

ADOPTIONS, CHILD WELFARE, AND FOSTER CARE

SB 841 (Alpert) – Foster Care: Early Start to Emancipation Programs

(Adds and repeals Section 16012 of the Welfare and Institutions Code)

Requires the Department of Social Services (DSS) to provide technical assistance to counties electing to establish programs similar to the Early Start to Emancipation Program (ESTEP) operated by Los Angeles County.

Requires county early emancipation support programs to serve foster youth ages 14 to 15, and include outreach and assessment, high school preparation, and tutoring services.

Requires DSS to adopt regulations in consultation with Los Angeles County and the Community College Foundation as necessary to implement the program.

Appropriates \$125,000 from the General Fund to DSS, \$25,000 for support of the department's technical assistance activities, and \$100,000 for allocation to a county that has already begun planning for implementation of an ESTEP program.

Establishes a sunset date for the program of January 1, 2007.

Status: Chapter 694, Statutes of 2001

SB 1505 (Kuehl) – Teen Dating Violence: Child Welfare Services

(Amends Section 16206 of the Welfare and Institutions Code)

Adds teen dating violence to the issues required to be covered by a statewide training program for county child protective service social workers.

Ensures that child protective services social workers can recognize signs and symptoms of teen dating violence, and thereby make appropriate and effective referrals for teens to receive the services they need to protect themselves and end the violence in their lives.

Status: Chapter 354, Statutes of 2002

AB 364 (Aroner) – Child Welfare: Social Worker Caseloads

(Adds Section 10609.7 to the Welfare and Institutions Code)

Requires the Department of Social Services (DSS) to establish regulations requiring counties, over a five-year period, to implement reduced child welfare services caseload standards, to the following levels:

- Screening/hotline/intake: one worker per 116.10 children.
- Emergency response: one worker per 13.03 children.
- Family maintenance: one worker per 14.18 children.
- Family reunification: one worker per 15.58 children.
- Permanency planning: one worker per 23.69 children.

Exempts counties that opt to provide workload relief to child welfare social workers through methods other than the caseload reductions. Requires these counties to submit a workload relief plan to DSS for approval in order to be considered exempt.

Specifies that these provisions shall only be implemented to the extent that funding is provided in the Budget Act or another statute.

Requires DSS, in establishing compliance thresholds for outcome measures developed pursuant to statute adopted last year in AB 636 (Steinberg, Chapter 678), to take into consideration the extent to which the child welfare system is funded to meet caseload reductions or workload relief.

Status: Chapter 635, Statutes of 2002

AB 557 (Aroner) – Foster Care

(Adds Chapter 1.5, commencing with Section 16030, to Part 4 of Division 9 of the Welfare and Institutions Code)

States legislative findings that California has an urgent need to recruit and retain more licensed foster family homes to provide the least restrictive and most family-like settings possible for abused and neglected children.

Requires the Department of Social Services (DSS), in consultation with the County Welfare Directors Association (CWDA), to administer the Foster Parent Recruitment and Retention Program.

Allows participating counties to provide:

- Supplemental payments to foster homes that care for sibling groups;
- Respite care;
- First and third-party liability insurance to cover property damage;
- The use of additional caseworkers to assist and support foster families in the licensing and training process;
- The use of foster parents as recruiters and for peer support;
- Additional retention supports, including one-time costs to purchase necessary items; Other recruitment and retention activities that are designed locally.

Requires participating counties to submit annual recruitment and retention plans to DSS and to work with organizations representing current and former foster youth, foster family homes, and other interested groups to create the plans.

Requires participating counties to submit annual self-assessments to DSS regarding the effectiveness of local recruitment and retention activities.

Requires DSS, in consultation with CWDA, to determine the program's annual funding allocations.

Specifies that funding for the program shall not require a county match, and permits program funds to be used to draw down a federal match, if appropriate.

Status: Provisions Removed from Original Version Heard in Committee in 2001

AB 636 (Steinberg) – Child Welfare Services

(Adds Section 10601.2 to the Welfare and Institutions Code)

Requires Department of Social Services (DSS) to establish, by July 1, 2003, a Child and Family Service (CFS) Review System in order to review all county child welfare systems, based on outcome measures, and to ensure compliance with federal regulations for the receipt of federal foster care funds. Requires DSS to commence county CFS reviews beginning January 1, 2004.

Suspends the existing county compliance review system as of July 1, 2003 in order to transition to this new system.

Requires, by October 1, 2002, the Health and Human Services Agency (HHS), to develop a working group comprised of specified organizations, agencies, and departments, to establish a work plan for CFS reviews. In establishing the work plan, the workgroup shall consider, among others, any existing federal program improvement plans entered into by the state pursuant to federal regulations, the outcome indicators to be measured by compliance thresholds.

Requires that the first CFS review in each county utilize federal standards, and requires the work group to subsequently consider additional indicators that promote good health, mental health, behavioral, educational and other outcomes for children.

Requires counties that do not meet the CFS review outcome standards to receive technical assistance from joint state-county teams in order to improve their performance and implement best practice standards.

Requires DSS to identify and promote the replication of best practices in child welfare in order to achieve outcome measures developed by HHS.

Requires DSS to report to the Legislative Budget Committees each year, beginning with the 2001-02 fiscal year, on progress in meeting the outcome measures developed by HHS and progress on the federal review.

Status: Chapter 678, Statutes of 2001

AB 899 (Liu) – Rights of Foster Children

(Adds Section 1530.91 to the Health and Safety Code, and amends Sections 16164 and 16501.1 of, and adds Sections 27 and 16001.9 to, the Welfare and Institutions Code)

Establishes state policy that all children in foster care shall have the rights to:

- Live in a safe, healthy, comfortable home, and be treated with respect;
- Be free from abuse and corporal punishment;

- Receive adequate food and clothing, a reasonable allowance, and medical, dental, vision, and mental health services;
- Be free from medication unless authorized by a physician;
- Have contact with family members, including siblings, social workers, court officials, Department of Social Services officials, and others;
- Be free from threats or punishment for making a complaint;
- Receive and make phone calls and receive and send unopened letters;
- Attend religious services, school, and extracurricular activities;
- Maintain a bank account and manage personal income;
- Work and develop job skills;
- Have social contacts outside the foster care system; attend an independent living program;
- Attend court hearings and speak with the judge;
- Have private storage space;
- Be free from unreasonable searches and being locked in a room, building, or facility premises (except in a community treatment facility);
- Review their own case plan and be informed of changes in the plan if they are over the age of 12.

Requires licensed foster care facilities to provide each school-age child in foster care, and his or her authorized representative, with an age- and developmentally-appropriate orientation that includes an explanation of the rights of the child and addresses the child's questions and concerns.

Requires a foster child's social worker to inform the child of his or her rights at least once every six months.

Requires the Office of the State Foster Care Ombudsman, in consultation with specified parties, by July 1, 2002, to develop standardized information explaining the rights, as listed in the bill, in an age- and developmentally-appropriate manner and to include relevant licensing information regarding foster care providers' responsibility to adequately supervise children in their care. Permits this standardized information to be used by counties, foster care providers, and others in carrying out their legal responsibility to inform foster youth of their rights.

Requires the Office of the State Foster Care Ombudsman to design posters listing a foster child's rights and provide the posters to foster care facilities licensed to care for six or more children. Requires those facilities to display the posters.

Requires all agencies and departments that list the rights of foster children in regulations to incorporate the rights delineated in this bill.

Status: Chapter 683, Statutes of 2001

AB 1105 (Simitian) –Foster Family Homes: Child Care Reimbursement

(Repeals and adds Section 11465.6 of the Welfare and Institutions Code)

Establishes the Legislature's intent to: provide high quality early education and care, and safe and stable homelike placements to children in foster care; recruit and retain high quality foster families; avoid costly and inappropriate placements of children; and reduce financial barriers to finding child care for foster parents.

Makes findings and declarations regarding: the benefits of high quality child care; the need to provide foster families the necessary resources to ensure optimal development of children; and the cost-effectiveness of providing child care assistance to foster families.

Creates a statewide mandated program which provides child care assistance to foster caregivers in an amount equal to one-half of the regional child care market rate. The cost would be shared equally between federal and state funds.

Authorizes the provision of child care assistance for as long as the caregiver is: working outside the home; participating in foster parent training; or fulfilling necessary foster care-related duties.

Requires the need and plan for child care to be documented in the foster child's case plan, and requires the care to be provided by a licensed child care provider.

Requires counties to report specified data to the Department of Social Services (DSS) annually in order to determine the effects of child care assistance on the ability of counties to recruit and retain foster parents.

Allows counties that wish to cover more than half the cost of child care to submit a plan to DSS justifying the additional provisions. DSS shall then determine the level of payment based on statewide standards developed by the department, based on the county's cost of living and average cost and supply of child care. In these counties, up to the full cost of child care may be provided to foster families, and the cost would be shared between federal, state and county funds, consistent with current foster care cost sharing ratios (approximately: federal - 50%, state - 20%, county - 30%).

Makes implementation of the program contingent upon both the receipt of federal financial participation and an appropriation in the Budget Act or another statute.

Requires DSS, if federal approvals are required, to submit an amendment to the state's Title IV-E Foster Care Plan by February 1, 2002.

Status: Provisions Removed from Original Version Heard in Committee in 2001

AB 1330 (Steinberg) – Foster Youth

(Adds Sections 116124 and 16125 to, and repeals and adds Section 11461 of, the Welfare and Institutions Code)

Establishes the Child Welfare System Improvement and Accountability Act of 2001 and makes findings regarding the shortage of foster family homes (FFHs) in California.

Requires, subject to an appropriation in the Budget Act or another statute, that FFH rates be increased annually by 5% beginning in fiscal year (FY) 2002-03 and continuing through FY 2005-06.

Requires that the FFH rate schedule be adjusted by the cost-of-living adjustment established in the 2001-02 Budget.

Makes the existing automatic adjustment of specialized care increment and clothing allowance payments subject to an appropriation in the Budget Act or another statute.

States that no child under the jurisdiction of the juvenile court shall be designated as "unadoptable."

Requires the Department of Social Services (DSS) to establish, by January 1, 2003, a training and certification program for FFH providers, and establishes a supplemental rate increase of 10% above the basic rate for foster parents who become designated as "skilled certified family foster care providers."

Authorizes DSS to charge fees to cover the cost of the training and certification program, not to exceed 10% of one half of a year's rate increase that a foster parent would receive as a result of becoming a skilled certified family foster care provider.

Requires DSS, by March 31, 2002, to provide the Legislature with recommendations on methods to recruit and retain licensed foster parents.

Status: Provisions Removed from Original Version Heard in Committee in 2001

AB 2651 (Chu) - Foster Youth: Sexual Orientation and Religious Affiliation

(Amends Sections 903.8, 16001.9, 16164, and 16167 of, and adds Section 16013 to, the Welfare and Institutions Code)

Adds to the statutory rights of children in foster care the right to be free from discrimination and harassment based on actual or perceived race, color, religion, ancestry, ethnicity, national origin, physical or mental disability, medical condition, sex, including gender identity, or sexual orientation.

States the intent of the Legislature that protections for foster care providers be ensured, including the following:

- Prohibiting discrimination on the basis of race, color, national origin, political affiliation, religion, marital status, gender, age, disability, sexual orientation or gender identity in the delivery of services and benefits.
- Prohibiting discrimination against any person, including discrimination based on the sexual orientation or gender identity of foster parents, or foster family home members, in licensing and placement decisions.
- Prohibiting discrimination based on the HIV or AIDS status of foster parents who are capable of performing caregiver responsibilities.

States the intent of the Legislature that the Office of the State Foster Care Ombudsperson address complaints brought by all foster youth, including gay, lesbian, bisexual or transgender foster youth and that the Ombudsperson's toll-free telephone number be made available to all youth in foster care to use for any reason, including, but not limited to, if a youth in foster care is being physically, sexually, or emotionally abused, regardless of whether the abuse is specifically related to his or her sexual orientation or gender identity.

Requires the Ombudsperson to refer allegations of licensing violation to Community Care licensing, within DSS, and allegations of civil rights violations to the Office of Civil Rights.

Requires the state to recruit gay, lesbian, and other foster care providers, in the same way it recruits other minority foster care providers.

Amends current law on training to permit the training to include sensitivity to issues related to sexual orientation and gender identity.

Status: Vetoed by the Governor

AGING AND LONG-TERM CARE

SB 370 (Ortiz) – Senior Wellness Act of 2001

(Adds Chapter 10.5, commencing with Section 9650, to Chapter 2 of Division 8.5 of the Welfare and Institutions Code)

Establishes, within the State Department of Aging (SDA), the Senior Wellness Program that includes the Stay Well Program and the Program for Injury Prevention in the Home Environment.

Specifies the Stay Well Program shall:

- Focus on educating California's seniors about the importance of living a healthy lifestyle;
- Provide educational information on the resources and services available for seniors from both private and public entities;

- Deliver information through a variety of means, including the Internet, radio, television, newspaper advertising, brochures, posters and newsletters.

Specifies that the Program for Injury Prevention in the Home Environment shall:

- Be established within SDA's Senior Housing and Information Center;
- Provide grants to eligible local level entities for injury prevention information and education programs;
- Include up to \$700 per household for injury prevention equipment;
- Limit eligibility to families, households and individuals whose incomes do not exceed 80 percent of the county median income, with adjustments for family and household size;
- Require the director to establish, in consultation with various state and national groups, a methodology for awarding grants and criteria to be considered.

Status: Chapter 689, Statutes of 2001

SB 696 (Speier) – Pharmaceuticals: Affordable Prescriptions for Medicare Beneficiaries

(Amends Section 4426 of the Business and Professions Code, and to add Division 111, commencing with Section 130400, to the Health and Safety Code)

Enacts the Golden Bear State Pharmacy Assistance Program, a prescription drug discount program under which any Medicare beneficiary, pharmacy, and drug company may voluntarily participate.

Requires, as a condition of participation, Medicare beneficiaries to register and pay an initial administrative fee.

Permits the Department of Health Services (DHS) to negotiate rebate amounts with drug manufacturers, contingent upon sufficient participation by the drug manufacturers.

Requires rebates received from drug manufacturers to be deposited into the Golden Bear State Pharmacy Assistance Program Rebate Fund. The fund will be used to reimburse pharmacies and to offset administration costs.

Requires that the reduced negotiated prescription prices be based upon the amount of rebate monies available in the fund. Permits the pharmacy to bill DHS for reimbursement, at which time DHS would notify the drug manufacturer to receive the negotiated rebate.

Appropriates \$1 million as a loan from the General Fund to provide startup funds for implementation of the article. Funds will be repaid to the general fund, once the program is operational. States legislative intent that a second loan of \$1 million would be appropriated upon DHS determination that rebate agreements are sufficient for program implementation.

Status: Chapter 693, Statutes of 2001

SB 827 (Perata) – Adult Day Services

(Adds Chapter 3.31, commencing with Section 1596.51, to Division 2 of the Health and Safety Code)

Requires the Department of Health Services (DHS) to design an integrated model of adult day services that reflects current research, literature, and recommendations by experts in adult day services and community-based long-term care.

Requires DHS in designing the model to: consult with recognized experts; identify the statutory and regulatory changes required to fully implement a program based on the model; and identify state plan amendments or waivers necessary to implement a program based on the model.

Requires DHS to provide the model to the Legislature by June 1, 2005.

Status: Vetoed by the Governor

SB 922 (Soto) – Prescription Drug Assistance Program for Seniors

(Adds Division 110, commencing with Section 140000, to the Health and Safety Code)

Requires the Health and Human Services Agency, or a designated department, to establish the Prescription Drug Assistance Program for Seniors. The program would provide reduced prescription drug costs to Medicare-eligible persons who suffer from chronic illnesses and meet certain income requirements.

Requires the Agency to develop program eligibility criteria, a formulary for prescription drugs used under the program, a procedure for the sale and timely reimbursement to the pharmacies, a list of maximum prices that may be charged by participating pharmacies, and a dispensing fee for drugs dispensed under the program.

Permits manufacturers and pharmacies to participate in the program. Participating manufacturers will enter into a purchasing agreement that will require the rebate amount to equal the rebate amount calculated under the Medi-Cal program. The manufacturer will make rebate payments to the agency according to an established schedule.

Directs the Agency to establish a one-time enrollment fee of \$20 or less.

Status: Died in the Senate Appropriations Committee

SB 953 (Vasconcellos) – Aging

(Adds Sections 2915.5, 2915.7, 4980.39, 4980.395, 4996.25, and 4996.26 to, and adds Article 14, commencing with Section 860, to Chapter 1 of Division 2 of, the Business and Professions Code, adds Article 6, commencing with Section 51280, of Chapter 2 of Part 28 of Division 4 of Title 2 of, and adds Article 9, commencing with Section 66085, to Chapter 2 of Part 40 of Division 5 of Title 3 of, the Education Code, adds Article 6, commencing with Section 9910, to Chapter 2 of Part 1 of Division 3 of the Unemployment Insurance Code, amends Section 9661 of, adds Article 3, commencing with Section 9118, to Chapter 2 of Division 8.5 of, adds Chapter 3.5, commencing with

Section 9250, to Division 8.5 of, adds Article 2.5, commencing with Section 9664, to Chapter 10.5 of Division 8.5 of, and adds Article 5, commencing with Section 9687, to Chapter 10.5 of Division 8.5 of, the Welfare and Institutions Code)

Requests that the Governor's Office on Service and Volunteerism to pursue resources to develop an Elder Corps master plan to expand opportunities for engaging California's seniors, and set standards for the effective training and supervision of volunteers.

Requests that the Governor's Office on Service and Volunteerism to ensure that California's portion of federal funds from the USA Freedom Corps be used to enhance senior volunteer opportunities.

Provides that the master plan is to be completed only if and when private funding is received for that purpose.

Requires the California Health and Human Services Agency to set standards for CalCareNet with the goal of creating an Internet site that links counties and planning service areas, and provides information on the long-term care services available to the consumer.

