State of California
COMMISSION ON STATE MANDATES
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Claim No. 03-TC-14

TEST CLAIM FORM

Local Agency or School District Submitting Claim

County of Santa Clara

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Representative Organization to be Notified

California State Association of Counties

This test claim alleges the existence of a reimbursable state mandated program within the meaning of section 17514 of the Government Code and section 6, article XIIIB of the California Constitution. This test claim is filed pursuant to section 17551(a) of the Government Code.

Identify specific section(s) of the chaptered bill or executive order alleged to contain a mandate, including the particular statutory code section(s) within the chaptered bill, if applicable.

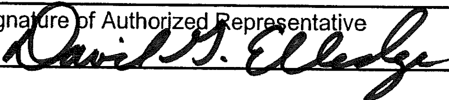
Chapter 676, Statutes of 1993, Chapter 685, Statutes of 1994, Chapter 294, Statutes of 1997 and Chapter 763, Statutes of 2002

IMPORTANT: PLEASE SEE INSTRUCTIONS AND FILING REQUIREMENTS FOR COMPLETING A TEST CLAIM ON THE REVERSE SIDE.

Name and Title of Authorized Representative | Telephone No.

Dave Elledge, Controller-Treasurer
(408) 299-5200

Signature of Authorized Representative



Date
9/23/03

BEFORE THE
COMMISSION ON STATE MANDATES

Test Claim of:
The County of Santa Clara

Tuberculosis Control

Chapter 676, Statutes of 1993, Chapter 685, Statutes of 1994, Chapter 294, Statutes of 1997, Chapter 116, Statutes of 1997; and Chapter 763, Statutes of 2002

STATEMENT OF THE CLAIM

A. MANDATE SUMMARY

During the 1993-1994 session, two bills were passed that substantially changed the manner that Tuberculosis (TB) cases were handled. The first of the two, Chapter 676, empowered local health officers and allowed greater control over those infected or believed to be infected with TB. Upon the issuance of an order from a local health officer, an individual infected with TB or suspected of having TB must submit to an examination, be admitted to a health facility, complete a prescribed course of medication, follow a course of directly observed therapy, not be allowed into the workplace or isolated at home. In addition, an individual infected with TB or reasonably believed to have TB cannot be discharged, released, or transferred from health facilities or penal institutions without noticing the local health officer and creating a treatment plan which the local health officer must review. Health officers are required to provide notice regarding parolees with TB. Finally, local health officers are empowered to detain individuals with TB in a treatment facility upon issuance of a health officer order with specified notice requirements for up to 60 days subject to a court hearing process which involves the patient's right to counsel.

The second bill, Chapter 685, made small changes to clarify the statutes created by Chapter 676. This Chapter ensures that the health officer have the ability to delegate his duties to the head of medical services in penal institutions in addition to his deputies. This Chapter also provides that the health officer review treatment plans connected with the discharge, release or transfer of an individual infected with TB out of a hospital of penal institution within a 24 hour period.

Health and Safety Code §121357 (former §3279.3)[1] places the state department as the lead agency for TB control and prevention. Section 121358, added by Chapter 294, Statutes of 1997, sets forth that correctional facilities shall not be used to house individuals detained as part of TB control and provides for co-operation between state and local health jurisdictions in obtaining appropriate places for such housing. Section 121360.5, added by Chapter 763, Statutes of 2002, sets forth an optional program for certification of tuberculin skin test technicians.

Health and Safety Code §121361 (former §3281) currently reads:

> (a)(1) A health facility, local detention facility, or state correctional institution shall not discharge or release any of the following persons unless subdivision (e) is complied with:
> (A) A person known to have active tuberculosis disease.
> (B) A person who the medical staff of the health facility or of the penal institution has reasonable grounds to believe has active tuberculosis disease.
> (2) In addition, persons specified in this subdivision may be discharged from a health facility only after a written treatment plan described in Section 121362 is approved by a local health officer of the jurisdiction in which the health facility is located. Any treatment plan submitted for approval pursuant to this paragraph shall be reviewed by the local health officer within 24 hours of the receipt of that plan.
> (3) The approval requirement of paragraph (2) shall not apply to any transfer to a general acute care hospital when the transfer is due to an immediate need for a higher level of care, nor to any transfer from any health facility to a correctional institution. Transfers or discharges in this paragraph shall occur only after the notification and treatment plan required by Section 121362 have been received by the local health officer.
> (4) This subdivision shall not apply to any transfer within the state correctional system or to any interfacility transfer occurring within a local detention facility system.
> (b) No health facility shall, without first complying with subdivision (e), transfer a person described in subparagraph (A) or (B) of paragraph (1) of subdivision (a) to another health facility. This subdivision shall not apply to any transfer within the state correctional system or to any

[1] In 1995, the Health and Safety Code was updated and code sections renumbered. The code sections quoted reflect these changes.

interfacility transfer occurring within a local detention facility system.

(c) No state correctional institution or local detention facility shall transfer a person described in subparagraph (A) or (B) of paragraph (1) of subdivision (a) from a state to a local, or from a local to a state, penal institution unless notification and a written treatment plan are received by the chief medical officer of the penal institution receiving the person.

(d) No local detention facility shall transfer a person described in subparagraph (A) or (B) of paragraph (1) of subdivision (a) to a local detention facility in another jurisdiction unless subdivision (e) is complied with and notification and a written treatment plan are received by the chief medical officer of the local detention facility receiving the person.

(e) Any discharge, release, or transfer described in subdivision (a), (b), (c), and (d) may occur only after notification and a written treatment plan pursuant to Section 121362 has been received by the local health officer. When prior notification would jeopardize the person's health, the public safety, or the safety and security of the penal institution, the notification and treatment plan shall be submitted within 24 hours of discharge, release or transfer.

(2) When a person described in paragraph (1) of subdivision (a) is released on parole from a state correctional institution, the notification and written treatment plan specified in the subdivision shall be provided to both the local health officer for the county in which the parolee intends to reside and to the local health officer for the county in which the state correctional institution is located.

(3) Notwithstanding any other provision of law, the Department of Corrections shall inform the parole agent, and other parole officials as necessary, that the person described in paragraph (1) of subdivision (a) has active or suspected active tuberculosis disease and provide information regarding the need for evaluation or treatment. The parole agent and other parole officials shall coordinate with the local health officer in supervising the person's compliance with medical evaluation or treatment related to tuberculosis, and shall notify the local health officer if the person's parole is suspended as a result of being absconded from supervision.

> (f) No health facility that declines to discharge, release, or transfer a person pursuant to this section shall be civilly or criminally liable or subject to administrative sanction therefor. This subdivision shall apply only if the health facility complies with this section in good faith.
> (g) Nothing in this section shall relieve a local health officer of any other duty imposed by this chapter.

Section 121362 (former §3282) currently reads:

> Each health care provider who treats a person for active tuberculosis disease, each person in charge of a health facility, or each person in charge of a clinic providing outpatient treatment for active tuberculosis disease shall promptly report to the health officer at the times that the health officer requires, but no less frequently that when there are reasonable grounds to believe that a person has active tuberculosis disease, and when a person ceases treatment for tuberculosis disease. Situations in which the provider may conclude that the patient has ceased treatment include times when the patient fails to keep an appointment, relocates without transferring care, or discontinues care. The initial disease notification report shall include an individual treatment plan that includes the patient's name, address, date of birth, tuberculin skin test results, pertinent radiologic, microbiologic, and pathologic reports whether final or pending, and any other information required by the local health officer. Subsequent reports shall provide updated clinical status and laboratory results, assessment of treatment adherence, name of current care provider if the patient transfers care, and any other information required by the local health officer. A facility discharge, release, or transfer report shall include all pertinent and updated information required by the local health officer not previously reported on any initial or subsequent report, and shall specifically include a verified patient address, the name of the medical provider who has specifically agreed to provide medical care, clinical information used to assess the current infectious state, and any other information required by the local health officer. Each health care provider who treats a person with active tuberculosis disease, and each person in charge of a health facility or a clinic providing outpatient treatment for active tuberculosis disease, shall maintain written documentation of each patient's adherence to his or her individual treatment plan. Nothing in this section shall authorize the

> disclosure of test results for human immunodeficiency virus (HIV) unless authorized by Chapter 7 (commencing with Section 120975 of, Chapter 8 (commencing with Section 121025) of, and Chapter 10 (commencing with Section 121075) of Part 4 of Division 105.
>
> In the case of a parolee under the jurisdiction of the Department of Corrections, the local health officer shall notify the assigned parole agent, when known, or the regional parole administrator, when there are reasonable grounds to believe the parolee has active tuberculosis disease and when the parolee ceases treatment for tuberculosis. Situations where the local health officer may conclude that the parolee has ceased treatment include times when the parolee fails to keep an appointment, relocates without transferring care, or discontinues care.

These sections mandate communication between local health officers, their staff, detention facility staff and/or detention facility medical staff, and others. A treatment plan must be created by medical staff of the detention facility prior to discharge, release, or transfer of a person infected with TB. This treatment plan must be transmitted to and reviewed by the health officer and/or staff via telephone, facsimile, courier or other means. The health officer and staff are also charged with the communication with and review of treatment plans created by medical providers and hospital staff. This information exchange will necessitate the drafting, review and establishment of policies, procedures, forms and protocols and the training to implement them for local health officers, their staff, detention facility staff and/or detention facility medical staff, and others.

Section 121363 (former §3283) currently reads:

> Each health care provider who treats a person for active tuberculosis disease shall examine, or cause to be examined, all household contacts or shall refer them to the health officer for examination. Each health care provider shall promptly notify the local health officer of the referral. When required by the local health officer, nonhousehold contacts and household contacts not examined by a health care provider shall submit to examination by the local health officer or designee. If any abnormality consistent with tuberculosis disease is found, steps satisfactory to the local health officer shall be taken to refer the person promptly to a health care provider for further investigation, and if necessary, treatment. Contacts shall be reexamined at times and in a manner as the local health officer may require. When requested by the local health officer, a

> health care provider shall report the results of any examination related to tuberculosis of a contact.

This section acts a safety net mandating that the health officer examine contacts of an individual known to have TB when a health care provider will not do so. The health officer is also required to maintain oversight of the case to ensure that contacts are reexamined properly which means increased communication as discussed above between the health officer and health care providers.

Section 121364 (former §3284) currently reads:

> (a) Within the territory under his or her jurisdiction, each local health officer may order examinations for tuberculosis infection for the purposes of directing preventative measures for persons in the territory, except those incarcerated in a state correctional institution, for whom the local health officer has reasonable grounds to determined are at heightened risk of tuberculosis exposure.
> (b) An order for examination pursuant to this section shall be in writing and shall include other terms and conditions as may be necessary to protect the public health.

This is the first of several sections that deal with the health officer order. This section addresses the order for examination and requires that health officer orders for examination be in writing.

Section 121365 (former §3285) currently reads:

> Each local health officer is hereby directed to use every available means to ascertain the existence of, and immediately investigate all reported or suspected cases of active tuberculosis disease in the jurisdiction, and to ascertain the sources of those infections. In carrying out the investigations, each local health officer shall follow applicable local rules and regulations and all general and special rules, regulations, and orders of the state department. If the local health officer determines that the public health in general or the health of a particular person is endangered by exposure to a person who is known to have active tuberculosis disease, or to a person for whom there are reasonable grounds to believe has active tuberculosis disease, the local health officer may issue any orders he or she deems necessary to protect the public health or the health of any other person, and may make application to a court for enforcement of the orders. Upon the receipt of information that any order has been violated,

the health officer shall advise the district attorney of the county in which the violation has occurred, in writing, and shall submit to the district attorney the information in his or her possession relating to the subject matter of the order, and of the violation or violations thereof.
The orders may include, but shall not be limited to, any of the following:
(a) An order authorizing the removal to, detention in, or admission into, a health facility or other treatment facility for the appropriate examination for active tuberculosis disease of a person who is known to have active tuberculosis disease, or a person for who there are reasonable grounds to believe that the per has active tuberculosis disease and who is unable or unwilling voluntarily to submit to the examination by a physician or by the local health officer. Any person whom the health officer determines should have an examination for tuberculosis disease may have the examination made by a physician and surgeon of his or her own choice who is licensed to practice medicine under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code under terms and conditions as the local health officer shall determine on reasonable grounds to be necessary to protect the public health. This section does not authorize the local health officer to mandate involuntary anergy testing.
(b) An order requiring a person who has active tuberculosis disease to complete an appropriate prescribed course of medication for tuberculosis disease and, if necessary, to follow required infectious control precautions for tuberculosis disease. This subdivision does not allow forcible or involuntary administration of medication.
(c) An order requiring a person who has active tuberculosis disease and who is unable or unwilling otherwise to complete an appropriate prescribed course of medication for tuberculosis disease to follow a course of directly observed therapy. This subdivision does not allow forcible or involuntary administration of medication.
(d) An order for the removal to, detention in, or admission into, a health facility or other treatment facility of a person if both of the following occur:
(1) The person has infectious tuberculosis disease, or who presents a substantial likelihood of having infectious tuberculosis disease, based on proven epidemiologic evidence, clinical evidence, X-ray readings, or tuberculosis laboratory test results.

(2) The local health officer finds, based on recognized infection control principles, that there is a substantial likelihood the person may transmit tuberculosis to others because of his or her inadequate separation from others.
(e) An order for the removal to, detention in, or admission into, a health facility or other treatment facility of a person if both of the following occur:
(1) The person has active tuberculosis disease, or has been reported to the health officer as having active tuberculosis disease with no subsequent report to the health officer of the completion of an appropriate prescribed course of medication for tuberculosis disease.
(2) There is a substantial likelihood, based on the person's past or present behavior, that he or she cannot be relied upon to participate in or complete an appropriate prescribed course of medication for tuberculosis disease and, if necessary, follow required infectious control precautions for tuberculosis disease. The behavior may include, but is not limited to, refusal or failure to take medication for tuberculosis disease, refusal or failure to keep appointments or treatment for tuberculosis disease, refusal or failure to complete the treatment for tuberculosis disease, or disregard for infection control precautions for active tuberculosis disease.
(f) An order for exclusion from attendance at the workplace for persons with infectious tuberculosis disease. The order may, also, exclude the person from any place when the local health officer determines that the place cannot be maintained in a manner adequate to protect others against the spread of tuberculosis disease.
(g) An order for isolation of persons with infectious tuberculosis disease to their place of residence until the local health officer has determined that they no longer have infectious tuberculosis disease.
(h) This section shall apply to all persons except those incarcerated in a state correctional institution.
(i) This section shall not be construed to require a private hospital or other private treatment facility to accept any patient without a payment source, including county responsibilities under Section 17000 of the Welfare and Institutions Code, except as required by Sections 1317 et seq. or by federal law.

This section expands on the health officer order of §121364 describing the types of health officer orders available to control the spread of TB. They include: order to detain for purposes of examination, order to complete medication, order for direct observed therapy,

order to detain to prevent spread of TB, order to detain to ensure compliance with medication regimen, order to exclude presence at work, and order to isolate at home. These orders will necessitate the drafting, review and establishment of policies, procedures, forms and protocols and the training to implement them for local health officers, their staff and others. To carry out the orders will necessitate the use of staff time to locate and detain individuals by transporting them to and from places for examination and/or housing, to ensure the individual remains at home or is excluded from the workplace as well as the costs related to the detention itself including, but not limited to, housing and use of security or law enforcement personnel.

Section 121366 (former §3285.1) currently reads:

> The local health officer may detain in a hospital or other appropriate place for examination or treatment, a person who is the subject of an order of detention issued pursuant to subdivision (a), (d) or (e) of Section 121365 without prior court order except that when a person detained pursuant to subdivision (a), (d) or (e) of Section 121365 has requested release, the local health officer shall make an application for a court order authorizing the continued detention within 72 hours after the request or, if the 72-hour period ends on a Saturday, Sunday, or legal holiday, by the end of the first business day following the Saturday, Sunday, or legal holiday, which application shall include a request for a expedited hearing. After the request for release, detention shall not continue for more than five business days in the absence of a court order authorizing detention. However, in no event shall any person be detained for more than 60 days without a court order authorizing the detention. The local health officer shall seek further court review of the detention within 90 days following the initial court order authorizing detention and thereafter within 90 days of each subsequent court review. In any court proceeding to enforce a local health officer's order for the removal or detention of a person, the local health officer shall prove the particularized circumstances constituting the necessity for the detention by clear and convincing evidence. Any person who is subject to a detention order shall have the right to be represented by counsel and upon the request of the person, counsel shall be provided.

This section sets forth the procedure by which a individual detained pursuant to a health officer order obtains court review. The responsibility for bringing the matter before the court is not on the shoulders of the detainee but rather on the health officer. The detainee need only request release to trigger a carefully timed procedure which, if not followed

precisely, will result in his automatic release. Incumbent within the procedure is the health officer's need for counsel to put forth the case in court, the detainee's right to counsel and that counsel shall be provided upon request. This court process will necessitate the drafting, review and establishment of policies, procedures, forms and protocols and the training to implement them for local health officers, their staff, their counsel, counsel's staff as well as counsel for the detainee such as the public defender, public defender staff and others. Hearings will necessitate the following be done on an expedited hearing calendar: preparation of declarations, review of records, preparation of witnesses, assembling evidence, exchange of discovery, drafting of pleadings, and any other procedures necessary to ensure the matter is well-prepared, placed on calendar and heard timely. Also necessary is the attendance at the hearing of counsel for both sides as well as witnesses from the health officer's staff, and the detainee. Other costs include, but are not limited to, transportation of the detainee to and from court, security costs, copy costs, witness fees, and filing fees.

Section 121367 (former §3285.2) currently reads:

> (a) An order of a local health officer pursuant to Section 121365 shall set forth all of the following:
> (1) The legal authority under which the order is issued, including the particular sections of state law or regulations.
> (2) An individualized assessment of the person's circumstances or behavior constituting the basis for the issuance of the order.
> (3) The less restrictive treatment alternatives that were attempted and were unsuccessful, or the less restrictive treatment alternatives that were considered and rejected, and the reasons the alternatives were rejected.
> (4) The orders shall be in writing, and shall include the name of the person, the period of time during which the order shall remain effective, the location, payer source if known, and other terms and conditions as may be necessary to protect the public health. Upon issuing an order, a copy of the order shall be served upon the person named in the order.
> (b) An order for the detention of a person shall do all of the following:
> (1) Include the purpose of the detention.
> (2) Advise the person being detained that he or she has the right to request release from detention by contacting a person designated on the local health officer's order at the telephone number stated on the order and that the detention shall not continue for more that five business days after the request for release, in the absence of a court order authorizing the detention.

(3) Advise the person being detained that, whether or not he or she requests release from detention, the local health officer is required to obtain a court order authorizing detention within 60 days following the commencement of detention and thereafter shall further seek court review of the detention within 90 days of the court order and within 90 days of each subsequent court review.
(4) Advise the person being detained that he or she has the right to arrange to be represented by counsel or to have counsel provided, and that if he or she chooses to have counsel provided, the counsel will be notified that the person has requested legal representation.
(5) Be accompanied by a separate notice that shall include, but not be limited to, all of the following additional information:
(A) That the person being detained has the right to request release from detention by contacting a person designated on the local health officer's order at a telephone number stated on the order, and that the detention shall not continue for more that five business days after the request in the absence of a court order authorizing the detention.
(B) That he or she has the right to arrange to be advised and represented by counsel or to have counsel provided, and that if he or she chooses to have counsel provided, the counsel will be notified that the person has requested legal representation.
(C) That he or she may supply the addresses or telephone numbers of not more than two individuals to receive notification of the person's detention, and that the local health officer shall, at the patient's request, provide notice within the limits of reasonable diligence to those people that the person is being detained.

This section sets forth the requirements for the issuance of a health officer order. Health officer staff must ensure that the order in writing and that it include information regarding the reasons for detention, the right to counsel and the right to request release from detention. In addition to the health officer order, this section requires the preparation of a separate notice on the issues of right to counsel, the right to request release and the ability to have others noticed of the detention. Incumbent in that notice is that health officer staff will make reasonable efforts to contact the persons designated by the detainee. Finally, a copy of the health officer order must be served on the person to be detained. This section will necessitate the drafting, review and establishment of policies, procedures, forms and protocols and the training to implement them, especially training on the proper service of legal documents, for local health officers, their staff, their counsel, counsel's staff and others.

Section 121368 (former §3285.3) currently reads:

> Notwithstanding any inconsistent provision of Section 121365, 121366 or 121367, all of the following shall apply:
> (a) A person who is detained solely pursuant to subdivision (a) of Section 121365 shall not continue to be detained beyond the minimum period of time required, with the exercise of all due diligence, to make a medical determination of whether a person who is suspected of having tuberculosis disease, has active tuberculosis or whether a person who has active tuberculosis disease has infectious tuberculosis disease. Further detention of the person shall be authorized only upon the issuance of a local health officer's order pursuant to subdivision (d) or (e) of Section 121365.
> (b) A person who is detained solely for the reasons described in subdivision (d) of Section 121365 shall not continue to be detained after he or she ceases to be infectious or after the local health officer ascertains that changed circumstances exist that permit him or her to be adequately separated from others so as to prevent transmission of tuberculosis disease after his or her release from detention.
> (c) A person who is detained for the reasons described in subdivision (e) of Section 121365 shall not continue to be detained after he or she has completed an appropriate prescribed course of medication.

This section sets forth the situations that trigger a release from detention which include those situations where the public health is no longer in danger. This section will necessitate the drafting, review and establishment of policies, procedures, forms and protocols and the training to implement them for local health officers, their staff, and others.

Section 121369 (former §3285.4) currently reads:

> For purposes of Sections 121365, 121366, and 121367, all of the following shall apply:
> (a) If necessary, language interpreters and persons skilled in communicating with vision and hearing impaired individuals shall be provided in accordance with applicable law.
> (b) Nothing in those sections shall be construed to permit or require the forcible administration of any medication without prior court order.

> (c) Any and all orders authorized under those sections shall be made by the local health officer. His or her authority to make the orders may be delegated to the person in charge of medical treatment of inmates in penal institutions within the local health officer's jurisdiction, or pursuant to Section 7. The local health officer shall not make any orders incorporating by reference any other rules or regulations.

This section requires the use of interpreters when necessary and allows the health officer to delegate his duties to the head of medical treatment in penal institutions. The use of interpreters and the delegation of authority will necessitate the drafting, review and establishment of policies, procedures, forms and protocols and the training to implement them for local health officers, their staff, detention facility staff and/or detention facility medical staff, and others.

The net effect of this legislation is to cause an increase in the paperwork that must be reviewed, created, drafted, transmitted, maintained, and in the case of a health officer order to detain, served by the health officer and staff. In addition, the health officer and staff must prepare for and appear at hearings to obtain court orders to detain. The local detention facilities are also burdened by an increase in paperwork that must be created, drafted, transmitted and maintained for purposes of releasing or transferring individuals infected with TB. Costs are incurred by housing, detaining, transporting, and following up on individuals infected with TB. The legislation necessitates that counsel to the health officer, be it county counsel, city attorney or district attorney, review legal forms, serve documents, and prepare for and appear at hearings for court orders for detention. The local public defender, private defender or conflicts attorney, when counsel is requested by the detainee, must also prepare for and appear at hearings. Finally, a program of this magnitude and complexity requires the drafting, review and establishment of policies, procedures, forms and protocols as well as training to accomplish the above-stated requirements in compliance with law. Thus, the total costs of this program are reimbursable.

The County of Santa Clara does not have complete estimates on the cost of discharging this program, but estimates that the costs will exceed $1000.00 per year.

B. LEGISLATIVE HISTORY PRIOR TO 1975

There was no requirement prior to 1975, nor in any of the intervening years, until the passage of Chapter 676, Statutes of 1993, and Chapter 685, Statutes of 1994, filed on October 4, 1993, and September 21, 1994, respectively, which mandated the use of health officer orders, notices and hearings and the creation and review of discharge, release or transfer and initial disease notification reports.

C. SPECIFIC STATUTORY SECTIONS THAT CONTAIN THE MANDATED ACTIVITIES

As related above, the mandated activities are contained in Health and Safety Code §§121361, 121362, 121363, 121364, 121365, 121366, 121367, 121368, and 121369. These sections directly relate to the reimbursable provisions of this test claim.

D. COST ESTIMATES

The County of Santa Clara does not have complete estimates on the cost of discharging this program, but estimates that the costs exceed $1000.00 per year.

E. REIMBURSABLE COSTS MANDATED BY THE STATE

The costs incurred by the County of Santa Clara as a result of the statute on which this test claim is based are all reimbursable costs as such costs are "costs mandated by the State" under Article XIII B (6) of the California Constitution, and Government Code §17500 *et seq.* of the Government Code. Section 17514 of the Government Code defines "costs mandated by the state", and specifies the following three requirements:

1. There are "increased costs which a local agency is required to incur after July 1, 1980."

2. The costs are incurred "as a result of any statute enacted on or after January 1, 1975."

3. The costs are the result of "a new program or higher level of service of an existing program within the meaning of Section 6 of Article XIIIB of the California Constitution."

All three of the above requirements for finding costs mandated by the State are met as described previously herein.

MANDATE MEETS BOTH SUPREME COURT TESTS

The mandate created by this statute clearly meets both tests that the Supreme Court in the *County of Los Angeles* v. *State of California* (1987) created for determining what constitutes a reimbursable state mandated local program. Those two tests, which the Commission on State Mandates relies upon to determine if a reimbursable mandate exists, are the "unique to government" and the "carry out a state policy" tests. Their application to this test claim is discussed below.

<u>Mandate Is Unique to Local Government</u>

The sections of the law claimed involve local health officers, their departments, local detention facility staff and medical staff, local government counsel and public defenders. Only local government employs health officers and staff for the control of disease and promotion of health within the jurisdiction. And, only governmental entities maintain facilities for the incarceration of individuals.

Finally, only local government employs county counsels, city attorneys, district attorneys and public defenders for equal representation of parties in an adjudication of legal cases. Thus, this requirement is unique to government.

Mandate Carries Out a State Policy

From the legislation, it is clear that the Legislature wishes carry out its charge to protect the public health through expansion and definition of the powers of the local health officer to contain the spread of TB and through mandating communication between health officers and medical personnel in hospitals, treatment facilities and detention facilities. In addition, this legislation carries out the constitutional policy of an individual's right to be heard, right to counsel and equal access to the courts by ensuring that the individual who has been detained to prevent the spread of TB has counsel and an opportunity to challenge the detention.

In summary, these statutes mandate that local government bear the burden of the increase in paperwork, the requirement of increased communication, the use of health officer orders, the hearing process to challenge health officer orders, and the requirement of counsel in putting such court cases forward. The County of Santa Clara believes that the TB control program as set forth above satisfies the constitutional requirements for a mandate.

STATE FUNDING DISCLAIMERS ARE NOT APPLICABLE

There are seven disclaimers specified in Government Code §17556 which could serve to bar recovery of "costs mandated by the State", as defined in Government Code §17556. None of the seven disclaimers apply to this test claim:

1. The claim is submitted by a local agency or school district which requests legislative authority for that local agency or school district to implement the Program specified in the statutes, and that statute imposes costs upon the local agency or school district requesting the legislative authority.

2. The statute or executive order affirmed for the State that which had been declared existing law or regulation by action of the courts.

3. The statute or executive order implemented a federal law or regulation and resulted in costs mandated by the federal government, unless the statute or executive order mandates costs which exceed the mandate in that federal law or regulation.

4. The local agency or school district has the authority to levy service charges, fees or assessments sufficient to pay for the mandated program or increased level of service.

5. The statute or executive order provides for offsetting savings to local agencies or school districts which result in no net costs to the local agencies or school districts, or includes additional revenue that was specifically intended to fund the costs of the State mandate in an amount sufficient to fund the cost of the State mandate.

6. The statute or executive order imposed duties which were expressly included in a ballot measure approved by the voters in a Statewide election.

7. The statute created a new crime or infraction, eliminated a crime or infraction, or changed the penalty for a crime or infraction, but only for that portion of the statute relating directly to the enforcement of the crime or infraction.

None of the above disclaimers have any application to the test claim herein stated by the County of Santa Clara.

CONCLUSION

The enactment of Chapter 676, Statutes of 1993 and Chapter 685, Statutes of 1994 imposed a new state mandated program and cost on the County of Santa Clara by establishing a program for the control of TB which resulted in additional burdens on local health officers, local government attorneys, and local detention facility staff. The mandated program meets all of the criteria and tests for the Commission on State Mandates to find a reimbursable state mandated program. None of the so-called disclaimers or other statutory or constitutional provisions that would relieve the State from its constitutional obligation to provide reimbursement have any application to this claim.

G. CLAIM REQUIREMENTS

The following elements of this test claim are provided pursuant to Section 1183, Title 2, of the California Code of Regulations:

Exhibit 1: Chapter 676, Statutes of 1993
Exhibit 2: Chapter 685, Statutes of 1994
Exhibit 3: Chapter 294, Statutes of 1997
Exhibit 4: Chapter 116, Statutes of 1997
Exhibit 5: Chapter 763, Statutes of 2002

CLAIM CERTIFICATION

The foregoing facts are known to me personally and if so required, I could and would testify to the statements made herein. I declare under penalty of perjury under the laws of the State of California that the statements made in this document are true and complete to the best of my personal knowledge and as to all matters, I believe them to be true.

Executed this 23 day of September, 2003, at San Jose, California, by:

Dave Elledge, Controller-Treasurer
County of Santa Clara

DECLARATION OF DAVE ELLEDGE

I, Dave Elledge, make the following declaration under oath:

I am the Controller-Treasurer for County of Santa Clara. As part of my duties, I am responsible for the complete and timely recovery of costs mandated by the State.

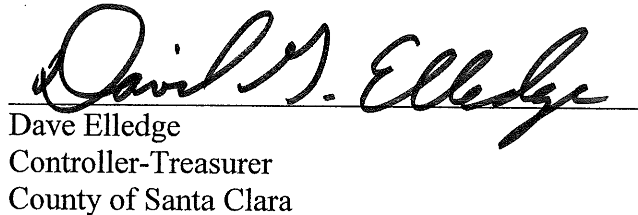
I declare that I have examined the County of Santa Clara's State mandated duties and resulting costs, in implementing the subject law, and find that such costs are, in my opinion, "costs mandated by the State", as defined in Government Code, Section 17514:

> " 'Costs mandated by the State' means any increased costs which a local agency or school district is required to incur after July 1, 1980, as a result of any statute enacted on or after January 1, 1975, or any executive order implementing any statute enacted on or after January 1, 1975, which mandates a new program or higher level of service of an existing program within the meaning of Section 6 of Article XIII B of the California Constitution."

I am personally conversant with the foregoing facts, and if so required, I could and would testify to the statements made herein.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct of my own knowledge, except as to the matters which are stated upon information or belief, and as to those matters, I believe them to be true.

Executed this 23 day of September, 2003, at San Jose, California.



Dave Elledge
Controller-Treasurer
County of Santa Clara

BILL NUMBER: AB 803 CHAPTERED 10/04/93
BILL TEXT

CHAPTER 676
FILED WITH SECRETARY OF STATE OCTOBER 4, 1993
APPROVED BY GOVERNOR OCTOBER 1, 1993
PASSED THE ASSEMBLY SEPTEMBER 10, 1993
PASSED THE SENATE SEPTEMBER 9, 1993
AMENDED IN SENATE SEPTEMBER 7, 1993
AMENDED IN SENATE AUGUST 30, 1993
AMENDED IN SENATE AUGUST 18, 1993
AMENDED IN SENATE AUGUST 17, 1993
AMENDED IN SENATE JULY 12, 1993
AMENDED IN ASSEMBLY APRIL 15, 1993

INTRODUCED BY Assembly Member Gotch

FEBRUARY 25, 1993

An act to amend Section 3351 of, to add Sections 3003, 3006, 3054, 3279.3, 3281, 3282, 3283, 3284, 3285.1, 3285.2, 3285.3, and 3285.4 to, and to repeal and add Section 3285 of, the Health and Safety Code, relating to communicable disease.

