yearly increments identified in the Special Terms and Conditions.

(3) "Designated public hospital" has the meaning given in subdivision (d) of Section 14166.1.

(4) "Excess certified public expenditures" means the amount of allowable uncompensated care expenditures reported and certified for the applicable demonstration year under Section 14166.8 by designated public hospitals (DPHs), including the governmental entities with which they are affiliated, that is in excess of the amount necessary to draw the maximum amount of federal funding for DPHs for uncompensated care under the safety net care pool and for disproportionate share hospital payments without regard to subdivision (c) or to the amount authorized pursuant to paragraph (5).

(5) "Reserved SNCP funds for DSHP" means the amount of SNCP uncompensated care funds used to fund expenditures for the Designated State Health Programs, as specified in the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration.

(6) "Redirected SNCP funds" means the amount of federal funding available for a specified demonstration year that would otherwise be restricted for expenditures associated with the Health Care Coverage Initiative (HCCI) program, for which there are insufficient HCCI expenditures to draw the federal funds and which CMS has authorized to be available for uncompensated care expenditures under the safety net care pool in either the demonstration year for which the funds were initially reserved or a subsequent demonstration year.

(7) "Safety net care pool" or "SNCP" means the federal funds available under the Medi-Cal Hospital/Uninsured Care Demonstration Project and the successor demonstration project, California's Bridge to Reform, to ensure continued government support for the provision of health care services to uninsured populations.

(c) Notwithstanding any other provision of law, the state shall annually seek authority from CMS under the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration to redirect to the uncompensated care category within the SNCP the portion of the restricted funds used to fund expenditures under the HCCI that will not be fully utilized by the end of the demonstration year for use in any demonstration year.

(d) Designated public hospitals may utilize the redirected SNCP funds described in subdivision (c) as follows:

(1) Designated public hospitals may opt to utilize excess certified public expenditures to claim the redirected SNCP funds.

(2) As a condition of exercising the option in paragraph (1), DPHs voluntarily agree that, up to the amount of redirected SNCP funds available, the excess certified public expenditures are to be allocated equally between the state and the DPHs, such that for every dollar of excess certified public expenditure used by the DPHs, the DPHs will voluntarily allow the state to use a corresponding excess certified public expenditure amount for claiming purposes.

(3) As a condition of receiving any of the funding in paragraph (2), DPHs voluntarily agree that, to the extent the state is unable to fully claim the maximum annual amount of reserved SNCP funds for DSHP, the excess certified public expenditures will be used to enable the state to receive total SNCP uncompensated care funds, in conjunction with its claims for expenditures for DSHP, to the maximum amount described in paragraph (5) of subdivision (b).

(e) Participation in the utilization of the excess certified public expenditures and redirected SNCP funds under this section is voluntary on the part of the DPHs for the purpose of all applicable federal laws.

(f) The department shall consult with DPH representatives regarding the availability of excess certified public expenditures, how to optimize the level of claimable federal Medicaid funding, and the appropriate allocation of SNCP funds under paragraphs (2) and (3) of subdivision (d). The department may make interim determinations and allocations of such SNCP funds, provided that the interim determinations and allocations take into account adjustments to reported expenditures for possible audit disallowances, consistent with the type of adjustments applied in prior projects years under Article 5.2 (commencing with Section 14166). Any interim determinations and allocations of redirected SNCP funds based on excess certified public expenditures shall be subject to interim and final reconciliations.

(g) Notwithstanding any other provision of law, upon the receipt of a notice of disallowance or deferral from the federal government related to any certified public expenditures for uncompensated care incurred by DPHs that are used for federal claiming under the SNCP pursuant to California's Bridge to Reform Section 1115(a) Demonstration after this section is implemented, and subject to the processes described in subdivisions (a) through (d) of Section 14166.24, the following shall apply with respect to the disallowance or deferral:

(1) The department and the DPH shall each be responsible for half of the repayment of the federal portion of any federal disallowance or deferral for the applicable demonstration year, up to the amount claimed and allocated pursuant to paragraph (2) of subdivision (d) for that particular year.

(2) If there are additional disallowances or deferrals beyond those described in paragraph (1), the department shall be solely responsible for the repayment of the federal portion of any federal disallowance or deferral for the applicable demonstration year, up to the amount claimed and allocated pursuant to paragraph (3) of subdivision (d) for that particular year.

(3) If there are additional disallowances or deferrals beyond those described in paragraphs (1) and (2) for the applicable demonstration year, the DPH shall be solely responsible for the repayment of the federal portion of all remaining federal disallowances or deferrals for that particular year.

(h) The department shall obtain federal approvals or waivers as necessary to implement this section and to obtain federal financial participation to the maximum extent permitted by federal law. This section shall be implemented only to the extent other federal financial participation is not jeopardized.

SEC. 121. Section 24000 of the Welfare and Institutions Code is amended to read:

24000. There is established in the State Department of Health Care Services the State-Only Family Planning Program to provide comprehensive clinical family planning services to low-income men and women. This division shall be known and may be cited as the State-Only Family Planning Program.