Requires the agency to recommend to the Legislature, by January 1, 2004, standards for care navigation including suggestions for connecting consumers from acute care systems, to and through the long-term care system.

Requires any applicant for licensure as a psychologist, social worker, or marriage and family therapist, or for renewal of a license to complete specified educational requirements regarding aging and long-term care.

Requires the Superintendent of Public Instruction to make available to teachers a curriculum on human growth, human development, and financial preparedness.

Requests the California Community Colleges, California State University and the University of California to develop standards and guidelines for the biological, social, and psychological aspects of aging.

Requests that the Senior Worker Advocate Office of the Employment Development Department conduct outreach to the business community directed at educating employers regarding matters relating to aging.

Status: Chapter 541, Statutes of 2002

AB 20 (Koretz) – Senior Centers

(Adds Article 3, commencing with Section 9150, to Chapter 2 of Division 8.5 of the Welfare and Institutions Code)

Requires the California Department of Aging, by December 31, 2002, to conduct a statewide survey and needs analysis to determine the geographic, fiscal, and structural needs for senior centers.

Requires the survey and needs analysis to consider factors including the number of seniors in different regions of the state, the projected growth in the senior population, access issues, potential intergenerational use of senior centers, the age and physical condition of existing senior centers, and the estimated fiscal investment necessary to meet the statewide need.

Status: Vetoed by the Governor

AB 101 (Alquist) – Geriatric Specialist Training

(Adds Chapter 4.5, commencing with Section 128300, to Part 3 of Division 107 of the Health and Safety Code)

Makes a series of findings and declarations regarding the need for geriatric specialists to serve the current and future generation of seniors, and the importance of educating physicians and students who pursue careers serving older adults.

Requires the Office of Statewide Health Planning and Development (OSHPD) to administer a program that awards scholarships to students who enroll in a program leading to a bachelor's degree in gerontology, a master's degree with an emphasis in gerontology, a master's certificate in gerontology, or an advanced practice nursing degree or social work degree specializing in gerontology. The scholarships will cover the cost of campus-based fees, and other associated costs.

Requires a student who fails to complete the program or who does not practice in gerontology or geriatrics in California for less than three years to repay the full amount of the scholarship.

Defines "geriatrician" for purposes of this bill as a physician who has completed a fellowship in geriatrics, and has received a Certificate of Added Qualifications (CAQ).

Requires OSHPD to administer \$60,000 grants to medical residents who complete a fellowship in geriatrics leading to eligibility for a CAQ pursuant to specified criteria.

Requires OSHPD to establish criteria for the participation in and evaluation of the programs prescribed by this bill, in consultation with representatives from state agencies, academic medical centers and institutions.

Requires OSHPD to ensure that there is reasonable parity between the number of participating medical residents and the number of participants seeking a bachelor's or

master's degree in gerontology, a master's certificate in gerontology, or an advanced practice nursing or social work degree specializing in gerontology.

Requires OSHPD to submit an annual report to the Legislature regarding the implementation and effectiveness of this bill.

Limits the total amount of scholarships or grants awarded annually under this bill to \$500,000. The provisions of this bill will be implemented only to the extent that funds are appropriated for this purpose.

Status: *Vetoed by the Governor*

AB 830 (Cohn) – Senior Legal Services

(Adds Chapter 6.5, commencing with Section 9320, to Division 8.5 of the Welfare and Institutions Code)

Makes a series of findings and declarations regarding the need for legal assistance for seniors with low-and moderate means.

Establishes a task force to study and make recommendations on the improvement of legal services delivery, including the following:

- Actions to ensure that all area agencies on aging allocate sufficient funding to local legal assistance providers. Actions may include, but not be limited to, the establishment of a minimum percentage of area agency on aging funding for legal assistance providers in California.
- Ways to ensure uniformity in the provision of legal services throughout the state, including, but not limited to, possible development of uniform statewide standards for the delivery of legal services in California.
- Measures to evaluate and monitor local legal assistance programs to ensure compliance with the federal Older Americans Act and its implementing regulations.
- Establishment of a statewide reporting system to assess the effectiveness of legal assistance programs for seniors in the state.
- The possible establishment of a statewide legal hotline for seniors.
- Opportunities to enhance communications among the various service providers and to ensure efficient service delivery involving local programs and a statewide hotline, should it come into existence.
- Opportunities for joint training for senior legal services advocates around the state.
- Other states' legal services delivery networks.

Requires the Director of the California Department of Aging (CDA) to serve on the task force and appoint other members, including a member of the Legislature or his or her representative, three senior legal service program directors, the CDA Legal Services Developer, two Area Agencies on Aging directors, two senior advocacy representatives, and a representative of the California State Bar.

Status: *Chapter 682, Statutes of 2001*

AB 1075 (Shelley) – Skilled Nursing Facilities: Staffing Ratios

(Adds Section 1276.65 to the Health and Safety Code, and amends Section 14126.02 of the Welfare and Institutions Code)

Requires the Department of Health Services (DHS) to develop a staff-to-patient ratio standard for all facilities. The staffing ratios will be equal to the 3.2 hours per-patient-day standard, deleting precise ratios in a manner that minimizes state costs, maximizes resident access to care, and takes into account the length of shift worked. The bill further directs DHS to develop a waiver procedure that allows facilities to adjust ratios according to individual patient needs, provided that the ratios do not fall below the 3.2 hourly standard. The ratio conversion must be in effect by August 1, 2003.

Requires facilities to post information about staffing levels by January 1, 2003, pursuant to federal requirements that also includes state staffing standards.

Establishes that a violation of the standards may be subject to a citation of either class "B" or "A" or "AA", providing DHS with the same discretion applied with most enforcement codes.

Requires DHS to implement a facility-specific rate-setting system by August 1, 2004, in a manner that reflects the costs and staffing levels in nursing facilities and considers rate models used in other states, among other factors.

Requires DHS to submit a status report on April 1, 2002, April 1, 2003, and April 1, 2004. The bill also permits DHS to adopt emergency regulations and to contract with consultants to implement the provisions of this article as expeditiously as possible.

Status: Chapter 684, Statutes of 2001

AB 1347 (Pescetti) – Dementia Caregiver Training

(Adds Section 1263 to the Health and Safety Code)

Requires Certified Nurse Assistants (CNAs) employed by a skilled nursing facility (SNF) or intermediate care facility (ICF) to complete at least two hours of dementia-specific training as part of the facility's orientation program.

Requires SNF and ICF facilities to develop a dementia-specific training component within the existing orientation program, to be implemented no later than July 1, 2002.

Requires the Department of Health Services to review each facility's modified orientation program in a phase-in schedule that begins no later than July 1, 2002, and is completed no later than July 1, 2005.

Requires CNAs employed by a SNF or ICF to complete five hours of dementia-specific in-service training per year, as part of the facility's in-service training requirements.

Exempts free-standing and hospital-based pediatric SNFs with exclusively pediatric occupancy from these requirements.

Status: Chapter 339, Statutes of 2001

AB 1946 (Corbett) – Written Materials for Patients

(Amends Section 1599.74 of, and adds Chapter 4, commencing with Section 123222.1, to Part 1 of Division 106 of, the Health and Safety Code)

Requires the text of the statutory and regulatory Patients' Bill of Rights currently required to be contained in every contract of admission to a long-term care facility to be in 12-point type, as opposed to the current requirement that the text be in 10-point type.

Requires any printed materials specified below, that are provided to a patient by an employee or authorized agent on behalf of a general acute care hospital (GAC), a skilled nursing facility (SNF), an intermediate care facility (ICF), a nursing facility (NF), or a residential care facility for the elderly (RCF), to be printed in at least a 12-point font that is clear and legible.

Requires the 12-point font condition to apply to the following:

- Admission and discharge papers and forms from GACs, SNFs, ICFs, and NFs;
- Medical and therapeutic instructions prepared by the facility specifically for an individual upon his or her discharge from a GAC, a SNF, an ICF, or a NF;
- Any contract for consent for hospitalization, or agreement to assume financial responsibility between a patient and any of the facilities specified above;
- Instructions and forms for advance health care directives;
- Information produced by the hospital or facility regarding the rights and responsibilities of patients or residents while receiving care at the hospital or facility, and regarding grievances and appeals, including forms and instructions; and,
- Correspondence written, printed, or produced, by any of the facilities specified above.

Permits any entity described above and any RCF to continue to use its supply of materials that exists on January 1, 2003, until that supply is exhausted or until January 1, 2006, whichever occurs first, and requires thereafter the facilities to comply with the requirements of this bill.

Requires upon admission of a patient to a GAC, SNF, an ICF, or a NF, the facility to ask the patient if he or she would like the facility to provide the patient's next of kin or agent under a durable power of attorney for health care with materials regarding patients' rights and responsibilities. Requires the materials provided by the facility to include a comprehensive Patients' Bill of Rights, as described in a specified provision of law relating to the consolidation and development of a comprehensive Patient's Bill of Rights by the Department of Health Services (DHS). Requires that the comprehensive Patient's Bill of Rights contain rights contained in specified provisions of law relating to patients' rights until DHS has fully implemented the consolidation and development of the comprehensive Patients' Bill of Rights.

Requires upon the request of the patient, or of the patient's next of kin or agent under a durable power of attorney for health care, a representative of any facility or hospital providing patients' rights information or other documentation described in this bill to explain the materials provided.

Status: Chapter 550, Statutes of 2002

AB 1961 (Canciamilla) - Residential Care Facilities for the Elderly: Terminally Ill Persons

(Amends Section 1569.73 of the Health and Safety Code)

Permits a residential care facility for the elderly to obtain a waiver from the Department of Social Services, when certain requirements are met, for the purpose of allowing a person who has been diagnosed by his or her physician and surgeon as being terminally ill to become a resident of the facility if that person is already receiving hospice services, and would continue to receive those services without disruption.

Provides an alternative to the current requirement that a patient who is transferring to another type of facility must first terminate their current services, move into the new facility, and formally qualify as a resident in order to resume services.

Status: Chapter 109, Statutes of 2002

AB 1989 (Liu) - Care Facilities: Change in Health Status: Violations: Notice

(Adds Chapter 12, commencing with Section 1795, to Division 2 of the Health and Safety Code)

Requires a skilled nursing facility, intermediate care facility, congregate living health facility, or residential care facility for the elderly to make reasonable efforts to contact the person named in the resident's admission agreement as the resident's contact person, or the resident's responsible person, within 24 hours after a significant change in the resident's health or mental status.

Attempts to strengthen current law and provide family members with better information on the health condition of their relatives living in residential facilities. Although federal and state regulations require that family members be notified when a patient's condition undergoes major changes, facilities may fail to notify a designee when a patient's health status falters.

Status: Chapter 272, Statutes of 2002

AB 2208 (Wyland) - California Department of Aging: Area Agencies on Aging: Controller: Electronic Transfer of Funds

(Adds Section 9103 to the Welfare and Institutions Code)

Requires the California Department of Aging (CDA), in consultation with the State Controller (Controller), to develop and implement a procedure for the electronic transfer of funds from CDA to the Area Agencies on Aging no later than July 1, 2003.

Requires the procedure developed by CDA to include the transfer of all funds, including federal funds received by the state pursuant to the Older Americans Act.

Requires CDA to submit the appropriate documentation to the Controller to facilitate the electronic transfer of funds.

Status: Vetoed by the Governor

AIDS/HIV

SB 1785 (Vasconcellos) – Hypodermic Needles and Syringes

(Amends Sections 4140, 4142, 4145, and 4147 of, and to repeal Section 4146 of, the Business and Professions Code, and amends Sections 11364 and 11364.5 of the Health and Safety Code)

Finds that injection drug use is linked to 19 percent of all AIDS cases and one half of an estimated 500,000 to 600,000 Hepatitis C cases in California, and that most users become infected and transmit these diseases by sharing blood-contaminated syringes. Finds that the lifetime cost of treating one person with AIDS is over \$195,000.

Finds that the United States Public Health Service and the Centers for Disease Control and Prevention recommend that injection drug users who cannot or will not stop injecting drugs use a sterile needle for every injection to limit blood-borne disease transmission.

Authorizes pharmacists or specially licensed persons to sell at a licensed pharmacy up to 30 hypodermic needles or syringes without a prescription to a person who is over 18 years of age.

Requires a licensed pharmacy that sells nonprescription syringes, hypodermic needles or syringes to:

- Notify the local health officer that it will be selling needles and syringes without a prescription.
- Store needles and syringes in a manner than makes them only available to authorized personnel.
- Provide information regarding safe disposal of syringes to each purchaser including information about criminal penalties for improper disposal.
- Information about prevention testing and treatment of substance abuse, including the availability of substance abuse treatment and a telephone number to call for assistance.
- Information on the transmission of blood-borne diseases, including information about the prevention, testing and treatment of HIV and hepatitis C.
- Provide one or more of the following safe syringe disposal programs: an on-site safe disposal program; make available for purchase mail-back sharps disposal packages with prepaid postage, an approved sharps container, and tracking forms; and make available for purchase or furnish personal sharps disposal containers and refer

purchasers to local authorized home-generated sharps consolidation points or to local medical waste generators that accept home-generated medical sharps waste for disposal.

- Report the number of syringes sold per month and the number of sales transactions for syringe and needles sold without a prescription per month to the local health officer.

Requires the local public health officer to be available to consult with pharmacies on sales and disposal of syringes and needles and other specified activities.

Repeals the requirement that pharmacists record specified information about individuals who purchase needles or syringes without a prescription.

Prohibits discarding or disposing of a hypodermic needle or syringe on a playground, public beach, public park, or the grounds of an elementary, vocational, junior high or high school. Establishes penalties for violation of this provision.

Exempts possession of up to 30 needles or syringes acquired from authorized sources and possessed solely for personal use, from the prohibition of possessing drug paraphernalia.

Status: Vetoed by the Governor

AB 937 (Koretz) - Health Care: HIV Treatment: Risk-Adjusted Capitated Rates

(Adds Section 1367.03 to the Health and Safety Code, and adds Section 14132.51 to the Welfare and Institutions Code)

Requires every health plan that covers hospital, medical or surgical expenses and contracts with providers on a capitation basis, to consider when developing rates for the reimbursement of providers and primary care case management programs for the treatment of enrollees infected with human immunodeficiency virus (HIV):

- Rates should not unnecessarily restrict access to care;
- Rates should be commensurate with national standards of reimbursement;
- Rates should reflect efficiency, cost effectiveness, quality of care, and access to care;
- Rates should facilitate the ability of providers and primary care case management programs to develop a quality HIV program without a negative financial impact from adverse selection;
- Rates should reduce the likelihood that, as a result of rates, a provider or a primary care case management program will have a financial incentive to limit treatment and medications for HIV infected individuals.

Requires the rates developed to become operative on July 1, 2002 and be paid to providers and primary care case management programs for the treatment provided on and after that date to enrollees infected with HIV.

Specifies that these provisions do not apply to a certain health care service plan that contracts with a provider organization

Specifies that the Department of Managed Health Care (DMHC) is not responsible for enforcing the above.

Requires the Department of Health Services to establish risk-adjusted capitated rates for treating Medi-Cal beneficiaries with HIV in managed care plans and primary care case management programs. Requires the rates to be based on total costs of providing medical care and not rely solely on historical fee-for-service claims, and to be sufficient to enlist participation of HIV specialty providers in the program. Requires Medi-Cal managed care plans to pass on a proportional amount of the rate to providers treating Medi-Cal patients with HIV. Rates become effective on July 1, 2002 and are paid for services rendered on or after that date.

Requires the Financial Solvency Standards Board to hold hearings on the advantages and disadvantages of risk-adjusted provider capitation rates for chronic health conditions and to report to DMHC by October 1, 2002. Requires DMHC to review the findings and report to the Legislature by December 31, 2002, on the advisability, feasibility and potential costs of health plans implementing risk-adjusted provider capitation rates for chronic conditions.

Provides that all confidentiality protections applicable to the state AIDS Assistance Program shall apply with regard to any individual who participates in a capitated health care service plan and would qualify for an HIV risk-adjusted rate. Provides that this section shall not require the reporting of an individual's HIV status without his or her consent.

Status: Vetoed by the Governor

AB 1263 (Migden) - AIDS: HIV: Rapid Testing Programs

(Adds Section 120917 to the Health and Safety Code)

Makes findings and declarations regarding the number of people who are tested for HIV every year, the percentage of people tested who do not return for their results, and the fact that rapid HIV testing technology may increase the number of people who learn of their HIV status and may reduce the need for field efforts to locate and counsel HIV positive persons who do not return for their test results.

Authorizes the Department of Health Services (DHS) Office of AIDS to participate in a rapid HIV test research program conducted with the federal Centers for Disease Control and Prevention.

Authorizes DHS to perform and report clinical test results using a rapid HIV test for diagnosis, prior to test approval by the federal Food and Drug Administration (FDA). Provides, however, that test performance and reporting shall only be done to the extent allowed under that device's investigational approval by the FDA and pursuant to a California Health and Human Services Agency Institutional Review Board-approved research protocol. Authorizes DHS to use a second independent HIV test to confirm

initially reactive test results to the extent allowed under the investigational approval by the FDA.

Requires all rapid tests to be confirmed using technology approved by the FDA. Provides that if the results from this confirmatory testing differ from the results of the rapid test, the subject shall be notified. Prohibits participation in the research protocol without appropriate contact information.

Authorizes an HIV counselor who is trained by the Office of AIDS and working in an HIV counseling and testing site funded by DHS to:

- Perform any HIV test that is classified as waived under the federal Clinical Laboratory Improvement Act provided certain specified conditions exist.
- Order and report HIV test results from tests performed to patients without authorization from a licensed health care professional or his or her authorized representative. Provides that patients with indeterminate or positive test results shall be referred to a specified licensed health care provider for further evaluation.