LEGISLATIVE COUNSEL'S DIGEST

AB 803, Gotch. Communicable disease: tuberculosis.
(1) Existing law requires the State Department of Health Services to maintain a program for the control of tuberculosis.

This bill would authorize the State Director of Health Services and a local health officer to order examinations for tuberculosis infection, as defined, of certain persons.
The bill would require the department to be the lead agency for all tuberculosis control and prevention activities at the state level.
The bill would, with certain exceptions, prohibit a person known to have active tuberculosis disease, as defined, or a person for whom the medical staff has reasonable grounds to believe has active tuberculosis disease from being discharged from a licensed health facility, or penal institution, or

transferred, until certain notification and in some situations, treatment plan approval requirements are met.

The bill would require a health care provider who provides treatment to, or a person in charge of a health facility or clinic providing outpatient treatment for, a person with active tuberculosis, to report to the local health officer, as prescribed. The bill would require the health care provider to examine, or cause to be examined all household contacts of the person, as specified.

This bill would require a health officer to notify the medical officer of the parole region when there are reasonable grounds to believe that a parolee under the jurisdiction of the Department of Corrections has active tuberculosis disease. By imposing new duties upon a local entity, this bill would impose a state-mandated local program.

(2) Existing law requires a local health officer to use every available means to ascertain the existence of, and investigate, all reported or suspected cases of tuberculosis in the infection stages, to make examinations and isolate, or quarantine and isolate certain persons, following local rules and regulations, and to make an examination order and isolation or quarantine order under certain circumstances, as prescribed.

This bill would in addition authorize the local health officer, under prescribed conditions, to issue an order authorizing removal to, or admission into, a health facility or other treatment facility, an order requiring completion of an appropriate prescribed course of medication, an order to follow a course of directly observed therapy, or an order for exclusion from the workplace. The bill would authorize a health officer to issue an order for isolation of persons with infectious tuberculosis in their residence. The order would be required to include certain information, including payer source. The bill would authorize a health officer to issue an order authorizing removal to, or admission into, a health facility or other treatment facility, as prescribed. The bill would exclude persons incarcerated in a state correctional institution from being subject to one of those orders.

The bill would prohibit anything in that provision from being construed to permit or require forcible administration of medication.

This bill would authorize a health officer to remove to, or detain in, a hospital or other place for examination or

treatment persons subject to an order under this act, as prescribed.

(3) Existing law provides that any person who violates or fails to comply with an order of a health officer directing his or her isolation or examination is guilty of a misdemeanor.

This bill would instead provide that any person who violates or fails to comply with any order described in (2) is guilty of a misdemeanor. By changing the definition of a crime, the bill would impose a state-mandated local program.

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

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

Moreover, this bill would provide that, if the Commission on State Mandates determines that this bill contains other costs mandated by the state, reimbursement for those costs shall be made pursuant to those statutory procedures and, if the statewide cost does not exceed $1,000,000, shall be made from the State Mandates Claims Fund.

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

SECTION 1. Section 3003 is added to the Health and Safety Code, to read:

3003. As used in this division, a person has "active tuberculosis disease" when either one of the following occur:

(a) A smear or culture taken from any source has tested positive for tuberculosis and the person has not completed the appropriate prescribed course of medication for tuberculosis disease.

(b) There is radiographic, current clinical, or laboratory evidence sufficient to establish a medical diagnosis of tuberculosis for which treatment is indicated.

SEC. 2. Section 3006 is added to the Health and Safety Code, to read:

3006. As used in this division the following terms have the following meanings, unless the context indicates otherwise:

(a) "Infectious tuberculosis disease" means active or suspected active tuberculosis disease in an infectious state.

(b) "Tuberculosis infection" means the latent phase of tuberculosis, during which the infected person cannot spread tuberculosis to others.

(c) "Heightened risk of tuberculosis exposure" means likely exposure to persons with infectious tuberculosis disease.

(d) "The appropriate prescribed course of medication for tuberculosis disease" means that course recommended by the most recent guidelines of the department, the most recent guidelines of the Centers for Disease Control and Prevention, or the most recent guidelines of the American Thoracic Society.

(e) "Directly observed therapy" means the appropriately prescribed course of treatment for tuberculosis disease in which the prescribed antituberculosis medications are administered to the person or taken by the person under direct observation.

(f) An "examination" for tuberculosis infection or disease means conducting tuberculosis specific tests, including, but not limited to, Mantoux tuberculin skin tests, laboratory examination, and X-rays, as recommended by the most recent guidelines of any of the following:

(1) The local health officer.

(2) The department.

(3) The Centers for Disease Control and Prevention.

(4) The American Thoracic Society.

(g) "State correctional institution" means a prison, institution, or other facility under the jurisdiction of the Department of Corrections or the Department of the Youth Authority.

(h) "Local detention facility" is defined in Section 6031.4 of the Penal Code.

(i) "Penal institution" means either a state correctional institution or a local detention facility.

(j) "Health facility" means a licensed health facility as defined in Sections 1250, 1250.2, and 1250.3.

SEC. 3. Section 3054 is added to the Health and Safety Code, to read:

3054. (a) The state director may order examinations for tuberculosis infection in the following persons for the purpose of directing preventive measures:

(1) Persons in close contact with persons with infectious tuberculosis disease.

(2) Other persons for whom the state director has reasonable grounds to determine are at heightened risk of tuberculosis exposure.

(b) An order for examination for tuberculosis infection shall be in writing and shall include other terms and conditions as may be necessary to protect the public health.

SEC. 4. Section 3279.3 is added to the Health and Safety Code, to read:

3279.3. The state department shall be the lead agency for all tuberculosis control and prevention activities at the state level.

SEC. 5. Section 3281 is added to the Health and Safety Code, to read:

3281. (a) A health facility, local detention facility, or state correctional institution shall not discharge or release any of the following persons unless subdivision (e) is complied with:

(1) A person known to have active tuberculosis.

(2) A person who the medical staff of the health facility or of the penal institution has reasonable grounds to believe has active tuberculosis.

In addition, persons specified in this subdivision may be discharged from a health facility only after a written treatment plan described in Section 3282 is approved by a health officer.

Persons specified in this subdivision may be discharged from a penal institution only after a written treatment plan described in Section 3282 is received by a health officer. This subdivision shall not apply to transfers within the state correctional system or to interfacility transfers occurring within a local detention facility system.

(b) No health facility shall transfer a person described in paragraph (1) or (2) of subdivision (a) to another health facility unless subdivision (e) is complied with. This subdivision shall not apply to transfers within the state correctional system or to interfacility transfers occurring within a local detention facility system.

(c) No state correctional institution or local detention facility shall transfer a person described in paragraph (1) or (2) of subdivision (a) from a state to a local, or from a local to a state, penal institution unless notification and a written treatment plan are received by the chief medical officer of the penal institution receiving the person.

(d) No local detention facility shall transfer a person described in paragraphs (1) and (2) of subdivision (a) to a local detention facility in another jurisdiction unless subdivision (e) is complied with and notification and a written

treatment plan are received by the chief medical officer of the local detention facility receiving the person.

(e) Persons specified in paragraph (1) or (2) of subdivision (a), in subdivision (b), in subdivision (c), or in subdivision (d) may be discharged, released, or transferred, as the case may be, only after notification and a written treatment plan pursuant to Section 3282 has been received by the local health officer. When prior notification is not possible or would jeopardize the public safety or the safety and security of the penal institution, then the notification and treatment plan shall be submitted within 24 hours of discharge, release, or transfer.

SEC. 6. Section 3282 is added to the Health and Safety Code, to read:

3282. Each health care provider who treats a person for active tuberculosis, each person in charge of a health facility, or each person in charge of a clinic providing outpatient treatment for active tuberculosis shall promptly report to the local health officer at the times that the health officer requires, but no less frequently than when there are reasonable grounds to believe that a person has active tuberculosis, and when a person ceases treatment for tuberculosis. Situations in which the provider may conclude that the patient has ceased treatment include times when the patient fails to keep an appointment, relocates without transferring care, or discontinues care. The report shall include an individual treatment plan that indicates the name of the medical provider who has specifically agreed to provide medical care, the address of the person, and any other pertinent clinical or laboratory information required by the health officer. Each health care provider who treats a person with active tuberculosis disease, and each person in charge of a health facility or a clinic providing outpatient treatment for active tuberculosis disease, shall maintain written documentation of each patient's adherence to his or her individual treatment plans. Nothing in this section shall authorize the disclosure of test results for human immunodeficiency virus (HIV) unless authorized by Chapter 1.11 (commencing with Section 199.20) of, Chapter 1.12 (commencing with Section 199.30) of, and Chapter 1.13 (commencing with Section 199.42) of, Division 1.

In the case of a parolee under the jurisdiction of the Department of Corrections, the health officer shall notify the medical officer of the parole region when there are reasonable

grounds to believe that the parolee has active tuberculosis disease and when the parolee ceases treatment for tuberculosis. Situations where the health officer may conclude that the parolee has ceased treatment include times when the parolee fails to keep an appointment, relocates without transferring care, or discontinues care.

SEC. 7. Section 3283 is added to the Health and Safety Code, to read:

3283. Each health care provider who treats a person for active tuberculosis disease shall examine, or cause to be examined, all household contacts or shall refer them to the local health officer for examination. Each health care provider shall promptly notify the health officer of the referral. When required by the health officer, nonhousehold contacts and household contacts not examined by a health care provider shall submit to examination by the health officer or designee. If any abnormality consistent with the symptoms of tuberculosis disease is found, steps satisfactory to the health officer shall be taken to refer the person promptly to a health care provider for further investigation, and if necessary, treatment. Contacts shall be reexamined at times and in a manner as the health officer may require. When requested by the health officer, a health care provider shall report the results of any examination related to tuberculosis of a contact.

SEC. 8. Section 3284 is added to the Health and Safety Code, to read:

3284. (a) Within the territory under his or her jurisdiction, each health officer may order examinations for tuberculosis infection for the purposes of directing preventive measures for persons in the territory, except those incarcerated in a state correctional institution, for whom the health officer has reasonable grounds to determine are at heightened risk of tuberculosis exposure.

(b) An order for examination pursuant to this section shall be in writing and shall include other terms and conditions as may be necessary to protect the public health.

SEC. 9. Section 3285 of the Health and Safety Code is repealed.

SEC. 10. Section 3285 is added to the Health and Safety Code, to read:

3285. Each health officer is hereby directed to use every available means to ascertain the existence of, and immediately investigate all reported or suspected cases of active

uberculosis disease in the jurisdiction, and to ascertain the
ources of those infections. In carrying out the
nvestigations, each health officer shall follow applicable
ocal rules and regulations and all general and special rules,
egulations, and orders of the state department. If the health
fficer determines that the public health in general or the
ealth of a particular person is endangered by exposure to a
erson who is known to have active tuberculosis disease, or to a
erson for whom there are reasonable grounds to believe has
ctive tuberculosis disease, the health officer may issue any
rders he or she deems necessary to protect the public health or
he health of any other person, and may make application to a
ourt for enforcement of the orders. The orders shall be in
riting, and shall include the name of the person, the period of
ime during which the order shall remain effective, the
ocation, payor source, and other terms and conditions as may be
ecessary to protect the public health. Upon issuing an order,
copy of the order shall be served upon the person named in
he order. Upon the receipt of information that any order has
een violated, the health officer shall advise the district
ttorney of the county in which the violation has occurred, in
riting, and shall submit to the district attorney the
nformation in his or her possession relating to the subject
atter of the order, and of the violation or violations thereof.

Any and all orders authorized under this chapter shall be
ade by the health officer, and his or her authority to make the
rders may be delegated to the person in charge of medical
reatment of inmates in penal institutions within the territory,
r pursuant to Section 7. The health officer shall not make
ny orders incorporating by reference any other rules or
egulations.

The orders may include, but shall not be limited to, any of
he following:

(a) An order authorizing the removal to, or admission into, a
ealth facility or other treatment facility for appropriate
xamination for tuberculosis of a person who is known to have
ctive tuberculosis, or a person for whom there are reasonable
rounds to believe that the person has active tuberculosis and
ho is unable or unwilling voluntarily to submit to the
xamination by a physician or by the health officer. Any person
hom the health officer determines should have an examination
for tuberculosis may have the examination made by a physician of

of medication for tuberculosis and, if necessary, follow required contagion precautions for tuberculosis. The behavior may include, but is not limited to, refusal or failure to take medication for tuberculosis, refusal or failure to keep appointments or treatment for tuberculosis, refusal or failure to complete the treatment for tuberculosis, or disregard for contagion precautions for tuberculosis.

(f) An order for exclusion from attendance at the workplace for persons with infectious tuberculosis. The order may, also, exclude the person from any place when the health officer determines that the place cannot be maintained in a manner adequate to protect others against the spread of tuberculosis.

(g) An order for isolation of persons with infectious tuberculosis to their place of residence until the health officer has determined that they no longer have infectious tuberculosis.

(h) This section shall apply to all persons except those incarcerated in a state correctional institution.

(i) This section shall not be construed to require a private hospital or other private treatment facility to accept any patient without a payment source, including county responsibilities under Section 17000 of the Welfare and Institutions Code, except as required by Sections 1317 et seq. or by federal law.

SEC. 11. Section 3285.1 is added to the Health and Safety Code, to read:

3285.1. The health officer may remove to, or detain in, a hospital or other place for examination or treatment a person who is the subject of an order of removal or detention issued pursuant to Section 3285 without a prior court order except that when a person detained pursuant to Section 3285 has requested release, the health officer shall make an application for a court order authorizing the detention within 72 hours after the request or, if the 72-hour period ends on a Saturday, Sunday, or legal holiday, by the end of the first business day following the Saturday, Sunday, or legal holiday, which application shall include a request for an expedited hearing. After the request for release, detention shall not continue for more than five business days in the absence of a court order authorizing detention. However, in no event shall any person be detained for more than 60 days without a court order authorizing the detention. The health officer shall seek further court review of the detention within 90 days following the initial court

his or her own choice who is licensed to practice medicine under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code under terms and conditions as the health officer shall determine on reasonable grounds to be necessary to protect the public health.

(b) An order requiring a person who has active tuberculosis to complete an appropriate prescribed course of medication for tuberculosis and, if necessary, to follow required contagion precautions for tuberculosis. This subdivision does not allow the forceable or involuntary administration of medication. If an order to complete therapy is not complied with, the health officer may issue orders pursuant to subdivision (d), (e), (f), or (g).

(c) An order requiring a person who has active tuberculosis and who is unable or unwilling otherwise to complete an appropriate prescribed course of medication for tuberculosis to follow a course of directly observed therapy. This subdivision does not allow forceable or involuntary administration of medication. If an order to follow a course of directly observed therapy is not complied with, the health officer may issue orders pursuant to subdivision (d), (e), (f), or (g).

(d) An order for the removal to, or admission into, a health facility or other treatment facility of a person if both of the following occur:

(1) The person has infectious tuberculosis, or who presents a substantial likelihood of having infectious tuberculosis, based upon proven epidemiologic evidence, clinical evidence, X-ray readings, or tuberculosis laboratory test results.

(2) The health officer finds, based on recognized infection control principles, that there is a substantial likelihood the person may transmit tuberculosis to others because of his or her inadequate separation from others.

(e) An order for the removal to, or admission into, a health facility or other treatment facility of a person if both of the following occur:

(1) The person has active tuberculosis disease, or has been reported to the health officer as having active tuberculosis disease with no subsequent report to the health officer of the completion of an appropriate prescribed course of medication for tuberculosis.

(2) There is a substantial likelihood, based on the person's past or present behavior, that he or she cannot be relied upon to participate in or complete an appropriate prescribed course

order authorizing detention and thereafter within 90 days of each subsequent court review. In any court proceeding to enforce a health officer's order for the removal or detention of a person, the health officer shall prove the particularized circumstances constituting the necessity for the detention by clear and convincing evidence. Any person who is subject to a detention order shall have the right to be represented by counsel and upon the request of the person, counsel shall be provided.

SEC. 12. Section 3285.2 is added to the Health and Safety Code, to read:

3285.2. (a) An order of a health officer pursuant to Section 3285 shall set forth all of the following:

(1) The legal authority under which the order is issued, including the particular sections of state law or regulations.

(2) An individualized assessment of the person's circumstances or behavior constituting the basis for the issuance of the order.

(3) The less restrictive treatment alternatives that were attempted and were unsuccessful, or the less restrictive treatment alternatives that were considered and rejected, and the reasons the alternatives were rejected.

(b) An order for the removal and detention of a person shall do all of the following:

(1) Include the purpose of the detention.

(2) Advise the person being detained that he or she has the right to request release from detention by contacting a person designate on the health officer's order at the telephone number stated on the order and that the detention shall not continue for more than five business days after the request, in the absence of a court order authorizing the detentions.

(3) Advise the person being detained that, whether or not he or she requests release from detention, the health officer is required to obtain a court order authorizing detention within 60 days following the commencement of detention and thereafter shall further seek court review of the detention within 90 days of the court order and within 90 days of each subsequent court review.

(4) Advise the person being detained that he or she has the right to arrange to be represented by counsel or to have counsel provided, and that if he or she chooses to have counsel provided, the counsel will be notified that the person has requested legal representation.

(5) Be accompanied by a separate notice that shall include, but not be limited to, all of the following additional information:

(A) That the person being detained has the right to request release from detention by contacting a person designated on the health officer's order at a telephone number stated on the order, and that the detention shall not continue for more than five business days after the request in the absence of a court order authorizing the detention.

(B) That he or she has the right to arrange to be advised and represented by counsel or to have counsel provided, and that if he or she chooses to have counsel provided, the counsel will be notified that the person has requested legal representation.

(C) That he or she may supply the addresses or telephone numbers of friends or relatives to receive notification of the person's detention, and that the health officer shall, at the patient's request, provide notice to a reasonable number of those people that the person is being detained.

SEC. 13. Section 3285.3 is added to the Health and Safety Code, to read:

3285.3. Notwithstanding any inconsistent provision of Section 3285, 3285.1 or 3285.2, all of the following shall apply:

(a) A person who is detained solely pursuant to subdivision (a) of Section 3285 shall not continue to be detained beyond the minimum period of time required, with the exercise of all due diligence, to make a medical determination of whether a person who is suspected of having tuberculosis, has active tuberculosis or whether a person who has active tuberculosis has infectious tuberculosis. Further detention of the person shall be authorized only upon the issuance of a health officer's order pursuant to subdivision (d) or (e) of Section 3285.

(b) A person who is detained solely for the reasons described in subdivision (d) of Section 3285 shall not continue to be detained after he or she ceases to be infectious or after the health officer ascertains that changed circumstances exist that permit him or her to be adequately separated from others so as to prevent transmission of tuberculosis after his or her release from detention.

(c) A person who is detained for the reasons described in subdivision (f) of Section 3285 shall not continue to be detained after he or she has completed an appropriate prescribed course of medication.

SEC. 14. Section 3285.4 is added to the Health and Safety Code, to read:

3285.4. For the purposes of Sections 3285, 3285.1, and 3285.2, all of the following shall apply:

(a) If necessary, language interpreters and persons skilled in communicating with vision and hearing impaired individuals shall be provided in accordance with applicable law.

(b) Nothing in those sections shall be construed to permit or require the forcible administration of any medication without a prior court order.

(c) Any and all orders authorized under those sections shall be made by the health officer and his or her authority to make the orders shall be delegated only pursuant to Section 7. The health officer shall not make any orders incorporating by reference any other rules or regulations.

SEC. 15. Section 3351 of the Health and Safety Code is amended to read:

3351. Inasmuch as the orders provided for by Section 3285 are for the protection of the public health, any person who, after service upon him or her of an order of a health officer as provided in Section 3285 violates or fails to comply with the order, is guilty of a misdemeanor. Upon conviction thereof, in addition to any and all other penalties that may be imposed by law upon the conviction, the person may be ordered by the court confined until the order of the health officer shall have been fully complied with or terminated by the health officer, but not exceeding one year from the date of passing judgment upon the conviction, further, the court, upon suitable assurances that the order of the health officer will be complied with, may place any person convicted of a violation of the order of the health officer upon probation for a period not to exceed two years, upon condition that the order of the health officer be fully complied with, further, upon any subsequent violation of the order of the health officer, the probation shall be terminated and confinement as provided for in this section shall be ordered by the court.

SEC. 16. Section 3355 of the Health and Safety Code is amended to read:

3355. The district attorney of the county in which a violation of Sections 3285 and 3351 may be committed, shall prosecute all such violations and, upon the request of a health officer, shall prosecute, as provided in Section 3351, violations of any order of a health officer made and served as

provided in Section 3285 or Section 3002.
SEC. 17. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs which may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, changes the definition of a crime or infraction, changes the penalty for a crime or infraction, or eliminates a crime or infraction. Moreover, notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.

Also, notwithstanding Section 17580 of the Government Code, unless otherwise specified in this act, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution. Section 17580 of the Government Code, unless otherwise specified in this act, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

BILL NUMBER: AB 804 CHAPTERED 09/21/94
BILL TEXT

CHAPTER 685
FILED WITH SECRETARY OF STATE SEPTEMBER 21, 1994
APPROVED BY GOVERNOR SEPTEMBER 20, 1994
PASSED THE ASSEMBLY AUGUST 26, 1994
PASSED THE SENATE AUGUST 23, 1994
AMENDED IN SENATE AUGUST 9, 1994
AMENDED IN SENATE JUNE 30, 1994
AMENDED IN ASSEMBLY MAY 6, 1993
AMENDED IN ASSEMBLY APRIL 22, 1993

INTRODUCED BY Assembly Member Gotch

FEBRUARY 25, 1993

An act to amend Sections 3003, 3006, 3281, 3282, 3283, 3284, 3285, 3285.1, 3285.2, 3285.3, 3285.4, and 3351 of the Health and Safety Code, relating to communicable disease.

LEGISLATIVE COUNSEL'S DIGEST

AB 804, Gotch. Communicable disease: tuberculosis.

Existing law requires the State Department of Health Services to maintain a program for the control of tuberculosis and administer the funds made available to it by the state for the care of tuberculosis patients.

Existing law, with certain exceptions, prohibits discharge or release of persons from certain facilities if the person is known to have tuberculosis, or if there are reasonable grounds to believe the person has tuberculosis, unless certain procedures are followed, including providing a notice and report to the local health officer.

This bill would clarify that local health officers may delegate duties and authority relating to the issuance of related orders, and would make conforming and other technical changes. The bill would require review of related treatment plans within 24 hours, and would thereby impose a state-mandated local program.

Existing law requires that related delegations of authority

by the local health officer be made pursuant to specified provisions of law relating to delegation of authority to a deputy.

This bill would provide that delegation may also be made to the person in charge of medical treatment of inmates at penal institutions. The bill would specify that in cases of court enforcement of an order, confinement may be accomplished by placement in any appropriate facility, penal institution, or dwelling specifically approved by the local health officer.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates which do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that, if the Commission on State Mandates determines that this bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to those statutory procedures and, if the statewide cost does not exceed $1,000,000, shall be made from the State Mandates Claims Fund.

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

SECTION 1. Section 3003 of the Health and Safety Code is amended to read:

3003. As used in this division, a person has "active tuberculosis disease" when either one of the following occur:

(a) A smear or culture taken from any source in the person's body has tested positive for tuberculosis and the person has not completed the appropriate prescribed course of medication for active tuberculosis disease.

(b) There is radiographic, current clinical, or laboratory evidence sufficient to support a medical diagnosis of tuberculosis for which treatment is indicated.

SEC. 2. Section 3006 of the Health and Safety Code is amended to read:

3006. As used in this division the following terms have the following meanings, unless the context indicates otherwise:

(a) "Infectious tuberculosis disease" means active or

suspected active tuberculosis disease in an infectious state.
(b) "Tuberculosis infection" means the latent phase of tuberculosis, during which the infected person cannot spread tuberculosis to others.
(c) "Heightened risk of tuberculosis exposure" means likely exposure to persons with infectious tuberculosis disease.
(d) "The appropriate prescribed course of medication for tuberculosis disease" means that course recommended by the health officer, the most recent guidelines of the department, the most recent guidelines of the Centers for Disease Control and Prevention, or the most recent guidelines of the American Thoracic Society.
(e) "Directly observed therapy" means the appropriately prescribed course of treatment for tuberculosis disease in which the prescribed antituberculosis medications are administered to the person or taken by the person under direct observation of a health care provider or a designee of the health care provider approved by the local health officer.
(f) An "examination" for tuberculosis infection or disease means conducting tests, including, but not limited to, Mantoux tuberculin skin tests, laboratory examination, and X-rays, as recommended by any of the following:
(1) The local health officer.
(2) The most recent guidelines of the state department.
(3) The most recent guidelines of the Centers for Disease Control and Prevention.
(4) The most recent guidelines of the American Thoracic Society.
(g) "State correctional institution" means a prison, institution, or other facility under the jurisdiction of the Department of Corrections or the Department of the Youth Authority.
(h) "Local detention facility" is defined in Section 6031.4 of the Penal Code.
(i) "Penal institution" means either a state correctional institution or a local detention facility.
(j) "Health facility" means a licensed health facility as defined in Sections 1250, 1250.2, and 1250.3.
(k) "Health officer" or "local health officer" includes his or her designee.
SEC. 3. Section 3281 of the Health and Safety Code is amended to read:
3281. (a) (1) A health facility, local detention facility,

or state correctional institution shall not discharge or release any of the following persons unless subdivision (e) is complied with:

(A) A person known to have active tuberculosis disease.

(B) A person who the medical staff of the health facility or of the penal institution has reasonable grounds to believe has active tuberculosis disease.

(2) In addition, persons specified in this subdivision may be discharged from a health facility only after a written treatment plan described in Section 3282 is approved by a local health officer of the jurisdiction in which the health facility is located. Treatment plans submitted for approval pursuant to this paragraph shall be reviewed by the local health officer within 24 hours of receipt of the plans.

(3) The approval requirement of paragraph (2) shall not apply to any transfer to a general acute care hospital when the transfer is due to an immediate need for a higher level of care, nor to any transfer from any health facility to a correctional institution. Transfers or discharges described in this paragraph shall occur only after the notification and treatment plan required by Section 3282 have been received by the local health officer.

(4) This subdivision shall not apply to transfers within the state correctional system or to interfacility transfers occurring within a local detention facility system.

(b) No health facility shall transfer a person described in subparagraph (A) or (B) of paragraph (1) of subdivision (a) to another health facility unless subdivision (e) is complied with. This subdivision shall not apply to transfers within the state correctional system or to interfacility transfers occurring within a local detention facility system.

(c) No state correctional institution or local detention facility shall transfer a person described in subparagraph (A) or (B) of paragraph (1) of subdivision (a) from a state to a local, or from a local to a state, penal institution unless notification and a written treatment plan are received by the chief medical officer of the penal institution receiving the person.

(d) No local detention facility shall transfer a person described in subparagraph (A) or (B) of paragraph (1) of subdivision (a) to a local detention facility in another jurisdiction unless subdivision (e) is complied with and notification and a written treatment plan are received by the

chief medical officer of the local detention facility receiving the person.

(e) All discharges, releases, or transfers described in subdivisions (a), (b), (c), and (d) may occur only after notification and a written treatment plan pursuant to Section 3282 has been received by the local health officer. When prior notification would jeopardize the person's health, the public safety, or the safety and security of the penal institution, then the notification and treatment plan shall be submitted within 24 hours of discharge, release, or transfer.

SEC. 4. Section 3282 of the Health and Safety Code is amended to read:

3282. Each health care provider who treats a person for active tuberculosis disease, each person in charge of a health facility, or each person in charge of a clinic providing outpatient treatment for active tuberculosis disease shall promptly report to the local health officer at the times that the health officer requires, but no less frequently than when there are reasonable grounds to believe that a person has active tuberculosis disease, and when a person ceases treatment for tuberculosis disease. Situations in which the provider may conclude that the patient has ceased treatment include times when the patient fails to keep an appointment, relocates without transferring care, or discontinues care. The initial disease notification report shall include an individual treatment plan that includes the patient name, address, date of birth, tuberculin skin test results, pertinent radiologic, microbiologic, and pathologic reports whether final or pending, and any other information required by the local health officer. Subsequent reports shall provide updated clinical status and laboratory results, assessment of treatment adherence, name of current care provider if patient transfers care, and any other information required by the local health officer. A facility discharge, release, or transfer report shall include all pertinent and updated information required by the local health officer not previously reported on initial or subsequent reports, and shall specifically include verified patient address, the name of the medical provider who has specifically agreed to provide medical care, clinical information used to assess the current infectious state, and any other information required by the local health officer. Each health care provider who treats a person with active tuberculosis disease, and each person in charge of a health facility or a clinic providing

outpatient treatment for active tuberculosis disease, shall maintain written documentation of each patient's adherence to his or her individual treatment plans. Nothing in this section shall authorize the disclosure of test results for human immunodeficiency virus (HIV) unless authorized by Chapter 1.11 (commencing with Section 199.20) of, Chapter 1.12 (commencing with Section 199.30) of, and Chapter 1.13 (commencing with Section 199.42) of, Division 1.

In the case of a parolee under the jurisdiction of the Department of Corrections, the local health officer shall notify the medical officer of the parole region or the physician and surgeon designated by the Director of Corrections when there are reasonable grounds to believe that the parolee has active tuberculosis disease and when the parolee ceases treatment for tuberculosis. Situations where the local health officer may conclude that the parolee has ceased treatment include times when the parolee fails to keep an appointment, relocates without transferring care, or discontinues care.

SEC. 5. Section 3283 of the Health and Safety Code is amended to read:

3283. Each health care provider who treats a person for active tuberculosis disease shall examine, or cause to be examined, all household contacts or shall refer them to the local health officer for examination. Each health care provider shall promptly notify the local health officer of the referral.

When required by the local health officer, nonhousehold contacts and household contacts not examined by a health care provider shall submit to examination by the local health officer or designee. If any abnormality consistent with tuberculosis disease is found, steps satisfactory to the local health officer shall be taken to refer the person promptly to a health care provider for further investigation, and if necessary, treatment.

Contacts shall be reexamined at times and in a manner as the local health officer may require. When requested by the local health officer, a health care provider shall report the results of any examination related to tuberculosis of a contact.

SEC. 6. Section 3284 of the Health and Safety Code is amended to read:

3284. (a) Within the territory under his or her jurisdiction, each local health officer may order examinations for tuberculosis infection for the purposes of directing preventive measures for persons in the territory, except those incarcerated in a state correctional institution, for whom the

local health officer has reasonable grounds to determine are at heightened risk of tuberculosis exposure.

(b) An order for examination pursuant to this section shall be in writing and shall include other terms and conditions as may be necessary to protect the public health.

SEC. 7. Section 3285 of the Health and Safety Code is amended to read:

3285. Each local health officer is hereby directed to use every available means to ascertain the existence of, and immediately investigate all reported or suspected cases of active tuberculosis disease in the jurisdiction, and to ascertain the sources of those infections. In carrying out the investigations, each local health officer shall follow applicable local rules and regulations and all general and special rules, regulations, and orders of the state department. If the local health officer determines that the public health in general or the health of a particular person is endangered by exposure to a person who is known to have active tuberculosis disease, or to a person for whom there are reasonable grounds to believe has active tuberculosis disease, the local health officer may issue any orders he or she deems necessary to protect the public health or the health of any other person, and may make application to a court for enforcement of the orders. Upon the receipt of information that any order has been violated, the health officer shall advise the district attorney of the county in which the violation has occurred, in writing, and shall submit to the district attorney the information in his or her possession relating to the subject matter of the order, and of the violation or violations thereof.