SEC. 122. Section 24001 of the Welfare and Institutions Code is amended to read:

24001. (a) (1) For purposes of this division, "family planning" means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, natural family planning, abstinence methods and basic, limited fertility management. Family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Family planning shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, not including contraceptives, or pregnancy care that is not incident to the diagnosis of pregnancy.

(2) Family planning services for males shall be expanded to include laboratory tests for sexually transmitted

infections and comprehensive physical examinations. Within 60 days of approval of the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program, provided for pursuant to subdivision (aa) of Section 14132, the department shall seek to amend the waiver to add this expansion. The implementation of this paragraph shall be dependent upon federal approval and receipt of federal financial participation.

(b) For purposes of this division, “department” means the State Department of Health Care Services.

SEC. 123. (a) It is the intent of the Legislature that the State Department of Education and the State Department of Health Care Services modify or repeal regulations that are no longer supported by statute due to the amendments in Sections 1, 2, 32, 33, 33.5, and 34 of this act.

(b) The State Department of Education shall review regulations to ensure the appropriate implementation of educationally necessary occupational and physical therapy services required by the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and Sections 1, 2, 32, 33, 33.5, and 34 of this act.

(c) The State Department of Education may adopt regulations to implement Sections 1, 2, 32, 33, 33.5, and 34 of this act. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the State Department of Education is hereby exempted, for this purpose, from the requirements of subdivision (a) of Section 11346.1 of the Government Code. For purposes of subdivision (e) of Section 11346.1 of the Government Code, the 180-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative Law, is hereby extended to one year.

(d) Implementation of Sections 1, 2, 32, 33, 33.5, and 34 of this act shall occur no later than October 1, 2012.

(e) The State Department of Health Care Services shall report in the November 2012 and May 2013 Family Health Estimate on the status of the implementation of the provisions of Sections 1, 2, 32, 33, 33.5, and 34 of this act. The report shall include, but not be limited to, the following:

(1) The number of children enrolled in the California Children’s Services by county known to the county California Children’s Services Programs to be receiving physical and occupational therapy services from the California Children’s Services Medical Therapy Program assessed and determined to be educationally necessary by the individualized education program team and included in a child’s individualized education program.

(2) The estimated California Children’s Services Program savings from implementation of Sections 1, 2, 32, 33, 33.5, and 34 of this act.

(3) An update on the implementation of Sections 1, 2, 32, 33, 33.5, and 34 of this act, including a description of implementation successes and challenges.

(f) The State Department of Education and the State Department of Health Care Services shall work together to collect the relevant data necessary for the report described in subdivision (e).

SEC. 124. By no later than January 1, 2013, the Department of Managed Health Care shall provide the fiscal and appropriate policy committees of the Legislature with its final report on surveys conducted under the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and the department’s contractual requirements, for the dental plans participating in the Sacramento Geographic Managed Care Program.

SEC. 125. 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 the Low Income Health Program pursuant to Part 3.6 (commencing with Section 15909) of the Welfare and Institutions Code, the State Department of Public Health shall report to the Joint Legislative Budget Committee by October 1, 2012, on whether any of the projections or assumptions used to develop the AIDS Drug Assistance Program (ADAP) estimated budget for the Budget Act of 2012 may result in an inability of ADAP to provide services to eligible ADAP clients. If this occurs before October 1, 2012, and ADAP is unable to provide services to eligible ADAP clients, the State Department of Public Health shall provide notification to the Joint Legislative Budget Committee within 15 calendar days of this determination.

SEC. 126. Notwithstanding the amendments made in Sections 18 to 25, inclusive, and Sections 35, 116, 121, and 122 of this act, if this act becomes effective before July 1, 2012, it is the intent of the Legislature that the transfer of duties, powers, functions, responsibilities, and jurisdiction described in those sections from the State Department of Public Health to the State Department of Health Care Services shall occur in accordance with

Sections 131051, 131052, and 131055.1 of the Health and Safety Code, as amended or added by this act.

SEC. 127. The Legislature finds and declares that Sections 55 to 63, inclusive, 66 to 68, inclusive, and 70 and 71 of this act clarify procedures and terms of the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.

SEC. 128. The Legislature finds and declares that, for the purposes of Sections 78 and 111 of this act, a special law is necessary and that a general law cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because the counties listed in subdivision (a) of Section 14087.98 of the Welfare and Institutions Code, as added by this act, are Medi-Cal fee-for-service counties and this act would provide expansion of Medi-Cal managed care to these counties.

SEC. 129. The Legislature finds and declares that, for the purposes of Sections 79, 80, 112, 114, 115, and 124 of this act, a special law is necessary and that a general law cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because the Counties of Los Angeles and Sacramento are the only counties that have Medi-Cal dental managed care arrangements and the County of Sacramento is the only county with mandatory dental managed care enrollment.

SEC. 130. Section 33.5 of this bill incorporates amendments to Section 123870 of the Health and Safety Code proposed by this bill and Assembly Bill 1494 and Senate Bill 1034. It shall only become operative if (1) either Assembly Bill 1494 or Senate Bill 1034 and this bill are enacted and become effective on or before January 1, 2013, (2) each bill amends Section 123870 of the Health and Safety Code, and (3) this bill is enacted after either Assembly Bill 1494 or Senate Bill 1034, in which case Section 33 of this bill shall not become operative.

SEC. 131. 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.