Status: Chapter 324, Statutes of 2001

AB 2197 (Koretz) - Medi-Cal: Benefits For Persons Infected with HIV Who Are Not Disabled

(Adds Article 4.9, commencing with Section 14149, to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code)

States legislative intent to expand eligibility for Medi-Cal benefits, with the exception of prescription drug benefits provided by the AIDS Drug Assistance Program (ADAP), to persons with HIV who are not disabled.

Grants eligibility to individuals who are, and remain, enrolled in ADAP and who are not disabled, but who, if disabled, would qualify for Medi-Cal benefits.

States legislative intent to provide Medi-Cal benefits to at least 1,000 persons with HIV by the end of the first year of implementation of this bill.

Requires any person who is eligible for enrollment in Medi-Cal under this program to elect a Medi-Cal managed care plan in those counties in which a managed care plan is available except as specified.

Requires DHS to develop a program allocation method so those eligible individuals can be enrolled in Medi-Cal on a first-come, first-served basis.

Requires DHS to begin enrolling HIV patients into this program on July 1, 2003, or the date that all necessary federal waivers have been obtained, whichever is later.

Requires DHS to meet federal revenue neutrality requirements through the savings generated by the voluntary enrollment into Medi-Cal managed care of persons who are disabled as a result of AIDS, and who are either receiving Medi-Cal benefits on a fee-for-

service basis as of January 1, 2003 or who become eligible to receive Medi-Cal benefits on or after January 1, 2003.

Authorizes DHS to implement other means of meeting the federal revenue neutrality requirements.

Requires DHS to encourage the voluntary enrollment into Medi-Cal managed care of persons who are disabled as a result of AIDS.

Requires DHS to conduct all outreach and awareness necessary to implement this bill.

Requires that DHS use the savings generated by increased voluntary enrollments in Medi-Cal managed care to fund enrollment in the program created by this bill.

Requires DHS to establish capitation rates to be paid to Medi-Cal Managed Care plans for services provided pursuant to this bill. Prohibits capitation rates from exceeding 95% of the FFS equivalent costs to the Medi-Cal program for medical services for persons with HIV.

States that DHS may not provide the Medi-Cal expansion until DHS can ensure sufficient savings equal to the cost of providing benefits to newly enrolled HIV patients.

Requires DHS to seek appropriate waivers from federal government. Requires the provisions of this bill to be implemented only if, and to the extent that, DHS determines that federal financial participation is available.

Status: Chapter 684, Statutes of 2002

AB 2930 (Wright) - Human Immunodeficiency Virus (HIV): Maternal and Newborn Health

(Amends Sections 125085, 125090, and 125107 of, and adds Section 125092 to, the Health and Safety Code)

Requires the blood specimen obtained from a pregnant patient pursuant to existing law, to be tested for HIV.

Requires the health care provider to obtain a blood specimen from the woman for a test for blood type, hepatitis B, or HIV, if during the final prenatal care standard medical tests results of one of the required tests is missing.

Requires providers, prior to obtaining a blood specimen from a pregnant woman, to ensure that the woman is informed of the intent to perform an HIV test, the routine nature of the test, the purpose of the testing and the risks and benefits of the test. Requires that the woman is also informed of the risk of perinatal transmission of HIV, that approved treatments are known to decrease the risk of perinatal transmission of HIV and that the woman has a right to accept or refuse this testing. Requires that the acceptance of HIV testing be documented in writing and be maintained in the medical record.

Requires the results to be reported to both the woman tested and to the physician or other person engaged in the prenatal care of the woman or attending the woman at the time of delivery. Requires the blood specimen to be tested as early as possible during prenatal care and be tested by a method that will ensure the earliest possible results.

Requires providers, after the results of the tests have been received, to ensure that the woman receives with the test results, information and counseling to explain the results and the implications for the mother's and infant's health, including any follow-up care needed.

Requires, if the woman tests positive for HIV, that she receive, whenever possible, a referral to a provider, provider group, or institution specializing in prenatal care for HIV positive women. Providers are strongly encouraged to seek consultation with other providers specializing in the care of pregnant HIV positive woman.

Requires the State Department of Health Services (DHS), in consultation with specified entities, to develop culturally sensitive informational material to fulfill the requirements for the provision of specified information at the time a pregnant woman is tested for HIV. Requires that these materials be available in English, Spanish and other languages used by DHS when providing information to clients under the Medi-Cal program.

Makes various legislative findings and declarations, including that the HIV infection rate among childbearing women is estimated at 0.6 per 1,000 in California, which is lower than in many other areas of the country. Finds that universal testing of pregnant women could help further decrease the risk of perinatal transmission of HIV to the newborn.

Status: Vetoed by the Governor

ALCOHOL AND DRUGS, PRESCRIPTION DRUGS, AND DIETARY SUPPLEMENTS

SB 187 (Vasconcellos) – Medical Marijuana

(Adds Article 2.5, commencing with Section 11362.7, to Chapter 6 of Division 10 of the Health and Safety Code)

Requires the Department of Health Services (DHS) to establish and maintain a voluntary program for the issuance of identification cards (IC) to qualified patients who benefit from access to medical marijuana. Requires DHS to develop protocols that are required to be used by county health departments, application forms, and a IC that identifies a person authorized to use medical marijuana and a IC that identifies the person's designated primary caregiver. Prohibits a person or designated primary caregiver in possession of a valid IC from being subject to arrest for possession, transportation, delivery, or cultivation of medical marijuana in an amount approved by DHS.

Exempts certain legitimate patients and their caregivers from criminal liability under specified provisions of law relating to marijuana possession. Permits qualified patients, persons with valid ICs, and the designated primary caregivers to cultivate marijuana for medical purposes.

Requires DHS have the right to inspect the cultivation projects to ensure compliance with the methods, procedures, and criteria.

Prohibits a state or local law enforcement agency or officer from refusing to accept a IC issued by DHS unless the state or local law enforcement agency or officer has reasonable cause to believe that the information contained in the card is false.

States that nothing in this bill requires any accommodation of any medical use of marijuana on the property or premises of any place of employment or during the hours of employment or on the property or premises of any jail, correctional facility, or other type of penal institution.

States that nothing in this bill requires a governmental, private, or any other health insurance provider or health care service plan to be liable for any claim for reimbursement for the medical use of marijuana.

Status: Died on the Senate Floor Unfinished Business

SB 397 (Speier) - Ephedrine Group Alkaloids: Dietary Supplements: Sale, Distribution, and Labeling

(Adds Article 4, commencing with Section 110423, to Chapter 4 of Part 5 of Division 104 of the Health and Safety Code)

Requires a warning label on dietary supplement products containing natural or herbal ephedrine group alkaloids and prohibits their sale to minors.

Requires the product label to include specified information, including:

- The amount of ephedrine, caffeine alkaloids, and other stimulants;
- A warning that the product is not for use by minors and pregnant or nursing women;
- A list of health conditions and drugs that contraindicate use of the product;
- Possible adverse reactions, such as dizziness and rapid heartbeat, from use; and
- A toll-free telephone number for the federal Food and Drug Administration's (FDA) MedWatch medical product reporting hotline.

Requires all advertising and promotional literature to be reviewed and approved by the manufacturer or distributor, retained for two years by the company, and available upon request to the Department of Health Services (DHS). Specifies criteria for DHS to use in determining compliance with these requirements.

Prohibits any manufacturer, wholesaler, retailer, or other person to sell, transfer, or otherwise furnish the product to a minor. Requires a seller to request identification from any purchaser who appears to be a minor.

Authorizes DHS to assess a civil penalty against an individual or company that fails to comply with the above. Maximum penalties range from \$1,000 for the first violation to \$25,000 for the third and subsequent violations.

Exempts licensed acupuncturists who prescribe and/or dispense herbs in the course of treating their patients.

Status: Died in the Assembly Appropriations Committee

SB 443 (Perata) – Medi-Cal: Substance Abuse Programs

(Amends Section 11758.46 of the Health and Safety Code, and amends Section 14021 of, and adds Section 14021.45 to, the Welfare and Institutions Code)

Expands the definition of drug Medi-Cal services to include outpatient drug-free services provided in a community setting, residential and day care rehabilitative services for clients other than pregnant and parenting women, and medication management. Changes the drug Medi-Cal program from the clinic option to the rehabilitation option under federal Medicaid law. Limits the addition of the rehabilitation option to drug Medi-Cal providers who are certified.

Requires the Department of Drug and Alcohol Programs (DADP) to prepare by an unspecified date, amendments to the medical assistance state plan to expand the location including home, school, and community-based sites, and type of therapeutic services offered under drug Medi-Cal available to states under the category of "other diagnostic, screening, preventative, and rehabilitative services"; expand federal financial participation (FFP) in alcohol and drug treatment services; expand FFP for services that meet the rehabilitation needs of alcohol or other drug dependent persons; and improve fiscal systems and accountability structures for drug Medi-Cal costs and rates.

Requires the Department of Health Services (DHS) to review DADP's state plan revision and submit it for federal approval if DHS approves it. If DHS does not approve it, requires DHS to report to the Joint Legislative Budget Committee by an unspecified date.

Specifies that the state and local funds required to match FFP may include, but not be limited to, drug Medi-Cal and other nonfederal funds at county discretion. Additional state General Fund monies shall be subject to appropriation in the annual Budget Act.

States legislative intent that the rehabilitation option become operative only after federal approval and a correction plan approved by DADP for audit issues identified for the Medi-Cal Drug Treatment Program has been submitted and the requirements of the section have been fully satisfied.

Status: Died in the Senate Appropriations Committee

SB 599 (Chesbro) - Health Care Coverage: Substance Related Disorders

(Amends Section 1367.2 of the Health and Safety Code, and amends Section 10123.14 of the Insurance Code)

Requires every health plan that provides hospital, medical, or surgical expenses on a group or individual basis to provide coverage for the medically necessary treatment of substance-related disorders, with the exception of caffeine-related disorders, as listed in the Diagnostic and Statistical Manual of Mental Disorders IV, published by the American Psychiatric Association, in a nondiscriminatory manner on the same basis as any other medical care.

Requires health plans to provide the continuum of clinically effective and appropriate services and continuing treatment in a licensed facility or by a licensed physician, a licensed psychologist, a licensed marriage and family therapist or other provider licensed or certified in the treatment of substance related disorders.

Requires coverage and funding to be the same as benefits covering other physical illness, including medications, with the same cost-sharing provisions, deductibles, appropriate caps or limits on number of outpatient visits, residential or inpatient treatment days, payments, lifetime benefits, and catastrophic coverage.

Requires every health plan to communicate the availability of this coverage to all enrollees and to all prospective subscribers with whom they are negotiating.

Requires every health plan and its contracting entities to provide an augmentation for reimbursement to the providers of services required by this bill for any mandate for coverage contained in existing law regulating health plans that has been enacted after the date that a contract has been signed between the provider and the health plan or its contracting entity.

Prohibits a disability health insurer from seeking indemnity from its contracting providers or otherwise transferring to its contracting providers financial responsibility for any mandate set forth in this bill.

Prohibits a health care service plan that directly contracts with an individual provider or provider organization from delegating the risk-adjusted treatment cost of providing services under this bill unless specified requirements are met. Permits a health plan to limit nonhospital residential care to 60 days per calendar year. Defines "nonhospital residential care" as the provision of medical, nursing, counseling, or therapeutic services to patients suffering from substance-related disorders in a residential environment, according to individualized treatment plans.

Permits a health plan to provide coverage for all or part of the substance-related services required by this bill through a separate specialized health care service plan or substance abuse plan and prohibits the health plan from being required to obtain an additional or specialized license for this purpose.

Exempts from the provisions of this bill Medi-Cal, vision-only, dental-only, accident-only, hospital indemnity, Medicare supplement, specified disease, or long-term care coverage.

Status: Died on the Assembly Floor Inactive File

SB 696 (Speier) – Pharmaceuticals: Affordable Prescriptions for Medicare Beneficiaries

(Amends Section 4426 of the Business and Professions Code, and adds Division 111, commencing with Section 130400, to the Health and Safety Code)

Enacts the Golden Bear State Pharmacy Assistance Program, a prescription drug discount program under which any Medicare beneficiary, pharmacy, and drug company may voluntarily participate.

Requires, as a condition of participation, Medicare beneficiaries to register and pay an initial administrative fee.

Permits the Department of Health Services (DHS) to negotiate rebate amounts with drug manufacturers, contingent upon sufficient participation by the drug manufacturers.

Requires rebates received from drug manufacturers to be deposited into the Golden Bear State Pharmacy Assistance Program Rebate Fund. The fund will be used to reimburse pharmacies and to offset administration costs.

Requires that the reduced negotiated prescription prices be based upon the amount of rebate monies available in the fund.

Permits the pharmacy to bill DHS for reimbursement, at which time DHS would notify the drug manufacturer to receive the negotiated rebate.

Appropriates \$1 million as a loan from the General Fund to provide startup funds for implementation of the article. Funds will be repaid to the general fund, once the program is operational. States legislative intent that a second loan of \$1 million would be appropriated upon DHS determination that rebate agreements are sufficient for program implementation.

Status: Chapter 693, Statutes of 2001

SB 922 (Soto) – Prescription Drugs Assistance Program Fund for Seniors

(Adds Division 110, commencing with Section 140000, to the Health and Safety Code)

Requires the Health and Human Services Agency, or a designated department, to establish the Prescription Drug Assistance Program for Seniors. The program would provide reduced prescription drug costs to Medicare-eligible persons who suffer from chronic illnesses and meet certain income requirements.

Requires the Health and Human Services Agency to develop program eligibility criteria, a formulary for prescription drugs used under the program, a procedure for the sale and timely reimbursement to the pharmacies, a list of maximum prices that may be charged by participating pharmacies, and a dispensing fee for drugs dispensed under the program.

Permits manufacturers and pharmacies to participate in the program. Participating manufacturers will enter into a purchasing agreement that will require the rebate amount to equal the rebate amount calculated under the Medi-Cal program. The manufacturer will make rebate payments to the agency according to an established schedule.

Directs the Agency to establish a one-time enrollment fee of \$20 or less.

Status: Died in the Senate Appropriations Committee

SB 1000 (Johannessen) – Schedule II Controlled Substances: Prescription Requirements

(Amends Section 11165 of, and adds Section 11165.1 to, the Health and Safety Code)

Allows a practitioner eligible to obtain triplicate prescription forms (e.g., a physician), or a pharmacist to make a written request for the history of controlled substances dispensed to an individual under his or her care based on data contained in the Controlled Substance Utilization Review and Evaluation System (CURES).

Provides that in order to prevent the inappropriate, improper, or illegal use of Schedule II controlled substances, the Department of Justice (DOJ) may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to practitioners, pharmacists, or both, providing care or services to the individual.

Provides that the history received by a practitioner or pharmacist from DOJ shall be considered medical information subject to the provisions of the Confidentiality of Medical Information Act.

Requires the Attorney General, in consultation with the Board of Pharmacy, the Medical Board of California, the medical community, and patient advocates, to produce and submit a report to the Legislature on or before July 1, 2002, describing how CURES needs to be modified in order to make it a secure stand-alone electronic monitoring system. Permits the report to include a discussion of similar systems used by other states. Requires an existing report to the Legislature on CURES currently due on January 1, 2002 to be submitted on January 1st of each year the CURES project remains operative.

Appropriates \$145,000 from the General Fund to DOJ for CURES in the 2001-02 fiscal year.

Repeals language in existing law requiring CURES to be implemented as a pilot project to be administered concurrently with the existing triplicate prescription process to examine the comparative efficiencies between the two systems.

States legislative intent to abolish the requirement that prescriptions for Schedule II controlled substances be prepared in triplicate when a secure stand-alone electronic monitoring system is in place. States legislative intent that the triplicate prescription requirement be done away with as soon as possible.

Status: Vetoed by the Governor

SB 1134 (Escutia) - Drug Overdose Deaths

(Adds Sections 1797.8 and 1797.9 to, and adds Chapter 2.5, commencing with Section 11758, to Division 10.5 of, the Health and Safety Code)

Requires Emergency Medical Services (EMS) to adopt regulations that will allow EMT-I's to be trained in the administration of naloxone hydrochloride through intramuscular injection or by means other than intravenous administration no later than September 1, 2002.

Requires the regulations above and their implementation to be limited to projects ordered and supervised by a local emergency medical services medical director, in consultation with the local health officer of the affected county or counties.

Prohibits EMT-I's from undertaking naloxone hydrochloride administration except in a project coordinated and supervised by the director or as part of any project authorized by EMS.

Establishes within the agency the Drug Overdose Prevention, Recognition, and Response Program.

Requires the agency to convene a working group to develop guidelines for county medical examiners and coroners for specified purposes, including promoting uniform reporting of fatal drug overdose cases. Requires the agency to send the guidelines developed pursuant to this bill to county medical examiners and to the coroner of each county on or before July 1, 2003.

Requires the program, to publish a report on drug overdose trends statewide that reviews aggregate county and state death rates from available data set records, to ascertain changes in the causes or rates of fatal and nonfatal drug overdose for the preceding period of not less than five years, by December 31, 2002. Requires the report to also provide information on interventions that would be effective in reducing the rate of fatal or nonfatal drug overdose. Requires the program to make grants to support local drug overdose prevention, recognition, and response projects, and to approve grants according to criteria adopted by the program pursuant to this bill.

Requires the program to take into consideration the necessity for overdose prevention projects in various settings, and to encourage all grant applicants to develop interventions that will be effective and viable in their local areas.

Requires the program to consider specified areas to be priorities for funding when considering grant applications including policies and projects to encourage people, including drug users, to call 911 when they witness a potentially fatal drug overdose.

Requires the program to apply to private foundations, the federal government, and other sources to fund the grants under this bill and to fund an evaluation of the programs supported by the grants.