The orders may include, but shall not be limited to, any of the following:

(a) An order authorizing the removal to, detention in, or admission into, a health facility or other treatment facility for appropriate examination for active tuberculosis disease of a person who is known to have active tuberculosis disease, or a person for whom there are reasonable grounds to believe that the person has active tuberculosis disease and who is unable or unwilling voluntarily to submit to the examination by a physician or by the local health officer. Any person whom the health officer determines should have an examination for tuberculosis disease may have the examination made by a physician and surgeon of his or her own choice who is licensed to practice medicine under Chapter 5 (commencing with Section

2000) of Division 2 of the Business and Professions Code under terms and conditions as the local health officer shall determine on reasonable grounds to be necessary to protect the public health. This section does not authorize the local health officer to mandate involuntary anergy testing.

(b) An order requiring a person who has active tuberculosis disease to complete an appropriate prescribed course of medication for tuberculosis disease and, if necessary, to follow required infection control precautions for tuberculosis disease. This subdivision does not allow the forceable or involuntary administration of medication.

(c) An order requiring a person who has active tuberculosis disease and who is unable or unwilling otherwise to complete an appropriate prescribed course of medication for tuberculosis disease to follow a course of directly observed therapy. This subdivision does not allow forceable or involuntary administration of medication.

(d) An order for the removal to, detention in, or admission into, a health facility or other treatment facility of a person if both of the following occur:

(1) The person has infectious tuberculosis disease, or who presents a substantial likelihood of having infectious tuberculosis disease, based upon proven epidemiologic evidence, clinical evidence, X-ray readings, or tuberculosis laboratory test results.

(2) The local health officer finds, based on recognized infection control principles, that there is a substantial likelihood the person may transmit tuberculosis to others because of his or her inadequate separation from others.

(e) An order for the removal to, detention in, or admission into, a health facility or other treatment facility of a person if both of the following occur:

(1) The person has active tuberculosis disease, or has been reported to the health officer as having active tuberculosis disease with no subsequent report to the health officer of the completion of an appropriate prescribed course of medication for tuberculosis disease.

(2) There is a substantial likelihood, based on the person's past or present behavior, that he or she cannot be relied upon to participate in or complete an appropriate prescribed course of medication for tuberculosis disease and, if necessary, follow required infection control precautions for tuberculosis disease. The behavior may include, but is not limited to,

refusal or failure to take medication for tuberculosis disease, refusal or failure to keep appointments or treatment for tuberculosis disease, refusal or failure to complete the treatment for tuberculosis disease, or disregard for infection control precautions for active tuberculosis disease.

(f) An order for exclusion from attendance at the workplace for persons with infectious tuberculosis disease. The order may, also, exclude the person from any place when the local health officer determines that the place cannot be maintained in a manner adequate to protect others against the spread of tuberculosis disease.

(g) An order for isolation of persons with infectious tuberculosis disease to their place of residence until the local health officer has determined that they no longer have infectious tuberculosis disease.

(h) This section shall apply to all persons except those incarcerated in a state correctional institution.

(i) This section shall not be construed to require a private hospital or other private treatment facility to accept any patient without a payment source, including county responsibilities under Section 17000 of the Welfare and Institutions Code, except as required by Sections 1317 et seq. or by federal law.

SEC. 8. Section 3285.1 of the Health and Safety Code is amended to read:

3285.1. The local health officer may detain in a hospital or other appropriate place for examination or treatment, a person who is the subject of an order of detention issued pursuant to subdivision (a), (d), or (e) of Section 3285 without a prior court order except that when a person detained pursuant to subdivision (a), (d), or (e) of Section 3285 has requested release, the local health officer shall make an application for a court order authorizing the continued detention within 72 hours after the request or, if the 72-hour period ends on a Saturday, Sunday, or legal holiday, by the end of the first business day following the Saturday, Sunday, or legal holiday, which application shall include a request for an expedited hearing. After the request for release, detention shall not continue for more than five business days in the absence of a court order authorizing detention. However, in no event shall any person be detained for more than 60 days without a court order authorizing the detention. The local health officer shall seek further court review of the detention within 90 days

following the initial court order authorizing detention and thereafter within 90 days of each subsequent court review. In any court proceeding to enforce a local health officer's order for the removal or detention of a person, the local health officer shall prove the particularized circumstances constituting the necessity for the detention by clear and convincing evidence. Any person who is subject to a detention order shall have the right to be represented by counsel and upon the request of the person, counsel shall be provided.

SEC. 9. Section 3285.2 of the Health and Safety Code is amended to read:

3285.2. (a) An order of a local health officer pursuant to Section 3285 shall set forth all of the following:

(1) The legal authority under which the order is issued, including the particular sections of state law or regulations.

(2) An individualized assessment of the person's circumstances or behavior constituting the basis for the issuance of the order.

(3) The less restrictive treatment alternatives that were attempted and were unsuccessful, or the less restrictive treatment alternatives that were considered and rejected, and the reasons the alternatives were rejected.

(4) The orders shall be in writing, and shall include the name of the person, the period of time during which the order shall remain effective, the location, payer source if known, and other terms and conditions as may be necessary to protect the public health. Upon issuing an order, a copy of the order shall be served upon the person named in the order.

(b) An order for the detention of a person shall do all of the following:

(1) Include the purpose of the detention.

(2) Advise the person being detained that he or she has the right to request release from detention by contacting a person designated on the local health officer's order at the telephone number stated on the order and that the detention shall not continue for more than five business days after the request for release, in the absence of a court order authorizing the detention.

(3) Advise the person being detained that, whether or not he or she requests release from detention, the local health officer is required to obtain a court order authorizing detention within 60 days following the commencement of detention and thereafter shall further seek court review of the detention

within 90 days of the court order and within 90 days of each subsequent court review.

(4) Advise the person being detained that he or she has the right to arrange to be represented by counsel or to have counsel provided, and that if he or she chooses to have counsel provided, the counsel will be notified that the person has requested legal representation.

(5) Be accompanied by a separate notice that shall include, but not be limited to, all of the following additional information:

(A) That the person being detained has the right to request release from detention by contacting a person designated on the local health officer's order at a telephone number stated on the order, and that the detention shall not continue for more than five business days after the request in the absence of a court order authorizing the detention.

(B) That he or she has the right to arrange to be advised and represented by counsel or to have counsel provided, and that if he or she chooses to have counsel provided, the counsel will be notified that the person has requested legal representation.

(C) That he or she may supply the addresses or telephone numbers of not more than two individuals to receive notification of the person's detention, and that the local health officer shall, at the patient's request, provide notice within the limits of reasonable diligence to those people that the person is being detained.

SEC. 10. Section 3285.3 of the Health and Safety Code is amended to read:

3285.3. Notwithstanding any inconsistent provision of Section 3285, 3285.1 or 3285.2, all of the following shall apply:

(a) A person who is detained solely pursuant to subdivision (a) of Section 3285 shall not continue to be detained beyond the minimum period of time required, with the exercise of all due diligence, to make a medical determination of whether a person who is suspected of having tuberculosis disease, has active tuberculosis or whether a person who has active tuberculosis disease has infectious tuberculosis disease. Further detention of the person shall be authorized only upon the issuance of a local health officer's order pursuant to subdivision (d) or (e) of Section 3285.

(b) A person who is detained solely for the reasons described in subdivision (d) of Section 3285 shall not continue to be

detained after he or she ceases to be infectious or after the local health officer ascertains that changed circumstances exist that permit him or her to be adequately separated from others so as to prevent transmission of tuberculosis disease after his or her release from detention.

(c) A person who is detained for the reasons described in subdivision (e) of Section 3285 shall not continue to be detained after he or she has completed an appropriate prescribed course of medication.

SEC. 11. Section 3285.4 of the Health and Safety Code is amended to read:

3285.4. For the purposes of Sections 3285, 3285.1, and 3285.2, all of the following shall apply:

(a) If necessary, language interpreters and persons skilled in communicating with vision and hearing impaired individuals shall be provided in accordance with applicable law.

(b) Nothing in those sections shall be construed to permit or require the forcible administration of any medication without a prior court order.

(c) Any and all orders authorized under those sections shall be made by the local health officer. His or her authority to make the orders may be delegated to the person in charge of medical treatment of inmates in penal institutions within the local health officer's jurisdiction, or pursuant to Section 7. The local health officer shall not make any orders incorporating by reference any other rules or regulations.

SEC. 12. Section 3351 of the Health and Safety Code is amended to read:

3351. Inasmuch as the orders provided for by Section 3285 are for the protection of the public health, any person who, after service upon him or her of an order of a local health officer as provided in Section 3285 violates or fails to comply with the order, is guilty of a misdemeanor. Upon conviction thereof, in addition to any and all other penalties that may be imposed by law upon the conviction, the person may be ordered by the court confined until the order of the local health officer shall have been fully complied with or terminated by the local health officer, but not exceeding one year from the date of passing judgment upon the conviction, further, the court, upon suitable assurances that the order of the local health officer will be complied with, may place any person convicted of a violation of the order of the local health officer upon probation for a period not to exceed two years, upon condition

that the order of the local health officer be fully complied with, further, upon any subsequent violation of the order of the local health officer, the probation shall be terminated and confinement as provided for in this section shall be ordered by the court. Confinement may be accomplished by placement in any appropriate facility, penal institution, or dwelling approved for the specific case by the local health officer.

SEC. 13. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund. Notwithstanding Section 17580 of the Government Code, unless otherwise specified in this act, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

Senate Bill No. 391

CHAPTER 294

An act to repeal Article 6 (commencing with Section 58105) of Chapter 1 of Part 1 of Division 21 of the Food and Agricultural Code, to amend Sections 95004 and 95030 of, and to add Section 95001.5 to, to amend Sections 104380, 106805, 115065, 115080, 120955, 121200, 121260, and 121305 of, to add Sections 110241, 120970, 121358, 123255, and 123279 to, to add Chapter 1.5 (commencing with Section 124450) to Part 4 of Division 106 of, to add and repeal Section 1179.3 of, and to repeal Sections 349.109, 104485, 104550, 104569, 120450, 121205, 121215, 121220, and 124950 of, the Health and Safety Code, to amend Section 12696.05 of, and to repeal Section 12699.50 of, the Insurance Code, and to amend Section 1372 of the Penal Code, to amend Sections 4643.5, 4681.1, 4681.3, 6600.05, 7228, 14094.3, 14105.31, 14105.33, 14132.22, 14154.15, 14163, 16809.5, 16909, 16945, and 16990.5 of, to add Sections 4418.1, 4418.7, 4433, 4596.5, 4639, 7200.06, 7200.07, 7202, 7204, 7229, 7230, 7231, 7232, 7233, 14005.75, 14005.76, 14005.82, 14005.83, 14005.84, 14005.88, 14005.89, 14011.4, 14029, 14067, 14093.07, 14093.09, 14109.6, 14133.14, 14138.5, 14459.5, 14459.7, and 17000.51 to, and to add and repeal Sections 14085.7, 14085.8, 14148.99, and 16997.1 of, the Welfare and Institutions Code, relating to human services, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor August 18, 1997. Filed with Secretary of State August 18, 1997.]

LEGISLATIVE COUNSEL'S DIGEST

SB 391, Solis. Health.

Existing law authorizes the Department of Food and Agriculture to establish a program designed to provide eligible persons with coupons that may be exchanged for fresh, nutritious foods at farmers' markets pursuant to a program established by federal law, the WIC Farmers' Market Nutrition Act of 1992.

This bill would delete this authority and would instead authorize the State Department of Health Services to establish this program.

Existing law specifies that the provisions requiring the implementation of the Comprehensive Perinatal Outreach Program shall become inoperative July 1, 1997, and shall be repealed on January 1, 1998, unless a later enacted statute revises or repeals that date.

This bill would repeal the provision repealing the program.

Existing law requires the Secretary of the Health and Welfare Agency to establish an Office of Rural Health, or an alternative

organizational structure, in one of the departments of the Health and Welfare Agency to promote a strong working relationship between the state government and local and federal agencies, universities, and other entities, develop health initiatives, and maximize the use of existing resources relating to health services.

This bill would, until July 1, 1998, require that council, through the Office of Statewide Health Planning and Development, to develop and administer a program of grants for projects located in rural areas, as determined by the council.

Existing law provides for the allocation of funds to local lead agencies for the implementation of tobacco use prevention programs, and specifies that no local lead agency shall receive an allocation of less than $110,000.

This bill would increase that minimum allocation limit to $150,000.

Existing law specifies that the provisions requiring the implementation of the Tobacco Use Prevention Program shall become inoperative July 1, 1997, and shall be repealed on January 1, 1998, unless a later enacted statute revises or repeals that date.

This bill would repeal that provision repealing the program.

Existing law specifies that the provisions requiring the implementation of the Cigarette and Tobacco Product Surtax Medical Research Program shall become inoperative July 1, 1997, and shall be repealed on January 1, 1998, unless a later enacted statute revises or repeals that date.

This bill would repeal the provision repealing that program.

Existing law specifies that the provisions requiring the reimbursement of selected primary care clinics for the delivery of medical services, including preventative health care and smoking prevention and cessation services, including case management services, to eligible beneficiaries whose income is under 200% of the federal poverty level shall become inoperative July 1, 1997, and shall be repealed on January 1, 1998, unless a later enacted statute revises or repeals that date.

This bill would repeal the provision repealing that program.

Existing federal regulations for the federal Early Intervention Program for Infants and Toddlers with Disabilities requires participating states to establish a state interagency coordinating council in order to receive federal financial assistance.

This bill would prohibit any member of the council from casting a vote on any matter that would provide direct financial benefit to that member or otherwise give the appearance of a conflict of interest.

Under existing law, the California Early Intervention Services Act, various state departments provide coordinated services to infants and toddlers with disabilities and their families. Existing law requires early intervention services to be provided directly to eligible infants and toddlers and their families through the regional center system and the local education agency system. Under existing law, the act

will repeal on January 1, 1998, unless the state terminates its participation in a specified federal program before that date.

This bill would require these services to be provided by family resource centers that provide certain services. The bill would extend the operation of the act to January 1, 2000.

Existing law establishes requirements for the certification of radon measurement laboratories, radon testing and consulting specialists, and radon mitigation contracts, and requires the application fees for certification to be deposited into the Radon Contractor Certification Fund.

This bill would instead require these fees to be deposited in the General Fund.

Existing law establishes requirements regarding the issuance of export documents for the exportation of food, drugs, or devices manufactured or produced in this state, and establishes an Export Document Program Fund.

This bill would require all fees collected by the State Department of Health Services pursuant to requests to conduct a voluntary medical device review to be deposited into the Export Document Program Fund and to be expended, upon appropriation, for the purpose of determining if the device is a new device or is substantially equivalent to a current or previously marked device.

Existing law establishes requirements regarding the licensing and regulation of sources of ionizing radiation.

This bill would amend certain of these provisions to notwithstand a provision contained in the Government Code that prohibits prescribed governmental bodies from paying certain filing fees.

Existing law requires medical expenses to be reimbursed in an amount not to exceed $25,000 when incurred due to a severe adverse reaction to an immunization required by state law.

This bill would repeal this provision.

Existing law requires, to the extent funds are appropriated, the department to establish and administer a program to provide drug treatments to persons infected with HIV.

This bill would establish additional client assistance provisions applicable if the department utilizes a contractor or subcontractor to administer any aspect of this program.

Existing law requires the State Director of Health Services to develop a list of drugs to be provided under a program for the treatment of the human immunodeficiency virus (HIV) and requires manufacturers of drugs on the list to pay the department a rebate of 15% of the average wholesale cost price of each drug.

This bill would instead require these manufacturers to pay the department a rebate that is equal to the rebate that would apply to the drug under certain provisions of federal law.

Existing law establishes the AIDS Vaccine Research and Development Grant Program.

This bill would repeal certain provisions of law relating to the creation and implementation of this program.

Existing law requires the department and each county to administer a tuberculosis control, prevention, and detention program.

This bill would prohibit individuals housed under this program, other than criminal offenders, from residing in correctional facilities. It would require the department and local health jurisdiction, by January 1, 1998, to identify a detention site for recalcitrant tuberculosis patients for each local health jurisdiction.

Existing law specifies that the provisions requiring the implementation of the Access for Infants and Mothers (AIM) Program and establishment of the continuously appropriated Perinatal Insurance Fund shall become inoperative July 1, 1997, and shall be repealed on January 1, 1998, unless a later enacted statute revises or repeals that date.

This bill would repeal the provision for the repeal of that program, and would make conforming changes to provisions authorizing the Major Risk Medical Insurance Board to adopt regulations for administration of that program.

Existing law requires the State Department of Health Services to maintain a program of maternal and child health.

This bill would authorize the department to maintain a child health program in each county, and to allocate funds to counties for these purposes that submit plans in compliance with minimum standards established by the department.

Existing law provides for various benefits through the implementation of programs for persons with developmental disabilities (consumers) through the State Department of Developmental Services. Existing law provides for the delivery of services to consumers through regional centers pursuant to contracts with the department.

This bill would require the department to contract with an independent agency or organization for the tracking and monitoring of consumers who are moved from state hospitals to the community to ensure that they are receiving necessary services and supports. The bill would require the department to monitor corrective actions taken by regional centers as a result of this tracking and monitoring and to establish a task force to review the findings of the contractor and make recommendations regarding tracking and monitoring.

The bill would provide for the provision of services on an emergency basis when the community placement of a consumer is at risk of failing and admittance to a state developmental center is likely. The bill would require the department to immediately seek admission to a state developmental center when it determines that admission is necessary to protect the health and welfare of the consumer.

This bill would require the department to contract with a nonprofit agency or agencies to provide clients' rights advocacy services, beginning January 1, 1998.

Existing law establishes area boards on developmental disabilities to protect and advocate the rights of all persons in the area who have developmental disabilities.

This bill would require the State Department of Developmental Services, by July 1, 1998, to enter into an interagency agreement with the Organization of Area Boards, on behalf of area boards, under which each area board would conduct life quality assessments of consumers at least once every 3 years or more frequently on the request of a consumer or, when appropriate, a family member, subject to appropriation of funds in the Budget Act.

Under existing law, a consumer who has been determined to be eligible for services by a regional center shall be considered eligible by any other regional center if he or she moves to another location within the state.

This bill would provide for the provision of equivalent levels and types of services when a consumer transfers from one regional center catchment area to another, pending the development of a new individual program plan.

This bill would require the governing board of a regional center to annually contract with an independent accounting firm for an audited financial statement.

Existing law requires the department to annually establish reimbursement rates for developmental services, including reimbursement rates for out-of-home care, with these rates to be reviewed by the State Council on Developmental Disabilities. Existing law requires that, in establishing reimbursement rates for out-of-home care services, one of the cost elements to be included is an adequate amount to be paid to facilities for the basic living needs of a person with developmental disabilities. The department is required to make a redetermination of basic living costs every 3 years, with the first report to be made on March 1, 1999.

This bill would, instead, require that the first report be made by March 1, 2000. The bill would provide for the increase of the rate schedule for the 1997–98 fiscal year based on the amount appropriated in the Budget Act of 1997.

Under existing law, a person cannot be tried or adjudged to punishment while that person is mentally incompetent. Existing law sets forth procedures under which a criminal defendant who was adjudged mentally incompetent and who has regained mental competence, shall be returned to the committing court, and subsequently returned to a hospital or other commitment facility based on a need for continued treatment in order to maintain competence to stand trial.

This bill would revise these procedures, and would require the State Department of Mental Health to report to the Legislature regarding specified time limits.

Existing law states legislative intent that persons committed to a secure facility for mental health treatment shall be placed in Atascadero State Hospital unless unique circumstances preclude the placement.

This bill would instead require Atascadero State Hospital to be used whenever a person is committed to a secure facility for mental health treatment and is placed in a state hospital at the direction of the department, unless unique circumstances preclude the placement.

Under existing law, the State Department of Mental Health has jurisdiction over 4 state hospitals for the care, treatment, and education of the mentally disordered.

This bill would provide for the commitment of sexually violent predators to Atascadero State Hospital. The bill would limit the number of patients whose placement has been required pursuant to the Penal Code to 980, who may be placed at Napa State Hospital and would limit the hospital's total patient population to 1,200. This bill would require the department to regularly consult with the Napa State Hospital Task Force on proposed policy or structural modifications to the hospital that may affect the Napa community.

This bill would provide for grounds privileges or passes for patients in these state hospitals whose placement has been required pursuant to the Penal Code.

Under existing law, the State Department of Mental Health is required to evaluate each patient committed to state hospitals pursuant to specified provisions of the Penal Code to determine whether they need to be treated in a secure setting, and requires the department to treat all Penal Code commitments and mentally disordered sex offenders who do not require a secure treatment setting as near to the patient's community as possible.

This bill would instead provide that prior to admission to the Napa State Hospital or Metropolitan State Hospital, the department shall evaluate these patients. The bill would provide that patients determined to be a high security risk shall be treated in the department's most secure facilities, and that those patients not needing this level of security shall be treated as near to the patient's community as possible if an appropriate treatment program is available.

This bill would prohibit the admission to Napa State Hospital of patients whose placement has been required pursuant to the Penal Code, until specified conditions are met, except as provided. The bill would prohibit placement of those patients whose placement is required under the Penal Code outside of the perimeter security fence, with certain exceptions, and would limit the number of those patients that may be placed at that facility. The bill would prohibit

placement of high security risk patients at Metropolitan State Hospital or Napa State Hospital. The bill would require the department to develop policies and procedures at each state hospital, to notify appropriate law enforcement agencies in the event of a patient escape or walkaway. The bill would require the department to issue a state hospital administrative directive to require patients whose placement has been required pursuant to the Penal Code and other patients within the secured perimeter at each state hospital to wear clothing that enables them to be readily identified.

This bill would state legislative intent to complete the 250-bed addition at Atascadero State Hospital as expeditiously as feasible and to provide funding for the construction phase of this project in the Budget Act of 1998.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, under which qualified low-income persons are provided with health care services.

Existing law provides for extended eligibility for Medi-Cal benefits for a limited time for families whose eligibility for Medi-Cal benefits is terminated due to the loss of eligibility for assistance due to increased hours of employment, income from employment, or the loss of earned income disregards.

This bill would require the department, if federal financial participation is available, to notify beneficiaries of the availability of extended assistance under these provisions to seek a waiver from the federal government to simplify these extended benefits, to contract for an independent evaluation of changes to the program, and to develop a community outreach campaign to inform beneficiaries of the availability of extended benefits. The department would be permitted to implement the community outreach campaign through a contract that would be exempt from approval by the Director of General Services and from the Public Contract Code. The bill would also require the department to monitor participation rates and would, if federal financial participation is available, alter eligibility for these extended benefits. Since each county is required to determine Medi-Cal eligibility, modification of eligibility for extended Medi-Cal benefits would constitute a state-mandated local program.

The bill would also require the department, not later than 6 months following the effective date of the bill, to create and implement a simplified eligibility process for pregnant women and children, as described.

The bill would also require the department, not later than 6 months following the effective date of the bill, to develop and conduct a community outreach and education campaign to help people learn about and apply for Medi-Cal benefits.

Existing law authorizes the department to enter into contracts with hospitals for inpatient services to be rendered to Medi-Cal

program beneficiaries. These contracts are negotiated by the California Medical Assistance Commission.

This bill would create the Medi-Cal Medical Education Supplemental Payment Fund and the Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund in the State Treasury, to be under the administrative control of the State Department of Health Services, and to consist of moneys from specified sources. The bill would require that moneys deposited in these funds qualify for federal financial participation, and would require moneys in these funds to be paid to specified types of hospitals for medical education costs incurred for services rendered to Medi-Cal beneficiaries. The bill would require the department to obtain federal matching funds to the full extent permitted by law. The bill would provide that these funds shall be continuously appropriated, thereby making an appropriation.

This bill would make these provisions inoperative on June 30, 1999, and repeal them by January 1, 2000.

This bill would state legislative intent that the University of California work with the department and the commission to develop a federal demonstration project to address future funding of graduate medical education in the state, and that implementing legislation be enacted by June 30, 1999. The bill would request the University of California to submit a progress report to the Governor and the Legislature by November 1, 1998.

Existing law relating to the Medi-Cal program requires the State Department of Health Services to establish the County Administrative Cost Control Plan to establish standards and performance criteria to which counties are required to adhere. Existing law authorizes a county to petition the department for an augmentation of its plan in order to implement a plan for the outstationing of one or more eligibility workers at alternative sites in order to facilitate receipt and processing of applications for Medi-Cal eligibility for pregnant women, infants, and children.

This bill would revise the requirements applicable to that petition process and would recast that provision to authorize a county to petition for an augmentation of its county administrative cost control plan to implement a plan for outstationing eligibility workers at all types of outstation locations meeting specified federal requirements.

Under existing law, services covered under the California Children's Services program, when provided to Medi-Cal recipients, prohibited from being incorporated into any Medi-Cal managed care contract entered into after August 1, 1994, and pursuant to specified provisions of law, until 3 years after the effective date of the contract.

This bill would, instead prohibit these services from being incorporated into a contract until August 1, 2000, and would exempt from this prohibition contracts entered into for county-organized

health systems in the Counties of San Mateo, Santa Barbara, Solano, and Napa.

Under existing law, low-income children in foster care are covered under the Medi-Cal program.

This bill would require the county child welfare agency with the responsibility for the care and placement of the child, in consultation with the child's foster care giver, to determine whether it is in the best interest of the child to enroll in a Medi-Cal managed care plan. By imposing this requirement on local agencies, this bill would impose a state-mandated local program.

Existing law, under the Medi-Cal program, provides that home and community-based services, in-home medical care services, and early and periodic screening, diagnosis, and treatment for individuals under 21 years of age may be covered if certain conditions are met.

This bill would require that any decision to transfer a child who is being case managed by the California Children's Services program to the home setting, for whom any of the above services has been requested, be made in consultation with the child's California Children's Services program case manager.

Existing law requires the department, in administering the Medi-Cal program, to enter into contracts with manufacturers of drugs for the best price and requires that the contract provide for an equalization payment amount to be remitted to the department quarterly. The law requires that the department submit an invoice to each manufacturer for the equalization payment based on supporting data.

This bill would require transmittal of the invoice and the supporting data within 30 days of the federal Health Care Financing Administration's file of manufacturer rebate information, would establish procedures for the calculation and payment of rebate interest, and would provide a procedure for contesting the invoice amount. This bill would establish certain collection procedures for rebate payments, including default and termination provisions. The bill would establish procedures for availability of drugs upon prior approval.

Existing law provides that drugs of any manufacturer who did not renew or enter into a contract within a prescribed period of time would be available only through prior approval.

This bill would delete this provision.

Existing law authorizes Medi-Cal reimbursement for transitional inpatient care, as defined, in general acute care hospitals and other specified health facilities.

Existing law provides, however, that, for the initial 2 years following implementation of reimbursement for this care, transitional inpatient care shall be made available only to persons 18 years of age or over, and that this care shall not be available to patients in acute care hospitals defined as small and rural.

This bill would indefinitely extend these limitations.

Existing law imposes certain requirements regarding the implementation of prior authorization procedures for the provision of services under the Medi-Cal program.

This bill would require the department to use certain criteria to identify providers to be placed on prior authorization for noninvasive testing procedures.

Existing law requires the department to administer certain provisions related to child health and disability prevention programs.

This bill would require the department to report to the Legislature by January 1, 1998, regarding prescribed data with respect to the programs.

Under the Medi-Cal program, the department is required to make supplemental payments to certain disproportionate share hospitals based on specified criteria. Existing law generally defines a disproportionate share hospital as a hospital that has proportionately higher costs, volume, or services related to the provision of services to Medi-Cal or other low-income patients than the statewide average. Payments are made from moneys paid by hospitals into the Medi-Cal Inpatient Payment Adjustment Fund, with this fund being continuously appropriated for specified purposes, including, for the 1994–95 and 1995–96 fiscal years, an annual transfer of $239,757,690, and for the 1996–97 fiscal year and each fiscal year thereafter, an annual transfer of $229,757,690, to the Health Care Deposit Fund.

This bill would provide that the amount to be transferred each fiscal year subsequent to the 1996–97 fiscal year to the Health Care Deposit Fund would be $154,757,690.

By increasing the amount available in the fund for appropriation to disproportionate share hospitals, this bill would make an appropriation.

This bill would authorize a local initiative entity that has performed unanticipated work resulting in additional costs attributable to the development of its local initiative health delivery system to file a claim with the department under the disproportionate share hospital reimbursement provisions for the costs due to delays in start dates.

Existing law requires a prepaid health plan to maintain financial records and to have an independent annual audit or additional audits, and requires the department to perform routine auditing of prepaid health plan contractors and affiliated subcontractors providing services under the Medi-Cal program.

This bill would require the department to make only the final report of each external review available to the Legislature within 30 calendar days of completion, and to the public upon request.

This bill would require the department to implement a management information and decision support system to integrate data from managed care plans to monitor and evaluate the quality of care, to provide the Legislature with annual progress reports, and to

provide the Legislature with system or information access with the most cost-effective technology available.

Existing law requires each county to provide aid and medical care to indigent persons. These programs are known as county general assistance programs.

Existing law prescribes a formula under which counties must provide minimum aid grant levels for general assistance recipients, but specifies that counties may reduce these levels by, among other things, the monthly actuarial value of up to $40 per month of medical care. A recent court decision held that this provision permitted a county either to make the aid grant reduction or not provide any medical care if it chose not to make the reduction.

This bill would provide that, notwithstanding this court decision, this provision was not intended, and shall not be construed, to give a county or city and county specified authority relating to the provision of health care services, except that this provision would cease to be implemented if, and only to the extent that, a final court decision holds that the provisions imposes a state-mandated local program.

This bill would also declare that it confirms and is declarative of, rather than a change in, existing law.

Existing law, operative until July 1, 1997, and repealed on January 1, 1998, provides for the provision of perinatal services, perinatal outreach, coordination, and expansion services, provides limitations on the use of funds from the Health Education Account in the Cigarette and Tobacco Products Surtax Fund for purposes of the perinatal outreach, coordination, and expansion services.

This bill would repeal the provision for the repeal of that program.

Existing law contained in the California Health Care for the Indigent Program (CHIP) provides, operative until July 1, 1997, and repealed on January 1, 1998, for the allocation of money from the Cigarette and Tobacco Products Surtax Fund to the counties to provide health care benefits, and requires each county that receives CHIP funds to submit reports containing specified information to the State Department of Health Services.

This bill would repeal the provision for the repeal of that program, and would make conforming changes to provisions for the administration of the program.

This bill would authorize the Director of Finance to authorize the augmentation or reduction of amounts appropriated in the Budget Act for the programs authorized by this act if the funds in the Cigarette and Tobacco Products Surtax Fund are insufficient to support the Budget Act appropriations for the programs authorized by this act, and, by authorizing the augmentation of those appropriated funds, this bill would result in an appropriation.

This bill would specify that the State Department of Health Services may adopt emergency regulations to implement this bill.

This bill would specify that funds appropriated in the Budget Act of 1999 for certain tobacco use prevention media campaign grant programs shall be available for expenditure only until July 1, 2000, and would make funds appropriated in the Budget Act of 1997 for the Tobacco Use Prevention Program and for the rural health improvement grant program established by this bill available for expenditure until July 1, 1999. By extending the period those appropriations would be available for expenditure, this bill would result in an appropriation.

Existing law requires the department to administer certain programs relating to AIDS.