Status: Vetoed by the Governor

SB 1169 (Alpert) – Pharmacy

(Amends Section 4052 of the Business and Professions Code)

Authorizes pharmacists to initiate emergency contraception drug therapy using protocols developed by the pharmacist and an authorized prescriber. The pharmacist must complete a training program on emergency contraception and provide the recipient with a standardized fact sheet to be developed by the Board of Pharmacy containing information on using the drug and the need for medical follow-up.

Seeks to make emergency contraceptives more widely available to women who are at risk of an unwanted pregnancy. Currently, a woman must have a prescription to obtain these drugs on an outpatient basis, or may obtain them from a pharmacist without a prescription in an inpatient setting based on a facility protocol.

Authorizes a trained pharmacist to dispense emergency contraceptives without a prescription in outpatient settings, provided a standardized protocol or procedure developed in collaboration with a physician or other authorized prescriber is followed. The pharmacist must also provide the woman with a standardized fact sheet containing specified information.

Increases women's access to this health service by avoiding the need for an appointment with a physician prior to obtaining the drugs. For these drugs to be effective, the window of opportunity is very short - within 72 hours of intercourse.

Status: Chapter 900, Statutes of 2001

SB 1278 (Speier) - Pharmacies: Prescription Benefits: Medicare Beneficiaries

(Amends Section 4425 of, and repeals Section 4427 of, the Business and Professions Code, and amends Sections 130400, 130401, 130403, 130404, 130406, 130407, 130408, and 130409 of, and adds Sections 130401.1, 130406.5, 130407.5, and 130410 to, the Health and Safety Code)

Permits the Department of Health Services (DHS) to accept on behalf of the State any gift, bequest, or donation of outreach services or materials to inform eligible Medicare beneficiaries of their right to participate in this program. Prohibits any provision of law requiring approval by a state officer of a gift, bequest, or donation from applying to these gifts, bequests or donations. Defines outreach services, for purposes of this provision, to include, but not be limited to, coordinating and implementing outreach efforts and plans,

and outreach materials to include, but not be limited to, brochures, pamphlets, fliers, posters, advertisements, and other promotional items. Exempts advertisements provided as a gift, bequest, or donation pursuant to this provision from a provision of law requiring the State Department of General Services to have exclusive control over all advertisements by a state agency.

Permits DHS, as part of the Golden Bear Program, to establish a system to provide a Medicare beneficiary access to a drug discount program operated by a drug manufacturer that would provide greater prescription drug discounts than are otherwise available through the Golden Bear Program. Requires the Golden Bear Program's registration card to serve as the single point of entry to these private drug discount programs. Makes prescription drugs available to Medicare beneficiaries at the lower rate paid by the state Medi-Cal program.

Permits DHS, in order to establish the system above, to negotiate a contract with a drug manufacturer that operates a prescription drug discount program, and permits DHS to contract with a public or private entity to assist in these negotiations.

Prohibits Medicare beneficiaries in any circumstance from being required to participate in, or to disclose information that would determine his or her eligibility to participate in, the private drug discount programs above in order to participate in the Golden Bear Program. Specifies that this provision does not prohibit or preclude a Medicare beneficiary from voluntarily disclosing or providing information that may be necessary to determine eligibility for participation in a private drug discount program.

Status: Chapter 542, Statutes of 2002

SB 1695 (Escutia) – Drug Overdose Deaths

(Adds Section 1797,8 to, and adds Chapter 2.5, commencing with Section 11758, to Division 10.5 of, the Health and Safety Code)

Authorizes any county, at the discretion of the county or regional medical director of emergency medical services, to develop a program to certify EMT-Is to administer naloxone hydrochloride by means other than intravenous injection consistent with guidelines established by the State Emergency Medical Services Authority.

Specifies that an EMT-I may be authorized by the EMT certifying authority to administer naloxone hydrochloride by means other than intravenous injection only if the EMT-I has completed training and passed an examination administered or approved by the EMT-II certifying authority in the area.

Specifies that the above shall be operative only until the operative date of specified regulations.

Requires the State Department of Alcohol and Drug Programs, beginning July 1, 2004, to place on the Internet Web site of the State Department of Alcohol and Drug Programs information on drug overdose trends in California, including county and state death rates,

in order to ascertain changes in the causes or rates of fatal and nonfatal drug overdoses for the preceding five years.

Requires the information to include, to the extent available, data on all of the following: trends in drug overdose death rates by county or city, or both; suggested improvements in data collection; and a description of interventions that may be effective in reducing the rate of fatal or nonfatal drug overdoses.

Status: Chapter 678, Statutes of 2002

SB 1750 (Speier) – Dietary Supplements

(Adds Article 4, commencing with Section 110423, to Chapter 4 of Part 5 of Division 104 of the Health and Safety Code

Prohibits the sale or distribution of any dietary supplement product containing ephedrine group alkaloids or steroid hormone precursors (SHPs), unless the product label contains specified language that: warns against use by minors, contraindications for use by persons with specified diseases, possible adverse health effects, and other information; and states, for ephedrine supplements, the amount of ephedrine in the product.

Requires labels for these products to prominently display the federal Food and Drug Administration's MedWatch medical product hotline for reporting adverse events.

Makes it a misdemeanor for any manufacturer, wholesaler, retailer, or other person to sell, transfer, or otherwise furnish a dietary supplement with ephedrine or SHPs to persons under 18 years, and requires a seller to request identification from buyers who appear to be minors.

Exempts a retail clerk who fails to request identification from being charged with a misdemeanor, subjected to a civil penalty, or subjected to disciplinary action or discharge by an employer, unless the clerk is a willful participant in an ongoing criminal conspiracy.

Exempts a retail establishment from a misdemeanor charge if it has provided every checkout clerk with standardized training on the ban on sales to minors, methods of identifying the prohibited products, and procedures for requesting identification; training updates; and a written list of the prohibited products. However, if the store violates the ban three or more times in a 12-month period, it is guilty of a misdemeanor.

Exempts from the above, any licensed health care practitioner who prescribes or dispenses herbs or herbal products in the course of treating patients.

Status: Died in the Assembly Appropriations Committee

SB 1964 (Alpert) – Banned Substances: Sale to Minors

(Adds Chapter 5, commencing with Section 104895.5, to Part 3 of Division 103 of the Health and Safety Code)

Makes it unlawful to sell any product containing a substance banned by the National Collegiate Athletic Association (NCAA) to any person under the age of 18. Provides an exemption for products containing caffeine, purchased with a prescription, and approved by the Federal Drug Administration as over-the-counter drugs.

Requires retailers to check the identification of purchasers of these products who appear to be under the age of 18.

Establishes that violations of the requirements of this bill by a director, officer or agent of a corporation, constitute an infraction punishable by a fine not exceeding \$1,000 for a first violation, \$2,000 for a second violation and \$5,000 for a third and subsequent violations.

Establishes an eight-member panel to advise the Legislature on the use of performance enhancing supplements by minors. Requires the panel to review all banned drugs currently on the NCAA list, monitor changes to the list of NCAA Banned-Drug Classes and recommend to the Legislature whether changes to the requirements of this bill are necessary.

Status: Died in the Senate Health and Human Services Committee

AB 686 (Koretz) - Pharmaceutical Companies: Marketing Expenditures: Rebates

(Adds Division 112, commencing with Section 140000, to the Health and Safety Code)

Finds the cost of drugs a major contributor to overall health costs; finds the pharmaceutical industry one of the most profitable in the nation; finds drug market costs often exceed research and development costs; finds the cost of drugs can imperil patients' well-being; and states intent that California cease paying marketing costs for life-threatening chronic conditions.

Requires manufacturers of drugs for life-threatening chronic conditions or listed for Medi-Cal or the AIDS Drug Assistance Program to pay the department a rebate equal to the costs of marketing each drug.

Requires each drug manufacturer to disclose all costs incurred in marketing of AIDS drugs to consumers and physicians. Permits complying companies to retain 10 percent of reported costs, assesses non-complying companies one-quarter of the Public Health Service price for the same drug.

Specifies that this marketing rebate supplements but does not supplant any other rebate. Permits removal from the Medi-Cal formulary for any drug failing to pay the market cost rebate.

Defines "marketing" cost to include all direct to consumer advertising, all payments and gifts to physicians, and any payments to physicians which is not "reasonable and necessary for physician education." Defines "life-threatening chronic condition" as any disease which will result in death within five years without an appropriate drug regimen.
Status: Died in the Senate Health and Human Services Committee

AB 2317 (Chu) - Substance Abuse: Adult Recovery Maintenance Facilities

(Amends Sections 11831.5, 11834.01, 11834.02, 11834.09, 11834.10, 11834.15, 11834.17, 11834.18, 11834.20, 11834.21, 11834.22, 11834.23, 11834.24, 11834.25, 11834.26, 11834.30, 11834.31, 11834.32, 11834.36, and 11834.50 of, adds Sections 11834.04 and 11834.11 to, and repeals and adds Section 11834.16 of, the Health and Safety Code)

Requires the Department of Alcohol and Drug Programs (DADP) to develop and adopt emergency regulations governing the licensing and operation of adult recovery maintenance facilities (ARMFs), in consultation with specified entities, on or before July 1, 2003.

Prohibits any state or local social services, law enforcement, or corrections agency, or court, probation officer, or parole officer from referring any person to an alcoholism or drug abuse recovery or treatment facility or ARMF that is not licensed by DADP, after January 1, 2004.

Authorizes the collection of license and certification fees in amounts sufficient to offset the costs of DADP to administer the licensure and certification program.

Deletes the prohibition against collecting fees from nonprofit and local government facilities for such purposes.

Status: Died in the Senate Appropriations Committee

CALWORKS AND OTHER PUBLIC ASSISTANCE PROGRAMS

SB 217 (Kuehl) - CalWORKs: Domestic Violence

(Adds Section 11325.3 to the Welfare and Institutions Code)

Requires that each county include in its county CalWORKs implementation plan, provisions for domestic violence services. Requires the plan to be developed jointly by the county and providers of services to domestic violence victims.

Requires that services to be provided by counties include, but not be limited to, outreach, emergency and transition shelter, counseling, legal services, case management, job preparation, etc.

Status: Died in the Senate Appropriations Committee

SB 249 (Chesbro) - CalWORKs: Eligibility

(Amends Sections 366, 366.1, 11203, and 16501.1 of the Welfare and Institutions Code)

Allows CalWORKs assistance and services to be continued to a parent or needy caretaker relative for up to 180 days during which a child is not residing in the home, if during that time the county determines the assistance is necessary in order for family reunification.

Status: Died in the Senate Appropriations Committee

SB 380 (Murray) - CalWORKs: Community College Students: Study Time

(Amends Section 11325.23 of the Welfare and Institutions Code)

Allows CalWORKs recipients, who have an approved self-initiated education and/or training program to have an hour of study each hour in the classroom, up to a maximum of six hours per week, to apply toward their weekly hourly work requirement. This bill applies to students who participate in welfare-to-work program. Limits the number of study hours that may be counted to the weekly hourly work requirement to six per week.

Clarifies that the requirements of this bill shall be implemented within the existing CalWORKs funding streams.

Status: Vetoed by the Governor

AB 144 (Cedillo) - Public Social Services: Eligibility: Vehicles

(Amends Section 11155 of, and adds Section 18901.8 to, the Welfare and Institutions Code)

Modifies the valuation of vehicles in determining a family's eligibility for the California Work Opportunity and Responsibility to Kids (CalWORKs) and Food Stamp programs.

Permits applicants or recipients of the CalWORKs and Food Stamp programs to keep one motor vehicle with a fair market value of up to \$15,000 when the applicants or recipients are: employed or engaged in work activities; or, expected to satisfactorily participate in work activities in preparation for employment.

Permits applicants or recipients of the CalWORKs and Food Stamp programs who are victims of abuse to retain one motor vehicle, regardless of the vehicle's value, until no longer subject to abuse or risk of abuse, as determined using regulation standards developed by the Department of Social Services (DSS) and interested stakeholders.

Requires DSS to adopt regulations that minimize counties' administrative burden.

Requires counties to apply Food Stamp program motor vehicle exclusion rules in determining the resources of CalWORKs or Food Stamp program applicants and recipients.

Requires DSS to use the same vehicle resource rules in the Food Stamp program and the CalWORKs program.

Makes technical changes to conform this bill to federal law.

Status: Vetoed by the Governor

AB 313 (Goldberg) - Women, Infants, and Children's Nutrition

(Amends Sections 123302 and 123320 of, and adds and repeals Section 123296 of, the Health and Safety Code)

Permits Women, Infants, and Children (WIC) coupons to be redeemed, commencing July 1, 2002, at any authorized vendor.

Requires the Department of Health Services (DHS) to report to the Legislature by July 1, 2004 on the impact of implementing an "any authorized vendor" system, including an assessment of the impact of these provisions on fraud and the integrity of the program.

Requires DHS to develop a plan to determine the feasibility of implementing an electronic benefits transfer system for the California Special Supplemental Food Program for WIC by January 1, 2003, and report its findings to the Legislature by July 1, 2003.

Requires DHS, to the extent feasible, to print specified information on WIC coupons in a form readable by optical scanning technology. Makes implementation contingent on a budget appropriation.

Requires DHS to report to the Legislature by March 15, 2002 on the feasibility and costs of printing WIC coupons for use with optical scanning technology.

Status: Chapter 842, Statutes of 2001

AB 767 (Goldberg) - CalWORKs: Food Stamps: General Assistance

(Amends and repeals Section 11251.3 of, and adds Section 18901.3 to, the Welfare and Institutions Code)

Permits individuals who were convicted of possession or use of a controlled substance after December 31, 1997 to participate in the CalWORKs and the Food Stamp programs, if they:

- Successfully completed, are currently participating in, or are willing to enroll in a state-licensed, certified, or county-run drug treatment program;
- Currently participate in a court-mandated drug treatment or diversion program;
- Fulfilled court-imposed conditions in the disposition of their criminal case at least five years prior to the application for assistance; or
- Are not currently using a controlled substance.

Requires individuals not currently enrolled in drug treatment to take and pass a drug-screening test to demonstrate they are not using a controlled substance prior to receiving

assistance. Requires these individuals to periodically take and pass drug screens to continue receiving benefits and applies financial sanctions to individuals who fail or refuse to take drug screens.

Prohibits participation under the exemption provided in this bill to individuals who have failed or refused to participate in the drug treatment or diversion program without good cause and applies financial sanctions to these individuals.

Requires that results of drug screens be treated as private, confidential medical records and be protected from discovery. Requires counties to establish interagency teams, including the county departments of social services, alcohol and drug services, mental health services, and probation, to provide case management services to individuals.

Requires counties to coordinate CalWORKs services with the State Department of Corrections' Female Offender Treatment and Employment Program, or requires a representative of the Department of Corrections' Parole and Community Services Division to cooperate with the interagency team.

Makes aid available to participants in the form of vouchers or vendor payments for at least rent and utilities.

Status: Vetoed by the Governor

AB 1652 (Goldberg) - Public Social Services: Relocation Assistance

(Adds Section 11008.16 to the Welfare and Institutions Code)

Excludes private payments for relocation assistance, as defined, from income and resources for purposes of eligibility and aid determination under the CalWORKs program and other public assistance or aid programs, as specified.

Defines relocation assistance, for the purposes of this bill, as:

- Payments made by a private landlord under local rent control ordinances for evicting a tenant.
- Payments made pursuant to state or local law to compensate a person for moving when the payment is not otherwise exempted from consideration as income and resources for public assistance recipients under another statute.

Establishes that this bill does not make an appropriation of state public assistance funds.

Provides that the provisions of the bill do not apply to general assistance programs.

Status: Vetoed by the Governor

AB 2926 (Longville) – Food Stamps: County Reporting

(An act to relating to social services)

Requires the Legislative Analyst Office (LAO) to study reporting practices in five counties, including San Bernardino County, a rural county, an urban county, a county in northern California, and a county in southern California.

Requires the LAO study to describe each county's procedures for determining Food Stamp eligibility and each county's number of caseworker data errors, failures to act on errors, Food Stamp benefit underpayments and overpayments, and recipient reporting errors.

Requires the LAO to report its findings to the Legislature by December 31, 2003.

Status: Withdrawn from enrollment. Died on the Senate Floor Inactive File

CANCER

SB 224 (Speier) – Breast and Cervical Cancer Prevention and Treatment Program

(Adds Section 14021.8 to, and adds Division 24.5, commencing with Section 24100, to the Welfare and Institutions Code)

Requires, to the extent federal financial participation (FFP) is available, the Department of Health Services (DHS) to submit a state plan amendment to the federal Health Care Financing Administration (HCFA) adopting the optional categorically needy eligibility group described in the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000.

Authorizes, if the state plan amendment described above is approved by HCFA, DHS to implement above by issuing all-county letters or similar instructions. Requires, subsequent to DHS issuing all-county letters or similar instructions, DHS to adopt regulations in accordance with the rulemaking provisions of the Administrative Procedure Act, as specified.

Prohibits this bill from being construed to limit California Breast and Cervical Cancer Treatment Program (CBCCTP), as established in this bill, to do any of the following: a) provide only supplementary services for those individuals who qualify for services under CBCCTP; b) prohibit CBCCTP from continuing to operate with regard to covered conditions not included in this bill; c) provide services to any person who meets the eligibility requirements, as specified below; and d) provide services to any person who meets the eligibility requirements contained in contracts pursuant to the state's existing Breast Cancer Treatment Program.

States legislative intent that moneys appropriated from the General Fund to DHS in the annual Budget Act be used to provide services to any person described above, if FFP is not available pursuant to above.

Requires DHS to create and implement a simplified application process for persons applying for services pursuant to this bill. Exempts CBCCTP applications from existing Medi-Cal requirements regarding the applicant's county of residence in determining eligibility. Prohibits asset information from being used to determine eligibility. Requires the process to permit a certified entity to enroll a person who appears to be eligible on a temporary basis pending a full eligibility determination.

Prohibits DHS from requiring an applicant who submits a simplified application pursuant to this bill to complete a face-to-face interview. Requires eligibility for coverage to begin three months prior to the month in which the person applies. States that eligibility ends when the course of treatment is completed.