This bill would authorize the department to use the sum of $1,600,000 appropriated pursuant to Item 4260-111-0001 of the Budget Act of 1997 for the extension of the term of contracts with entities receiving funds in the 1996–97 fiscal year to provide HIV testing services, would authorize the department to amend these contracts for the 1997–98 fiscal year, and would authorize advance payments not to exceed 25% of the expected funding, thereby making an appropriation. This provision would become inoperative on July 1, 1998, and would be repealed on January 1, 1999.

Existing law provides for the funding of clinics for the provision of health care under the seasonal and migratory workers program, the rural health services development program, and the expanded access to primary care program.

This bill would require a clinic funded under those programs to provide nonelective primary health care to all persons eligible for these programs who are impacted by a declared emergency or disaster and who present themselves for treatment at the clinic. The bill would require the department to deny payment to any clinic funded by these programs that charges patients for care without utilizing a sliding-fee scale based on income.

This bill would authorize the State Department of Health Services to adopt emergency regulations to implement this act and specified Medi-Cal benefits established by the Budget Act of 1997.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

The bill would declare that it is to take effect immediately as an urgency statute.

Appropriation: yes.

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

SECTION 1. Article 6 (commencing with Section 58105) of Chapter 1 of Part 1 of Division 21 of the Food and Agricultural Code is repealed.

SEC. 2. Section 95001.5 is added to the Government Code, to read:

95001.5. In order to prevent any potential conflict of interest and pursuant to Section 303.604 of Title 34 of the Code of Federal Regulations, no member of the interagency coordinating council may cast a vote on any matter that would provide direct financial benefit to that member or otherwise give the appearance of a conflict of interest.

SEC. 3. Section 95004 of the Government Code, as added by Section 2 of Chapter 945 of the Statutes of 1993, is amended to read:

95004. The early intervention services specified in this title shall be provided as follows:

(a) Direct services for eligible infants and toddlers and their families shall be provided pursuant to the existing regional center system under the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code) and the existing local education agency system under appropriate sections of Part 30 (commencing with Section 56000) of the Education Code and regulations adopted pursuant thereto, and Part H of the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1471 et seq.).

(b) Services shall be provided by family resource centers that provide, but are not limited to, parent-to-parent support, information dissemination and referral, public awareness, family professional collaboration activities, and transition assistance for families.

(c) Existing obligations of the state to provide these services at state expense shall not be expanded.

(d) It is the intent of the Legislature that services be provided in accordance with Sections 303.124, 303.126, and 303.527 of Title 34 of the Code of Federal Regulations.

SEC. 4. Section 95030 of the Government Code is amended to read:

95030. Unless repealed earlier pursuant to subdivision (c) of Section 95003, this division shall remain in effect only until January 1, 2000, and as of that date is repealed, unless a later enacted statute, which is chaptered before January 1, 2000, deletes or extends that date.

SEC. 5. Section 349.109 of the Health and Safety Code, as amended by Chapter 199 of the Statutes of 1996, is repealed.

SEC. 6. Section 1179.3 is added to the Health and Safety Code, to read:

1179.3. (a) (1) The Rural Health Policy Council shall develop and administer a competitive grants program for projects located in rural areas of California.

(2) The Rural Health Policy Council shall define "rural area" for the purposes of this section after receiving public input and upon recommendation of the Interdepartmental Rural Health Coordinating Committee and the Rural Health Programs Liaison.

(3) The purpose of the grants program shall be to fund innovative, collaborative, cost-effective, and efficient projects that pertain to the delivery of health and medical services in rural areas of the state.

(4) The Rural Health Policy Council shall develop and establish uses for the funds to fund special projects that alleviate problems of access to quality health care in rural areas and to compensate public and private health care providers associated with direct delivery of patient care. The funds shall be used for medical and hospital care and treatment of patients who cannot afford to pay for services and for whom payment will not be made through private or public programs.

(5) The Office of Statewide Health Planning and Development shall administer the funds appropriated by the Budget Act of 1997 for purposes of this section. Entities eligible for these funds shall include rural health providers served by the programs operated by the departments represented on the Rural Health Policy Council, which include the State Department of Alcohol and Drug Programs, the Emergency Medical Services Authority, the State Department of Health Services, the State Department of Mental Health, and the Office of Statewide Health Planning and Development. The grant funds shall be used to expand existing services or establish new services and shall not be used to supplant existing levels of service.

(b) The Rural Health Policy Council shall establish the criteria and standards for eligibility to be used in requests for proposals or requests for application, the application review process, determining the maximum amount and number of grants to be awarded, preference and priority of projects, compliance monitoring, and the measurement of outcomes achieved after receiving comment from the public at a meeting held pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

(c) The Office of Statewide Health Planning and Development shall periodically report to the Rural Health Policy Council on the status of the funded projects. This information shall also be available at the public meetings.

(d) This section shall become inoperative on July 1, 1998, and, as of January 1, 1999, is repealed, unless a later enacted statute, that

becomes operative on or before January 1, 1999, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 7. Section 104380 of the Health and Safety Code is amended to read:

104380. (a) Funds appropriated to the department for local lead agencies for purposes of this article shall be allocated prospectively, on a quarterly basis in accordance with this section.

(b) No local lead agency shall be allocated less than one hundred fifty thousand dollars ($150,000).

(c) (1) Except as provided in subdivision (b), counties not listed in subdivision (d) shall receive an allocation based on each county's proportion of the statewide population.

(2) Counties that receive their allocations pursuant to paragraph (1) shall receive 73 percent of their 1990–91 fiscal year allocation.

(d) Except as provided in subdivision (b), the balance of the funds after the allocation contained in subdivision (c) have been made, shall be allocated to the following specified counties in accordance with the following percentages:

COUNTY	ALLOCATION
Alameda	4.7427%
Contra Costa	1.8032%
Fresno	2.6855%
Kern	1.7083%
Lake	0.1826%
Los Angeles	43.8057%
Mendocino	0.2664%
Merced	0.7244%
Monterey	1.2937%
Orange	5.1382%
Placer	0.3697%
Riverside	3.1828%
Sacramento	3.2922%
San Bernardino	3.7972%
San Diego	5.9971%
San Francisco	5.3898%
San Joaquin	1.7413%
San Luis Obispo	0.8096%
San Mateo	1.4582%
Santa Barbara	0.7918%
Santa Clara	5.2450%
Santa Cruz	0.7709%
Stanislaus	1.2793%

Tulare	1.3768%
Ventura	1.5472%
Yolo	0.6004%

(e) Except as provided in subdivision (b), the allocation for those counties in which a city health department which is a local lead agency as defined by subdivision (*l*) of Section 104355 is located shall be apportioned among the local lead agencies in that county based on their jurisdiction's proportionate share of the countywide population.

(f) Reductions in allocations necessary to comply with subdivision (b) shall be distributed among the counties listed in subdivision (d) proportionately based on the table contained in subdivision (d).

(g) The department shall use population estimates for 1989 for each county and for each city as specified in the Department of Finance E-1 Report.

(h) Payments shall be made prospectively, on a quarterly basis, to local jurisdictions.

(i) (1) The department shall conduct a fiscal and program review on a regular basis.

(2) If the department determines that any county is not in compliance with any provision of this chapter, the county shall submit to the department, within 60 days, a plan for complying with this article.

(3) The department may withhold funds from local lead agencies allocated funds under this section that are not in compliance with this chapter in the same manner as the department is authorized under Chapter 5 (commencing with Section 16940) of Part 4.7 of Division 9 of the Welfare and Institutions Code. The department may terminate the agreement with the noncompliant local lead agency, recoup any unexpended funds from the noncompliant local lead agency, and reallocate both the withheld and recouped funds to provide services available under this section to the jurisdiction of the noncompliant agency through an agreement with a different governmental or private nonprofit agency capable of delivering those services based on the department's local lead agency guidelines for local plans and a process determined by the department. The department may encumber and reallocate these funds no sooner than three months after the date of the first notification that the department has determined the local lead agency to be out of compliance with statutory requirements.

SEC. 8. Section 104485 of the Health and Safety Code is repealed.

SEC. 9. Section 104550 of the Health and Safety Code is repealed.

SEC. 10. Section 104569 of the Health and Safety Code, as amended and renumbered by Section 133 of Chapter 1023 of the Statutes of 1996, is repealed.

SEC. 11. Section 106805 of the Health and Safety Code is amended to read:

106805. (a) The application fees for certification are nonrefundable and shall be in the following amounts:

(1) Radon Measurement Laboratory	$300
(2) Radon Testing and Consulting Specialist	$100
(3) Radon Mitigation Contractor	$200

(b) These fees shall be deposited into the General Fund. The moneys in this fund are available, upon appropriation by the Legislature, to the department for the purposes of this article.

SEC. 12. Section 110241 is added to the Health and Safety Code, to read:

110241. All fees collected by the department pursuant to requests to conduct a voluntary medical device review shall be deposited into the Export Document Program Fund and, upon appropriation, shall be expended for the purpose of determining if the device is a new device or is substantially equivalent to a current or previously marked device.

SEC. 13. Section 115065 of the Health and Safety Code is amended to read:

115065. (a) Notwithstanding Section 6103 of the Government Code, the department shall provide by regulation a schedule of the fees that shall be paid by the following persons:

(1) Persons possessing radioactive materials under licenses issued by the department or under other state or federal licenses for the use of these radioactive materials, when these persons use these radioactive materials in the state in accordance with the regulations adopted pursuant to subdivision (d) of Section 115060.

(2) Persons generally licensed for the use of devices and equipment utilizing radioactive materials that are designed and manufactured for the purpose of detecting, measuring, gauging, or controlling thickness, density, level, interface location, radiation, leakage, or qualitative or quantitative chemical composition, or for producing light or an ionized atmosphere, if the devices are manufactured pursuant to a specific license authorizing distribution to general licensees.

(b) The revenues derived from the fees shall be used, together with other funds made available therefor, for the purpose of the issuance of licenses or the inspection and regulation of the licensees.

(c) The department may adopt emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code to establish and adjust fees for radioactive materials licenses in an amount to produce estimated revenues equal to at least 95 percent of the department's costs in

carrying out these licensing requirements, if the new fees were to remain in effect throughout the fiscal year for which the fee is established or adjusted.

(d) A local agency participating in a negotiated agreement pursuant to Section 114990 shall be fully reimbursed for direct and indirect costs based upon activities governed by Section 115070. With respect to these agreements, any salaries, benefits, and other indirect costs shall not exceed comparable costs of the department.

(e) The fees for licenses for radioactive materials and of devices and equipment utilizing those materials shall be adjusted annually pursuant to Section 100425.

SEC. 14. Section 115080 of the Health and Safety Code is amended to read:

115080. (a) Notwithstanding Section 6103 of the Government Code, the department shall provide by regulation a ranking of priority for inspection, as determined by the degree of potentially damaging exposure of persons by ionizing radiation and the requirements of Section 115085, and a schedule of fees, based upon that priority ranking, that shall be paid by persons possessing sources of ionizing radiation that are subject to registration in accordance with subdivisions (b) and (e) of Section 115060, and regulations adopted pursuant thereto. The revenues derived from the fees shall be used, together with other funds made available therefor, for the purpose of carrying out any inspections of the sources of ionizing radiation required by this chapter or regulations adopted pursuant thereto. The fees shall, together with any other funds made available to the department, be sufficient to cover the costs of administering this chapter, and shall be set in amounts intended to cover the costs of administering this chapter for each priority source of ionizing radiation. Revenues generated by the fees shall not offset any general funds appropriated for the support of the radiologic programs authorized pursuant to this chapter, and the Radiologic Technology Act (Section 27), and Chapter 7.6 (commencing with Section 114960). Persons who pay fees shall not be required to pay, directly or indirectly, for the share of the costs of administering this chapter of those persons for whom fees are waived. The department shall take into consideration any contract payment from the Health Care Financing Administration for performance of inspections for Medicare certification and shall reduce this fee accordingly.

(b) A local agency participating in a negotiated agreement pursuant to Section 114990 shall be fully reimbursed for direct and indirect costs based upon activities governed by Section 115085. With respect to these agreements, any salaries, benefits, and other indirect costs shall not exceed comparable costs of the department. Any changes in the frequency of inspections or the level of reimbursement to local agencies made by this section or Section

115085 during the 1985–86 Regular Session shall not affect ongoing contracts.

(c) The fees paid by persons possessing sources of ionizing radiation shall be adjusted annually pursuant to Section 100425.

(d) The department shall establish two different registration fees for mammography equipment pursuant to this section based upon whether the equipment is accredited by an independent accrediting agency recognized under the federal Mammography Quality Standards Act (42 U.S.C. Sec. 263b).

SEC. 15. Section 120450 of the Health and Safety Code is repealed.

SEC. 16. Section 120955 of the Health and Safety Code is amended to read:

120955. (a) To the extent that state and federal funds are appropriated in the Budget Act for these purposes, the director shall establish and may administer a program to provide drug treatments to persons infected with human immunodeficiency virus (HIV), the etiologic agent of acquired immune deficiency syndrome (AIDS). The director shall develop, maintain, and update as necessary a list of drugs to be provided under this program. Drugs on the list shall include, but not be limited to, the drugs zidovudine (AZT) and aerosolized pentamidine.

(b) The director may grant funds to a county public health department through standard agreements to administer this program in that county. To maximize the recipients' access to drugs covered by this program, the director shall urge the county health department in counties granted these funds to decentralize distribution of the drugs to the recipients.

(c) The director shall establish a rate structure for reimbursement for the cost of each drug included in the program. Rates shall not be less than the actual cost of the drug. However, the director may purchase a listed drug directly from the manufacturer and negotiate the most favorable bulk price for that drug.

(d) Manufacturers of the drugs on the list shall pay the department a rebate equal to the rebate that would be applicable to the drug under Section 1927(c) of the federal Social Security Act (42 U.S.C. Sec. 1396r-8(c)), except that no rebates shall be paid to the department under this section on drugs for which the department has received a rebate under Section 1927(c) of the federal Social Security Act (42 U.S.C. Sec. 1396r-8(c)) or that have been purchased on behalf of county health departments or other eligible entities at discount prices made available under Section 256b of Title 42 of the United States Code.

(e) The department shall submit an invoice, not less than two times per year, to each manufacturer for the amount of the rebate required by subdivision (d).

(f) Drugs may be removed from the list for failure to pay the rebate required by subdivision (d), unless the department determines that removal of the drug from the list would cause substantial medical hardship to beneficiaries.

(g) The department may adopt emergency regulations to implement amendments to this chapter made during the 1997–98 Regular Session, in accordance with the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The initial adoption of emergency regulations shall be deemed to be an emergency and considered by the Office of Administrative Law as necessary for the immediate preservation of the public peace, health and safety, or general welfare. Emergency regulations adopted pursuant to this section shall remain in effect for no more than 180 days.

(h) Reimbursement under this chapter shall not be made for any drugs that are available to the recipient under any other private, state, or federal programs, or under any other contractual or legal entitlements, except that the director may authorize an exemption from this subdivision where exemption would represent a cost savings to the state.

SEC. 17. Section 120970 is added to the Health and Safety Code, to read:

120970. In the event the department utilizes a contractor or subcontractor to administer any aspect of the program provided for under this chapter, the following additional client assistance provisions shall apply:

(a) The contractor shall, either directly or through subcontracted pharmacy outlets, obtain and dispense the necessary drugs, in their approved forms according to the program formulary, and shall comply with all applicable provisions of the California Pharmacy Law (Chapter 9 (commencing with Section 4000) of Division 2 of the Business and Professions Code) and regulations adopted thereunder.

(b) Upon receipt of notification by the department, the contractor shall be able to accommodate additions or changes in the formulary within 10 business days.

(c) Clients shall receive drugs from a participating pharmacy either directly, through the client's designated representative, or mailed or delivered to the client's place of residence by the contractor or subcontractor, whichever the client prefers. Proof of delivery of the prescription to the client's designated address, by signature acknowledging receipt thereof, shall be required for all mail order prescriptions.

(d) Clients shall have their prescriptions filled within 24 hours of submission of prescription requests, and mail order prescriptions shall be shipped by the contractor within 48 hours of receipt of client prescription requests.

(e) The contractor shall provide 24-hour free telephone and fax machine access for physicians and surgeons, or medical care providers as authorized under state law, to call in or transmit prescriptions for mail order pharmacy.

(f) Clients shall have toll-free telephone access during business hours to speak with licensed pharmacists for medication counseling and for mail order prescription requests. The contractor shall provide consultation in the prevention of potentially harmful drug interactions in connection with prescriptions filled for clients.

(g) The contractor shall have the ability to subcontract with any willing provider, including independent and sole proprietorship pharmacies, provided the subcontractor accepts the rates offered by the contractor, supplies the contractor with timely information, and complies with necessary contract terms and conditions and other needs of the program as determined by the contractor or the department.

(h) It is the intent of the Legislature that the contractor subcontract with all willing providers accepting the terms and conditions provided for in subdivisions (a) to (g), inclusive, in order to facilitate continuity of care for clients under this chapter.

(i) All types of information, whether written or oral, concerning a client, made or kept in connection with the administration of this program shall be confidential, and shall not be used or disclosed except for purposes directly connected with the administration of the program.

(j) Information regarding program policies and procedures, including enrollment procedures, eligibility guidelines, and lists of drugs covered, shall be made available to clients in appropriate literacy levels in English, Spanish, Mandarin/Cantonese, Tagalog, and in other languages, as determined by the department.

(k) The contractor shall develop and maintain a timely and accessible grievance procedure for clients to resolve problems regarding all components of the delivery of drugs under this chapter.

SEC. 18. Section 121200 of the Health and Safety Code is amended to read:

121200. The Legislature finds and declares all of the following:

(a) Over the past five years AIDS has reached an epidemic stage and is estimated to affect 30,000 Californians by 1990.

(b) The estimated cost of medical care alone for the 4,000 AIDS cases that have occurred to date in California totals approximately two hundred fifty million dollars ($250,000,000). By the end of 1990, medical care is projected to approach three billion five hundred million dollars ($3,500,000,000) and the total public health and medical care expenditures are expected to exceed five billion dollars ($5,000,000,000).

(c) There is no cure for the AIDS virus. The long-term solution to the elimination of AIDS lies in conducting vaccine research.

(d) Much research has already been completed by the private sector and should be utilized to the maximum extent possible, including supplementing with public funds.

(e) Profitmaking corporations are (1) not eligible for most of the existing public funding sources as are institutions of higher learning and nonprofit corporations; (2) when eligible, the public funding amounts are not adequate to conduct research; and (3) private grants are only available to nonprofit corporations.

(f) Moreover, private research companies, already having established vaccine development and manufacturing capabilities, are uniquely situated to maximize available resources and to utilize both management and research staff, equipment, and technical innovations to their greatest efficiency towards the specific goal of developing and manufacturing an AIDS vaccine at the earliest possible time.

(g) Exclusion of private corporations from public funding to develop an approved vaccine will likely result in (1) a delay in the development of a vaccine to prevent AIDS; (2) continued spread of AIDS to the general population; and (3) continued increases in private and public funds to provide care to AIDS victims.

(h) It is appropriate to mandate that a grant made to a private entity to develop an AIDS vaccine, once the vaccine has been approved by the FDA for use by the general population, should be reimbursed to the state from the sale of the vaccine.

SEC. 19. Section 121205 of the Health and Safety Code is repealed.

SEC. 20. Section 121215 of the Health and Safety Code is repealed.

SEC. 21. Section 121220 of the Health and Safety Code is repealed.

SEC. 22. Section 121260 of the Health and Safety Code is amended to read:

121260. The Legislature further finds and declares all of the following:

(a) The average cost per patient in the treatment of AIDS until death is now one hundred fifty thousand dollars ($150,000). It is estimated that total costs including health care of the first 10,000 AIDS cases in the United States totaled more than six billion three hundred million dollars ($6,300,000,000). By 1990, according to the department, Californians will spend almost five billion dollars ($5,000,000,000) in medical costs alone in care and treatment of 30,000 AIDS patients, with no realistic hope for their remission or cure. This cost does not include money spent on education, research, and lost income.

(b) To date, the costs of caring for people with AIDS related complex (ARC) has not been officially calculated. However, it is safe to assume the costs are substantial over time. Experts fear that the

illnesses of ARC patients, although they may not be fatal, are severe. For example, the virus invades the brain rendering the patients incapable of caring for themselves. It is, therefore, plausible that a percentage of ARC patients will need to be institutionalized.

(c) The Legislature intends by this chapter to take uncommon action to remove the impediments to the expeditious development of an AIDS vaccine.

(d) It is further the intent of the Legislature to provide to any person, whose injury is proximately caused by the use of the vaccine, except to the extent the injuries are attributable to the comparative negligence of the claimant in the use of the vaccine, all of the following:

(1) Compensation for related medical costs associated with the care and treatment of the injury.

(2) Compensation for the loss of any and all earnings caused by the injury.

(3) Compensation for pain and suffering caused by the injury, except that in no action shall the amount of damages for noneconomic losses exceed five hundred fifty thousand dollars ($550,000).

(e) It is further the intent of the Legislature to establish the AIDS Clinical Trials Testing Fund that will be available to not more than three California manufacturers of an AIDS vaccine approved by the federal Food and Drug Administration (FDA) or the department pursuant to Part 5 (commencing with Section 109875) of Division 104 for clinical trials with humans.

(f) The AIDS Vaccine Research and Development Advisory Committee shall review requests from California manufacturers for funds from the AIDS Clinical Trials Testing Fund and shall make recommendations to the department regarding the award of funds, including the appropriate amount of funding. The department, taking into consideration the committee's recommendations, may allocate the funds to the manufacturers specified in the protocol approved by the FDA or the department pursuant to Part 5 (commencing with Section 109875) of Division 104 for administering the clinical trials.

(g) A California manufacturer seeking the approval of the FDA, rather than the department, for administering clinical trials of an AIDS vaccine may apply while FDA approval is pending to the AIDS Vaccine Research and Development Advisory Committee for the committee's recommendation that the manufacturer receive funds from the AIDS Clinical Trials Testing Fund upon FDA approval.

SEC. 23. Section 121305 of the Health and Safety Code is amended to read:

121305. For the purposes of this chapter, the following definitions apply:

(a) "AIDS" means acquired immune deficiency syndrome.

(b) "An HIV-positive individual" means an individual who is infected with the AIDS virus.

(c) "Committee" means the AIDS Vaccine Research and Development Advisory Committee.

(d) "Grant award" means an AIDS Vaccine Clinical Trial Grant Award for the Prevention of Maternal Transmission of HIV Infection.

(e) "AIDS vaccine," for the purposes of this chapter, means a vaccine that has been developed by a manufacturer and is being tested and administered for the purposes of determining whether immunization of HIV-infected pregnant women will protect against maternal transmission of the AIDS virus. Clinical trials must be conducted under an investigational new drug (IND) application on file with the federal Food and Drug Administration (FDA).

(f) "Research subject" means a person who is administered an AIDS vaccine, or a fetus of a woman administered an AIDS vaccine, or a child born to a woman administered an AIDS vaccine during pregnancy.

(g) "Researcher" means a person employed by or affiliated with a manufacturer or a research institution, who participates in the development or testing or administration of an AIDS vaccine, or who is involved in the diagnosis and treatment of a research subject.

SEC. 24. Section 121358 is added to the Health and Safety Code, to read:

121358. (a) Notwithstanding any other provision of law, individuals housed or detained through the tuberculosis control, housing, and detention program shall not reside in correctional facilities, and the funds available under that program with regard to those individuals shall not be disbursed to, or used by, correctional facilities. This section shall not be interpreted to prohibit the institutionalization of criminals with tuberculosis in correctional facilities.

(b) The department shall work with local health jurisdictions to identify a detention site for recalcitrant tuberculosis patients appropriate for each local health jurisdiction in the state. The department shall notify all counties of their designated site by January 1, 1998.

SEC. 25. Section 123255 is added to the Health and Safety Code, to read:

123255. (a) The department may maintain a maternal and child health program in each county.

(b) Notwithstanding any other provision of law, the department may allocate, for the purposes of maintaining a maternal and child health program, to a county an amount determined in a manner as the director shall provide. The total of all county allocations shall not exceed the annual appropriation for this purpose.

(c) To be considered for an allocation, the county's governing board shall submit a plan and budget for the county's program in

accordance with maternal and child health plans and priorities to be approved by the department under Title V of the Public Health Service Act (42 U.S.C. Sec. 701 et seq.). The department shall establish the procedures and format for submission of the plan and budget. The plan shall conform to the department's maternal and child health priorities that are in accordance with the core public health functions of needs assessment, policy development, and assurance.

(d) The department shall establish minimum standards that govern the basis for allocations to counties, including, but not limited to, the services to be provided, administration, staffing, fiscal accountability, and eligibility for services. The department may recoup or withhold all or part of a county's allocation for failure to comply with those standards.

(e) Claims for reimbursement shall be made in a manner as provided by the director for activities provided in accordance with the plan and budget for the fiscal year in which the expenses upon which the claim is based are incurred.

(f) There shall be no reimbursement for any of the following:

(1) Projects or programs identified unless previously approved by the department as part of the maternal and child health plan.

(2) Capital improvements.

(3) The purchase or construction of buildings except for the equipment items and remodeling expenses as may be allowed by the department on a case-by-case basis.

(g) The department and counties shall maximize the use of federal funds available to implement this section, including using state or county funds to match funds claimable under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(h) (1) For purposes of this program, the department shall reimburse a county pursuant to this section in lieu of renewing or commencing a cooperative agreement with a county for the operation of a maternal and child health program.

(2) It is the intent of the Legislature that cooperative agreements between the department and a county for the operation of a maternal and child health program pursuant to this section be replaced by the process described in this section beginning with the 1997–98 fiscal year.

SEC. 26. Section 123279 is added to the Health and Safety Code, to read:

123279. (a) It is the intent of the Legislature in adding this section to authorize the establishment of a program designed to implement the federal WIC Farmers' Market Nutrition Act of 1992 (Public Law 102-314), which is designed to accomplish the following:

(1) Provide resources to persons who are nutritionally at risk, in the form of fresh, high-quality agricultural products from certified farmers' markets.

(2) Expand the awareness and use of certified farmers' markets and increase sales at those markets.

(b) The department may establish a program designed to implement the federal WIC Farmers Market Nutrition Act of 1992.

(c) If the program is established, the department shall develop criteria to permit any producer authorized by the department to participate in the program to sell fresh nutritious foods to recipients in exchange for nutrition coupons.

(d) If the program is established, the department shall authorize local agencies to distribute nutrition coupons to all recipients, as defined by subdivision (c) of Section 123285 of the Health and Safety Code.

(e) If the program is established, the department shall design the nutrition coupon issuance process to ensure that nutrition coupons are bearer-only, nonnegotiable, and nontransferable by the recipient and that they may be redeemed by recipients only to purchase fresh produce and redeemed for reimbursement only by authorized producers.

(f) It is the intent of the Legislature that the program established by this section to implement the federal WIC Farmers' Market Nutrition Act of 1992 (Public Law 102-314) be funded 70 percent by federal funds and 30 percent by private or other funds, as specified by the federal act.

SEC. 27. Chapter 1.5 (commencing with Section 124450) is added to Part 4 of Division 106 of the Health and Safety Code, to read:

CHAPTER 1.5. CLINIC SERVICES

124450. (a) In any emergency or disaster, as declared by the Governor, clinics funded under the seasonal agricultural and migratory workers program provided for by Chapter 3 (commencing with Section 124550), the rural health services development program provided for by Chapter 5 (commencing with Section 124600) or the expanded access to primary care program provided for by Article 2 (commencing with Section 124900) of Chapter 7 shall provide nonelective, primary health care services, utilizing a sliding-fee scale based on income, including a zero payment option, to all persons who are impacted by the emergency or disaster and who present themselves for treatment at the clinic.

(b) The department shall deny or recoup payment under Chapter 3 (commencing with Section 124550), Chapter 5 (commencing with Section 124600), and Article 2 (commencing with Section 124900) of Chapter 7, assess civil penalties, revoke or suspend the license of the clinic pursuant to Section 1229, or impose other sanctions or other penalties authorized by law, when the clinic charges patients for care and fails to utilize a sliding-fee scale based on income, including a

zero-payment option, to determine the fees to be charged to any patient pursuant to subdivision (a).

(c) To the extent that the department enters into contracts or renews contracts with clinics identified in subdivision (b) on or after the effective date of this section, those contracts shall require clinics to utilize a sliding-fee scale based on income, including a zero-payment option, when determining fees to be assessed for patients.

SEC. 28. Section 124950 of the Health and Safety Code is repealed.

SEC. 29. Section 12696.05 of the Insurance Code is amended to read:

12696.05. The board may do all of the following:

(a) Determine eligibility criteria for the program. These criteria shall include the requirements set forth in Section 12698.

(b) Determine the eligibility of applicants.

(c) Determine when subscribers are covered and the extent and scope of coverage.

(d) Determine subscriber contribution amounts schedules. Subscriber contribution amounts shall be indexed to the federal poverty level and shall not exceed 2 percent of a subscriber's annual gross family income.

(e) Provide coverage through participating health plans or through coordination with other state programs, and contract for the processing of applications and the enrollment of subscribers. Any contract entered into pursuant to this part shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The board shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on projected and actual subscriber enrollments in a total amount not to exceed the amount appropriated for the program.

(f) Authorize expenditures from the fund to pay program expenses which exceed subscriber contributions, and to administer the program as necessary.

(g) Develop a promotional component of the program to make Californians aware of the program and the opportunity that it presents.

(h) Issue rules and regulations as necessary to administer the program. All rules and regulations issued pursuant to this subdivision that manage program integrity, revise the benefit package, or reduce the eligibility criteria below 300 percent of the federal poverty level may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of these regulations shall be deemed an

emergency and necessary for the immediate preservation of the public peace, health, and safety, or general welfare. The regulations shall become effective immediately upon filing with the Secretary of State.

(i) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this part.

SEC. 30. Section 12699.50 of the Insurance Code is repealed.

SEC. 31. Section 1372 of the Penal Code is amended to read:

1372. (a) (1) If the medical director of the state hospital or other facility to which the defendant is committed, or the community program director, county mental health director, or regional center director providing outpatient services, determines that the defendant has regained mental competence, the director shall immediately certify that fact to the court by filing a certificate of restoration with the court by certified mail, return receipt requested. For purposes of this section, the date of filing shall be the date on the return receipt.

(2) The court's order committing an individual to a state hospital or other treatment facility pursuant to Section 1370 shall include direction that the sheriff shall redeliver the patient to the court without any further order from the court upon receiving from the state hospital or treatment facility a copy of the certificate of restoration. The defendant shall be returned to the committing court in the following manner: A patient who remains confined in a state hospital or other treatment facility shall be redelivered to the sheriff of the county from which the patient was committed. The sheriff shall immediately return the person from the state hospital or other treatment facility to the court for further proceedings. The patient who is on outpatient status shall be returned by the sheriff to court through arrangements made by the outpatient treatment supervisor. In all cases, the patient shall be returned to the committing court no later than 10 days following the filing of a certificate of restoration. The state shall only pay for 10 hospital days for patients following the filing of a certificate of restoration of competency. The State Department of Mental Health shall report to the fiscal and policy committees of the Legislature on an annual basis in January, on the number of days that exceed the 10-day limit.

(b) If the defendant becomes mentally competent after a conservatorship has been established pursuant to the applicable provisions of the Lanterman-Petris-Short Act, Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code, and Section 1370, the conservator shall certify that fact to the sheriff and district attorney of the county in which defendant's case is pending, defendant's attorney of record, and the committing court.

(c) When a defendant is returned to court with a certification that competence has been regained, the court shall notify either the community program director, the county mental health director, or

the regional center director and the Director of Developmental Services, as appropriate, of the date of any hearing on the defendant's competence and whether or not the defendant was found by the court to have recovered competence.