Requires services covered by the program to include all services provided as benefits under Medi-Cal. Requires, to the maximum extent possible, services to be consistent with optimal standards of practice.

Requires, for purposes of administering CBCCTP, DHS to do all of the following:

- Ensure that there is an adequate statewide network to cover all enrollees.
- Establish quality, access, and linguistic and cultural competency standards.
- Establish a quality and access monitoring and enforcement system.
- Provide the maximum possible choice of health care service delivery options.
- Use provider reimbursement systems that will encourage provider participation as well as protect program integrity.

Requires DHS to report to the Legislature regarding the feasibility of implementing a patient care coordination program in coordination with Breast Cancer Early Detection Program regional partnerships. Requires the patient care coordination program to include application assistance and care coordination.

Status: Died in the Assembly Appropriations Committee

SB 417 (Vasconcellos) - Cancer: Alternative Treatment Project

(Amends Section 140187 of, and adds Article 3.5, commencing with Section 104210, to Part 1 of Division 103 of, the Health and Safety Code)

Finds and declares that state funding was critical to the early development of the profound successes that have been achieved in the treatment of heart disease through the financing of early research to test the effectiveness of intensive behavioral changes, focused on diet, exercise and stress management.

Finds and declares that a timely investment in research to examine the value of noninvasive and holistically based techniques in managing potentially life-threatening illnesses, including cancer could provide similar value. Finds and declares that preventive research is in the interest of the health of all Californians, and the quality of life of those diagnosed with serious medical conditions.

Requires the Department of Health Services to establish an alternative treatment cancer research project, focused on preventive and holistic measures, to test the effectiveness of intensive behavioral changes in reducing or reversing illness and disease with specific attention to diet, exercise and stress management.

Requires that the initial research address the emerging research on prostate cancer that is already underway in California, while also seeking potential research opportunities for other cancers, including, but not limited to, breast and colon cancer.

Status: Died in the Senate Appropriations Committee

SB 646 (Ortiz) - Cancer: Clinical Research Trials Registry

(Adds Section 104205 to the Health and Safety Code)

Requires the Department of Health Services (DHS) to conduct a study to determine the feasibility, efficacy, and cost of establishing and maintaining a state registry listing, to the extent possible, all cancer clinical research trials that are in operation, or soon to be in operation, in California. Permits DHS to use consultant services for the purposes of the study.

Permits DHS, in conducting the study, to consider the following questions:

- Whether the registry should give priority to listing those clinical trials that are actively in the process of seeking participants, in contrast to those that have satisfied or almost satisfied their participation goals;
- Whether the list of trials and any essential information regarding the trial should be available to the public through the Internet and a toll-free telephone number; and,
- Whether, and to what extent, the registry should duplicate data available through the registry operated by the National Cancer Institute (NCI), and what linkages between the registries are feasible.

Requires DHS to establish a program to promote the participation of adults with cancer in clinical research trials, where appropriate, through information and referral and education of cancer patients on the availability of the option to participate in a clinical trial and the available sources of information about trials seeking participants. Requires DHS, for purposes of the program, to do all of the following:

- Establish a two-year competitive grant program to provide grants to cancer survivor support groups and advocacy groups for the purpose of educating cancer patients on the possibility of participation in a clinical research trial and providing referrals to the full range of publicly available sources of information about clinical trials;
- Develop criteria for the awarding of grants. Requires the criteria to include, but not be limited to, the demonstrated experience of the support or advocacy group in serving cancer patients and cancer survivors; the ability of the grantee to reach a diverse population of cancer patients, including consideration of gender, ethnicity, geographic regions, and cultural and linguistic diversity; and the ability of the grantee to provide referral and information about the general risks and advantages of

participation in a clinical trial, including providing information and referral on issues relating to informed consent and conflict of interest; and

- Conduct an evaluation of the effectiveness of the grant program in increasing the percentage of adult cancer patients participating in clinical research trials. Permits DHS to consult with the following regarding design of the study described above, including representatives of cancer patients and cancer survivor support groups, oncologists, researchers engaged in clinical research trials, and the NCI's Cancer Information Service of California.

Makes various legislative findings that participation of cancer patients in appropriate clinical research trials can advance the development of scientific understanding of, and cures for, cancer, and have the potential to benefit the patient as well, that only approximately 3% of adult cancer patients participate in cancer related clinical research trials, while it is estimated that 20% are eligible to participate in the trials, and the lack of timely information about the range of cancer related clinical research trials seeking participants is one barrier to the participation of adults in these trials.

Status: Provisions Removed from Original Version Heard in Committee in 2001

AB 42 (Wayne) - Colorectal Cancer

(Adds Chapter 8, commencing with Section 104322, to Part 1 of Division 103 of the Health and Safety Code)

Makes findings and declarations related to the prevalence, severity, and prevention of colorectal cancer.

Establishes the Colorectal Cancer Screening and Treatment Program (CCST) within the Department of Health Services (DHS) for the following groups:

- Uninsured and underinsured persons 50 years of age and older with incomes at or below 200 percent of the federal poverty level (\$17,180 for an individual for 2001);
- Uninsured and underinsured persons below 50 years of age who are at high-risk for colorectal cancer and who have incomes at or below 200 percent of the federal poverty level.

Requires that services provided under this program include, but not be limited to, all of the following:

- Screening of men and women for colorectal cancer as an early detection health care measure;
- Medical referral of the screened person and services necessary for definitive diagnosis after screening;
- Assistance and advocacy to help the person obtain necessary treatment if a positive diagnosis is made;
- Necessary treatment in accordance with the most recent cancer treatment guidelines of American Cancer Society; and,
- Outreach and health education activities to ensure that uninsured and underinsured persons are aware of, and appropriately utilize, the services provided by the program.

Permits DHS, in accordance with emerging developments in scientific or medical research, to expand the definition of a high-risk individual or to require coverage of additional medically recognized screening tests or treatments, or both, for colorectal cancer.

Requires DHS to award one or more contracts to provide colorectal cancer screening and treatment through private or public nonprofit organizations.

Authorizes the CCST Program to use the Medi-Cal program fiscal intermediary, to enroll providers and to pay claims, only if services provided under this program are specifically identified and reimbursed in a manner that does not claim federal financial reimbursement.

Status: Provisions Removed from Original Version Heard in Committee in 2001

AB 480 (Robert Pacheco) – Cancer

(Amends Section 104180 of the Health and Safety Code)

Provides that the Cancer Research Fund shall include money accepted by DHS from grants and donations from private entities and public moneys transferred to the fund.

Status: Chapter 246, Statutes of 2001

AB 1843 (Robert Pacheco) – Pancreatic Cancer Research and Education

(Adds and repeals Article 4, commencing with Section 104240, of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code)

Requires the Department of Health Services (DHS) to establish and administer the Pancreatic Cancer Research and Education Project Act created by this bill in a manner that will ensure the participation of both private sector and public sector research organizations.

Appropriates \$500,000 from the General Fund to DHS for fiscal year 2002-03 for the purposes of this bill. States legislative intent that all future appropriations be made through the annual Budget Act.

Requires DHS to award grants only to those nonprofit organizations, foundations, or public entities that are exclusively chartered in California.

Provides that no more than 10 percent of the annual allocation for this program, up to a maximum of fifty thousand dollars (\$50,000), be expended annually for the total administrative costs of the program. States that these administrative costs shall be kept to a strict minimum.

Requires DHS to grant two-thirds of remaining funds appropriated for purposes of this bill that are awarded during any fiscal year to applicants proposing pancreatic cancer research for the development of improved methods of detecting and treating pancreatic cancer.

Requires DHS to grant one-third of remaining funds appropriated for purposes of this bill that are awarded during any fiscal year to applicants proposing to support public education, information, and awareness about pancreatic cancer.

Defines "pancreatic cancer research" as research to develop improved methods of detecting and treating pancreatic cancer and to increase public education and information about the disease.

Requires the provisions of this bill to be known as the Dr. Ronald Hockwalt Memorial Pancreatic Cancer Research and Education Project Act of 2002.

Status: Died in the Senate Appropriations Committee

AB 2459 (Diaz) - Physicians And Surgeons: Prostate Cancer

(Adds Section 2248.5 to the Business and Professions Code, and amends Sections 109280 and 109282 of the Health and Safety Code)

Requires the Department of Health Services (DHS) to approve and send the Medical Board of California (MBC) an updated copy of its summary on alternative methods of treating prostate cancer each time the summary is modified.

Requires the MBC to make the updated summary available to its licensees, its physicians and surgeons.

Urges physicians and surgeons to make the summary available to patients when appropriate.

Requires DHS and MBC to post the updated summary, and any subsequent updates, on their websites for public use.

Requires posted signs or notices to include the website addresses for DHS and MBC, as well as a notice regarding the availability of an updated prostate cancer summary on these websites.

Status: Chapter 531, Statutes of 2002

CHILD CARE

SB 993 (Figueroa) – Early Care and Education

(Amends Sections 8200, 8201, 8203, 8208, 8236, 8265, and 8470 of, adds Sections 8217 and 8235.5 to, and amends the heading of Chapter 2, commencing with Section 8200, of Part 6 of, the Education Code)

Grants a one-time cost-of-living adjustment (COLA) and raises maximum rates as follows: appropriates \$115,074,862 million from the General Fund to the Superintendent of Public Instruction (SPI) for one-time COLAs.

Programs that serve infants, toddlers, and preschool children:

- Raises the standard reimbursement rate (from an annual rate, equal to \$26.62 per child day) to \$33.22 per child day of enrollment, increased by the COLA beginning July 1, 2002, and increased annually by a COLA equal to the COLA for school districts;
- Provides a one-time COLA of 25.17 percent on January 1, 2002, excluding resource and referral and alternative payment programs.

Programs that serve school age children:

- Establishes a new maximum standard reimbursement rate to be \$21.03 per child day of enrollment, and \$2.63 per child hour of enrollment, increased by the COLA granted by the Legislature beginning July 1, 2001, except for agencies already exceeding this rate;
- Provides a one-time COLA of 11.07 percent on January 1, 2002;
- Increases state preschool income eligibility as follows: requires income eligibility levels for state preschool to be the same as those for general child care (75 percent of state median income), with exceptions for abused and neglected children and children eligible for special education who shall be served without regard to income level.

Codifies the following current practices:

- Requires the state to provide child care and development services which, in addition to current requirements, are educational and include early brain development, language development, early literacy and numeracy, and educational enrichment;
- Establishes that one of the purposes of this Act is to promote school success by providing age-appropriate educational curricula at infant and toddler centers, preschool centers, and school age centers;
- Requires the SPI to use the following indicators of quality to guide the development of standards and implementation of these programs:

Contracted centers: age appropriate, meet the developmental needs of the child, and are based on clearly defined educational curriculum, chosen by the contractor.

Infant and toddler centers: a focus on language development and early brain development.

Preschool centers: a focus on language development, early literacy, early numeracy and educational enrichment.

School age centers: a focus on reading and language arts, and time and staff support for pupils to do school homework.

Status: Provisions Removed from Original Version Heard in Committee in 2001

SB 1335 (Dunn) – Child Day Care Facilities: Criminal Record Information: Disclosure

(Amends Section 1596.871 of the Health and Safety Code)

Requires individuals working in licensed child care facilities, who have received a criminal history exemption, to agree that their conviction information and a summary of the incident may be disclosed by the Department of Social Services (DSS) to any parent

who has children in care at the facility or to any parent who is a prospective client of the facility.

Requires DSS to hold records of convictions, for individuals for whom DSS has granted an exemption from disqualification, for at least two years after the employee is no longer employed by the facility, and make them available, upon request, to any parent, guardian, or prospective client, unless the employee has requested that DSS seal the records upon the employee's discontinuation of employment by a licensed child care facility.

Provides that DSS shall not require a licensee to notify the parent or guardian of a prospective client in the licensee's child care facility of specific information regarding any person who has been granted an exemption from disqualification.

Provides that DSS shall develop a document to inform the parents or guardians of a client or prospective client in a child day care facility of the process DSS undertakes in granting an exemption and of the parents right to receive information regarding exemptions and DSS may require licensees to distribute the document.

Provides that an exemption must be sought if a person is convicted of any felony not on the non-exemptible list, any misdemeanor that is less than five years old and specified misdemeanors that are more than five years old. However, if a person was convicted of a non-enumerated misdemeanor that is more than five years old then no exemption is needed if it is more than five years old unless there are three or more convictions.

Status: Died on the Senate Floor Inactive File

AB 297 (Kehoe) - Before and After School Programs

(Adds and repeals Article 23.4, commencing with Section 8488.5, of Chapter 2 of Part 6 of the Education Code)

Establishes the statewide "Six-to-Six Before and After School Program" (6 to 6) to be similar to the After School Learning Safe Neighborhoods and Partnership Program (ASLSNPP) for schools in which less than 50% of their students qualify for free or reduced-priced lunches, and therefore do not receive funding through ASLSNPP, and allows these programs to operate without obtaining a license or special permit, as required under the California Child Day Care Facilities Act.

Requires 6 to 6 programs to:

- Serve children in kindergarten through ninth grade.
- Operate only on school sites, or parks or recreation areas adjacent to school sites.
- Operate for a maximum of 30 hours per week.
- Operate for a minimum of three hours per day and until at least 6 p.m. every schoolday.
- Consider all children in attendance at the school eligible to participate in the program.
- Include educational and literacy components, including homework assistance.

- Include educational enrichment, which may include recreation, physical activity, and conflict resolution.
- Establish, and post at each site, a formal complaint process.
- Report annually to the school district and superintendent of the school district on measures, as determined in conjunction with the school district and the site principal, for academic performance, attendance and positive behavior changes. Requires programs to provide these reports to the Education and Human Services Committees of the Legislature.

Requires priority for funding programs to be given to elementary, middle, and junior high schools with the highest percentage of pupils eligible for free or reduced-cost meals through the school lunch program of the U.S. Department of Agriculture.

Requires 6 to 6 programs to be governed by either a local education agency (LEA) or a city or county, in partnership with a community-based organization (CBO), only with the approval of the LEA, governing board of the school district, and the principal of each school site. Requires that all partners (LEA, CBO, and school district) share the responsibility of ensuring the quality of the program. Requires the fiscal agent to be either the LEA, county board of supervisors, or city council.

Requires the city or county to annually review the program.

Requires full-time site supervisors to possess a bachelor's degree or have completed at least 15 units of coursework in education, child development, recreation or a related field.

Requires all staff to be subject to health screening and fingerprint clearance requirements in current law and school district policy.

Requires programs to maintain a pupil-to-staff ratio of no more than 20 to 1.

Status: Chapter 453, Statutes of 2001

AB 685 (Wayne) - Family Day Care Homes: Reporting Requirements: Unannounced Visits

(Adds Section 1597.467 to the Health and Safety Code)

Requires a report to be made to the Department of Social Services (DSS) by telephone or fax during the department's normal business hours before the close of the next working day following the occurrence during the operation of a family day care home of any of the following events: death of any child from any cause; any injury to any child that requires medical treatment; and any unusual incident or child absence that threatens the physical or emotional health or safety of any child.

Requires a written report to be submitted to DSS within seven days following the occurrence of any events specified above containing all of the following information:

child's name, age, sex, and date of admission; date and nature of the event; attending physician's name and findings and treatment, if any; and disposition of the case.

Allows DSS to develop the report form to be used for this purpose, and requires DSS to maintain all forms in a manner that allows DSS to report data to the Legislature. Requires DSS to treat failure to report injuries, as required by this section of law, as grounds for suspension of a provider's license.

Requires licensed child care providers to report all injuries and acts of violence that occur to children in their care to the child's parent(s) or guardian as soon as possible.

Allows DSS, to the extent that funds are available, to conduct, either directly or pursuant to a contract with a public or private entity, an evaluation to determine the overall effectiveness of unannounced site visits to licensed family day care homes, including the issue of the frequency of these visits. Provides that this evaluation may include, but is not limited to, a comparative evaluation based on information collected in a pilot project in which the effectiveness of the increased frequency of licensed family day care homesite visits, among other things, is tested.

Requires DSS to seek non-General Fund resources for the implementation of this evaluation if it proceeds with the evaluation.

Status: Chapter 679, Statutes of 2001

AB 1105 (Simitian) – Foster Family Homes: Child Care Reimbursement

(Repeals and adds Section 11465.6 of the Welfare and Institutions Code)

Establishes the Legislature's intent to: provide high quality early education and care, and safe and stable homelike placements to children in foster care; recruit and retain high quality foster families; avoid costly and inappropriate placements of children; and reduce financial barriers to finding child care for foster parents.

Makes findings and declarations regarding: the benefits of high quality child care; the need to provide foster families the necessary resources to ensure optimal development of children; and the cost-effectiveness of providing child care assistance to foster families.

Creates a statewide mandated program which provides child care assistance to foster caregivers in an amount equal to one-half of the regional child care market rate. The cost would be shared equally between federal and state funds.

Authorizes the provision of child care assistance for as long as the caregiver is: working outside the home; participating in foster parent training; or fulfilling necessary foster care-related duties.

Requires the need and plan for child care to be documented in the foster child's case plan, and requires the care to be provided by a licensed child care provider.

Requires counties to report specified data to the Department of Social Services (DSS) annually in order to determine the effects of child care assistance on the ability of counties to recruit and retain foster parents.

Allows counties that wish to cover more than half the cost of child care to submit a plan to DSS justifying the additional provisions. DSS shall then determine the level of payment based on statewide standards developed by the department, based on the county's cost of living and average cost and supply of child care. In these counties, up to the full cost of child care may be provided to foster families, and the cost would be shared between federal, state and county funds, consistent with current foster care cost sharing ratios (approximately: federal - 50%, state - 20%, county - 30%).

Makes implementation of the program contingent upon both the receipt of federal financial participation and an appropriation in the Budget Act or another statute.