(d) Where the committing court approves the certificate of restoration to competence as to a person in custody, the court shall hold a hearing to determine whether the person is entitled to be admitted to bail or released on own recognizance status pending conclusion of the proceedings. Where the superior court approves the certificate of restoration to competence regarding a person on outpatient status, unless it appears that the person has refused to come to court, that person shall remain released either on own recognizance status, or, in the case of a developmentally disabled person, either on the defendant's promise or on the promise of a responsible adult to secure the person's appearance in court for further proceedings. Where the person has refused to come to court, the court shall set bail and may place the person in custody until bail is posted.

(e) A defendant subject to either subdivision (a) or (b) who is not admitted to bail or released under subdivision (d) may, at the discretion of the court, upon recommendation of the director of the facility where the defendant is receiving treatment, be returned to the hospital or facility of his or her original commitment or other appropriate secure facility approved by the community program director, the county mental health director, or the regional center director. The recommendation submitted to the court shall be based on the opinion that the person will need continued treatment in a hospital or treatment facility in order to maintain competence to stand trial or that placing the person in a jail environment would create a substantial risk that the person would again become incompetent to stand trial before criminal proceedings could be resumed.

(f) Notwithstanding subdivision (e), if a defendant is returned by the court to a hospital or other facility for the purpose of maintaining competency to stand trial and that defendant is already under civil commitment to that hospital or facility from another county pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code) or as a developmentally disabled person committed pursuant to Article 2 (commencing with Section 6500) of Chapter 2 of Part 2 of Division 6 of the Welfare and Institutions Code, the costs of housing and treating the defendant in that facility following return pursuant to subdivision (e) shall be the responsibility of the original county of civil commitment.

SEC. 32. Section 4418.1 is added to the Welfare and Institutions Code, to read:

4418.1. (a) The Legislature recognizes that it has a special obligation to ensure the well-being of persons with developmental disabilities who are moved from state hospitals to the community.

(b) To ensure that persons with developmental disabilities who are moved from state hospitals to the community are receiving necessary services and supports, the department shall contract with an independent agency or organization for the tracking and monitoring of those persons, including all persons moved as a result of the Coffelt v. State Department of Developmental Services settlement agreement and any persons moved after the terms of that agreement have been met.

(c) The contractor shall be experienced in all of the following:

(1) Designing valid tracking instruments.

(2) Tracking the quality of community programs, including outcome-based measures such as health and safety, quality of life, integration, choice, and consumer satisfaction.

(3) Tracking the quality and appropriateness of community placements for persons moving from large institutions into community settings.

(4) Developing data systems.

(5) Data analysis and report preparation.

(d) The contractor shall measure consumer and family satisfaction with services provided, including case management and quality of life, including, but not limited to, health and safety, independence, productivity, integration, opportunities for choice, and delivery of needed services.

(e) The information maintained for each person shall include the person's name, address, nature of disability, medical condition, scope of community-based services and supports, and the annual data collected by the contractor.

(f) The contractor shall meet with each person, and the person's family, legal guardian, or conservator, when appropriate, no less than once a year to discuss quality of life and observe the person's services and supports. In cases where the consumer is not capable of communicating his or her responses and where there is no family member, guardian, or conservator involved, the contractor shall meet with no less than two persons familiar with the consumer. Additionally, the contractor shall interview staff and friends who know the consumer best and review records, as appropriate.

(g) If the contractor identifies any suspected violation of the legal, civil, or service rights of an individual, or if the contractor determines that the health and welfare of the individual is at risk, that information shall be provided immediately to the regional center providing case management services, the client rights advocate, and to the department.

(h) The department shall monitor the corrective actions taken by the regional center and maintain a report in the person's file. The

consumer and, when appropriate, his or her parents, legal guardian, or conservator, shall be provided with access to the person's file and be provided with copies of all reports filed with the regional center or department relative to them.

(i) The department shall establish a task force, including representatives from stakeholder organizations, to annually review the findings of the contractor and make recommendations regarding additional or differing criteria for information to be gathered by the contractor in future interviews.

(j) As of July 1, 1998, and annually thereafter, the contractor shall provide a report to the Governor, the Legislature, and the department outlining the activities and findings of this process. The reports shall be public and shall contain no personally identifying information about the persons being monitored.

SEC. 33. Section 4418.7 is added to the Welfare and Institutions Code, to read:

4418.7. (a) If the regional center determines, or is informed by the consumer's parents, legal guardian, or conservator, that the community placement of a consumer is at risk of failing, and that admittance to a state developmental center is a likelihood, the regional center shall immediately notify the department, the consumer, and the parents, legal guardian, or conservator.

(b) In these cases, the department shall immediately arrange for an assessment of the situation. If, based on the assessment, the department determines that additional or different services and supports are necessary, the department shall ensure that the regional center provides those services and supports on an emergency basis. An individual program plan meeting, including the department's representative, shall be convened as soon as possible to review the emergency services and supports and determine the consumer's ongoing needs for services and supports.

(c) If the department, in consultation with the regional center, the consumer, and the consumer's parents, legal guardian, or conservator, when appropriate, determines that admittance to a state developmental center is necessary to protect the health and welfare of the consumer, the department shall immediately seek that admission.

SEC. 34. Section 4433 is added to the Welfare and Institutions Code, to read:

4433. (a) The Legislature finds and declares all of the following:

(1) The State of California accepts its responsibility to ensure and uphold the rights of persons with developmental disabilities and an obligation to ensure that laws, regulations, and policies on the rights of persons with developmental disabilities are observed and protected.

(2) Persons with developmental disabilities are vulnerable to abuse, neglect, and deprivations of their rights.

(3) Clients' rights advocacy services provided by the regional centers, the advocacy services currently provided by the department at the state hospitals, and the services provided by the department's Office of Human Rights may have conflicts of interest, or the appearance of a conflict of interest.

(4) The services provided to individuals with developmental disabilities and their families are of such a special and unique nature that they cannot satisfactorily be provided by state agencies or regional centers and must be contracted out pursuant to paragraph (3) of subdivision (b) of Section 19130 of the Government Code.

(b) (1) To avoid the potential for a conflict of interest or the appearance of a conflict of interest, beginning January 1, 1998, the department shall contract for clients' rights advocacy services. The department shall solicit a single statewide contract with a nonprofit agency that results in at least three responsive bids that meet all of the criteria specified in paragraph (2) to perform the services specified in subdivision (d). If three responsive bids are not received, the department may rebid the contract on a regional basis, not to exceed three regional contracts and one contract for developmental centers and headquarters.

(2) Any contractor selected shall meet the following requirements:

(A) The contractor can demonstrate the capability to provide statewide advocacy services to individuals with developmental disabilities living in developmental centers and in the community.

(B) The contractor does not directly or indirectly provide services to individuals with developmental disabilities, except advocacy services.

(C) The contractor has knowledge of the service system, entitlements, and service rights of persons receiving services from regional centers and in state hospitals.

(D) The contractor can demonstrate the capability of coordinating services with the protection and advocacy agency specified in Division 4.7 (commencing with Section 4900) and the area boards.

(E) The contractor has not provided any services, except advocacy services, to, or been employed by, any regional center or the Association of Regional Center Agencies during the two-year period prior to the effective date of the contract.

(c) For the purposes of this section, the Legislature further finds and declares that because of a potential conflict of interest or the appearance of a conflict of interest, the goals and purposes of the regional center clients' rights advocacy services, the state hospitals, and the services of the Office of Human Rights, cannot be accomplished through the utilization of persons selected pursuant to the regular civil service system, nor can the services be provided through the department's contracts with regional centers.

Accordingly, contracts into which the department enters pursuant to this section are permitted and authorized by paragraphs (3) and (5) of subdivision (b) of Section 19130 of the Government Code.

(d) The contractor shall do all of the following:

(1) Provide clients' rights advocacy services to persons with developmental disabilities who are consumers of regional centers and to individuals who reside in the state developmental centers and hospitals, including ensuring the rights of persons with developmental disabilities, and assisting persons with developmental disabilities in pursuing administrative and legal remedies.

(2) Investigate and take action as appropriate and necessary to resolve complaints from, or concerning persons with, developmental disabilities residing in licensed health and community care facilities regarding abuse, and unreasonable denial, or punitive withholding, of rights guaranteed under this division.

(3) Provide consultation, technical assistance, supervision and training, and support services for clients' rights advocates that were previously the responsibility of the Office of Human Rights.

(4) Coordinate the provision of clients' rights advocacy services in consultation with the department, stakeholder organizations, and persons with developmental disabilities and their families representing California's multicultural diversity.

(5) Provide at least two self-advocacy trainings for consumers and family members.

(e) In order to ensure that individuals with developmental disabilities have access to high quality advocacy services, the contractor shall establish a grievance procedure and shall advise persons receiving services under the contract of the availability of other advocacy services, including the services provided by the protection and advocacy agency specified in Division 4.7 (commencing with Section 4900) and the area boards.

(f) The department shall contract on a multiyear basis for a contract term of up to three years, subject to the annual appropriation of funds by the Legislature.

(g) This section shall not prohibit the department and the regional centers from advocating for the rights, including the right to generic services, of persons with developmental disabilities.

SEC. 35. Section 4596.5 is added to the Welfare and Institutions Code, to read:

4596.5. (a) In order to remain informed about the quality of services in the area and protect the legal, civil, and service rights of persons with developmental disabilities pursuant to Section 4590, the Legislature finds that it is necessary to conduct life quality assessments with consumers served by the regional centers.

(b) It is the intent of the Legislature that life quality assessments described in this section be conducted by area boards, unless an independent evaluation of the life quality assessment process, that

shall be completed by April 30, 1998, identifies compelling reasons why this function should not be conducted by area boards.

(c) By July 1, 1998, the department shall enter into an interagency agreement with the Organization of Area Boards, on behalf of the area boards, to conduct the life quality assessments described in this section.

(d) Consistent with the responsibilities described in this chapter, the area board, with the consent of the consumer and, when appropriate, a family member, shall conduct life quality assessments with consumers living in out-of-home placements, supported living arrangements, or independent living arrangements no less than once every three years or more frequently upon the request of a consumer, or, when appropriate, a family member. A regional center shall annually provide the local area board with a list, including the name, address, and telephone number of each consumer, and, when appropriate, a family member, the consumer's date of birth, and the consumer's case manager, for all consumers living in out-of-home placements, supported living arrangements, or independent living arrangements, in order to facilitate area board contact with consumers and, when appropriate, family members, for the purpose of conducting life quality assessments.

(e) The life quality assessments shall be conducted by utilizing the State Department of Developmental Services' Looking at Life Quality Handbook.

(f) The assessments shall be conducted by consumers, families, providers, and others, including volunteer surveyors. Each area board shall recruit, train, supervise, and coordinate surveyors. Upon request, and if feasible, the area board shall respect the request of a consumer and, when appropriate, family member, for a specific surveyor to conduct the life quality assessment. An area board may provide stipends to surveyors.

(g) A life quality assessment shall be conducted within 90 days prior to a consumer's triennial individual program plan meeting, so that the consumer and regional center may use this information as part of the planning process.

(h) Prior to conducting a life quality assessment, the area board shall meet with the regional center to coordinate the exchange of appropriate information necessary to conduct the assessment and ensure timely followup to identified violations of any legal, civil, or service rights.

(i) Following the conduct of each life quality assessment, the area board shall develop a report of its findings and provide a copy of the report to the consumer, when appropriate, family members, and the regional center providing case management services to the consumer. In the event that a report identifies alleged violations of any legal, civil, or service right, the area board shall notify the regional center and the department of the alleged violation. The

department shall monitor the regional center to ensure that violations are addressed and resolved in a timely manner.

(j) Regional centers shall review information from the life quality assessments on a systemic basis in order to identify training and resource development needs.

(k) Effective August 1, 1999, and annually thereafter, the Organization of Area Boards shall prepare and submit a report to the Governor, the Legislature, and the department describing the activities and accomplishments related to the implementation of this section. The report shall include, but not be limited to, the number of life quality assessments conducted, the number of surveyors, including those provided stipends, a description of the surveyor recruitment process and training program, including any barriers to recruitment, the number, nature, and outcome of any identified violations of legal, civil, or service rights reported to regional centers, and recommendations for improvement in the life quality assessment process.

(*l*) Implementation of this section shall be subject to an annual appropriation of funds in the state Budget Act for this purpose.

(m) If the department finds, based on the results of the independent study described in subdivision (b), that there is a compelling reason why the area boards should not conduct the life quality assessments, it may select an alternative governmental agency or contract with a nonprofit agency to conduct the life quality assessments as described in this section. The department shall notify the Governor and the Legislature of such a finding, including the reasons for the finding and a description of the alternative method by which the department will ensure the life quality assessment process is completed.

SEC. 36. Section 4639 is added to the Welfare and Institutions Code, to read:

4639. The governing board of a regional center shall annually contract with an independent accounting firm for an audited financial statement. The audit report and accompanying management letter shall be reviewed and approved by the regional center board and submitted to the department within 60 days of completion and before April 1 of each year. Upon submission to the department, the audit report and accompanying management letter shall be made available to the public by the regional center. It is the intent of the Legislature that no additional funds be appropriated for this purpose.

SEC. 37. Section 4643.5 of the Welfare and Institutions Code is amended to read:

4643.5. (a) If a consumer is or has been determined to be eligible for services by a regional center, he or she shall also be considered eligible by any other regional center if he or she has moved to another location within the state.

(b) An individual who is determined by any regional center to have a developmental disability shall remain eligible for services from regional centers unless a regional center, following a comprehensive reassessment, concludes that the original determination that the individual has a developmental disability is clearly erroneous.

(c) Whenever a consumer transfers from one regional center catchment area to another, the level and types of services and supports specified in the consumer's individual program plan shall be authorized and secured, if available, pending the development of a new individual program plan for the consumer. If these services and supports do not exist, the regional center shall convene a meeting to develop a new individual program plan within 30 days. Prior to approval of the new individual program plan, the regional center shall provide alternative services and supports that best meet the individual program plan objectives in the least restrictive setting. The department shall develop guidelines that describe the responsibilities of regional centers in ensuring a smooth transition of services and supports from one regional center to another, including, but not limited to, pretransferring planning and a dispute resolution process to resolve disagreements between regional centers regarding their responsibilities related to the transfer of case management services.

SEC. 38. Section 4681.1 of the Welfare and Institutions Code is amended to read:

4681.1. (a) By July 1 each year, the department shall establish rates, that shall be reviewed by the state council. Payment of these rates shall be subject to the appropriation of sufficient funds for that purpose in the Budget Act. In reviewing the sufficiency of these rates that is required by March 1, 1989, the department shall take into account the findings and recommendations of the study conducted by the State Council on Developmental Disabilities pursuant to Section 4541.

(b) In establishing rates to be paid for out-of-home care, the department shall include each of the cost elements in this section as follows:

(1) Rates established for all facilities shall include an adequate amount to care for "basic living needs" of a person with developmental disabilities. "Basic living needs" shall include housing, shelter, utilities, furnishings, food, incidental transportation, housekeeping, and personal care items. The amount required for basic living needs shall be calculated each year as the average cost of these items in community care facilities. The department shall annually publish a listing of the allowable cost components of these cost items and the methodology used to determine the amounts of each item. The amount for basic living needs shall be adjusted depending on the extent to which there is a demonstrated variation

based on the size of the out-of-home facility. These amounts shall be adjusted annually to reflect cost-of-living changes. A redetermination of basic living costs shall be undertaken every three years by the State Department of Developmental Services, using the best available estimating methods. The first report shall be made on March 1, 2001. The department shall convene an advisory committee and develop a plan, including a proposal for an appropriate study methodology, for the redetermination of basic living costs. The advisory committee shall include, but not be limited to, service consumers, family members, residential service providers, and advocacy groups.

(2) Rates established for all facilities that provide direct supervision for persons with developmental disabilities shall include an amount for "direct supervision." The cost of "direct supervision" shall vary with the person's functioning in the areas of self-care and daily living skills, physical coordination and mobility, and behavioral self-control and shall reflect one of the following:

(A) Basic self-help and daily living skills, no significant limitations in physical coordination and mobility, and behavioral self-control.

(B) Poor self-help and daily living skills, some limitations in physical coordination and mobility, or some disruptive or self-injurious behavior.

(C) Severe deficits in self-care and daily living skills, severe impairments in physical coordination and mobility, or severely disruptive or self-injurious behavior.

The individual program plan developed pursuant to Section 4646 shall determine the amount of direct supervision required for each individual. The cost of direct supervision shall be calculated as the wage and benefit costs of caregiving staff depending on the level of service being provided to meet the functional needs of the person with developmental disabilities. These rates shall be adjusted annually to reflect wage changes and shall comply with all federal regulations for hospitals and residential care establishments under the federal Fair Labor Standards Act.

(3) Rates established for all facilities that provide "special services" for persons with developmental disabilities shall include an amount to pay for such "special services" for each person receiving special services. "Special services" include specialized training, treatment, supervision, or other services which the individual program plan of each person requires to be provided by the residential facility in addition to the direct supervision provided pursuant to the person's individual program plan in subdivision (b). Facilities shall be paid for providing special services for each individual to the extent that such services are specified in the person's individual program plan and the facility is a designated provider of such special services. Rates of payment for special services shall be the same as prevailing rates paid for similar services in the area.

(4) To the extent applicable, rates established for facilities shall include a reasonable amount for "unallocated services." These costs shall be determined using generally accepted accounting principles. "Unallocated services" means the indirect costs of managing a facility and includes costs of managerial personnel, facility operation, maintenance and repair, employee benefits, taxes, interest, insurance, depreciation, and general and administrative support. If a facility serves other persons in addition to developmentally disabled persons, unallocated services expenses shall be reimbursed under this section, only for the proportion of the costs associated with the care of developmentally disabled persons. The amount for unallocated services shall be adjusted depending on the extent to which there is a demonstrated variation due to such factors as facility size or administrative structure.

(5) Rates established for facilities shall include an amount to reimburse facilities for the depreciation of "mandated capital improvements and equipment" as established in the state's uniform accounting manual. For purposes of this section, "mandated capital improvements and equipment" are only those remodeling and equipment costs incurred by a facility because an agency of government has required such remodeling or equipment as a condition for the use of the facility as a provider of out-of-home care to persons with developmental disabilities.

(6) When applicable, rates established for proprietary facilities shall include a reasonable "proprietary fee."

(7) Rates established for all facilities shall include as a "factor" an amount to reflect differences in the cost of living for different geographic areas in the state.

(8) Rates established for developmentally disabled persons who are also mentally disordered may be fixed at a higher rate. The State Department of Mental Health shall establish criteria upon which higher rates may be fixed pursuant to this subdivision. The higher rate for developmentally disabled persons who are also mentally disordered may be paid when requested by the director of the regional center and approved by the Director of Developmental Services.

(c) This section shall apply to facility rates paid under the alternative residential model originally authorized in Item 4300-101-001 of the Budget Act of 1985 and as identified in the department's report of April 1987 entitled Alternative Residential Model (ARM).

(d) The department shall approve additional facilities to receive rates pursuant to this section upon the appropriation of funds for that purpose.

(e) It is the intent of the Legislature that the department phase in implementation of the alternative residential model during the fiscal years 1987–88, 1988–89, 1989–90, and 1990–91. The department

shall include all facilities providing services pursuant to this article in the alternative residential model by January 1, 1991.

(f) By April 1, 1989, the State Department of Developmental Services shall prepare draft regulations establishing quality service standards for facilities and procedures for administering the alternative residential model. The department shall confer with interested parties concerning the draft regulations by July 1, 1989. By July 1, 1990, the department shall submit to the Office of Administrative Law regulations establishing quality service standards for facilities, procedures for administering the Alternative Residential Model, and ratesetting methodology. Full statewide implementation of the Alternative Residential Model shall not occur until the department has submitted these regulations.

(g) In addition to establishing rates as required by this section, the State Department of Developmental Services shall detail obstacles to ensuring sufficient numbers of living arrangements for persons served by the department, and to providing an adequate quality of care and services to persons served by the department who reside in residential facilities, and make recommendations for overcoming these obstacles.

SEC. 39. Section 4681.3 of the Welfare and Institutions Code is amended to read:

4681.3. (a) Notwithstanding any other provision of this article, for the 1996–97 fiscal year, the rate schedule authorized by the department in operation June 30, 1996, shall be increased based upon the amount appropriated in the Budget Act of 1996 for that purpose. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

(b) Notwithstanding any other provision of this article, for the 1997–98 fiscal year, the rate schedule authorized by the department in operation on June 30, 1997, shall be increased based upon the amount appropriated in the Budget Act of 1997 for that purpose. The increase shall be applied as a percentage, and the percentage shall be the same for all providers.

SEC. 40. Section 6600.05 of the Welfare and Institutions Code is amended to read:

6600.05. Atascadero State Hospital shall be used whenever a person is committed to a secure facility for mental health treatment pursuant to Section 6600 and is placed in a state hospital under the direction of the State Department of Mental Health unless there are unique circumstances that would preclude the placement of a person at that facility. If a state hospital is not used, the facility to be used shall be located on a site or sites determined by the Director of Corrections and the Director of Mental Health. In no case shall a person committed to a secure facility for mental health treatment pursuant to Section 6600 be placed at Metropolitan State Hospital or Napa State Hospital.

SEC. 41. Section 7200.06 is added to the Welfare and Institutions Code, to read:

7200.06. (a) Of the total patient population residing at Napa State Hospital in any given fiscal year, not more than 80 percent shall be patients whose placement has been required pursuant to the Penal Code.

(b) After construction of the perimeter security fence is completed at Napa State Hospital, no patient whose placement has been required pursuant to the Penal Code shall be placed outside the perimeter security fences, with the exception of placements in the General Acute Care and Skilled Nursing Units. The State Department of Mental Health shall ensure that appropriate security measures are in place for the general acute care and skilled nursing units.

(c) After construction of the perimeter security fence is completed at Napa State Hospital, in no case shall the population of patients whose placement has been required pursuant to the Penal Code exceed 980.

SEC. 42. Section 7200.07 is added to the Welfare and Institutions Code, to read:

7200.07. Notwithstanding any other provision of law, not more than 824 patients whose placement has been required pursuant to the Penal Code shall be placed at Napa State Hospital in the 1998–99 fiscal year.

SEC. 43. Section 7202 is added to the Welfare and Institutions Code, to read:

7202. The State Department of Mental Health shall regularly consult with the Napa State Hospital Task Force, which consists of local community representatives, on proposed policy or structural modifications to Napa State Hospital that may affect the Napa community, including, but not limited to, all of the following:

(a) Changes in the patient population mix.

(b) Construction of, or significant alterations to, facility structures.

(c) Changes in the hospital security plan.

SEC. 44. Section 7204 is added to the Welfare and Institutions Code, to read:

7204. (a) Grounds privileges or passes may be earned by patients, whose placement has been required pursuant to the Penal Code, at all state hospitals. Grounds privileges shall be restricted to areas of the state hospital that are designated as secured campus areas.

(b) Off-ground privileges or passes shall not be granted to patients, whose placement has been required pursuant to the Penal Code, at state hospitals. When a patient whose placement has been required pursuant to the Penal Code leaves a state hospital for any purpose other than discharge, the patient shall be accompanied by staff at all times.

SEC. 45. Section 7228 of the Welfare and Institutions Code is amended to read:

7228. Prior to admission to the Napa State Hospital or the Metropolitan State Hospital, the State Department of Mental Health shall evaluate each patient committed pursuant to Section 1026 or 1370 of the Penal Code. A patient determined to be a high security risk shall be treated in the department's most secure facilities. A Penal Code patient not needing this level of security shall be treated as near to the patient's community as possible if an appropriate treatment program is available.

SEC. 46. Section 7229 is added to the Welfare and Institutions Code, to read:

7229. Notwithstanding any other provision of law, patients whose placement has been required pursuant to the Penal Code, above the 593 patients approved through the Budget Act of 1996, shall be admitted to Napa State Hospital only after all of the following conditions have been met:

(a) The perimeter security fence, as approved in the Budget Act of 1997, is completed. The completion of this fence is a matter of public safety and has the highest urgency to be completed as quickly as possible. It is the intent of the Legislature for the state administration to take the administrative action needed to ensure the timely construction of the perimeter security fence.

(b) An appropriately trained state hospital security force, as identified in the hospital's security plan developed in conjunction with the City of Napa, the County of Napa, local law enforcement personnel, local community leaders, and security consultants as needed, is in place to meet the security needs of the state hospital.

(c) Specialized training to level-of-care and, as necessary, nonlevel-of-care, staff has been provided to ensure the safest and most therapeutic environment possible for both patients and staff.

(d) A 30-day notification to the fiscal and policy committees of the Legislature has been provided.

SEC. 47. Section 7230 is added to the Welfare and Institutions Code, to read:

7230. Those patients determined to be high security risk patients, as described in Section 7228, shall be treated at Atascadero State Hospital or Patton State Hospital, a correctional facility, or other secure facility as defined by the State Department of Mental Health, but shall not be treated at Metropolitan State Hospital or Napa State Hospital. Metropolitan State Hospital and Napa State Hospital shall treat only low- to moderate-risk patients, as defined by the State Department of Mental Health.

SEC. 48. Section 7231 is added to the Welfare and Institutions Code, to read:

7231. The State Department of Mental Health shall develop policies and procedures, by no later than 30 days following the

effective date of the Budget Act of 1997, at each state hospital, to notify appropriate law enforcement agencies in the event of a patient escape or walkaway. Local law enforcement agencies, including local police and county sheriff departments, shall review the policies and procedures prior to final implementation by the department.

SEC. 49. Section 7232 is added to the Welfare and Institutions Code, to read:

7232. The State Department of Mental Health shall issue a state hospital administrative directive by no later than 30 days following the effective date of the Budget Act of 1997 to require patients whose placement has been required pursuant to the Penal Code, and other patients within the secured perimeter at each state hospital, to wear clothing that enables these patients to be readily identified.

SEC. 50. Section 7233 is added to the Welfare and Institutions Code, to read:

7233. It is the intent of the Legislature to complete the 250-bed addition at Atascadero State Hospital as expeditiously as feasible due to the need to provide appropriate, secure housing for patients whose placement has been required pursuant to the Penal Code. To facilitate this completion, it is the intent of the Legislature to provide funding for the construction phase of this project in the Budget Act of 1998.

SEC. 51. Section 14005.75 is added to the Welfare and Institutions Code, to read:

14005.75. (a) The Legislature finds and declares all of the following:

(1) As a result of federal welfare reform, unprecedented numbers of welfare recipients will be leaving welfare for work, and will face time limits on the receipt of aid.

(2) It is in the interest of the state both to encourage welfare recipients to seek employment and to ensure the continuity of health coverage for these recipients as they move from welfare to work.

(3) California's transitional Medi-Cal program is intended to encourage welfare recipients to seek employment and to ensure continuity of health coverage, but various procedural restrictions limit its effectiveness in achieving those goals.

(b) It is, therefore, the intent of the Legislature to streamline the transitional Medi-Cal program in order to maximize its effectiveness in assisting persons leaving welfare for work.

SEC. 52. Section 14005.76 is added to the Welfare and Institutions Code, to read:

14005.76. (a) The department shall provide a Medi-Cal beneficiary whose Medi-Cal eligibility is established pursuant to Section 1930 of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) with simple and clear written notice of the availability of the transitional Medi-Cal program and the requirements for that program. This notice shall be provided at the time that Medi-Cal

eligibility is conferred to the beneficiary and at least once every six months thereafter.

(b) When a beneficiary loses Medi-Cal eligibility established pursuant to Section 1930 of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) for failure to meet reporting requirements, the department shall provide the beneficiary with the notice described in subdivision (a), and a form with simple and clear instructions on how to complete and return the form to the county. The form shall be used to determine whether the beneficiary is eligible for the transitional Medi-Cal program.

(c) The notice and form described in subdivisions (a) and (b) shall be prepared by the department. The department shall seek input on the notice and form from beneficiaries of aid, beneficiary representatives, and counties.

(d) The department shall review, and if necessary for simplicity and clarity, revise the notice required by subdivision (b) of Section 14005.8 and Section 14005.81. The department shall seek input from beneficiaries, beneficiary representatives, and counties.

(e) Notwithstanding any other provision of law, this section shall become operative nine months after the effective date of this section.

(f) Notwithstanding any other provision of law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation, as provided under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), is available.

SEC. 53. Section 14005.82 is added to the Welfare and Institutions Code, to read:

14005.82. (a) Any person who the department determines, pursuant to the notice and information on the form required by subdivision (b) of Section 14005.76, is eligible for transitional Medi-Cal benefits, shall be made retroactively eligible for transitional Medi-Cal benefits from the date that person loses Medi-Cal eligibility established pursuant to Section 1931 of the federal Social Security Act (42 U.S.C. Sec. 1396u-1). All information contained on the form required by subdivision (b) of Section 14005.76 is subject to verification by the county using applicable criteria.

(b) Notwithstanding any other provision of law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation, as provided under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available.

SEC. 54. Section 14005.83 is added to the Welfare and Institutions Code, to read:

14005.83. (a) The director shall seek a waiver from the federal government to simplify the transitional Medi-Cal program described in Section 14005.81.

(b) The waiver required to be sought pursuant to subdivision (a) shall seek to include all of the following:

(1) Any family receiving Medi-Cal benefits whose Medi-Cal eligibility was established pursuant to Section 1931 of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) in the month prior to becoming ineligible for those benefits due to increased hours of employment, income from employment, or the loss of earned income disregards shall be eligible for Medi-Cal coverage subject to the time limits contained in Section 14005.81.

(2) Status reports to determine ongoing eligibility for transitional Medi-Cal benefits shall be required not more frequently than every six months.

(3) Receipt of transitional Medi-Cal coverage for any portion of the initial six-month period of eligibility shall be sufficient to establish eligibility for successive six-month periods of coverage, provided other applicable eligibility requirements are met.

(c) Notwithstanding any other provision of law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation, as provided under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), is available.

(d) This section shall not become operative until the director executes a declaration, which shall be retained by the director, stating that the federal approval necessary for implementation of this section has been obtained.

SEC. 55. Section 14005.84 is added to the Welfare and Institutions Code, to read:

14005.84. (a) The department shall develop and conduct a community outreach and education campaign to assist persons whose Medi-Cal eligibility is established pursuant to Section 1931 of the federal Social Security Act (42 U.S.C. Sec. 1396u-1), to learn about the availability of the transitional Medi-Cal program.

(b) Any managed care plan, local initiative, or county organized health system contracting with the department to provide services to Medi-Cal enrollees shall include in its evidence of coverage and marketing materials information about the transitional Medi-Cal program and how to apply for program benefits.

(c) To implement this section, the department may develop and execute a contract or may amend any existing or future outreach campaign contract that it has executed. Notwithstanding any other provision of law, any such contract developed and executed, or amended, as required to implement this section shall be exempt from the approval of the Director of General Services and from the Public Contract Code.

(d) Notwithstanding any other provision of law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation, as provided under

Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), is available.

SEC. 56. Section 14005.88 is added to the Welfare and Institutions Code, to read:

14005.88. (a) The department shall contract for an independent evaluation, to be completed no later than January 1, 2001, in order to determine the effect of changes made in the transitional Medi-Cal program by the enactment of Sections 14005.76, 14005.82, 14005.83, 14005.84, 14005.87, 14005.89, and the amendment to Section 14005.85 enacted during the first year of the 1997–98 Regular Session of the Legislature, on the employment of welfare recipients and the continuity of their health coverage.

(b) Notwithstanding any other provision of law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation, as provided under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), is available.

SEC. 57. Section 14005.89 is added to the Welfare and Institutions Code, to read:

14005.89. (a) The department shall monitor participation rates for transitional Medi-Cal and seek input from beneficiaries, beneficiary representatives, and counties, on a regular basis throughout each year to consider changes in transitional Medi-Cal procedures as may be necessary to ensure that participation rates are at levels that would reasonably be expected, given aid caseload developments. Before any such changes are made, the department shall seek any federal waivers, or obtain other federal approval, that may be necessary to implement the changes.

(b) The department shall make the participation rate monitoring data described in subdivision (a) available upon request.

SEC. 58. Section 14011.4 is added to the Welfare and Institutions Code, to read:

14011.4. The department shall, subject to the requirements of federal law, and not later than six months after the effective date of this section, develop a simple referral form to be used as proof of birth, in order to initiate Medi-Cal enrollment and the establishment of benefits for newborns who are eligible for one year of automatic continuous Medi-Cal eligible benefits pursuant to Section 1902(e)(4) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(4)). In developing the referral form, the department shall seek input from beneficiary representatives and health care providers serving pregnant women receiving, or eligible for, Medi-Cal benefits. The infant's parent or guardian, or, with the knowledge and written consent of the infant's parent or guardian, a health care provider or other hospital worker, may submit the referral form by mail or facsimile. Upon receipt of the form, the department shall, subject to

the requirements of federal law, assign a Medi-Cal number to the newborn and issue a Medi-Cal card.

SEC. 59. Section 14029 is added to the Welfare and Institutions Code, to read:

14029. Whenever a request for services authorized pursuant to subdivision (s), (t), or (v) of Section 14132 is made to the department for a child who is being case-managed by the California Children's Services program, any decision to transfer the child to the home setting shall be made only in consultation with the California Children's Services program case manager for the child.

SEC. 60. The Legislature finds and declares all of the following:

(a) It is estimated that a large number of children may meet the family income requirements for Medi-Cal, but are not enrolled in the program.

(b) Many families of uninsured children who are potentially eligible for Medi-Cal fail to successfully apply for the program because they are unaware their children may be eligible or because the application form and process are too complicated and difficult to complete.

(c) Under Public Law 104-193, eligibility for cash assistance under the Temporary Assistance for Needy Families (TANF) program may decline significantly in comparison to eligibility under the Aid to Families with Dependent Children (AFDC) program.

(d) Families who would have qualified for AFDC benefits under the eligibility requirements in effect on July 16, 1996, will be eligible for Medi-Cal benefits under Public Law 104-193.

(e) However, without adequate education and outreach about Medi-Cal, many of these families may fail to learn that they qualify and will not successfully apply for the program.

(f) Without health coverage, children are much more likely to go without crucial health care services.

(g) Almost 1.6 million children in California, or about one out of every five adolescents, lack health insurance.

(h) It is estimated that a significant number of these children may be eligible for Medi-Cal, but not enrolled.

SEC. 61. Section 14067 is added to the Welfare and Institutions Code, to read:

14067. (a) The department shall develop and conduct a community outreach and education campaign to help families learn about, and apply for, Medi-Cal, subject to the requirements of federal law. In conducting this campaign, the department may seek input from various entities and programs that serve children, including, but not limited to, the State Department of Education, counties, Women, Infants, and Children program agencies, Head Start and Healthy Start programs, and community-based organizations that deal with potentially eligible families and children.

(b) The outreach and education campaign shall be established and implemented no later than six months after the effective date of this section.

(c) In implementing this section, the department may amend any existing or future media outreach campaign contract that it has entered into pursuant to Section 14148.5. Notwithstanding any other provision of law, any such contract entered into, or amended, as required to implement this section, shall be exempt from the approval of the Director of General Services and from the provisions of the Public Contract Code.

SEC. 62. (a) It is the intent of the Legislature that the University of California work with the State Department of Health Services and the California Medical Assistance Commission to address future funding of graduate medical education in the State of California. It is further the intent of the Legislature that implementing legislation be enacted no later than June 30, 1999.

(b) The University of California, in coordination with the State Department of Health Services and the California Medical Assistance Commission, is requested to submit a progress report on efforts to develop future funding of graduate medical education to the Governor and the health policy and fiscal committees of each house of the Legislature by November 1, 1998.

SEC. 63. Section 14085.7 is added to the Welfare and Institutions Code, 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 (P.L. 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, 1999, and, as of January 1, 2000, is repealed, unless a later enacted statute, that becomes effective on or before January 1, 2000, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 64. Section 14085.8 is added to the Welfare and Institutions Code, 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 (P.L. 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, 1999, and, as of January 1, 2000, is repealed, unless a later enacted statute, that becomes effective on or before January 1, 2000, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 65. Section 14093.07 is added to the Welfare and Institutions Code, to read:

14093.07. For purposes of this article the following definitions apply:

(a) "Foster child" means any child who has been taken into custody or placed by a juvenile court pursuant to Article 6 (commencing with Section 300) of Chapter 2 of Part 1 of Division 2 or Section 601 or 602.

(b) "Medi-Cal managed care plan" means any person or entity that has entered into a contract with the director pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.9 (commencing with Section 14088), or Article 2.91 (commencing with Section 14089) of this chapter or pursuant to Article 1 (commencing with Section 14200) of Chapter 8.

(c) "Out-of-county placement" means any foster care placement in which the child has been placed outside of the county with the responsibility for the care and placement of the child.

SEC. 66. Section 14093.09 is added to the Welfare and Institutions Code, to read:

14093.09. (a) No child in foster care shall be required to enroll in a Medi-Cal managed care plan. A foster child may be voluntarily enrolled in a Medi-Cal managed care plan only when the county child welfare agency with responsibility for the care and placement of the child, in consultation with the child's foster caregiver, determines that it is in the best interest of the child to do so and the department determines that enrollment is available to the child.

(b) Whenever a foster child is placed in an out-of-county placement, the county child welfare agency with responsibility for the care and placement of the child shall determine, in consultation with the child's foster caregiver, if the child should remain in, or has enrolled in, a Medi-Cal managed care plan in the county where the child will be placed or in the county with responsibility for the care

and placement of the child, as long as the department determines that enrollment is available for the child.

(c) The State Department of Health Services shall establish for Medi-Cal managed care plans urgent disenrollment procedures that provide for disenrollment of foster children in out-of-county placements within two working days of receipt by the department's enrollment contractor, or the department, if the department has no enrollment contractor, of a request for disenrollment made by the child welfare services agency, the foster caregiver, or other person authorized to make medical decisions on behalf of the foster child.

(d) Medi-Cal managed care plans shall process and pay appropriately documented claims submitted by out-of-plan providers for services provided to foster children in out-of-county placements while they are Medi-Cal members of the plan. This section shall not be construed to prevent a plan from requiring prior authorization for nonemergency services consistent with the plan's established policies and procedures.

SEC. 67. Section 14094.3 of the Welfare and Institutions Code is amended to read:

14094.3. (a) Notwithstanding this article or Section 14093.05 or 14094.1, CCS covered services shall not be incorporated into any Medi-Cal managed care contract entered into after August 1, 1994, pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.9 (commencing with Section 14088), Article 2.91 (commencing with Section 14089), Article 2.95 (commencing with Section 14092); or either Article 2 (commencing with Section 14200), or Article 7 (commencing with Section 14490) of Chapter 8, until August 1, 2000, except for contracts entered into for county organized health systems in the Counties of San Mateo, Santa Barbara, Solano and Napa.

(b) Notwithstanding any other provision of this chapter, providers serving children under the CCS program who are enrolled with a Medi-Cal managed care contractor but who are not enrolled in a pilot project pursuant to subdivision (c) shall continue to submit billing for CCS covered services on a fee-for-service basis until CCS covered services are incorporated into the Medi-Cal managed care contracts described in subdivision (a).

(c) (1) The department may authorize a pilot project in Solano County in which reimbursement for conditions eligible under the CCS program may be reimbursed on a capitated basis pursuant to Section 14093.05, and provided all CCS program's guidelines, standards, and regulations are adhered to, and CCS program's case management is utilized.

(2) During the time period described in subdivision (a), the department may approve, implement, and evaluate limited pilot projects under the CCS program to test alternative managed care models tailored to the special health care needs of children under the

CCS program. The pilot projects may include, but need not be limited to, coverage of different geographic areas, focusing on certain subpopulations, and the employment of different payment and incentive models. Pilot project proposals from CCS program-approved providers shall be given preference. All pilot projects shall utilize CCS program-approved standards and providers pursuant to Section 14094.1.

(d) (1) The department shall submit to the appropriate committees of the Legislature an evaluation of pilot projects established pursuant to subdivision (c) based on at least one full year of operation.

(2) The evaluation required by paragraph (1) shall address the impact of the pilot projects on outcomes as set forth in paragraph (4) and, in addition, shall do both of the following:

(A) Examine the barriers, if any, to incorporating CCS covered services into the Medi-Cal managed care contracts described in subdivision (a).

(B) Compare different pilot project models with the fee-for-service system. The evaluation shall identify, to the extent possible, those factors that make pilot projects most effective in meeting the special needs of children with CCS eligible conditions.

(3) CCS covered services shall not be incorporated into the Medi-Cal managed care contracts described in subdivision (a) before the evaluation process has been completed.

(4) The pilot projects shall be evaluated to determine if:

(A) All children enrolled with a Medi-Cal managed care contractor described in subdivision (a) identified as having a CCS eligible condition are referred in a timely fashion for appropriate health care.

(B) All children in the CCS program have access to coordinated care that includes primary care services in their own community.

(C) CCS program standards are adhered to.

(e) For purposes of this section, CCS covered services include all program benefits administered by the program specified in Section 123840 of the Health and Safety Code regardless of the funding source.

(f) Nothing in this section shall be construed to exclude or restrict CCS eligible children from enrollment with a managed care contractor or from receiving from the managed care contractor with which they are enrolled primary and other health care unrelated to the treatment of the CCS eligible condition.

SEC. 68. Section 14105.31 of the Welfare and Institutions Code is amended to read:

14105.31. For purposes of the Medi-Cal contract drug list, the following definitions shall apply:

(a) "Single-source drug" means a drug that is produced and distributed under an original New Drug Application approved by the

federal Food and Drug Administration. This shall include a drug marketed by the innovator manufacturer and any cross-licensed producers or distributors operating under the New Drug Application, and shall also include a biological product, except for vaccines, marketed by the innovator manufacturer and any cross-licensed producers or distributors licensed by the federal Food and Drug Administration pursuant to Section 262 of Title 42 of the United States Code. A drug ceases to be a single-source drug when the same drug in the same dosage form and strength manufactured by another manufacturer is approved by the federal Food and Drug Administration under the provisions for an Abbreviated New Drug Application.

(b) "Best price" means the negotiated price, or the manufacturer's lowest price available to any class of trade organization or entity, including, but not limited to, wholesalers, retailers, hospitals, repackagers, providers, or governmental entities within the United States, that contracts with a manufacturer for a specified price for drugs, inclusive of cash discounts, free goods, volume discounts, rebates, and on- or off-invoice discounts or credits, shall be based upon the manufacturer's commonly used retail package sizes for the drug sold by wholesalers to retail pharmacies.

(c) "Equalization payment amount" means the amount negotiated between the manufacturer and the department for reimbursement by the manufacturer, as specified in the contract. The equalization payment amount shall be based on the difference between the manufacturer's direct catalog price charged to wholesalers and the manufacturer's best price, as defined in subdivision (b).

(d) "Manufacturer" means any person, partnership, corporation, or other institution or entity that is engaged in the production, preparation, propagation, compounding, conversion, or processing of drugs, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or in the packaging, repackaging, labeling, relabeling, and distribution of drugs.

(e) "Price escalator" means a mutually agreed upon price specified in the contract, to cover anticipated cost increases over the life of the contract.

(f) "Medi-Cal pharmacy costs" or "Medi-Cal drug costs" means all reimbursements to pharmacy providers for services or merchandise, including single-source or multiple-source prescription drugs, over-the-counter medications, and medical supplies, or any other costs billed by pharmacy providers under the Medi-Cal program.

(g) "Medicaid rebate" means the rebate payment made by drug manufacturers pursuant to Section 1927 of the federal Social Security Act (42 U.S.C. Sec. 1396r-8).

(h) "State rebate" means any negotiated rebate under the Drug Discount Program in addition to the medicaid rebate.

(i) "Date of mailing" means the date that is evidenced by the postmark date by the United States Postal Service or other common mail carrier on the envelope.

(j) This section shall remain in effect only until January 1, 1999, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 1999, deletes or extends that date.

SEC. 69. Section 14105.33 of the Welfare and Institutions Code is amended to read:

14105.33. (a) The department may enter into contracts with manufacturers of single-source and multiple-source drugs, on a bid or nonbid basis, for drugs from each major therapeutic category, and shall maintain a list of those drugs for which contracts have been executed.

(b) (1) Contracts executed pursuant to this section shall be for the manufacturer's best price, as defined in Section 14105.31, which shall be specified in the contract, and subject to agreed upon price escalators, as defined in that section. The contracts shall provide for an equalization payment amount, as defined in Section 14105.31, to be remitted to the department quarterly. The department shall submit an invoice to each manufacturer for the equalization payment amount, including supporting utilization data from the department's prescription drug paid claims tapes within 30 days of receipt of the Health Care Financing Administration's file of manufacturer rebate information. In lieu of paying the entire invoiced amount, a manufacturer may contest the invoiced amount pursuant to procedures established by the federal Health Care Financing Administration's Medicaid Drug Rebate Program Releases or regulations by mailing a notice, that shall set forth its grounds for contesting the invoiced amount, to the department within 38 days of the department's mailing of the state invoice and supporting utilization data. For purposes of state accounting practices only, the contested balance shall not be considered an accounts receivable amount until final resolution of the dispute pursuant to procedures established by the federal Health Care Financing Administration's Medicaid Drug Rebate Program Releases or regulations that results in a finding of an underpayment by the manufacturer. Manufacturers may request, and the department shall timely provide, at cost, Medi-Cal provider level drug utilization data, and other Medi-Cal utilization data necessary to resolve a contested department-invoiced rebate amount.

(2) The department shall provide for an annual audit of utilization data used to calculate the equalization amount to verify the accuracy of that data. The findings of the audit shall be documented in a written audit report to be made available to manufacturers within 90 days of receipt of the report from the auditor. Any manufacturer may

receive a copy of the audit report upon written request. Contracts between the department and manufacturers shall provide for any equalization payment adjustments determined necessary pursuant to an audit.

(3) Utilization data used to determine an equalization payment amount shall exclude data from both of the following:

(A) Health maintenance organizations, as defined in Section 300e(a) of Title 42 of the United States Code, including those organizations that contract under Section 1396b(m) of Title 42 of the United States Code.

(B) Capitated plans that include a prescription drug benefit in the capitated rate, and that have negotiated contracts for rebates or discounts with manufacturers.

(c) In order that Medi-Cal beneficiaries may have access to a comprehensive range of therapeutic agents, the department shall ensure that there is representation on the list of contract drugs in all major therapeutic categories. Except as provided in subdivision (a) of Section 14105.35, the department shall not be required to contract with all manufacturers who negotiate for a contract in a particular category. The department shall ensure that there is sufficient representation of single-source and multiple-source drugs, as appropriate, in each major therapeutic category.

(d) (1) The department shall select the therapeutic categories to be included on the list of contract drugs, and the order in which it seeks contracts for those categories. The department may establish different contracting schedules for single-source and multiple-source drugs within a given therapeutic category.

(2) The department shall make every attempt to complete the initial contracting process for each major therapeutic category by January 1, 1999.

(e) (1) In order to fully implement subdivision (d), the department shall, to the extent necessary, negotiate or renegotiate contracts to ensure there are as many single-source drugs within each therapeutic category or subcategory as the department determines necessary to meet the health needs of the Medi-Cal population. The department may determine in selected therapeutic categories or subcategories that no single-source drugs are necessary because there are currently sufficient multiple-source drugs in the therapeutic category or subcategory on the list of contract drugs to meet the health needs of the Medi-Cal population. However, in no event shall a beneficiary be denied continued use of a drug which is part of a prescribed therapy in effect as of September 2, 1992, until the prescribed therapy is no longer prescribed.

(2) In the development of decisions by the department on the required number of single-source drugs in a therapeutic category or subcategory, and the relative therapeutic merits of each drug in a therapeutic category or subcategory, the department shall consult

with the Medi-Cal Contract Drug Advisory Committee. The committee members shall communicate their comments and recommendations to the department within 30 business days of a request for consultation, and shall disclose any associations with pharmaceutical manufacturers or any remuneration from pharmaceutical manufacturers.

(3) In order to expedite implementation of paragraph (1), the requirements of Sections 14105.37, 14105.38, subdivisions (a), (c), (e), and (f) of Sections 14105.39, 14105.4, and 14105.405 are waived for the purposes of this section until January 1, 1994.

(f) In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this section is necessary. Therefore, contracts entered into on a nonbid basis shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(g) In no event shall a beneficiary be denied continued use of a drug that is part of a prescribed therapy in effect as of September 2, 1992, until the prescribed therapy is no longer prescribed.

(h) Contracts executed 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).

(i) The department shall provide individual notice to Medi-Cal beneficiaries at least 60 calendar days prior to the effective date of the deletion or suspension of any drug from the list of contract drugs. The notice shall include a description of the beneficiary's right to a fair hearing and shall encourage the beneficiary to consult a physician to determine if an appropriate substitute medication is available from Medi-Cal.

(j) In carrying out the provisions of this section, the department may contract either directly, or through the fiscal intermediary, for pharmacy consultant staff necessary to initially accomplish the treatment authorization request reviews.

(k) (1) Manufacturers shall calculate and pay interest on late or unpaid rebates. The interest shall not apply to any prior period adjustments of unit rebate amounts or department utilization adjustments.

(2) For state rebate payments, manufacturers shall calculate and pay interest on late or unpaid rebates for quarters that begin on or after the effective date of the act that added this subdivision.

(3) Following final resolution of any dispute pursuant to procedures established by the federal Health Care Financing Administration's Medicaid Drug Rebate Program Releases or regulations regarding the amount of a rebate, any underpayment by a manufacturer shall be paid with interest calculated pursuant to subdivisions (m) and (n), and any overpayment, together with

interest at the rate calculated pursuant to subdivisions (m) and (n), shall be credited by the department against future rebates due.

(*l*) Interest pursuant to subdivision (k) shall begin accruing 38 calendar days from the date of mailing of the invoice, including supporting utilization data sent to the manufacturer. Interest shall continue to accrue until the date of mailing of the manufacturer's payment.

(m) Except as specified in subdivision (n), interest rates and calculations pursuant to subdivision (k) for medicaid rebates and state rebates shall be identical and shall be determined by the federal Health Care Financing Administration's Medicaid Drug Rebate Program Releases or regulations.

(n) If the date of mailing of a state rebate payment is 69 days or more from the date of mailing of the invoice, including supporting utilization data sent to the manufacturer, the interest rate and calculations pursuant to subdivision (k) shall be as specified in subdivision (m), however the interest rate shall be increased by 10 percentage points. This subdivision shall apply to payments for amounts invoiced for any quarters that begin on or after the effective date of the act that added this subdivision.

(o) If the rebate payment is not received, the department shall send overdue notices to the manufacturer at 38, 68, and 98 days after the date of mailing of the invoice, and supporting utilization data. If the department has not received a rebate payment, including interest, within 180 days of the date of mailing of the invoice, including supporting utilization data, the manufacturer's contract with the department shall be deemed to be in default and the contract may be terminated in accordance with the terms of the contract. For all other manufacturers, if the department has not received a rebate payment, including interest, within 180 days of the date of mailing of the invoice, including supporting utilization data, all of the drug products of those manufacturers shall be made available only through prior authorization effective 270 days after the date of mailing of the invoice, including utilization data sent to manufacturers.

(p) If the manufacturer provides payment or evidence of payment to the department at least 40 days prior to the proposed date the drug is to be made available only through prior authorization pursuant to subdivision (o), the department shall terminate its actions to place the manufacturers' drug products on prior authorization.

(q) The department shall direct the state's fiscal intermediary to remove prior authorization requirements imposed pursuant to subdivision (o) and notify providers within 60 days after payment by the manufacturer of the rebate, including interest. If a contract was in place at the time the manufacturers' drugs were placed on prior authorization, removal of prior authorization requirements shall be

contingent upon good faith negotiations and a signed contract with the department.

(r) A beneficiary may obtain drugs placed on prior authorization pursuant to subdivision (o) if the beneficiary qualifies for continuing care status. To be eligible for continuing care status, a beneficiary must be taking the drug when its manufacturer is placed on prior authorization status. Additionally, the department shall have received a claim for the drug with a date of service that is within 100 days prior to the date the manufacturer was placed on prior authorization.

(s) A beneficiary may remain eligible for continuing care status, provided that a claim is submitted for the drug in question at least every 100 days and the date of service of the claim is within 100 days of the date of service of the last claim submitted for the same drug.

(t) Drugs covered pursuant to Sections 14105.43 and 14133.2 shall not be subject to prior authorization pursuant to subdivision (o), and any other drug may be exempted from prior authorization by the department if the director determines that an essential need exists for that drug, and there are no other drugs currently available without prior authorization that meet that need.

(u) It is the intent of the Legislature in enacting subdivisions (k) to (t), inclusive, that the department and manufacturers shall cooperate and make every effort to resolve rebate payment disputes within 90 days of notification by the manufacturer to the department of a dispute in the calculation of rebate payments.

(v) This section shall remain in effect only until January 1, 1999, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 1999, deletes or extends that date.

SEC. 70. Section 14109.6 is added to the Welfare and Institutions Code, to read:

14109.6. Notwithstanding Section 14109, effective September 1, 1997, and pursuant to Section 1396a(n) of Title 42 of the United States Code, as amended by Section 4714 of the federal Balanced Budget Act of 1997, the reimbursement rate for costs specified in Section 14109 for all services, including, but not limited to, hospital inpatient services, shall, to the extent feasible, not exceed the reimbursement rate for similar services established under this chapter. Effective for dates of service on or after September 1, 1997, the reimbursement rates established under this chapter for hospital inpatient services shall be no greater than the amounts paid by the Medicare program for similar services. Notwithstanding the provisions of this section, Section 14109.5 shall remain in effect for dates of service prior to September 1, 1997. It is the intent of the Legislature that regulations and the amendments to the medicaid state plan previously adopted pursuant to Section 14109.5 shall remain in effect for purposes of this section until amended or otherwise modified by the department.

SEC. 71. Section 14132.22 of the Welfare and Institutions Code is amended to read:

14132.22. (a) (1) Transitional inpatient care services, as described in this section and provided by a qualified health facility, is a covered benefit under this chapter, subject to utilization controls and subject to the availability of federal financial participation. These services shall be available to individuals needing short-term medically complex or intensive rehabilitative services, or both.

(2) The department shall seek any necessary approvals from the federal Health Care Financing Administration to ensure that transitional inpatient care services, when provided by a general acute care hospital, will be considered for purposes of determining whether a hospital is deemed to be a disproportionate share hospital pursuant to Section 1396r-4(b) of Title 42 of the United States Code or any successor statute.

(3) Transitional inpatient care services shall be available to Medi-Cal beneficiaries who do not meet the criteria for eligibility for the subacute program provided for pursuant to Section 14132.25, but who need more medically complex and intensive rehabilitative services than are generally available in a skilled nursing facility, and who are clinically stable and no longer need the level of diagnostic and ancillary services provided generally in an acute care facility.

(b) For purposes of this section, "transitional inpatient care" means the level of care needed by an individual who has suffered an illness, injury, or exacerbation of a disease, and whose medical condition has clinically stabilized so that daily physician services and the immediate availability of technically complex diagnostic and invasive procedures usually available only in the acute care hospital are not medically necessary, and when the physician assuming the responsibility of treatment management of the patient in transitional care has developed a definitive and time-limited course of treatment. The individual's care needs may be medical, rehabilitative, or both. However, the individual shall fall within one of the two following patient groups:

(1) "Transitional medical patient," which means a medically stable patient with short-term transitional care needs, whose primary barrier to discharge to a residential setting is medical status rather than functional status. These patients may require simple rehabilitation therapy, but not a rehabilitation program appropriate for multiple interrelated areas of functional disability.

(2) "Transitional rehabilitation patient," which means a medically stable patient with short-term transitional care needs, whose primary barrier to discharge to a residential setting is functional status, rather than medical status, and who has the capacity to benefit from a rehabilitation program as determined by a physiatrist or physician otherwise skilled in rehabilitation medicine. These patients may have unresolved medical problems, but these problems must be

sufficiently controlled to allow participation in the rehabilitation program.

(c) In implementing the transitional inpatient care program the department shall consider the differences between the two patient groups described in paragraphs (1) and (2) of subdivision (b) and shall assure that each group's specific health care needs are met.

(d) Transitional inpatient care services shall be made available only to qualifying Medi-Cal beneficiaries who are 18 years of age or older.

(e) Transitional inpatient care services shall not be available to patients in acute care hospitals defined as small and rural pursuant to Section 124840 of the Health and Safety Code.

(f) (1) Transitional inpatient care services may be provided by general acute care hospitals that are licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code. General acute care hospitals may provide transitional inpatient care services in the acute care hospital, an acute rehabilitation center, or the distinct part skilled nursing unit of the acute care hospital. Licensed skilled nursing facilities, as defined in subdivision (c) of Section 1250 of the Health and Safety Code that are certified to participate as a nursing facility in the Medicare and medicaid programs, pursuant to Titles XVIII and XIX of the federal Social Security Act, and licensed congregate living health facilities, as defined in Section 1265.7 of the Health and Safety Code, that are certified to participate as a nursing facility in the Medicare and medicaid programs pursuant to Titles XVIII and XIX of the federal Social Security Act, may also provide the services described in subdivision (b).

(2) Costs of providing transitional inpatient care services in nonsegregated parts of the distinct part skilled nursing unit of the acute care hospital shall be determinable, in the absence of distinct and separate cost centers established for this purpose. Costs of providing transitional inpatient care services in nondistinct parts of the acute care hospital shall be determinable, in the absence of distinct and separate cost centers established for this purpose. A separate and distinct cost center shall be maintained or established for each unit in freestanding certified nursing facilities in which the services described in subdivision (b) are provided, in order to identify and segregate costs for transitional inpatient care patients from costs for other patients who may be served within the parent facility.

(g) In order to participate as a provider in the transitional inpatient care program, a facility shall meet all applicable standards necessary for participation in the Medi-Cal program and all of the following:

(1) If the health facility is a freestanding certified nursing facility, it shall be located in close proximity to a general acute care hospital

with which the facility has a transfer agreement in order to support the capability to respond to medical emergencies.

(2) The health facility shall demonstrate, to the department, competency in providing high quality care to all patients for whom the facility provides care, experience in providing high quality care to the types of transitional inpatient care patients the facility proposes to serve, and the ability to provide transitional inpatient care to patients pursuant to this chapter.

(3) The health facility shall enter into a provider agreement with the department for the provision of transitional inpatient care. The provider agreement shall specify whether the facility is authorized to serve transitional medical patients or transitional rehabilitation patients or both, depending on the facility's demonstrated ability to meet standards specific to each patient group. Continuation of the provider agreement shall be contingent upon the facility's continued compliance with all the applicable requirements of this section and any other applicable laws or regulations.

(h) In determining a facility's qualifications for initial participation, an onsite review shall be conducted by the department. Subsequent review shall be conducted onsite as necessary, but not less frequently than annually. Initial and subsequent reviews shall be conducted by appropriate department personnel, which shall include a registered nurse and other health professionals where appropriate. The department shall develop written protocols for reviews.

(i) Transitional inpatient care services shall be available to patients receiving care in an acute care hospital. Under specified circumstances, as set forth in regulations, transitional inpatient care shall be available to patients transferring directly from a nursing facility level of care, a physician's office, a clinic, or from the emergency room of a general acute care hospital, provided they have received a comprehensive medical assessment conducted by a physician, and the physician determines, and documents in the medical record, that the patient has been clinically stable for the 24 hours preceding admission to the transitional inpatient care program.

(j) A health facility providing transitional inpatient care shall accept and retain only those patients for whom it can provide adequate, safe, therapeutic, and effective care, and as identified in its application for participation as a transitional inpatient care provider. The facility's determination to accept a patient into the transitional inpatient care unit shall be based on its preadmission screening process conducted by appropriate facility personnel.

(k) The department shall establish a process for providing timely, concurrent authorization and coordination, as required, of all medically necessary services for transitional inpatient care.

(*l*) The department shall adopt regulations specifying admission criteria and an admission process appropriate to each of the transitional inpatient care patient groups specified in subdivision (b). Patient admission criteria to transitional inpatient care shall include, but not be limited to, the following:

(1) Prior to admission to transitional inpatient care, the patient shall be determined to have been clinically stable for the preceding 24 hours by the attending physician and the physician assuming the responsibility of treatment management of the patient in the transitional inpatient care program.

(2) The patient shall be admitted to transitional inpatient care on the order of the physician assuming the responsibility of the management of the patient, with an established diagnosis, and an explicit time-limited course of treatment of sufficient detail to allow the facility to initiate appropriate assessments and services. No patient shall be transferred from an acute care hospital to a transitional inpatient care program that is in a freestanding certified nursing facility if the patient's attending physician documents in the medical record that the transfer would cause physical or psychological harm to the patient.

(3) (A) Medical necessity for transitional care shall include, but not be limited to, one or more of the following:

(i) Intravenous therapy.

(ii) Rehabilitative services.

(iii) Wound care.

(iv) Respiratory therapy.

(v) Traction.

(B) The department shall develop regulations further defining the services to be provided pursuant to clauses (i) to (v), inclusive, and the circumstances under which these services shall be provided.

(m) Registered nurses shall be assigned to the transitional inpatient care unit at all times and in sufficient numbers to allow for the ongoing patient assessment, patient care, and supervision of licensed and unlicensed staff. Participating facilities shall assure that staffing is adequate in number and skill mix, at all times, to address reasonably anticipated admissions, discharges, transfers, patient emergencies, and temporary absences of staff from the transitional care unit including, but not limited to, absences to attend meetings or inservice training. All licensed and certified health care personnel shall hold valid, current licensure or certification.

(n) Continued medical assessments shall be of sufficient frequency as to adequately review, evaluate, and alter plans of care as needed in response to patients' medical progress.

(o) The department shall develop a rate of reimbursement for transitional inpatient care services for providers as specified in subdivision (f). Reimbursement rates shall be specified in regulation

and in accordance with methodologies developed by the department and may include the following:

(1) All inclusive per diem rates.

(2) Individual patient specific rates according to the needs of the individual transitional care patient.

(3) Other rates subject to negotiation with the health facility.

(p) Reimbursement at transitional inpatient care rates shall only be implemented when funds are available for this purpose pursuant to the annual Budget Act. Funds expended to implement this section shall be used by providers to assure safe, therapeutic and effective patient care by staffing at levels which meet patients' needs, and to ensure that these providers have the needed resources and staff to provide quality care to transitional inpatient care patients.

(q) (1) The department shall reimburse physicians for all medically necessary care provided to transitional inpatient care patients and shall establish Medi-Cal physician reimbursement rates commensurate with those for visits to nontransitional acute care patients in acute care hospitals.

(2) It is the intent of this subdivision to cover physician costs not included in the per diem rate.

(r) No later than January 1, 1999, the department shall evaluate, and make recommendations regarding, the effectiveness and safety of the transitional inpatient care program. The evaluation shall be developed in consultation with representatives of providers, facility employees, and consumers. The department may contract for all or a portion of the evaluation. The evaluation shall be for the purpose of determining the impact of the transitional inpatient care program on patient care, including functional outcomes, if applicable, on whether the care costs less than other alternatives, and whether it results in the deterioration of patient health and safety as compared to other placements. The evaluation shall also be for the purpose of determining the effect on patients other than those receiving transitional inpatient care in participating facilities. The evaluation shall include:

(1) Data on patient mortality, patients served, length of stay, and subsequent placement or discharge.