Requires DSS, if federal approvals are required, to submit an amendment to the state's Title IV-E Foster Care Plan by February 1, 2002.

Status: Provisions Removed from Original Version Heard in Committee in 2001

CHILD SUPPORT

AB 1449 (Keeley) - Child Support

(Amends Section 17415 of, and adds Sections 17550 and 17552 to, the Family Code, and amends Section 903 of the Welfare and Institutions Code)

Requires the state Department of Child Support Services (DCSS), in consultation with the California Department of Social Services (CDSS), to establish regulations by which a local child support agency (LCSA) would be allowed to "compromise" an eligible parent's liability for child support debt, owed as reimbursement for public assistance payments under AFDC-Foster Care or CalWORKs resulting from separation or desertion of a parent from a child, when the child is now residing with the obligor parent and other conditions are met.

Requires the obligor parent to establish one of the following:

- The child had been adjudged a dependent of the court (under WIC Section 300), but has been reunified with the obligor parent pursuant to a court order;
- The child received public assistance while living with a guardian or relative caregiver and the child has been returned to the custody of the obligor parent (the parent with whom the child resided prior to the child's placement with the guardian or relative caregiver);
- The obligor parent, for whom the debt compromise is being considered, has an income less than 250 percent of the current federal poverty level;
- The local child support agency, pursuant to regulations set forth by the department, has determined that the compromise is necessary for the child's support.

Requires CDSS, in consultation with DCSS, to promulgate regulations under which county welfare departments must determine, in cases where separation or desertion of a parent from a child results in AFDC-Foster Care payments, whether it would be in the best interest of the child to refer the case to the LCSA for establishment of a support order for the reimbursement of public assistance (AFDC-FC). Provides that, if the county welfare department determines it is not in the best interest of the child to refer the matter to the LCSA, the department shall not refer the case for child support collection, and shall periodically revisit that determination after specified court hearings (those held under WIC Section 361.5). The county welfare department would be required to refer the case to the LCSA if there has been a change of circumstances such that a referral for child support collection is no longer contrary to the child's best interest.

Provides that this bill shall be implemented only to the extent that federal financial participation is not reduced for the AFDC-FC program and the CalWORKs program.

Status: Chapter 463, Statutes of 2001

DISABILITIES

SB 511 (Alpert) - Children with Disabilities

(Adds Chapter 4.3, commencing with Section 56400, to Part 30 of the Education Code)

Establishes legislative intent, to the extent feasible, to establish the Family Empowerment and Disability Councils (FECs) to ensure that children and young adults with disabilities receive the support necessary to complete their education. Requires FECs to be non-profit organizations governed by a majority of parents, guardians, and family members who have experience with related local and regional services, persons with disabilities, and representatives of community agencies serving persons with disabilities.

Requires the State Department of Education (SDE) to award grants to establish FECs in each of the 32 regions of the state served by the Early Start Resource Centers.

Requires SDE to award grants no later than February 15, 2002, and in subsequent years, to the extent funding is available, no later than February 15.

Establishes a formula for grants awarded that is determined by school enrollment in the region, includes a minimum base rate of \$150,000 for each center, and is sufficient to provide required services to families of children and young adults, from age 3 to age 33, with a full range of disabilities. Permits services to families with young adults over the age of 18 only if an individual education plan was completed to the young adult's 18th birthday.

Requires SDE to develop the grant application with advice from parents, guardians and family members of children and young adults with disabilities, adults with disabilities, and community agencies serving persons with disabilities. Requires FECs to:

- Provide training and information that meets the needs of parents and guardians of children and young adults with disabilities, particularly families and individuals that have been underserved;
- Work with community-based, state, and local agencies that serve children with disabilities;
- Train and support parents and guardians to understand their children's disabilities and educational and developmental needs, communicate effectively with specified professionals, participate effectively in decision-making and program development on behalf of their children and promote alternative forms of dispute resolution.

Appropriates \$2,372,000 from federal funds received by SDE under Part B of the Individuals with Disabilities Education Act.

Status: Chapter 690, Statutes of 2001

SB 1096 (Ortiz) – Children with Disabilities

(An act relating to health)

Requires the Health and Human Services Agency, to the extent funding is received, to contract for a study of the differing eligibility criteria and services available through existing state programs for children with disabilities aged 0 to 5 years.

Requires the contractor to identify gaps in services, or duplications of services, if any, to disabled children in this age group, and the number of disabled children who lose, at age three years, eligibility for services provided through the Early Start program.

Requires the contractor to recommend options and priorities for closing gaps in services to disabled children aged 0 to 5 years.

Requires the contractor to identify the levels of funding of current programs and the impact funding has on the type and availability of services, including the availability of services in urban and rural geographic areas.

Requires specified state department representatives and representatives of parents and families of disabled children to be included in the process of determining options and priorities for improving services for disabled children.

Requires the agency to apply for a grant from the California Families First Commission (Proposition 10 Commission), the federal Health Resources Services Agency, and other funding sources for the study.

Status: Died in the Assembly Appropriations Committee

SB 1190 (Health & Human Services Committee) – Assistive Dog Allowance

(Amends Section 12554 of the Welfare and Institutions Code)

Increases the dog-related allowance by \$15 per month (from \$35 per month to \$50 per month) for those Social Security Disability Insurance recipients who have a guide, signal or service dog and who have an income and resources less than the federal poverty level.

Status: Chapter, 452, Statutes of 2001

AB 896 (Aroner) – Developmental Services: Resources

(Adds Chapter 13, commencing with Section 4850, to Division 4.5 of the Welfare and Institutions Code)

Community Augmentation and Resource Enhancement (CARE) Account

- Establishes a CARE account, into which the Department of Developmental Services (DDS) would place funds equal to those projected savings.
- Requires regional centers to use CARE account funds to enhance services to persons residing in the community who have unmet needs, create new services, provide support including stipends to families of developmentally disabled (DD) consumers, contract with state employees, and supplement compensation of community-based providers. In creating a new service, with DDS approval, the regional center could modify a service method in existing statute.
- Requires regional centers to provide to DDS information on uses, amounts and sources of funds in the CARE accounts.

Provisions relating to Developmental Centers (DCs)

- Requires that DDS reduce the high overhead costs in DCs by "consolidating programs," unless doing so decreases DC client health or safety.
- Requires placements in the community to be based on the development and implementation of a "person-centered" individual program plan (IPP).

Lanterman Trust Fund/sale or lease of DC lands and buildings

- Establishes a Trust Fund, governed by a Board of Trustees with specified membership, to provide stable community-based housing to persons with developmental disabilities. Permits the trust fund to accept donations of family homes to be used for DD consumer housing.
- Requires that all proceeds from the sale or lease of state DC facility lands and buildings must be deposited into the Trust Fund. Further specifies that, upon appropriation by the Legislature, Trust Fund monies can be used for purposes of this bill, as specified.
- Provides that, notwithstanding any other provision of law, DC lands and buildings shall, when feasible, be leased or sold at fair market value.
- Provides that the Trust's funds shall be used to offer stable, neighborhood-based housing to persons with developmental disabilities. Further provides that, with approval of the Trust Fund Board of Trustees, DDS may utilize the funds to:
 - ❖ Provide low interest/deferred interest loans to public benefit housing corporations;

- ❖ Provide low interest/deferred interest loans to families caring for a developmentally disabled family member for purchase of or remodeling of a home;
- ❖ Subsidize mortgages for persons with developmental disabilities, through low or no interest loans;
- ❖ Establish "centers for adaptive needs" to produce adaptive equipment;
- ❖ Establish medical and dental service centers for serving developmentally disabled persons.
- Permits the Trust Fund's Board of Trustees, using interest generated from Trust Fund investments, to provide grants of funds for "special purposes". Requires that Trust Fund assets be used in such a way as to ensure the assets do not replace any appropriations for service programs (i.e., cannot be used to "supplant" other service program funds).

State employees transition--state-owned/operated facilities authorized but not required.

- Requires that DDS develop a "state staffing plan" through which DC employees with specialized skills, training and experience will be maintained on state staff for the purpose of meeting the needs of DD consumers in the community who otherwise would lack access to those specialized services. The plan would include identification of professional expertise available in the DC's (such as medical, dental, rehabilitation, social work, etc.); identification of the extent to which DD clients in the community need those services; identification of DC employees who would become available to meet those needs due to diminished need for their services in the DC's; deployment of a methodology through which these employees could serve DD consumers throughout the state; and development of a plan for financing these services that ensures maximum federal match.
- Authorizes but does not require DDS to establish state-owned, state-operated or state-staffed residential facilities or services, as specified, to meet the needs of DD consumers whose needs cannot otherwise be met. The services that would be provided could include: short-term residential crisis services for consumers in the community; services for DD consumers with psychiatric disabilities that cannot be handled in the community; short-term residential facilities for respite care for family members; services for persons with "significant needs" that cannot otherwise be met in the community; and community resource centers that provide outpatient specialized services, such as dental care, podiatry, habilitation, nursing consultant services, emergency behavioral intervention, etc.
- Requires DDS to report annually to the Legislature, by April 1 of each year, on the development of any such state facilities. Requires DDS to develop a training program for the successful transition of former DC employees .

Status: Died in the Senate Appropriations Committee

AB 925 (Aroner) - Employment of Persons With Disabilities

(Add Sections 12803.6, 12803.65, and 12803.7 to the Government Code, adds Division 10, commencing with Section 18000, to the Unemployment Insurance Code, and amends Sections 14006 and 14132.95 of, adds Sections 12305.7 and 14007.11 to, and amends, adds, and repeals Section 14007.9 of, the Welfare and Institutions Code)

Requires the Secretary of the Health and Human Services Agency (Secretary), in conjunction with the Workforce Inclusion Council established by this bill, to create a sustainable, comprehensive strategy to do all of the following: a) bring adults with disabilities into gainful employment at a rate that is as close as possible to that of the general population; b) support the goals of equality of opportunity, full participation, independent living, and economic self-sufficiency; and, c) ensure that state government is a model employer of individuals with disabilities.

Requires the goal of the comprehensive strategy to be to increase the capacity of state programs to support the employment related needs of individuals with disabilities by streamlining and expanding access to health care, work force investment, educational and other human resource services, activities, and programs.

Requires the California Workforce Investment Board (WIB) to monitor and enforce implementation of specified provisions of the federal Workforce Investment Act (WIA) of 1998 relating to nondiscrimination, and requires each local work force investment board choosing to participate to report to the WIB on the following: a) by July 1, 2002, on steps taken to ensure compliance with certain provisions of WIA as applied to persons with disabilities; and, b) by December 31, 2002, on its readiness to meet the eligibility standards to serve as an employment network under the federal Ticket to Work and Self-Sufficiency program.

Requires the Secretary to establish and staff a Workforce Inclusion Council, as described, and requires specified appointments to the Council.

Requires the Secretary, in collaboration with the Workforce Inclusion Council, to the extent funds are made available, to make grants available to counties and to local workforce investment boards (LWIs) to accomplish, through collaborative public and private organizations, the development of local strategies for enhancing employment opportunities for individuals with disabilities and to assist individuals with disabilities in removing barriers to work.

Extends eligibility for supportive services to persons who meet the income, disability and resource limitations for the Medi-Cal IHSS program but would otherwise be ineligible under current law because they elect to receive advance pay or because the provider of services is the spouse or a parent of a minor, to the extent that federal financial participation is available.

Establishes a new California Working Disabled (CWD) program, to take effect April 1, 2002, requiring DHS to adopt a new federal Medicaid option, including the following revised program requirements:

- Increases net countable income from 250% to 450% of the federal poverty level, and exempts the income of the individual's spouse or parent;
- Increases the resource limit to that allowed for community spouses, as specified;
- Adopts federal rules for averaging and determining adjusted gross income for self-employed persons;
- Permits individuals in the CWD program to have exempt resources in the form of moneys in designated independence accounts for the purpose of purchasing goods and services that increase the employability, independence or accessibility of the individual and requires the Department of Health Services (DHS), in consultation with the Department of Rehabilitation and the Council, to develop the rules and standards for these accounts;
- Limits sliding scale premium levels to conform to new federal requirements set at a minimum of \$20 per month for an individual or couple, not to exceed 7% of an individual's or couple's monthly gross income, and requires the premium to be reduced by the monthly amount of any health insurance premium paid by the individual, the individual's spouse or the individual's parent.

Expands the coverage of Medi-Cal personal care services to include services provided while the beneficiary is engaged in employment or educational or vocational training services so that, subject to federal approval, personal care services in these situations would be covered to the same extent that they would be covered in the home.

Status: *Chapter 1088, Statutes of 2002*

EMERGENCY MEDICAL SERVICES

SB 254 (Dunn) – Emergency Medical Services

(Amends Sections 1797.98a, 1797.98b, 1797.100, 1797.101, 1797.107, 1797.108, 1797.200, 1797.254, and 1798.161 of, to add Sections 1275.9, 1367.13, 1797.87, 1797.115, and 1797.251 to, and repeals Section 1798.166 of, the Health and Safety Code, adds Section 10126.7 to the Insurance Code, and amends Section 14106.6 of, and adds Section 14106.65 to, the Welfare and Institutions Code)

Seeks to stabilize the emergency medical services system by providing additional funding to facilities delivering emergency services.

Appropriates \$300 million from the General Fund to the Emergency Medical Services Authority, with \$200 million for critical emergency service facilities and \$100 million for payment of uncompensated emergency services provided by physicians and hospitals.

Creates the Critical Emergency Facility Fund for payments to critical emergency facilities and limits the portion of this Fund that can be used for administrative purposes

to no more than 10 percent. The money for uncompensated emergency care would be paid through county Maddy Emergency Medical Services (EMS) funds, and each county would be required to create such a fund.

Defines initial stabilizing services of emergency medical technicians to be a component of emergency medical services; and, requires health care service plans, disability insurers and Medi-Cal to reimburse EMS providers for initial stabilizing services provided to subscribers and enrollees in response to medical emergencies. Requires the Department of Health Services to annually update Medi-Cal reimbursements for advanced life support and basic life support ambulance services.

Status: Died in the Senate Appropriations Committee

SB 615 (Ortiz) - Medi-Cal and Healthy Families Program: Temporary Eligibility
(Adds Section 100132 to the Welfare and Institutions Code)

Creates an expedited enrollment mechanism to increase beneficiary participation in Medi-Cal and Healthy Families.

Directs the Department of Health services (DHS) to develop a screening instrument that hospitals which operate an emergency services department and community clinics may use to determine a patient's temporary eligibility for the Medi-Cal or Healthy Families program.

Specifies that the screening instrument must be simple and comprehensible to consumers must be easy to administer, and shall be available in languages spoken by a significant number of persons served by the provider. Requires that the screening instrument contain inquiries about factors that necessarily affect a person's Medi-Cal or Healthy Families program eligibility.

Permits hospitals that operate an emergency services department and community clinics to use the screening instrument developed by DHS. Requires participating providers to screen any person seeking care from a participating entity who chooses to be screened and to grant temporary eligibility to persons who meet the screening criteria. Requires that the screening be conducted after initial stabilizing services have been provided.

Requires that participating providers inform uninsured persons that they may be eligible for free or low-cost health insurance, that they can be screened for Medi-Cal or Healthy Families eligibility and that the screen may result in their temporary eligibility. Participating providers shall inquire if the person would like to be screened, and obtain the individual's written consent to the screening information being shared with the local Medi-Cal program or the entity that screens applications for the Healthy Families program.

Grants 60 days of temporary eligibility to each person who meets screening criteria. Considers the date of the screen as the date of application for purposes of determining Medi-Cal or Healthy Families eligibility.

Requires that participating providers forward information provided on the person's screen to the local agency that administers the Medi-Cal program or the entity that screens applications for the Healthy Families program within three days.

Authorizes the appropriate entities to contact applicants to request any additional necessary information. Requires providers to assist in the collection of necessary information. Prohibits the use of information contained in the screening instrument for any purpose other than determining eligibility and specifies who may access this information.

Specifies that persons granted temporary eligibility pursuant to this bill shall not be charged for any services received during the temporary period of eligibility. Requires DHS to monitor participating providers to ensure they are appropriately granting temporary eligibility. Entities that demonstrate a pattern of inappropriately qualifying applicants shall be ineligible for compensation for unqualified applicants from any fiscal source and shall be barred from conducting eligibility screens until the department reinstates the entity's ability to do so.

Status: Died in the Senate Appropriations Committee

SB 1134 (Escutia) - Drug Overdose Deaths

(Adds Sections 1797.8 and 1797.9 to, and adds Chapter 2.5, commencing with Section 11758, to Division 10.5 of, the Health and Safety Code)

Requires Emergency Medical Services (EMS) to adopt regulations that will allow EMT-I's to be trained in the administration of naloxone hydrochloride through intramuscular injection or by means other than intravenous administration no later than September 1, 2002.

Requires the regulations above and their implementation to be limited to projects ordered and supervised by a local emergency medical services medical director, in consultation with the local health officer of the affected county or counties.

Prohibits EMT-I's from undertaking naloxone hydrochloride administration except in a project coordinated and supervised by the director or as part of any project authorized by EMS.

Establishes within the agency the Drug Overdose Prevention, Recognition, and Response Program.

Requires the agency to convene a working group to develop guidelines for county medical examiners and coroners for specified purposes, including promoting uniform reporting of fatal drug overdose cases. Requires the agency to send the guidelines developed pursuant to this bill to county medical examiners and to the coroner of each county on or before July 1, 2003.

Requires the program, to publish a report on drug overdose trends statewide that reviews aggregate county and state death rates from available data set records, to ascertain changes in the causes or rates of fatal and nonfatal drug overdose for the preceding period of not less than five years, by December 31, 2002. Requires the report to also provide information on interventions that would be effective in reducing the rate of fatal or nonfatal drug overdose. Requires the program to make grants to support local drug overdose prevention, recognition, and response projects, and to approve grants according to criteria adopted by the program pursuant to this bill.