(2) Data on readmission to acute care and emergency room transfers.

(3) Staffing standards in the facilities.

(4) Other outcome measures and indicia of patient health and safety otherwise required to be reported by federal or state law.

(s) The department shall develop regulations to amend Sections 51540 to 51556, inclusive, of Title 22 of the California Code of Regulations, to exclude the cost of transitional inpatient care services rendered in general acute care hospitals from the hospital's inpatient services reimbursement.

(t) The department may adopt emergency regulations as necessary to implement this section in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The initial adoption of emergency regulations shall be deemed to be an emergency and considered by the Office of Administrative Law as necessary for the immediate preservation of public peace, health and safety, or general welfare. Emergency regulations adopted pursuant to this section shall remain in effect for no more than 180 days. If the department adopts emergency regulations to implement this section, the department shall obtain input from interested parties to address the unique needs of medically complex and intensive rehabilitative patients qualifying for transitional inpatient care. Notwithstanding the requirements of this section, the department shall, if it adopts emergency regulations to implement this section, address the following major subject areas:

(1) Patient selection and assessment criteria, including but not limited to, preadmission screening, patient assessments, physician services, and interdisciplinary teams.

(2) Facility participation criteria and agreements, including but not limited to, facility licensing and certification history, demonstration to the department of a preexisting history in providing care to medically complex or intensive rehabilitative patients, data reporting requirements, demonstration of continued ability to provide high quality of care to all patients, nurse staffing requirements, ancillary services, and staffing requirements.

(u) This section shall remain in effect only until January 1, 2000, and as of that date is repealed, unless a later enacted statute, that is enacted on or before January 1, 2000, deletes or extends that date.

SEC. 72. Section 14133.14 is added to the Welfare and Institutions Code, to read:

14133.14. The criteria that the department shall use to identify providers to be placed on prior authorization for noninvasive testing procedures shall include, but not be limited to, Medi-Cal trend analysis, provider profiling data, provider and beneficiary history data, or appropriateness of the services as related to diagnosis, volume of services, utilization patterns, and specialty of provider. The existing prior authorization appeals process shall be available to these providers for denial of services.

SEC. 73. Section 14138.5 is added to the Welfare and Institutions Code, immediately preceding Section 14139, to read:

14138.5. The State Department of Health Services shall report to the Legislature, by January 1, 1998, for the 1996–97 fiscal year and by January 1, 1999, for the period from October 1, 1997, to October 1, 1998, on all of the following data with respect to the child health and disability prevention program provided for pursuant to Article 6

(commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code:

(a) The number of children, by age and by county, enrolled in each plan contracting with the department or with the California Medical Assistance Commission.

(b) The improved reporting capabilities of the new contract for the Management Information System/Decision Support System (MIS/DSS), with specific emphasis on how it can be used to gather data from the PM 160 forms that are useful for analytical purposes.

(c) Information on what actions are being taken to ensure compliance with Child Health and Disability Prevention Program examination requirements.

(d) The statewide percentage of all children enrolled in managed care plans, by age, who received a comprehensive Child Health and Disability Prevention Program examination, and the percentage of all children enrolled who received a comprehensive Child Health and Disability Prevention Program examination, by county and by plan.

(e) The number of children in each plan, by age, who are current on periodicity health assessments, with appropriate documentation. If the capability to report this information does not exist, a timeline of when the information will be available and the barriers that exist to reporting the information.

(f) The number of children in each plan, by county and by age, who were referred for followup diagnosis or treatment following a Child Health and Disability Prevention Program comprehensive examination.

(g) The number of children in each plan, by county and by age, who received needed diagnosis and treatment as a result of a Child Health and Disability Prevention Program examination. If the capability to report this information does not exist, a timeline of when it will be available and the barriers that exist to reporting this information.

SEC. 74. Section 14148.99 of the Welfare and Institutions Code is repealed.

SEC. 75. Section 14154.15 of the Welfare and Institutions Code is amended to read:

14154.15. (a) Any county may petition the department for an augmentation of its County Administrative Cost Control Plan in order to implement a plan, as provided for in Section 1105 of the federal Social Security Act (42 U.S.C. Sec. 1305), for the outstationing of one or more eligibility workers at all types of outstation locations, as defined in Section 435.904(c)(3) of Title 42 of the Code of Federal Regulations in order to facilitate receipt and processing of applications for Medi-Cal eligibility for pregnant women, infants and children as specified by Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 and following). In order to participate pursuant to this

section, a county welfare department shall petition under this section in accordance with guidelines established by the department. The petition shall include, but not be limited to, information about the need for outstation workers at alternative sites and the language skills needed by the outstation workers.

(b) In reviewing a petition from a county for an augmentation of its County Administrative Cost Control Plan for outstationing purposes, the department shall take into account the likely success rate of applications processed by the proposed outstationed eligibility workers, the amount of travel and training time required to implement and continue the outstationing plan, and other productivity factors associated with the outstationing plan.

(c) The department may approve those proposed augmentations which, based on its review of the outstationing plan, offer potential to increase eligibility determinations and access to Medi-Cal perinatal services by pregnant women and Medi-Cal services by infants and children specified by Title XIX of the Social Security Act (42 U.S.C., Sec. 1396 and following). The department shall review the approved plan annually to determine if the plan shall be renewed, altered, discontinued, or incorporated into the county administrative funding base.

(d) In addition to any augmentations authorized by this section, the department may, at its discretion, advance administrative funding to a county welfare department for which it approves an augmentation of its County Administrative Cost Control Plan, to cover the initial incremental costs of outstationed eligibility workers under this section.

(e) The department shall conduct a one-time outreach plan to educate county welfare directors, county health officers, and county elected officials on the opportunities and advantages of outstationing Medi-Cal eligibility workers to facilitate access by pregnant women to Medi-Cal perinatal services and Medi-Cal eligibility for infants and children.

SEC. 76. Section 14163 of the Welfare and Institutions Code is amended to read:

14163. (a) For purposes of this section, the following definitions shall apply:

(1) "Public entity" means a county, a city, a city and county, the University of California, a local hospital district, a local health authority, or any other political subdivision of the state.

(2) "Hospital" means a health facility that is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code to provide acute inpatient hospital services, and includes all components of the facility.

(3) "Disproportionate share hospital" means a hospital providing acute inpatient services to Medi-Cal beneficiaries that meets the

criteria for disproportionate share status relating to acute inpatient services set forth in Section 14105.98.

(4) "Disproportionate share list" means the annual list of disproportionate share hospitals for acute inpatient services issued by the department pursuant to Section 14105.98.

(5) "Fund" means the Medi-Cal Inpatient Payment Adjustment Fund.

(6) "Eligible hospital" means, for a particular state fiscal year, a hospital on the disproportionate share list that is eligible to receive payment adjustment amounts under Section 14105.98 with respect to that state fiscal year.

(7) "Transfer year" means the particular state fiscal year during which, or with respect to which, public entities are required by this section to make an intergovernmental transfer of funds to the Controller.

(8) "Transferor entity" means a public entity that, with respect to a particular transfer year, is required by this section to make an intergovernmental transfer of funds to the Controller.

(9) "Transfer amount" means an amount of intergovernmental transfer of funds that this section requires for a particular transferor entity with respect to a particular transfer year.

(10) "Intergovernmental transfer" means a transfer of funds from a public entity to the state, that is local government financial participation in Medi-Cal pursuant to the terms of this section.

(11) "Licensee" means an entity that has been issued a license to operate a hospital by the department.

(12) "Annualized Medi-Cal inpatient paid days" means the total number of Medi-Cal acute inpatient hospital days, regardless of dates of service, for which payment was made by or on behalf of the department to a hospital, under present or previous ownership, during the most recent calendar year ending prior to the beginning of a particular transfer year, including all Medi-Cal acute inpatient covered days of care for hospitals that are paid on a different basis than per diem payments.

(13) "Medi-Cal acute inpatient hospital day" means any acute inpatient day of service attributable to patients who, for those days, were eligible for medical assistance under the California state plan, including any day of service that is reimbursed on a basis other than per diem payments.

(14) "OBRA 1993 payment limitation" means the hospital-specific limitation on the total annual amount of payment adjustments to each eligible hospital under the payment adjustment program that can be made with federal financial participation under Section 1396r-4(g) of Title 42 of the United States Code as implemented pursuant to the Medi-Cal State Plan.

(b) The Medi-Cal Inpatient Payment Adjustment 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 subdivision (d). The fund shall consist of the following:

(1) Transfer amounts collected by the Controller under this section, whether submitted by transferor entities pursuant to applicable provisions of this section or obtained by offset pursuant to subdivision (j).

(2) Any other intergovernmental transfers deposited in the fund, as permitted by Section 14164.

(3) Any interest that accrues with respect to amounts in the fund.

(c) Moneys in the fund, which shall not consist of any state general funds, shall be used as the source for the nonfederal share of payments to hospitals pursuant to Section 14105.98. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures, and used to make payments pursuant to Section 14105.98.

(d) Except as otherwise provided in Section 14105.98 or in any provision of law appropriating a specified sum of money to the department for administering this section and Section 14105.98, moneys in the fund shall be used only for the following:

(1) Payments to hospitals pursuant to Section 14105.98.

(2) Except for the amount transferred pursuant to paragraph (3), transfers to the Health Care Deposit Fund as follows:

(A) In the amount of two hundred thirty-nine million seven hundred fifty-seven thousand six hundred ninety dollars ($239,757,690), for the 1994–95 and 1995–96 fiscal years.

(B) In the amount of two hundred twenty-nine million seven hundred fifty-seven thousand six hundred ninety dollars ($229,757,690) for the 1996–97 fiscal year.

(C) In the amount of one hundred fifty-four million seven hundred fifty-seven thousand six hundred ninety dollars ($154,757,690) for the 1997–98 fiscal year and each fiscal year thereafter.

(D) Notwithstanding any other provision of law, the amount specified in this paragraph shall be in addition to any amounts transferred to the Health Care Deposit Fund arising from changes of any kind attributable to payment adjustment years prior to the 1993–94 payment adjustment year. These transfers from the fund shall be made in six equal monthly installments to the Medi-Cal local assistance appropriation item (Item 4260-101-001 of the annual Budget Act) in support of Medi-Cal expenditures. The first installment shall accrue in October of each transfer year, and all other installments shall accrue monthly thereafter from November through March.

(3) In the 1993–94 fiscal year, in addition to the amount transferred as specified in paragraph (2), fifteen million dollars ($15,000,000) shall also be transferred to the Medi-Cal local assistance appropriation item (Item 4260-101-001) of the Budget Act of 1993.

(e) For the 1991–92 state fiscal year, the department shall determine, no later than 70 days after the enactment of this section, the transferor entities for the 1991–92 transfer year. To make this determination, the department shall utilize the disproportionate share list for the 1991–92 fiscal year, which shall be issued by the department no later than 65 days after the enactment of this section, pursuant to paragraph (1) of subdivision (f) of Section 14105.98. The department shall identify each eligible hospital on the list for which a public entity is the licensee as of July 1, 1991. The public entity that is the licensee of each identified eligible hospital shall be a transferor entity for the 1991–92 transfer year.

(f) The department shall determine, no later than 70 days after the enactment of this section, the transfer amounts for the 1991–92 transfer year.

The transfer amounts shall be determined as follows:

(1) The eligible hospitals for 1991–92 shall be identified. For each hospital, the applicable total per diem payment adjustment amount under Section 14105.98 for the 1991–92 transfer year shall be computed. This amount shall be multiplied by 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days as determined from all Medi-Cal paid claims records available through April 1, 1991. The products of these calculations for all eligible hospitals shall be added together to determine an aggregate sum for the 1991–92 transfer year.

(2) The eligible hospitals for 1991–92 involving transferor entities as licensees shall be identified. For each hospital, the applicable total per diem payment adjustment amount under Section 14105.98 for the 1991–92 transfer year shall be computed. This amount shall be multiplied by 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days as determined from all Medi-Cal paid claims records available through April 1, 1991. The products of these calculations for all eligible hospitals with transferor entities as licensees shall be added together to determine an aggregate sum for the 1991–92 transfer year.

(3) The aggregate sum determined under paragraph (1) shall be divided by the aggregate sum determined under paragraph (2), yielding a factor to be utilized in paragraph (4).

(4) The factor determined in paragraph (3) shall be multiplied by the amount determined for each hospital under paragraph (2). The product of this calculation for each hospital in paragraph (2) shall be divided by 1.771, yielding a transfer amount for the particular transferor entity for the transfer year.

(g) For the 1991–92 transfer year, the department shall notify each transferor entity in writing of its applicable transfer amount or amounts no later than 70 days after the enactment of this section.

(h) For the 1992–93 transfer year and subsequent transfer years, transfer amounts shall be determined in the same procedural manner as set forth in subdivision (f), except:

(1) The department shall use all of the following:

(A) The disproportionate share list applicable to the particular transfer year to determine the eligible hospitals.

(B) The payment adjustment amounts calculated under Section 14105.98 for the particular transfer year. These amounts shall take into account any projected or actual increases or decreases in the size of the payment adjustment program as are required under Section 14105.98 for the particular year in question, including any decreases resulting from the application of the OBRA 1993 payment limitation. Subject to the installment schedule in paragraph (5) of subdivision (i) regarding transfer amounts, the department may issue interim, revised, and supplemental transfer requests as necessary and appropriate to address changes in payment adjustment levels that occur under Section 14105.98. All transfer requests, or adjustments thereto, issued to transferor entities by the department shall meet the requirements set forth in subparagraph (E) of paragraph (5) of subdivision (i).

(C) Data regarding annualized Medi-Cal inpatient paid days for the most recent calendar year ending prior to the beginning of the particular transfer year, as determined from all Medi-Cal paid claims records available through April 1 preceding the particular transfer year.

(D) The status of public entities as licensees of eligible hospitals as of July 1 of the particular transfer year.

(E) (i) Except as provided in subparagraph (ii), transfer amounts calculated by the department may be increased or decreased by a percentage amount consistent with the Medi-Cal State Plan.

(ii) For the 1995–96 transfer year, the nonfederal share of the secondary supplemental payment adjustments described in paragraph (9) of subdivision (y) of Section 14105.98 shall be funded as follows:

(I) Ninety-nine percent of the nonfederal share shall be funded by a transfer from the University of California.

(II) One percent of the nonfederal share shall be funded by transfers from those public entities that are the licensees of the hospitals included in the "other public hospitals" group referred to in clauses (ii) and (iii) of subparagraph (B) of paragraph (9) of subdivision (y) of Section 14105.98. The transfer responsibilities for this one percent shall be allocated to the particular public entities on a pro rata basis, based on a formula or formulae customarily used by

the department for allocating transfer amounts under this section. The formula or formulae shall take into account, through reallocation of transfer amounts as appropriate, the situation of hospitals whose secondary supplemental payment adjustments are restricted due to the application of the limitation set forth in clause (v) of subparagraph (B) of paragraph (9) of subdivision (y) of Section 14105.98.

(III) All transfer amounts under this subparagraph shall be paid by the particular transferor entities within 30 days after the department notifies the transferor entity in writing of the transfer amount to be paid.

(2) For the 1993–94 transfer year and subsequent transfer years, transfer amounts shall be increased on a pro rata basis for each transferor entity for the particular transfer year in the amounts necessary to fund the nonfederal share of the total supplemental lump-sum payment adjustment amounts that arise under Section 14105.98. For purposes of this paragraph, the supplemental lump-sum payment adjustment amounts shall be deemed to arise for the particular transfer year as of the date specified in Section 14105.98. Transfer amounts to fund the nonfederal share of the payments shall be paid by the transferor entities for the particular transfer year within 20 days after the department notifies the transferor entity in writing of the additional transfer amount to be paid.

(3) The department shall prepare preliminary analyses and calculations regarding potential transfer amounts, and potential transferor entities shall be notified by the department of estimated transfer amounts as soon as reasonably feasible regarding any particular transfer year. Written notices of transfer amounts shall be issued by the department as soon as possible with respect to each transfer year. All state agencies shall take all necessary steps in order to supply applicable data to the department to accomplish these tasks. The Office of Statewide Health Planning and Development shall provide to the department quarterly access to the edited and unedited confidential patient discharge data files for all Medi-Cal eligible patients. The department shall maintain the confidentiality of that data to the same extent as is required of the Office of Statewide Health Planning and Development. In addition, the Office of Statewide Health Planning and Development shall provide to the department, not later than March 1 of each year, the data specified by the department, as the data existed on the statewide data base file as of February 1 of each year, from all of the following:

(A) Hospital annual disclosure reports, filed with the Office of Statewide Health Planning and Development pursuant to Section 443.31 or 128735 of the Health and Safety Code, for hospital fiscal years that ended during the calendar year ending 13 months prior to the applicable February 1.

(B) Annual reports of hospitals, filed with the Office of Statewide Health Planning and Development pursuant to Section 439.2 or 127285 of the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

(C) Hospital patient discharge data reports, filed with the Office of Statewide Health Planning and Development pursuant to subdivision (g) of Section 443.31 or 128735 of the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

(D) Any other materials on file with the Office of Statewide Health Planning and Development.

(4) For the 1993–94 transfer year and subsequent transfer years, the divisor to be used for purposes of the calculation referred to in paragraph (4) of subdivision (f) shall be determined by the department. The divisor shall be calculated to ensure that the appropriate amount of transfers from transferor entities are received into the fund to satisfy the requirements of Section 14105.98 for the particular transfer year. For the 1993–94 transfer year, the divisor shall be 1.742.

(5) For the 1993–94 fiscal year, the transfer amount that would otherwise be required from the University of California shall be increased by fifteen million dollars ($15,000,000).

(6) Notwithstanding any other provision of law, the total amount of transfers required from the transferor entities for any particular transfer year shall not exceed the sum of the following:

(A) The amount needed to fund the nonfederal share of all payment adjustment amounts applicable to the particular payment adjustment year as calculated under Section 14105.98. Included in the calculations for this purpose shall be any decreases in the program as a whole, and for individual hospitals, that arise due to the provisions of Section 1396r-4(f) or (g) of Title 42 of the United States Code.

(B) The amount needed to fund the transfers to the Health Care Deposit Fund, as referred to in paragraphs (2) and (3) of subdivision (d).

(7) (A) Except as provided in subparagraph (B) and in paragraph (2) of subdivision (j), and except for a prudent reserve not to exceed two million dollars ($2,000,000) in the Medi-Cal Inpatient Payment Adjustment Fund, any amounts in the fund, including interest that accrues with respect to the amounts in the fund, that are not expended, or estimated to be required for expenditure, under Section 14105.98 with respect to a particular transfer year shall be returned on a pro rata basis to the transferor entities for the particular transfer year within 120 days after the department determines that the funds are not needed for an expenditure in connection with the particular transfer year.

(B) The department shall determine the interest amounts that have accrued in the fund from its inception through June 30, 1995,

and, no later than January 1, 1996, shall distribute these interest amounts to transferor entities, as follows:

(i) The total amount transferred to the fund by each transferor entity for all transfer years from the inception of the fund through June 30, 1995, shall be determined.

(ii) The total amounts determined for all transferor entities under clause (i) shall be added together, yielding an aggregate of the total amounts transferred to the fund for all transfer years from the inception of the fund through June 30, 1995.

(iii) The total amount determined under clause (i) for each transferor entity shall be divided by the aggregate amount determined under clause (ii), yielding a percentage for each transferor entity.

(iv) The total amount of interest earned by the fund from its inception through June 30, 1995, shall be determined.

(v) The percentage determined under clause (iii) for each transferor entity shall be multiplied by the amount determined under clause (iv), yielding the amount of interest that shall be distributed under this subparagraph to each transferor entity.

(C) Regarding any funds returned to a transferor entity under subparagraph (A), or interest amounts distributed to a transferor entity under subparagraph (B), the department shall provide to the transferor entity a written statement that explains the basis for the particular return or distribution of funds and contains the general calculations used by the department in determining the amount of the particular return or distribution of funds.

(i) (1) For the 1991–92 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in eight equal installments. Except as provided below, the first installment shall accrue on July 25, 1991, and all other installments shall accrue on the fifth day of each month thereafter from August through February.

(2) Notwithstanding paragraph (1), no installment shall be payable to the Controller until that date which is 20 days after the department notifies the transferor entity in writing that the payment adjustment program set forth in Section 14105.98 has first gained federal approval as part of the Medi-Cal program. For purposes of this paragraph, federal approval requires both (i) approval by appropriate federal agencies of an amendment to the Medi-Cal State Plan, as referred to in subdivision (o) of Section 14105.98, and (ii) confirmation by appropriate federal agencies regarding the availability of federal financial participation for the payment adjustment program set forth in Section 14105.98 at a level of at least 40 percent of the percentage of federal financial participation that is normally applicable for Medi-Cal expenditures for acute inpatient hospital services.

(3) If any installment that would otherwise be payable under paragraph (1) is not paid because of the provisions of paragraph (2), then subparagraphs (A) and (B) shall be followed when federal approval is gained.

(A) All installments that were deferred based on the provisions of paragraph (2) shall be paid no later than 20 days after the department notifies the transferor entity in writing that federal approval has been gained, in an amount consistent with subparagraph (B).

(B) The installments paid pursuant to subparagraph (A) shall be paid in full.

(4) All installments for the 1991–92 transfer year that arise in months after federal approval is gained shall be paid by the fifth day of the month or 20 days after the department notifies the transferor entity in writing that federal approval has been gained, whichever is later.

(5) (A) Except as provided in subparagraphs (B) and (C), for the 1992–93 transfer year and subsequent transfer years, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in eight equal installments. The first installment shall be payable on July 10 of each transfer year. All other installments shall be payable on the fifth day of each month thereafter from August through February.

(B) For the 1994–95 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in five equal installments. The first installment shall be payable on October 5, 1994. The next four installments shall be payable on the fifth day of each month thereafter from November through February.

(C) For the 1995–96 transfer year, each transferor entity shall pay its transfer amount or amounts to the Controller, for deposit in the fund, in five equal installments. The first installment shall be payable on October 5, 1995. The next four installments shall be payable on the fifth day of each month thereafter from November through February.

(D) Except as otherwise specifically provided, subparagraphs (A) to (C), inclusive, shall not apply to increases in transfer amounts described in paragraph (2) of subdivision (h) or to additional transfer amounts described in subdivision (o).

(E) All requests for transfer payments, or adjustments thereto, issued by the department shall be in writing and shall include (i) an explanation of the basis for the particular transfer request or transfer activity, (ii) a summary description of program funding status for the particular transfer year, and (iii) the general calculations used by the department in connection with the particular transfer request or transfer activity.

(6) A transferor entity may use any of the following funds for purposes of meeting its transfer obligations under this section:

(A) General funds of the transferor entity.

(B) Any other funds permitted by law to be used for these purposes, except that a transferor entity shall not submit to the Controller any federal funds unless those federal funds are authorized by federal law to be used to match other federal funds. In addition, no private donated funds from any health care provider, or from any person or organization affiliated with such a health care provider, shall be channeled through a transferor entity or any other public entity to the fund. The transferor entity shall be responsible for determining that funds transferred meet the requirements of this subparagraph.

(j) (1) If a transferor entity does not submit any transfer amount within the time period specified in this section, the Controller shall offset immediately the amount owed against any funds which otherwise would be payable by the state to the transferor entity. The Controller, however, shall not impose an offset against any particular funds payable to the transferor entity where the offset would violate state or federal law.

(2) Where a withhold or a recoupment occurs pursuant to the provisions of paragraph (2) of subdivision (r) of Section 14105.98, the nonfederal portion of the amount in question shall remain in the fund, or shall be redeposited in the fund by the department, as applicable. The department shall then proceed as follows:

(A) If the withhold or recoupment was imposed with respect to a hospital whose licensee was a transferor entity for the particular state fiscal year to which the withhold or recoupment related, the nonfederal portion of the amount withheld or recouped shall serve as a credit for the particular transferor entity against an equal amount of transfer obligations under this section, to be applied whenever the transfer obligations next arise. Should no such transfer obligation arise within 180 days, the department shall return the funds in question to the particular transferor entity within 30 days thereafter.

(B) For other situations, the withheld or recouped nonfederal portion shall be subject to paragraph (7) of subdivision (h).

(k) All amounts received by the Controller pursuant to subdivision (i), paragraph (2) of subdivision (h), or subdivision (o), or offset by the Controller pursuant to subdivision (j), shall immediately be deposited in the fund.

(*l*) For purposes of this section, the disproportionate share list utilized by the department for a particular transfer year shall be identical to the disproportionate share list utilized by the department for the same state fiscal year for purposes of Section 14105.98. Nothing on a disproportionate share list, once issued by the department, shall be modified for any reason other than mathematical or typographical errors or omissions on the part of the department or the Office of Statewide Health Planning and Development in preparation of the list.

(m) Neither the intergovernmental transfers required by this section, nor any elective transfer made pursuant to Section 14164, shall create, lead to, or expand the health care funding or service obligations for current or future years for any transferor entity, except as required of the state by this section or as may be required by federal law, in which case the state shall be held harmless by the transferor entities on a pro rata basis.

(n) No amount submitted to the Controller pursuant to subdivision (i), paragraph (2) of subdivision (h), or subdivision (o), or offset by the Controller pursuant to subdivision (j), shall be claimed or recognized as an allowable element of cost in Medi-Cal cost reports submitted to the department.

(o) Whenever additional transfer amounts are required to fund the nonfederal share of payment adjustment amounts under Section 14105.98 that are distributed after the close of the particular payment adjustment year to which the payment adjustment amounts apply, the additional transfer amounts shall be paid by the parties who were the transferor entities for the particular transfer year that was concurrent with the particular payment adjustment year. The additional transfer amounts shall be calculated under the formula that was in effect during the particular transfer year. For transfer years prior to the 1993–94 transfer year, the percentage of the additional transfer amounts available for transfer to the Health Care Deposit Fund under subdivision (d) shall be the percentage that was in effect during the particular transfer year. These additional transfer amounts shall be paid by transferor entities within 20 days after the department notifies the transferor entity in writing of the additional transfer amount to be paid.

(p) (1) Ten million dollars ($10,000,000) of the amount transferred from the Medi-Cal Inpatient Payment Adjustment Fund to the Health Care Deposit Fund due to amounts transferred attributable to years prior to the 1993–94 fiscal year is hereby appropriated without regard to fiscal years to the State Department of Health Services to be used to support the development of managed care programs under the department's plan to expand Medi-Cal managed care.

(2) These funds shall be used by the department for both of the following purposes: (A) distributions to counties or other local entities that contract with the department to receive those funds to offset a portion of the costs of forming the local initiative entity, and (B) distributions to local initiative entities that contract with the department to receive those funds to offset a portion of the costs of developing the local initiative health delivery system in accordance with the department's plan to expand Medi-Cal managed care.

(3) Entities contracting with the department for any portion of the ten million dollars ($10,000,000) shall meet the objectives of the

department's plan to expand Medi-Cal managed care with regard to traditional and safety net providers.

(4) Entities contracting with the department for any portion of the ten million dollars ($10,000,000) may be authorized under those contracts to utilize their funds to provide for reimbursement of the costs of local organizations and entities incurred in participating in the development and operation of a local initiative.

(5) To the full extent permitted by state and federal law, these funds shall be distributed by the department for expenditure at the local level in a manner that qualifies for federal financial participation under the medicaid program.

(q) (1) Any local initiative entity that has performed unanticipated additional work for the purposes identified in subparagraph (B) of paragraph (2) of subdivision (p) resulting in additional costs attributable to the development of its local initiative health delivery system, may file a claim for reimbursement with the department for the additional costs incurred due to delays in start dates through the 1996–97 fiscal year. Any such claim shall be filed by the local initiative entity not later than 90 days after the effective date of the act adding this subdivision, and shall not seek extra compensation for any sum that is or could have been asserted pursuant to the contract disputes and appeals resolution provisions of the local initiative entity's respective two-plan model contract. All claims for unanticipated additional incurred costs shall be submitted with adequate supporting documentation including, but not limited to, all of the following:

(A) Invoices, receipts, job descriptions, payroll records, work plans, and other materials that identify the unanticipated additional claimed and incurred costs.

(B) Documents reflecting mitigation of costs.

(C) To the extent lost profits are included in the claim, documentation identifying those profits and the manner of calculation.

(D) Documents reflecting the anticipated start date, the actual start date, and reasons for the delay between the dates, if any.

(2) In determining any amount to be paid, the department shall do all of the following:

(A) Conduct a fiscal analysis of the local initiative entity's claimed costs.

(B) Determine the appropriate amount of payment, after taking into consideration the supporting documentation and the results of any audit.

(C) Provide funding for any such payment, as approved by the Department of Finance through the deficiency process.

(D) Complete the determination required in subparagraph (B) within six months after receipt of a local initiative entity's completed claim and supporting documentation. Prior to final determination,

there shall be a review and comment period for that local initiative entity.

(E) Make reasonable efforts to obtain federal financial participation. In the event federal financial participation is not allowed for this payment, the state's payment shall be 50 percent of the total amount determined to be payable.

SEC. 77. Section 14459.5 is added to the Welfare and Institutions Code, to read:

14459.5. (a) As delegated by the federal government, the department has responsibility for monitoring the quality of all medicaid services provided in the state. A key component of this monitoring function is the performance of annual, independent, external reviews of the quality of services furnished under each state contract with a health maintenance organization, as specified by the federal Health Care Financing Administration.

(b) The Legislature finds and declares that the final report obtained from the external reviews will provide valid and reliable information regarding health care outcomes and the overall quality of care delivered by the managed care plans.

(c) The department shall make only the final report of each external review available, within 30 calendar days of completion, to the fiscal and health policy committees of the Legislature, and shall make only the final report available for public viewing upon request by any individual or organization.

SEC. 78. Section 14459.7 is added to the Welfare and Institutions Code, to read:

14459.7. (a) The department shall implement a Management Information System/Decision Support System (MIS/DSS) for the Medi-Cal Program, that shall integrate data from managed care plans to monitor and evaluate the quality of care provided to beneficiaries, including access to services, establish provider rates, and analyze ways to improve both the managed care and fee-for-service systems.

(b) The department shall provide the fiscal and health policy committees of the Legislature with an annual progress and status report on the implementation of the MIS/DSS. The annual progress and status report shall include a description of the current status of the project, including a list of the specific project objectives that have and have not been met at the time of the report and a comparison of the actual progress of the project with the most recent project schedule approved by the Legislature. The report also shall include estimated expenditures and staffing for the current fiscal year and proposed expenditures and staffing for the next fiscal year as well as a summary of cumulative total project expenditures to date and a projection of future expenditures necessary to complete the project.

(c) The department shall provide system or information access to the fiscal and health policy committees of the Legislature, with the most cost-effective technology available, by the conclusion of the

third phase of this multiphase project. Access shall include both the management information system and ad hoc report systems, or their equivalent, with safeguards to block access to individual patient identities. Public access shall be provided to at least the management information system summary presentation, or an equivalent, by the time of project completion.

SEC. 79. Section 16809.5 of the Welfare and Institutions Code is amended to read:

16809.5. (a) Funds appropriated for the purposes of this section shall be allocated on a monthly basis.

(b) Money allocated for the purposes of this section may be used to expand the scope of benefits, to fund special projects which alleviate problems of access to health and dental care under the County Medical Services Program and to compensate hospitals and other emergency health service providers for emergency treatment of out-of-county indigent patients and shall not be used to fund existing levels of service.

(c) Funds available from appropriations for the purposes of this chapter may be utilized to fund increased program costs due to caseload increases and provider rate increases.