Requires the program to take into consideration the necessity for overdose prevention projects in various settings, and to encourage all grant applicants to develop interventions that will be effective and viable in their local areas.

Requires the program to consider specified areas to be priorities for funding when considering grant applications including policies and projects to encourage people, including drug users, to call 911 when they witness a potentially fatal drug overdose.

Requires the program to apply to private foundations, the federal government, and other sources to fund the grants under this bill and to fund an evaluation of the programs supported by the grants.

Status: Vetoed by the Governor

SB 1202 (Romero) - Emergency Medical Services: Statewide Trauma System

(Adds Article 5, commencing with Section 1798.190, to Chapter 6 of Division 2.5 of the Health and Safety Code)

Directs the Emergency Medical Services Authority to develop a statewide trauma system that requires local emergency medical services agencies to develop and implement a local trauma plan approved by the Authority. Requires local emergency medical services agencies to conduct system evaluations and to negotiate with acute care hospitals to enter into transfer agreements with designated trauma centers.

Requires every general acute care hospital that is not a designated trauma center to submit a plan to the local emergency medical services agency, subject to approval by the Authority, specifying how the hospital will respond to trauma patients, including plans for transferring patients to the nearest trauma center.

Requires hospitals participating in the trauma program to provide data on the number of trauma patients transported and treated to the local emergency medical services agency. Creates the California Trauma Relief Fund in the State Treasury to fund the development, coordination, oversight and evaluation of the statewide trauma system and to develop a coordinated statewide transportation system for hospitals and physicians.

Appropriates \$180 million to the California Trauma Relief Fund to be allocated to the Authority as follows:

- \$2 million to develop, coordinate, oversee and evaluate the statewide trauma system and to create a statewide trauma registry;
- \$9 million to local emergency medical services agencies for the development of local trauma plans, local trauma registries and local land and air transportation systems;
- \$169 million to local emergency medical services agencies to designated trauma centers or acute care hospitals that have an emergency department.

Status: Died in the Senate Appropriations Committee

SCA 12 (Perata) – Sales and Use Tax: Munitions: Hospital Emergency Departments and Certified Trauma Centers

(A resolution to propose to the people of the State of California an amendment to the Constitution of the State, by adding Section 36 to Article XIII)

Imposes one of two taxes:

- Establishes a tax of 5 cents for each "munition" sold at a retail establishment in this state, or
- Imposes an excise tax of 5 cents on the storage, use, or other consumption of "munition" purchased from an out-of-state retailer.

Defines "munition" as a projectile fired from a weapon or any individual component thereof. Excludes a BB or a pellet from the definition of munition.

Imposes these provisions effective January 1, 2003.

Exempts munition purchased by a peace officer required to carry a firearm or by any governmental law enforcement agency employing these officers from this tax.

Creates the Trauma Center Fund (fund) to capture revenues generated by this measure and appropriates these moneys to counties for trauma care. The monies from the fund are to be appropriated as follows:

Provides administrative costs for the Board of Equalization to implement this program-not to exceed 10% of the total amount deposited in the fund during a fiscal year. The balance of the fund shall be provided to the Emergency Medical Services Authority. The authority allocates funds, once a year, to local emergency medical service agencies to support hospital emergency departments and certified trauma centers. The authority allocates money based on guidelines outlined in the bill and written guidelines promulgated by the authority.

Status: Died in the Senate Revenue and Taxation Committee

AB 559 (Wiggins) – Emergency Medical Services

(Adds Section 4119.2 to the Business and Professions Code, adds Section 49414 to the Education Code, and adds Section 1797.197 to the Health and Safety Code)

Permits each public and private elementary and secondary school in the state to voluntarily determine whether or not to make emergency epinephrine auto-injectors and trained personnel available at its school. Permits the school, in making this determination, to evaluate the emergency medical response time to the school and determine whether initiating emergency medical services is an acceptable alternative to epinephrine auto-injectors and trained personnel.

Permits each public and private elementary and secondary school in the state to designate one or more school personnel on a voluntary basis to receive initial and annual refresher training regarding the storage and emergency use of an epinephrine auto-injector from the school nurse or other qualified person designated by the school district physician, the medical director of the local health department, or the local emergency medical services director.

Permits a pharmacy to furnish epinephrine auto-injectors to a school district or county office of education if the auto-injectors are furnished exclusively for use at a school district site or county office of education, and a physician provides a written order that specifies the quantity of auto-injectors to be furnished.

Requires the state Superintendent of Public Instruction (SPI) to establish minimum training standards for the administration of epinephrine auto-injectors that satisfy the requirements specified above, and requires the SPI, in establishing standards, to consult with organizations and providers with expertise in administering epinephrine auto-injectors, including the Department of Health Services, EMSA, the American Academy of Allergy, Asthma, and Immunology, the California School Nurses Organization, the California Medical Association, and the American Academy of Pediatrics.

Permits a school nurse, or if the school does not have a school nurse, a person who has received the required training, to obtain from the school district physician, the medical director of the local health department, or the local emergency medical services director a prescription for epinephrine auto-injectors.

Permits a school nurse, or if the school does not have a school nurse, a person who has received the required training, to immediately administer an epinephrine auto-injector to a person exhibiting potentially life-threatening symptoms of anaphylaxis at school or a school activity when a physician is not immediately available.

Requires a person who has received the required training or a school nurse to initiate emergency medical services or other appropriate medical follow-up in accordance with the written training materials.

Status: Chapter 458, Statutes of 2001

AB 687 (Thomson) - Emergency Medical Services: Trauma Care Systems

(Amends Section 1798.162 of the Health and Safety Code)

Requires any local emergency medical services agency that has an established emergency medical services program but has not implemented a trauma care system to implement such a system by January 1, 2005.

States that funds provided to local emergency medical services agencies for purposes of developing a trauma care plan shall offset the costs of this bill.

Status: Vetoed by the Governor

AB 883 (Florez) – Emergency Medical Services

(Amends Sections 1797.98a, 1797.98b, 1797.98c, and 1797.98e of, and adds Section 1797.98h to, the Health and Safety Code)

Specifies that each administering agency may maintain a reserve of up to 10 percent of the amount in the fund.

Clarifies that the amount in the fund, reduced by the amount of administration and the reserve, will be utilized to reimburse physicians, surgeons, and hospitals.

Provides that funding may be used for purchasing equipment and for capital projects only to the extent that expenditures support emergency services and are consistent with the extent of this chapter.

Specifies that if funding under the 58 percent allocation from the fund for emergency services provided by all physicians and surgeons is greater than the amount required to make all of the reimbursements permitted at the 50 percent rate (i.e., if there is a surplus available), then physicians and surgeons shall be reimbursed for an amount up to 75 percent of the amount claimed. This is additionally contingent upon whether there are sufficient funds available within the Physician Services Account.

Creates in the State Treasury the Emergency Medical Services Equalization Fund and requires that any funds not disbursed in a county's emergency medical services fund be remitted to it.

Requires the Emergency Medical Services Authority to, upon appropriation by the Legislature, allocate the Equalization Fund to each county for each fiscal year on the basis that the proportion of emergency room visits in the county in a fiscal year bears to the total number of emergency room visits in the State in that fiscal year.

Requires the county administering officer to establish an advisory committee, with representatives comprised of local physicians and hospital administrators, to review payment distribution methodologies to ensure fair and timely payments.

Status: Referred back to the Assembly Health Committee—Died in Committee

AB 1833 (Nakano) - Local Emergency Medical Services Funds

(Amends Sections 1797.98c and 1797.98e of the Health and Safety Code)

Modifies one of the conditions physicians must meet in order to bill the Maddy Fund by requiring the physician, instead of being required to make reasonable efforts to obtain reimbursement under existing law, to instead make two attempts to obtain reimbursement during a period of at least three months from the date the physician or surgeon billed the patient or responsible third party.

Requires each county to adopt a fee schedule and reimbursement methodology, to establish a uniform reasonable level of reimbursement.

Requires each administering agency of a Maddy Fund to make all reasonable efforts to notify physicians and surgeons who provide, or are likely to provide, emergency services in the county as to the availability of the Maddy Fund and the process by which to submit a claim against the Fund. Specifies that the administering agency may satisfy this requirement by sending materials to local medical societies, hospitals, emergency rooms or other organizations, and by posting material in visible locations.

Requires the time schedule for disbursements of moneys in the Maddy Fund to be on at least a quarterly, instead of annual, basis.

Status: Chapter 403, Statutes of 2002

AB 1988 (Diaz) - Emergency Medical Services Authority: Task Force: Emergency And Trauma Services

(An act relating to emergency medical services)

Requires Emergency Medical Services Authority (EMSA) to convene a task force of interested parties to study the delivery and provision of emergency medical services in California.

Requires the task force to do all of the following:

- Develop a plan to ensure that all Californians are served by appropriate coverage areas for emergency and trauma services and that sufficient numbers of emergency departments and trauma centers exist to serve each area's population. Requires the task force, if it determines that some areas lack coverage, to develop recommendations to extend coverage to those areas. Requires the plan to include specific consideration of and recommendations developed by the task force for ensuring access to emergency and trauma services for uninsured patients.
- Review emergency department and trauma center standards to ensure appropriate levels of care that maximize state resources and ensure coverage for all Californians including, but not limited to, the Department of Health Services (DHS) emergency department regulations and EMSA trauma center regulations.
- Review the roles, responsibilities, and interactions of the EMSA and DHS, related to emergency medical service oversight and administration.

- Submit a report that includes the plan described in paragraph above and the recommendations of the task force with regard to above to the Legislature within two years from the date that funding and positions have been provided for the project.

Requires the task force to be comprised of 24 additional appointed members as follows:

- Three members appointed by the Senate Committee on Rules, at least one of whom is a member of the Senate and at least one of whom is a public member.
- Three members appointed by the Speaker of the Assembly, at least one of whom is a member of the Assembly and at least one of whom is a public member.
- One representative each appointed by EMSA from lists provided by each of the following: California Medical Association, California Healthcare Association, American College of Emergency Physicians, California Professional Firefighters, Emergency Medical Services Administrators Association of California, California Nurses Association, California Ambulance Association, consumer organizations, Rural Healthcare Center, California Children's Hospital Association, Children's Specialty Care Coalition, California Association of Public Hospitals and Healthy Systems, California Emergency Nurses Association, California State Firefighters' Association, California Fire Chiefs Association, and the California Dental Association.
- One representative of organized labor appointed by EMSA.
- One representative from the State Department of Health Services appointed by the director of the department.

Implements the provisions of this bill only to the extent that EMSA obtains private funding needed to support and monitor the work of the task force.

Status: Chapter 333, Statutes of 2002

AB 2328 (Wayne) – Medical Experiments

(Amends Section 24178 of the Health and Safety Code)

Permits informed consent required for medical experimentation in a nonemergency room environment for incapacitated individuals be given by surrogate decisionmakers with reasonable knowledge of the subject. Restricts such surrogate decisions to medical experiments that relate to the cognitive impairment, lack of capacity, or serious or life threatening diseases and conditions of research participants. Authorizes the following persons in descending order of priority to act as surrogate decisionmakers: agents identified by an advance health directive; the conservator or legal guardian; the spouse; the domestic partner; an adult son or daughter; a custodial parent; any adult sibling; any adult grandchild; and available adult relative with the closest degree of kinship.

States that if two or more available surrogates in the same order of priority disagree, consent is considered not to have been given. States refusal to consent by a higher priority surrogate cannot be superceded by a lower priority surrogate.

Requires that emergency room environment obtain consent from the same priority list as specified above, with the exception of any adult grandchild or available adult relative with the closest degree of kinship. Provides that when there are two or more available persons, refusal to consent by one person shall not be superceded by any other of those persons.

Exempts from this section individuals who have been involuntarily committed pursuant to the Lanterman-Petris-Short Act and persons voluntarily committed or committed by a conservator to mental hospitals or institutions.

Exempts researcher/investigators who are conducting medical experiments within institutions which have an agreement with the United States Department of Health and Human Services pursuant to part 46, Title 45 of the Federal Code of Regulations, from other provisions of California statute, but requires compliance with informed consent provisions. Requires research pursuant to this section to comply with federal regulations.

Status: Chapter 477, Statutes of 2002

HEALTH CARE

SB 187 (Vasconcellos) – Medical Marijuana

(Adds Article 2.5, commencing with Section 11362.7, to Chapter 6 of Division 10 of the Health and Safety Code)

Requires the Department of Health Services (DHS) to establish and maintain a voluntary program for the issuance of identification cards (IC) to qualified patients who benefit from access to medical marijuana. Requires DHS to develop protocols that are required to be used by county health departments, application forms, and a IC that identifies a person authorized to use medical marijuana and a IC that identifies the person's designated primary caregiver. Prohibits a person or designated primary caregiver in possession of a valid IC from being subject to arrest for possession, transportation, delivery, or cultivation of medical marijuana in an amount approved by DHS.

Exempts certain legitimate patients and their caregivers from criminal liability under specified provisions of law relating to marijuana possession. Permits qualified patients, persons with valid ICs, and the designated primary caregivers to cultivate marijuana for medical purposes.

Requires DHS have the right to inspect the cultivation projects to ensure compliance with the methods, procedures, and criteria.

Prohibits a state or local law enforcement agency or officer from refusing to accept a IC issued by DHS unless the state or local law enforcement agency or officer has reasonable cause to believe that the information contained in the card is false.

States that nothing in this bill requires any accommodation of any medical use of marijuana on the property or premises of any place of employment or during the hours of employment or on the property or premises of any jail, correctional facility, or other type of penal institution.

States that nothing in this bill requires a governmental, private, or any other health insurance provider or health care service plan to be liable for any claim for reimbursement for the medical use of marijuana.

Status: Died on the Senate Floor Unfinished Business

SB 456 (Speier) – Health Insurance Portability and Accountability Act of 2001

(Adds and repeals Division 110, commencing with Section 130300, of the Health and Safety Code, and adds Items 9009-001-0890, 9909-001-0001, 9909-001-0495, and 9909-001-0988 to Section 2.00 of the Budget Act of 2001)

Establishes the Health Insurance Portability and Accountability Implementation Act (HIPAA) of 2001.

Requires the Office of HIPAA Implementation established by the Office of the Governor in the Health and Human Services Agency to assume statewide leadership, coordination, policy formulation, direction, and oversight responsibilities for HIPAA implementation, and exercise full authority relative to state entities to establish policy, provide direction to state entities, monitor progress, and report on implementation efforts.

Requires the Office to be under the supervision and control of a director, known as the Director of the Office of HIPAA Implementation, appointed by, and serving at the pleasure of, the Secretary of the Health and Human Services Agency.

Requires the Office to be staffed with a minimum of specified personnel and to perform the following functions:

- Standardize the HIPAA implementation process used in all state entities.
- Represent the state of California in HIPAA discussions with the federal Department of Health and Human Services (DHHS) and at the Workgroup for Electronic Data Interchange and other national and regional groups developing standards for HIPAA implementation, including those authorized by DHHS to receive comments related to HIPAA. Monitor HIPAA implementation activities of state entities and require these entities to report on their implementation activities at times specified by the director using a format prescribed by the director. Provide state entities with technical assistance as the director deems necessary and appropriate to advance the state's implementation of HIPAA as required by the schedule adopted by the federal DHHS. Conduct a periodic assessment at least once every three years to determine whether staff positions established in the Office and in other state entities to perform HIPAA compliance activities continue to be necessary or whether additional staff positions are required to complete these activities.
- Review and approve contracts relating to HIPAA to which a state entity is a party prior to the contract's effective date.

- Review and approve all HIPAA legislation proposed by state entities, other than state control agencies, prior to the proposal's review by any other entity and reviewing all analyses and positions, other than those prepared by state control agencies, on HIPAA related legislation being considered by either Congress or the Legislature.
- Ensure state departments claim federal funding for those activities that qualify under federal funding criteria.
- Establish a website that is accessible to the public to provide information in a consistent and accessible format concerning state HIPAA implementation activities, timeframes for completing those activities, HIPAA implementation requirements that have been met, and the promulgation of federal regulations pertaining to HIPAA implementation.

Requires the Office, in performing these functions, to coordinate its activities with the State Office of Privacy Protection.

Requires the director to establish an advisory committee to obtain information on statewide HIPAA implementation activities. Requires all state entities subject to HIPAA to complete an assessment, in a form specified by the Office, prior to January 1, 2002, to determine the impact of HIPAA on their operations.

Requires the Office to report the statewide results of the assessment to the appropriate policy and fiscal committees of the Legislature on or before May 15, 2002. Requires the Department of Finance (DOF) to provide a complete accounting of HIPAA expenditures made by all state entities. Requires DOF, in consultation with the Office, to develop and annually publish prior to August 1, guidelines for state entities to obtain additional HIPAA funding. Requires funding requests pertaining to information technology activities to also be reviewed and approved by the Department of Information Technology.

Requires DOF to notify the Office and the Chairperson of the Senate Committee on Budget and Fiscal Review, the Chairperson of the Assembly Budget Committee, and the Chairperson of the Joint Legislature Committee of each allocation it approves. Requires DOF to also report to the Legislature quarterly on HIPAA allocations, redirections, and expenditures, categorized by state entity and by project.

Requires, to the extent that funds are appropriated in the annual Budget Act, the Office to perform the following functions in order to comply with HIPAA requirements:

- Establish and support HIPAA project management offices;
- Develop, revise, and issue HIPAA compliance policies;
- Modify programs in accordance with any revised policies;
- Train staff on HIPAA compliance policies and programs;
- Coordinate and communicate with other affected entities;
- Modify or replace information technology systems; and,
- Consult with appropriate stakeholders.

Requires the provisions of this bill to remain in effect only until January 1, 2008, and as of that date are repealed, unless a later enacted statute, that is enacted before January 1, 2008, deletes or extends that date.

Adds sections to the Budget Act of 2001, via this bill, to appropriate over \$150 million in support of HIPAA activities for applicant state agencies, departments, boards, commissions, or other entities of state governments.