SEC. 80. Section 16909 of the Welfare and Institutions Code is amended to read:

16909. (a) Any county which receives funds pursuant to this part shall deposit them in a special revenue fund or trust fund established solely for this purpose, in a hospital services account, a physician services account, and other county health services account, and any other account or subaccount the department may require, before transferring or expending them for any of the uses allowed in this part.

(b) Any county subject to the requirements of subdivision (a) shall deposit the funds in the special revenue fund or trust fund before transferring the funds to the county emergency medical services fund, as provided in subdivision (c) of Section 16933 and Section 16951.

(c) (1) Interest on each fund, account, or subaccount shall accrue to the benefit of the fund, account, or subaccount, and shall be expended for the same purposes as the other funds in the account or subaccount.

(2) Interest or other increments resulting from funds transferred to the county for noncounty hospitals pursuant to paragraph (1) or (2) of subdivision (b) of Section 16946 shall be expended under paragraph (1) or (2) of subdivision (b) of Section 16946.

(d) Counties shall submit a report that displays cost and utilization data for each account in the trust fund established pursuant to this section, to the department on a semiannual, preliminary annual, and final annual basis, in a form prescribed by the department.

(e) Data required by subdivision (d) shall include, but not be limited to, all of the following:
(1) For the Hospital Services Account, the data shall include all of the following:
(A) Inpatient stay, including child health and disability prevention followup treatment, including the following information:
(i) Facility name.
(ii) Amount paid by the county.
(iii) Number of discharges.
(iv) Patient days.
(B) Outpatient visits, including child health and disability prevention followup treatment, including the following information:
(i) Facility name.
(ii) Amount paid by the county.
(iii) Number of visits.
(C) Emergency room.
(i) Facility name.
(ii) Amount paid by the county.
(iii) Number of visits.
(2) For the Physician Services Account, the data shall include all of the following:
(A) Emergency services, including the following information:
(i) The number of providers.
(ii) The number of visits.
(iii) The amount paid by the county.
(B) Obstetrics, including the following information:
(i) The number of providers.
(ii) The number of visits.
(iii) The amount paid by the county.
(C) Pediatrics, including the following information:
(i) The number of providers.
(ii) The number of visits.
(iii) The amount paid by the county.
(D) Child health and disability prevention followup treatment, including the following information:
(i) The number of providers.
(ii) The number of visits.
(iii) The amount paid by the county.
(3) For the other county health services account, the data shall include all of the following:
(A) For funds expended for hospital services, those data in paragraph (1) of subdivision (e).
(B) For funds expended for physician services, those data in paragraph (2) of subdivision (e).
(C) For funds expended for services other than those provided and billed for by a hospital or physician, the data shall include:
(i) The number of providers by type of service.

(ii) The number of visits or units, or both, by type of service.
(iii) The amount paid by the county by type of service.
(D) Child health and disability prevention followup treatment, including the following information:
(i) The number of providers.
(ii) The number of visits.
(iii) The amount paid by the county.
(f) The Director of Health Services shall withhold, in part or in whole, payment of moneys governed by Chapter 4 (commencing with Section 16930) and Chapter 5 (commencing with Section 16940) of this part to a county, until the reports specified in this section have been submitted to the department in the form and according to the procedures established by the department.
SEC. 81. Section 16945 of the Welfare and Institutions Code is amended to read:
16945. (a) The department shall annually verify and transmit to each MISP county and each CMSP county the figures specified in subdivision (c), using data supplied by the office.
(b) (1) For purposes specified in subdivision (c), the office shall use data from the quarterly reports required by Section 128740 of the Health and Safety Code.
(2) For the 1989–90 fiscal year computations, the office shall use the 1988 calendar year data, as adjusted by the office, existing on the statewide file on September 1, 1989.
(3) For the computations for fiscal years after the 1989–90 fiscal year, the office shall use the data from the quarterly reports for the calendar year preceding the computational fiscal year, as adjusted by the office, existing on the statewide file on April 15 immediately preceding the computational fiscal year.
(4) (A) Except as provided in subparagraphs (B), (C), and (D), the definitions, procedures, and data elements specified in Chapter 3 (commencing with Section 16920) shall be used in all computations required in subdivision (c).
(B) For the 1991–92 fiscal year, the following definitions shall be used in all computations required in subdivision (c):
(i) "Uncompensated care charges" means the sum of the charges related to patients falling within the charity-other category in the 1990 calendar year and 25 percent of the charges related to patients falling within the bad debts category in the first two quarters of the 1990 calendar year, as both categories of charges are reported quarterly to the office pursuant to Section 128740 of the Health and Safety Code.
(ii) "Uncompensated care costs" means that amount calculated by applying an overall hospital cost-to-charge ratio, calculated by dividing gross operating expenses by gross inpatient and outpatient revenue, as reported quarterly to the office, to uncompensated care charges.

(C) For the 1992–93 fiscal year, the following definitions shall be used in all computations required in subdivision (c):

(i) "Uncompensated care charges" means the charges related to patients falling within charity-other, as reported quarterly to the office pursuant to Section 128740 of the Health and Safety Code.

(ii) "Uncompensated care costs" means that amount calculated by applying an overall hospital cost-to-charge ratio, calculated by dividing gross operating expenses by gross inpatient and outpatient revenue, as reported quarterly to the office, to uncompensated care charges.

(D) For the 1993–94, 1994–95, 1995–96, 1996–97 and subsequent fiscal years, the following definitions shall be used in all computations required in subdivision (c):

(i) (I) For county hospitals and for all hospitals operating in counties with no county hospital, "uncompensated care charges" means the charges related to patients falling within charity-other, gross inpatient revenue-county indigent programs and gross outpatient revenue-county indigent programs, as reported quarterly to the office pursuant to Section 128740 of the Health and Safety Code.

(II) For noncounty hospitals operating in a county with a county hospital, "uncompensated care charges" means the charges related to patients falling within charity-other and county indigent programs contractual adjustments, as reported quarterly to the office pursuant to Section 128740 of the Health and Safety Code.

(ii) "Uncompensated care costs" means that amount calculated by applying an overall hospital cost-to-charge ratio, calculated by dividing gross operating expenses less other operating revenue by gross inpatient and outpatient revenue, as reported quarterly to the office, to uncompensated care charges.

(c) The office shall compute the following data on uncompensated care costs reported by hospitals located within each MISP county and each CMSP county:

(1) The sum of uncompensated care costs for all hospitals.

(2) The sum of uncompensated care costs for all noncounty hospitals.

(3) The sum of uncompensated care costs for all county hospitals.

(4) The uncompensated care costs of each hospital within the county.

(5) The percentage derived from dividing the result of paragraph (2) by the result of paragraph (1).

(6) The percentage derived from dividing the result of paragraph (3) by the result of paragraph (1).

(7) The percentage for each individual hospital derived from dividing each noncounty hospital's uncompensated care cost in paragraph (4) by the amount in paragraph (2).

(d) The office shall transmit to the department the data specified in subdivision (c) within 30 days of the dates specified in paragraph (2) of subdivision (b) and paragraph (3) of subdivision (b) of this section.

SEC. 82. Section 16990.5 of the Welfare and Institutions Code is amended to read:

16990.5. (a) The following definitions shall govern the construction of this section, unless the context requires otherwise:

(1) "Capital outlay" means net disproportionate share hospital revenues used for projects that involve the acquisition, construction, renovation, improvement, modernization, expansion, or replacement of a plant, building, or fixed or movable equipment, including debt service for facilities used in the provision of county health care services or mental health services.

(2) "County health care services" means those services described in subdivision (a) of Section 16801.

(3) "County financial maintenance of effort" means the level of financial support required of a county pursuant to Section 16990.

(4) "Net disproportionate share hospital revenues" means the amount determined by subtracting the total intergovernmental transfers made by a county pursuant to Sections 14163 and 14164 from the total amount of the payment adjustments paid to the county's hospital or hospitals pursuant to Section 14105.98. This calculation shall reflect any amendment to Sections 14163 and 14164, including amendments to paragraph (2) of subdivision (d) of Section 14163.

(5) "Mental health services" means those programs transferred or otherwise financed pursuant to Chapters 89 and 91 of the Statutes of 1991.

(b) (1) Each county shall deposit all net disproportionate share hospital revenues into a fund or funds other than the county general fund, and shall retain those revenues until utilized for the purposes described in this section.

(2) All disproportionate share hospital revenues are intended to support health care services rendered by disproportionate share hospitals, including, but not limited to, health or mental health services and health or mental health capital outlays. Net disproportionate share hospital revenues shall not be used to supplant or offset county general funds or other funds that were expended or encumbered for those purposes prior to July 1, 1991.

(3) Net disproportionate share hospital revenues shall be included in computing county financial maintenance of effort only as set forth in subdivision (c).

(c) For the 1991–92 fiscal year, and for each fiscal year thereafter, for purposes of computing county financial maintenance of effort, net disproportionate share hospital revenues deposited in accordance with subdivision (b) shall be treated as follows:

(1) Net disproportionate share hospital revenues utilized for a county for mental health services, or for capital outlay for health or mental health services, shall not be counted as revenue in the computation of county financial maintenance of effort.

(2) Net disproportionate share hospital revenues that are not utilized as described in paragraph (1) shall be counted as revenue in the computation of a county's financial maintenance of effort only to the extent that by not counting those revenues for a particular fiscal year, a county's net county costs for county health care services exceeds the amount of county funds required to satisfy the requirements of Section 16990 for the particular fiscal year.

(3) Net disproportionate share hospital revenues counted as revenue in the calculation of county financial maintenance of effort for a particular year pursuant to paragraph (2) shall not be counted as revenue in the calculation of county financial maintenance of effort relating to any subsequent fiscal year.

(d) Net disproportionate share hospital revenues may not be used for deposits required by Sections 17608.05 and 17608.10 or as county funds required by Section 16990.

SEC. 83. Section 16997.1 of the Welfare and Institutions Code is repealed:

SEC. 84. Section 17000.51 is added to the Welfare and Institutions Code, to read:

17000.51. (a) Notwithstanding the decision in Caulk v. Superior Court, CO15355, June 27, 1997, a county's discretion granted pursuant to Section 17000.5 to include, as part of a general assistance aid grant, in-kind aid with a monthly actuarial value of up to forty dollars ($40) per month of medical care, was not intended, and shall not be construed, to do any of the following:

(1) Satisfy, in whole or in part, the duty of a county or a city or county to provide health care services to indigent and dependent poor persons under Section 17000.

(2) Permit a county or a city and county to cease providing health care services under Section 17000.

(3) Affect the eligibility of indigent and dependent poor persons for health care services under Section 17000.

(b) Subdivision (a) shall cease to be implemented if, and only to the extent that, a final court decision holds that subdivision (a) imposes a state-mandated local program.

(c) Subdivision (a) confirms, and is declarative of, rather than a change in, existing law, as provided for in Chapter 6 of the Statutes of 1996, which was intended only to provide a county or city and county with the discretion to reduce its general assistance grant level by up to forty dollars ($40) per month.

SEC. 85. (a) (1) Of the amount appropriated in Item 4260-111-0001 of the Budget Act of 1997, the State Department of Health Services may use the sum of one million six hundred thousand

dollars ($1,600,000) for the extension of the term of contracts with entities receiving funds in the 1996–97 fiscal year to provide HIV testing services.

(2) Notwithstanding any other provision of law, the State Department of Health Services may enter into amendments to the contracts described in paragraph (1) for the 1997–98 fiscal year, to be effective as of June 30, 1997. Any such amendment shall be exempt from the approval of the Director of General Services and from the provisions of the Public Contract Code.

(3) The department may make advance payments, not to exceed 25 percent of the expected amount of funding for the particular contract amendment, prior to the execution of the amendment. These advance payments shall be made only for services specified in the particular contract that was in effect prior to June 30, 1997, and that are provided after June 30, 1997.

(b) This section shall become inoperative on July 1, 1998, and, as of January 1, 1999, is repealed.

SEC. 86. In the event that funds in the Cigarette and Tobacco Products Surtax Fund are insufficient to support the Budget Act appropriations for the programs affected by this act, the Director of Finance may authorize the augmentation or reduction of the amounts appropriated in the Budget Act for the programs affected by this act pursuant to Section 27 of the Budget Act or any other provision of the Budget Act that governs deficiencies.

SEC. 87. Moneys in the Hospital Services Account, the Physician Services Account, the Health Education Account, and the Unallocated Account in the Cigarette and Tobacco Products Surtax Fund shall not be transferred to any other fund or account in the State Treasury, except as provided in this act or other legislation, and except for purposes of investment as provided in Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code. All interest or other increment resulting from investment shall be deposited to the respective account.

SEC. 88. (a) Notwithstanding any provision of law, funds appropriated by the Budget Act of 1997 for the tobacco use competitive grants program set forth in Section 104385 of the Health and Safety Code and the tobacco prevention media campaign set forth in subdivision (e) of Section 104375 of the Health and Safety Code shall be available for expenditure without regard to fiscal year until July 1, 2000.

(b) Notwithstanding any provision of law, funds appropriated by the Budget Act of 1997 for the evaluation of the State Department of Education's tobacco use prevention education program pursuant to subdivision (c) of Section 104375 of the Health and Safety Code, for the State Department of Education's allocation of funds for school-based tobacco use prevention pursuant to Sections 104425 and

104430 of the Health and Safety Code, for the tobacco use prevention program set forth in Section 104400 of the Health and Safety Code, and for the rural health improvement grants established in Section 1179.3 of the Health and Safety Code, shall be available for expenditure without regard to fiscal year until July 1, 1999.

SEC. 89. Due to the necessity to implement the mandates of Article 2 (commencing with Section 30121) of Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code, any contract made pursuant to any provision of this act referred to in Section 91 shall not be subject to Part 2 (commencing with Section 10100) of the Public Contract Code.

SEC. 90. In the event that this act is not enacted until after July 1, 1997, all programs authorized or amended by this act by the amendment of Sections 16909 and 16945 of the Welfare and Institutions Code, and by those sections referred to in the following sentence, shall be deemed to be operative for the entire 1997–98 fiscal year. Also, by repealing Sections 349.109, 104485, 104550, 104569, and 124950 of the Health and Safety Code, Section 12699.50 of the Insurance Code, Sections 14148.99 and 16997.1 of the Welfare and Institutions Code, and by deleting subdivision (e) of Section 16809.5 of the Welfare and Institutions Code, it is the intent of the Legislature to continue the effect and operation of the provisions affected by those repealed and deleted provisions. If this act is not enacted until after July 1, 1997, those affected provisions shall again become operative on the effective date of this act.

SEC. 91. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

SEC. 92. (a) The State Department of Health Services may adopt emergency regulations to implement this act in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(b) (1) The State Department of Health Services may adopt emergency regulations to implement any new Medi-Cal benefits established by the Budget Act of 1997 in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(2) In the regulations described in paragraph (1), the department may define terms and prescribe requirements applicable to those benefits, including, but not limited to, the following:

(A) The provider types and size of provider office that are eligible for payment for providing this benefit.

(B) The criteria required to be met for payment.

(C) The reimbursement rates for the services.

(D) Any certificate or license requirements that are required to be met by individuals providing the services.

(c) The initial adoption of emergency regulations described in subdivisions (a) and (b) following the effective date of this section and one readoption of those initial regulations shall be deemed to be emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this section and the readoption of those regulations shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations and shall remain in effect for no more than 180 days.

SEC. 93. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

SEC. 94. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to timely provide for the administration of this act relating to public health for the entire 1997–98 fiscal year, it is necessary that this act take effect immediately.

O

Senate Bill No. 362

CHAPTER 116

An act to amend Section 121361 of the Health and Safety Code, relating to communicable diseases.

[Approved by Governor July 27, 1997. Filed with Secretary of State July 28, 1997.]

LEGISLATIVE COUNSEL'S DIGEST

SB 362, Maddy. Tuberculosis: health facility.

Existing law prohibits a health facility, local detention facility, or state correctional institution from discharging, releasing, or transferring any person known to have or when the facility or institutional medical staff have reasonable grounds to believe the person has active tuberculosis, unless notification and a written treatment plan have been received by the local health officer, except as specified.

This bill would provide that no health facility that declines to discharge, release, or transfer a person pursuant to that provision shall be civilly or criminally liable or subject to administrative sanction as a result, if the health facility complies with that provision and acts in good faith. The bill would also provide that the local health officer under this provision is not relieved of any other duty imposed under state law governing tuberculosis control.

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

SECTION 1. Section 121361 of the Health and Safety Code is amended to read:

121361. (a) (1) A health facility, local detention facility, or state correctional institution shall not discharge or release any of the following persons unless subdivision (e) is complied with:

(A) A person known to have active tuberculosis disease.

(B) A person who the medical staff of the health facility or of the penal institution has reasonable grounds to believe has active tuberculosis disease.

(2) In addition, persons specified in this subdivision may be discharged from a health facility only after a written treatment plan described in Section 121362 is approved by a local health officer of the jurisdiction in which the health facility is located. Treatment plans submitted for approval pursuant to this paragraph shall be reviewed by the local health officer within 24 hours of receipt of the plans.

(3) The approval requirement of paragraph (2) shall not apply to any transfer to a general acute care hospital when the transfer is due

to an immediate need for a higher level of care, nor to any transfer from any health facility to a correctional institution. Transfers or discharges described in this paragraph shall occur only after the notification and treatment plan required by Section 121362 have been received by the local health officer.

(4) This subdivision shall not apply to transfers within the state correctional system or to interfacility transfers occurring within a local detention facility system.

(b) No health facility shall transfer a person described in subparagraph (A) or (B) of paragraph (1) of subdivision (a) to another health facility unless subdivision (e) is complied with. This subdivision shall not apply to transfers within the state correctional system or to interfacility transfers occurring within a local detention facility system.

(c) No state correctional institution or local detention facility shall transfer a person described in subparagraph (A) or (B) of paragraph (1) of subdivision (a) from a state to a local, or from a local to a state, penal institution unless notification and a written treatment plan are received by the chief medical officer of the penal institution receiving the person.

(d) No local detention facility shall transfer a person described in subparagraph (A) or (B) of paragraph (1) of subdivision (a) to a local detention facility in another jurisdiction unless subdivision (e) is complied with and notification and a written treatment plan are received by the chief medical officer of the local detention facility receiving the person.

(e) All discharges, releases, or transfers described in subdivisions (a), (b), (c), and (d) may occur only after notification and a written treatment plan pursuant to Section 121362 has been received by the local health officer. When prior notification would jeopardize the person's health, the public safety, or the safety and security of the penal institution, then the notification and treatment plan shall be submitted within 24 hours of discharge, release, or transfer.

(f) No health facility that declines to discharge, release, or transfer a person pursuant to this section shall be civilly or criminally liable or subject to administrative sanction therefor. This subdivision shall apply only if the health facility complies with this section and acts in good faith.

(g) Nothing in this section shall relieve a local health officer of any other duty imposed by this chapter.

O

Senate Bill No. 843

CHAPTER 763

An act to amend Sections 121361 and 121362 of, and to add and repeal Section 121360.5 of, the Health and Safety Code, relating to communicable diseases.

[Approved by Governor September 20, 2002. Filed with Secretary of State September 21, 2002.]

LEGISLATIVE COUNSEL'S DIGEST

SB 843, Perata. Omnibus Tuberculosis Control and Prevention Act of 2002.

Existing law establishes various communicable disease prevention and control programs, including one for tuberculosis. That program provides for testing of various persons for tuberculosis by prescribed licensed health professionals.

This bill would enact the Omnibus Tuberculosis Control and Prevention Act of 2002.

This bill would until January 1, 2006, permit any local health department to provide for certification, by the local health officer, of tuberculin skin test technicians, as defined, in accordance with specified requirements.

Existing law requires each health care provider who treats a person for active tuberculosis disease, each person in charge of a health facility, or each person in charge of a clinic providing outpatient treatment for active tuberculosis disease to promptly provide a disease notification report and written treatment plan to the local health officer at the times that the health officer requires, but no less frequently than when there are reasonable grounds to believe that a person has active tuberculosis disease, and when a person ceases treatment for tuberculosis disease.

Existing law prohibits a health facility, local detention facility, or state correctional institution from discharging or releasing a person known to have active tuberculosis disease or a person the medical staff of the health facility or of the penal institution has reasonable grounds to believe has active tuberculosis disease, unless the notification report and individual treatment plan requirements specified above have been met.

This bill would provide that when a person described above is released on parole from a state correctional institution, the notification and written treatment plan shall be provided to both the local health officer for the county in which the parolee intends to reside and the local health officer for the county in which the state correctional institution is

located. It would require the Department of Corrections to inform the parole agent, and other parole officials as necessary, that the person has active or suspected active tuberculosis disease and provide information regarding the need for evaluation or treatment. In addition, the bill would require the parole agent and other parole officials to coordinate with the local health officer in supervising the person's compliance with medical evaluation or treatment related to tuberculosis, and to notify the local health officer if the person's parole is suspended as a result of having absconded from supervision. The imposition of new duties on local health officers in connection with these provisions would create a state-mandated local program.

Existing law provides that in the case of a parolee under the jurisdiction of the Department of Corrections, the local health officer shall notify the medical officer of the parole region or the physician and surgeon designated by the Director of Corrections when there are reasonable grounds to believe that the parolee has active tuberculosis disease and when the parolee ceases treatment for tuberculosis.

This bill would instead require the local health officer to notify the assigned parole agent, when known, or the regional parole administrator.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) Each year, approximately 3,000 Californians develop tuberculosis (TB). Tuberculosis is a contagious disease transmitted through the air by bacteria when a person with active tuberculosis disease coughs or sneezes, and another person breathes in the tuberculosis bacteria.

(2) For each reported case of active tuberculosis disease, public health officials identify 10 or more individuals who have been directly exposed to the disease and are at risk of developing latent tuberculosis infection. These individuals who have been exposed to the disease are

at the highest risk of developing active tuberculosis disease soon after exposure. Finding and screening individuals who have been recently exposed to active tuberculosis disease, referred to as "contact investigation," is essential in preventing outbreaks of tuberculosis in communities.

(3) Public health officials estimate that as many as 3.4 million Californians may now be infected (latent tuberculosis infection) with the bacteria that can cause active tuberculosis disease. If undetected and untreated, an estimated 5 to 10 percent of persons in California, or 170,000 to 340,000 people, with latent tuberculosis infection will, throughout the course of their lives, develop active tuberculosis disease, thus continuing the cycle of transmission.

(4) Because persons with latent tuberculosis infection have no symptoms, the only way to detect their infection is by a tuberculin skin test.

(5) Tuberculin skin tests may now be placed and measured only by certain licensed health professionals, which do not include public health tuberculosis workers who are not licensed health professionals, but who are employed by, or under contract with, a city or county health department.

(6) The National Institute of Medicine's report on tuberculosis clearly recommends increased efforts at contact investigation, targeted skin testing, and bringing under treatment those individuals with latent tuberculosis infection in order to prevent the progression to active, transmissible, tuberculosis disease.

(b) It is the intent of the Legislature to enact legislation to permit any city or county health department to provide for certification, by the local health officer, of tuberculin skin test technicians, who are public health tuberculosis workers, and to authorize tuberculin skin test technicians to place and measure skin tests for tuberculosis for the local health department, in order to increase the number of persons qualified to administer tests and to thereby more effectively, and more cost-effectively, control the spread and contagion of this communicable disease.

SEC. 2. This act shall be known, and may be cited, as the Omnibus Tuberculosis Control and Prevention Act of 2002.

SEC. 3. Section 121360.5 is added to the Health and Safety Code, to read:

121360.5. (a) Any city or county health department may provide for one-year certification of tuberculin skin test technicians by local health officers.

(b) For purposes of this section, a "certified tuberculin skin test technician" is an unlicensed public health tuberculosis worker

employed by, or under contract with, a local public health department, and who is certified by a local health officer to place and measure skin tests in the local health department's jurisdiction.

(c) A certified tuberculin skin test technician may perform the functions for which he or she is certified only if he or she meets all of the following requirements:

(1) The certified tuberculin skin test technician is working under the direction of the local health officer or the tuberculosis controller.

(2) The certified tuberculin skin test technician is working under the supervision of a licensed health professional.

(d) A certified tuberculin skin test technician may perform intradermal injections only for the purpose of placing a tuberculin skin test and measuring the test result.

(e) A certified tuberculin skin test technician may not be certified to interpret, and may not interpret, the results of a tuberculin skin test.

(f) In order to be certified as a tuberculin skin test technician by a local health officer, a person shall meet all of the following requirements, and provide to the local health officer appropriate documentation establishing that he or she has met those requirements:

(1) The person has a high school diploma, or its equivalent.

(2) The person has completed a standardized course approved by the California Tuberculosis Controllers Association (CTCA), which shall include at least 24 hours of instruction in all of the following areas: Didactic instruction on tuberculosis control principles and instruction on the proper placement and measurement of tuberculin skin tests, equipment usage, basic infection control, universal precautions, and appropriate disposal of sharps, needles, and medical waste, client preparation and education, safety, communication, professional behavior, and the importance of confidentiality.

A certification of satisfactory completion of this CTCA-approved course shall be dated and signed by the local health officer, and shall contain the name and social security number of the tuberculin skin test technician, and the printed name, the jurisdiction, and the telephone number of the certifying local health officer.

(3) The person has completed practical instruction including placing at least 30 successful intradermal tuberculin skin tests, supervised by a licensed physician or registered nurse at the local health department, and 30 correct measurements of intradermal tuberculin skin tests, at least 15 of which are deemed positive by the licensed physician or registered nurse supervising the practical instruction. A certification of the satisfactory completion of this practical instruction shall be dated and signed by the licensed physician or registered nurse supervising the practical instruction.

(g) The certification may be renewed, and the local health department shall provide a certificate of renewal, if the certificate holder has completed inservice training, including all of the following:

(1) At least three hours of a CTCA-approved standardized training course to assure continued competency. This training shall include, but not be limited to, fundamental principles of tuberculin skin testing.

(2) Practical instruction, under the supervision of a licensed physician or registered nurse at the local health department, including the successful placement and correct measurement of 10 tuberculin skin tests, at least five of which are deemed positive by the licensed physician or registered nurse supervising the practical instruction.

(h) The local health officer or the tuberculosis controller may deny or revoke the certification of a tuberculin skin test technician if the local health officer or the tuberculosis controller finds that the technician is not in compliance with this section.

(i) This section shall remain in effect only until January 1, 2006, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2006, deletes or extends that date.

SEC. 4. Section 121361 of the Health and Safety Code is amended to read:

121361. (a) (1) A health facility, local detention facility, or state correctional institution shall not discharge or release any of the following persons unless subdivision (e) is complied with:

(A) A person known to have active tuberculosis disease.

(B) A person who the medical staff of the health facility or of the penal institution has reasonable grounds to believe has active tuberculosis disease.

(2) In addition, persons specified in this subdivision may be discharged from a health facility only after a written treatment plan described in Section 121362 is approved by a local health officer of the jurisdiction in which the health facility is located. Any treatment plan submitted for approval pursuant to this paragraph shall be reviewed by the local health officer within 24 hours of receipt of that plan.

(3) The approval requirement of paragraph (2) shall not apply to any transfer to a general acute care hospital when the transfer is due to an immediate need for a higher level of care, nor to any transfer from any health facility to a correctional institution. Transfers or discharges described in this paragraph shall occur only after the notification and treatment plan required by Section 121362 have been received by the local health officer.

(4) This subdivision shall not apply to any transfer within the state correctional system or to any interfacility transfer occurring within a local detention facility system.

(b) No health facility shall, without first complying with subdivision (e), transfer a person described in subparagraph (A) or (B) of paragraph (1) of subdivision (a) to another health facility. This subdivision shall not apply to any transfer within the state correctional system or to any interfacility transfer occurring within a local detention facility system.

(c) No state correctional institution or local detention facility shall transfer a person described in subparagraph (A) or (B) of paragraph (1) of subdivision (a) from a state to a local, or from a local to a state, penal institution unless notification and a written treatment plan are received by the chief medical officer of the penal institution receiving the person.

(d) No local detention facility shall transfer a person described in subparagraph (A) or (B) of paragraph (1) of subdivision (a) to a local detention facility in another jurisdiction unless subdivision (e) is complied with and notification and a written treatment plan are received by the chief medical officer of the local detention facility receiving the person.

(e) (1) Any discharge, release, or transfer described in subdivisions (a), (b), (c), and (d) may occur only after notification and a written treatment plan pursuant to Section 121362 has been received by the local health officer. When prior notification would jeopardize the person's health, the public safety, or the safety and security of the penal institution, the notification and treatment plan shall be submitted within 24 hours of discharge, release, or transfer.

(2) When a person described in paragraph (1) of subdivision (a) is released on parole from a state correctional institution, the notification and written treatment plan specified in this subdivision shall be provided to both the local health officer for the county in which the parolee intends to reside and the local health officer for the county in which the state correctional institution is located.

(3) Notwithstanding any other provision of law, the Department of Corrections shall inform the parole agent, and other parole officials as necessary, that the person described in paragraph (1) of subdivision (a) has active or suspected active tuberculosis disease and provide information regarding the need for evaluation or treatment. The parole agent and other parole officials shall coordinate with the local health officer in supervising the person's compliance with medical evaluation or treatment related to tuberculosis, and shall notify the local health officer if the person's parole is suspended as a result of having absconded from supervision.

(f) No health facility that declines to discharge, release, or transfer a person pursuant to this section shall be civilly or criminally liable or subject to administrative sanction therefor. This subdivision shall apply

only if the health facility complies with this section and acts in good faith.

(g) Nothing in this section shall relieve a local health officer of any other duty imposed by this chapter.

SEC. 5. Section 121362 of the Health and Safety Code is amended to read:

121362. Each health care provider who treats a person for active tuberculosis disease, each person in charge of a health facility, or each person in charge of a clinic providing outpatient treatment for active tuberculosis disease shall promptly report to the local health officer at the times that the health officer requires, but no less frequently than when there are reasonable grounds to believe that a person has active tuberculosis disease, and when a person ceases treatment for tuberculosis disease. Situations in which the provider may conclude that the patient has ceased treatment include times when the patient fails to keep an appointment, relocates without transferring care, or discontinues care. The initial disease notification report shall include an individual treatment plan that includes the patient's name, address, date of birth, tuberculin skin test results, pertinent radiologic, microbiologic, and pathologic reports, whether final or pending, and any other information required by the local health officer. Subsequent reports shall provide updated clinical status and laboratory results, assessment of treatment adherence, name of current care provider if the patient transfers care, and any other information required by the local health officer. A facility discharge, release, or transfer report shall include all pertinent and updated information required by the local health officer not previously reported on any initial or subsequent report, and shall specifically include a verified patient address, the name of the medical provider who has specifically agreed to provide medical care, clinical information used to assess the current infectious state, and any other information required by the local health officer. Each health care provider who treats a person with active tuberculosis disease, and each person in charge of a health facility or a clinic providing outpatient treatment for active tuberculosis disease, shall maintain written documentation of each patient's adherence to his or her individual treatment plan. Nothing in this section shall authorize the disclosure of test results for human immunodeficiency virus (HIV) unless authorized by Chapter 7 (commencing with Section 120975) of, Chapter 8 (commencing with Section 121025) of, and Chapter 10 (commencing with Section 121075) of Part 4 of Division 105.

In the case of a parolee under the jurisdiction of the Department of Corrections, the local health officer shall notify the assigned parole agent, when known, or the regional parole administrator, when there are

reasonable grounds to believe that the parolee has active tuberculosis disease and when the parolee ceases treatment for tuberculosis. Situations where the local health officer may conclude that the parolee has ceased treatment include times when the parolee fails to keep an appointment, relocates without transferring care, or discontinues care.

SEC. 6. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.

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