Requires, in the event that expenditures in support of HIPAA activities for applicant state agencies, departments, boards, commissions, or other entities of state government exceed the appropriations made by the Budget Act of 2001, DOF to utilize the Section 27 deficiency process.

Status: Chapter 635, Statutes of 2001

SB 1168 (Alpert) – Health Care Program: Consumer Assistance

(Adds Chapter 5.8, commencing with Section 18340, to Part 6 of Division 9 of the Welfare and Institutions Code)

Requires, on or before January 1, 2002, the Director of the Department of Health Services (DHS) to establish a process to allocate grant funding for independent health care consumer assistance projects targeted toward health care consumers within high-priority populations, as identified by a locally based process.

Requires, on or before July 1, 2002, not less than seven independent health care consumer assistance program grants in geographically distinct areas, if qualified applicants apply. Requires each approved project to serve a region containing not less than one county and not less than 650,000 residents, as estimated by the United States Census Bureau for county populations in July 1, 1999. Requires each region to be served by a single agency, and requires each project to serve local high-priority target populations identified in the application. Requires the target population to include persons who are income eligible for the Medi-Cal program or the Healthy Families program. Includes higher income consumers in counties with a population of less than nine million persons, as estimated by the United States Census Bureau, in the target population.

Requires program activities to include specified activities including:

- Outreach to eligible populations;
- Community education about health care consumer rights and responsibilities including the production and distribution of consumer-oriented material;
- Individual consumer assistance including counseling, advice, assistance, education, advocacy and policy advocacy on behalf of health care consumers with governmental agencies, health plans, health insurers, and health care providers;
- Individual assistance, policy analysis, advocacy, and community education on issues regarding eligibility, and enrollment in health care programs such as Medi-Cal, the Healthy Families program and county indigent health programs;

- Individual assistance, policy analysis, advocacy, and community education regarding how to obtain timely access to medically necessary, high-quality and appropriate health care services;
- Individual assistance, policy analysis, advocacy and community education on the health plan grievance process, the Medi-Cal fair hearing process, or other appeal, grievance, or review process applicable to the target population;
- Pursuing administrative, judicial or other remedies on behalf of health care consumers, or making referrals as appropriate; and,
- Establishing and operating a database.

Requires DHS to establish a competitive bidding process to select independent health care consumer assistance programs with specified criteria. Requires any independent health care consumer assistance program or statewide nongovernmental support program selected for funding to be a nonprofit corporation under Section 501(c)(3) of the Internal Revenue Code.

Requires any independent health care consumer assistance program or statewide nongovernmental support program selected for funding to be independent and not a part of any federal, state, or local government agency.

Prohibits any independent health care consumer assistance program or statewide nongovernment support program selected for funding from receiving more than 30% of its total funding from either health care plans or health care providers.

Requires DHS to provide necessary technical assistance and support to independent health care consumer assistance programs through funding to statewide nongovernmental support programs

Requires funding for services provided under this bill to be in the annual Budget Act. Requires the funding for a term of three years. Requires DHS to apply for qualifying matching federal funds, to the extent they are available, including but not limited to, Medi-Cal funding for administrative costs.

Status: Died in the Assembly Appropriations Committee

SB 1230 (Alpert) – Human Cloning

(Amends Sections 2260.5, 16004, and 16105 of the Business and Professions Code, and amends Section 24185 of, adds Section 24186 to, and repeals Section 24189 of, the Health and Safety Code)

Eliminates the sunset date of California's temporary ban on human reproductive cloning. Defines "human reproductive cloning" as the creation of a human fetus that is "substantially genetically identical to a previously born human being," and authorizes the Department of Health Services (DHS) to adopt, interpret, and update regulations to more precisely define procedures that constitute human reproductive cloning.

Requires that DHS establish a committee to advise the Legislature and the Governor on human cloning and other issues relating to human biotechnology. Specifies committee membership to include at least nine members who represent the areas of medicine, religion, biotechnology, genetics, law, and the general public. Requires three of the members to be independent bioethicists who possess specified qualifications.

Prohibits an independent bioethicist serving on the advisory committee from being employed by, consult with or have consulted with, or have any direct or indirect financial interest, in any corporation engaging in research relating to human cloning or human biotechnology.

Prohibits a person with any affiliation to the grant-funded cloning research programs operated by the University of California or the California State University from serving as a bioethicist on the advisory committee.

Requires that the committee report to the Legislature and the Governor on or before December 21, 2003 and annually thereafter.

Specifies that the activities of the committee shall, to the extent that funds are available, be funded by DHS out of existing resources.

Status: Chapter 821, Statutes of 2002

SB 1272 (Ortiz) – Stem Cell Research

(Adds Article 5, commencing with Section 125115, to Chapter 1 of Part 5 of Division 106 of the Health and Safety Code)

Finds that the United States has historically been a haven for scientific inquiry and technological innovation and that this environment coupled with a commitment of public and private resources has made the country a reigning leader in the fields of biomedicine and biotechnology.

Finds that the biomedical industry constitutes a significant portion of California's economy, employing over 225,000 Californians in over 2,500 companies, investing more than \$2.1 billion in research and creating \$12.8 billion in wages and salaries.

Finds that an estimated 128 million Americans suffer the economic and psychological burden of chronic, degenerative and acute diseases, and that the cost of these diseases constitutes billions of dollars every year.

Finds that stem cell research will provide a critical means to unlock fundamental questions of cellular biology and offers immense promise for developing new medical therapies to cure and treat debilitating diseases afflicting 128 million Americans.

Permits research involving the derivation and use of human embryonic stem cells, human embryonic germ cells and human adult stem cells, including research involving somatic cell nuclear transplantation.

Requires that stem cell research be reviewed by an approved Institutional Review Board.

Requires that individuals receiving infertility treatments be provided timely, relevant and appropriate information regarding the disposition of human embryos. Specifies information provided to include: storing unused embryos, donating them to another individual, discarding the embryos or donating the embryos for research.

Requires that individuals who elect to donate remaining embryos for research provide written consent.

Status: Died in the Assembly Health Committee. However, provisions of this measure were amended into SB 253—not heard in this Committee.

SB 1401 (Vincent) – Blood Products

(Amends Section 1626 of the Health and Safety Code)

Permits a hospital to use paid donor apheresis platelets if that hospital declares that, based on the prior year's availability, volunteers donated platelets are expected to be insufficient. Permits hospitals which contract for volunteer donated platelets to use paid donor platelets on a case-by-case basis.

Removes the December 31, 2002, sunset date exempting blood platelets from paid donors through the hemapheresis process, under specified conditions, from the current prohibition against using blood from paid donors.

Deletes legislative intent language, including language stating the intent of the Legislature that all health care providers who acquire blood platelets take appropriate steps to secure blood platelets from unpaid, volunteer donors to eliminate acquisition from paid donors.

Requires that paid apheresis platelets follow specified conditions and reporting requirements.

Status: Died in the Senate Health and Human Services Committee

SB 1414 (Speier) – Health Care Coverage

(Adds Division 100, commencing with Section 100000, to the Health and Safety Code, adds Section 12693.705 to the Insurance Code, amends Sections 14005.30 and 14011 of, adds Section 14005.41 to, and adds Sections 14005.41 and 14005.42 to the Welfare and Institutions Code)

Expands publicly funded health care coverage to provide health care benefits to all citizens and legal immigrants residing in California, and creates the Healthy California Program (HCP) to provide this coverage. Designates the Managed Risk Medical Insurance Board to administer HCP, conduct outreach programs, determine eligibility of applicants and monitor the quality of the program.

Proposes to expand coverage in two stages. The first includes consolidation and simplification of Medi-Cal, the Healthy Families Program and the Access for Infants and Mothers Program, and a federal waiver request to expand coverage to noncustodial adults with incomes up to 150 percent of the federal poverty level. The second stage would expand health insurance coverage to all uninsured citizens and legal residents.

Status: Died in the Senate Appropriations Committee

SB 1557 (Battin) – Human Cloning

(Amends Sections 2260.5, 16004, and 16105 of the Business and Professions Code, and amends Section 24185 of, to repeal Section 24189 of, and repeals and adds Section 24187 of, the Health and Safety Code)

Prohibits human reproductive cloning and therapeutic cloning. Therapeutic cloning involves somatic cell nuclear transplantation to produce embryonic stem cells and is closely associated with deriving therapies from stem cell research.

Defines "to clone a human being" as engaging in human asexual reproduction, accomplished by introducing nuclear material from one or more human somatic cells into a fertilized or unfertilized oocyte, which has had its nuclear material removed or inactivated so as to produce a living organism, at any stage of development, that is genetically virtually identical to a previously existing human organism.

Defines "asexual reproduction" as reproduction not initiated by the union of an oocyte and sperm, and "somatic cell" as a diploid cell having a complete set of chromosomes obtained from a human being at any stage of development.

Permits all scientific research that is not specifically prohibited by the Act. Prohibited research includes the use of cloning techniques to create human embryonic stem cells.

Eliminates the Department's authority to assess penalties for violations of California's human reproductive cloning ban and establishes criminal penalties for violations of up to \$1,000,000 for corporations, firms, clinics, hospitals, laboratories, or research facilities and \$250,000 for individuals.

Eliminates the sunset date of California's current ban on human reproductive cloning and of penalties associated with violations of the cloning ban.

Status: Failed Passage in the Senate Health and Human Services Committee

SB 2047 (Machado) – Health Services: Chronic Disease

(Adds Chapter 3.5, commencing with Section 104210, to Part 1 of Division 103 of the Health and Safety Code)

Requires the council to have 10 members with specified expertise, 6 appointed by the governor, 2 by the Speaker of the Assembly, and 2 by the Senate Rules Committee. Terms would be for four years.

Requires members to serve without compensation, but requires per diem of up to \$100 per meeting day for necessary travel and related expenses.

Gives the council the following responsibilities:

- Establish a baseline incidence of chronic disease in California and an inventory of existing DHS chronic disease prevention programs.
- Establish long-term goals and priorities for reducing the burden of chronic disease.
- Identify effective and successful chronic disease prevention strategies conducted by local, state, federal, and private agencies.
- Recommend effective strategies for achieving the state's goals and priorities.
- Promote information sharing and coordination among prevention programs.
- Periodically review and adjust the above.

Requires the council to submit an annual report to the Legislature and governor, starting December 31, 2004, on its activities and findings.

Specifies the bill shall be implemented to the extent that the department is able to support the council's efforts through existing General Fund dollars or from funding from private or federal sources.

Status: Vetoed by the Governor

AB 1461 (Aanestad) - Patient Safety Data Reporting and Analysis

(Adds and repeals Section 1157.8 of the Evidence Code, and adds and repeals Part 5.5, commencing with Section 128850, of Division 107 of the Health and Safety Code)

Makes various finding and declarations regarding the importance of collecting and analyzing health care outcome data and information on medical errors, and the relationship between data analysis and improving the quality of health care.

Requires the Office of Statewide Health Planning and Development (OSHPD) to contract with an experienced organization to create a database to receive and analyze information on medical events that compromise patient safety.

Defines a "medical event" as one that a reporter believes resulted, or could have resulted, in the occurrence or near occurrence of a compromise of patient safety by any health care professional, facility or organization licensed by the state.

Requires the contractor to design the elements of the reporting system by July 1, 2002, and to submit quarterly status reports starting July 1, 2003 to OSHPD and the Department of Health Services. The reports must include an analysis of reported data and recommendations for improving patient safety.

Exempts a reporter from civil or criminal liability for making a report.

Protects the identity of a medical event reporter, the reports made, and the data regarding medical events reported and collected from subpoena, disclosure or admissibility as evidence in a civil, administrative or other proceeding. Excepts from this protection any information upon which the report is based if that information exists independently of the reporting system and is otherwise discoverable under any other provision of law.

Specifies that the discovery protections do not preclude the discovery or admissibility of evidence from specified sources, including medical records and witnesses to a medical event.

Requires the contractor provided for under this bill to develop a medical event reporting form, for voluntary submission to the contractor, as specified, including a notice to the reporter that the report will not be made public and that making the report does not obviate their obligation to act or report this medical event under any other existing law

Requires the contractor, within 72 hours of receipt of a report, or within a timeframe to be determined by the contractor, in consultation with the advisory committee, to review the report and contact the reporter of the medical event, if necessary, to obtain additional information about the medical event, as specified.

Prohibits any supervisor or administrator of any health care professional, facility or organization from impeding or inhibiting the making of a report authorized by this bill and prohibits any sanctions related to reports under this bill.

Requires the administrative cost incurred by OSHPD in administering this bill, including the cost incurred by the organization contracting with OSHPD, to be funded from grants and donations from private or governmental entities. Specifies that the program will not be implemented until receipt of sufficient grants and donations to cover costs.

Status: Provisions Removed from Original Version Heard in Committee in 2001

HEALTH FACILITIES

SB 680 (Figueroa) - Health Facility Data

(Amends Sections 128735, 128737, 128745, 128750, 128755, and 128765 of, adds Sections 128747 and 128748 to, and repeals Section 1128815 of, the Health and Safety Code)

Adds "principal language spoken" to the data elements that hospitals are required to report to the Office of Statewide Health Planning and Development (OSHPD) as part of the Hospital Discharge Abstract Data Record, the Emergency Care Data Record, and the Ambulatory Surgery Data Record.

Requires OSHPD to report data for surgical procedures by individual hospital and individual surgeon, unless OSHPD determines that it is not appropriate to do so.

Deletes an existing requirement that reported procedures and conditions be divided equally among medical, surgical and obstetric conditions, and requires that reports be divided among these conditions.

Adds to specified criteria OSHPD must consider to select a condition on which to publish a report.

Requires OSHPD, in addition to any other established and pending reports, to publish a risk-adjusted outcome report by July 1, 2002, for coronary artery bypass graft (CABG) surgery by hospital for all hospitals opting to participate in the report. Requires OSHPD, commencing July 1, 2004, and every year thereafter, to publish risk-adjusted outcome reports for CABG surgery for all coronary artery bypass graft surgeries performed in the state. Requires OSHPD, for CABG surgery reports and any other outcome reports for which auditing is appropriate, to conduct periodic auditing of data at hospitals.

Requires OSHPD to publish in the annual risk-adjusted outcome reports the risk-adjusted mortality rate for each hospital, and for those reports that include physician reporting, for each physician.

Requires OSHPD to either include in the annual reports, or make separately available at cost to any person requesting it, risk-adjusted outcomes data assessing the statistical significance of hospital or surgeon data at each of the following three levels: 99% confidence level (0.01 p-value); 95% confidence level (0.05 p-value); and 90% confidence level (.10 p-value). Requires OSHPD to include any other analysis or comparisons of the data in the annual reports it deems appropriate to further the purposes of the provisions of law on hospital data.

Requires OSHPD to collect the minimum data necessary for purposes of testing or validating a risk-adjusted model. Prohibits OSHPD, except for specified purposes, from collecting data for an outcome report or from issuing an outcome report until the clinical panel established by this bill has approved the risk-adjusted model.

Requires, for each outcome report that includes reporting of data by an individual physician, OSHPD to appoint a clinical panel, which is required to have nine members, as specified. Requires that at least one-half of the appointees from the lists submitted by designated entities be experts in collecting and reporting outcome measurements for physicians or hospitals. The clinical panel shall review and approve the development of the risk-adjustment model to be used in preparation of the outcome report.

Requires any report that includes reporting by an individual physician to include, at a minimum, the risk-adjusted outcome data for each physician. Permits OSHPD to include in the report, after consultation with the clinical panel, any explanatory material, comparisons, groupings, and other information to facilitate consumer comprehension of the data.

Requires OSHPD, prior to the release of any outcome report that includes data by physician, to furnish a preliminary report to each physician that is included in the report and permits a physician who believes that the risk-adjusted outcome does not accurately reflect the quality of care provided by the physician to submit a statement to OSHPD explaining why the outcomes do not accurately reflect the care provided.

Requires OSHPD, upon notice that a physician is not satisfied with the conclusion reached by OSHPD, to forward the physician statement to the appropriate clinical panel. Requires the clinical panel to promptly review the physician statement and the conclusion of OSHPD, and to make a final determination regarding the physician statement. Requires the process set forth to be completed within 60 days from the date the office sends the report to the physician. Requires OSHPD to evaluate the impact of OSHPD's published risk-adjusted outcome reports required by this bill on mortality rates in California and on any other measure of quality OSHPD deems appropriate. Requires OSHPD to coordinate with other state agencies in promoting prevention and educational initiatives on reported procedures and conditions.

Requires all reports filed by OSHPD to include a simple executive summary that includes a discussion of findings, conclusions, and trends concerning the overall quality of medical outcomes. Requires OSHPD to disseminate the reports widely.

Deletes the inoperative date of June 30, 2004, and the repeal date of January 1, 2005, of the body of law requiring OSHPD to collect data and make reports.

Status: Chapter 898, Statutes of 2001

SB 842 (Speier) - Health Facilities: Seismic Building Standards

(Adds Sections 130060.5, 130060.7, 130062, 130062.3, 130062.5, and 130062.9 to the Health and Safety Code)

Requires, in addition to the extensions of January 1, 2008, structural performance deadline authorized under existing law, general acute care inpatient hospitals that comply with the 2030 hospital seismic compliance standards by no later than January 1, 2013, for all the hospital's buildings, to be granted a five-year delay for all their hospital buildings from the January 1, 2008, hospital seismic compliance requirements. Requires, in order to receive an extension of the 2008 deadline, a general acute care inpatient hospital to meet the requirements of the bill.

Requires on a case-by-case basis, if the hospital owner and the Office of Statewide Health Planning and Development (OSHPD) mutually agree on a work progress plan that extends the 2008 structural performance deadline to January 1, 2013, or an earlier mutually agreed to date, a general acute care inpatient hospital to have the option to comply with the 2008 structural performance deadlines by no later than January 1, 2013, or the earlier agreed to deadline.

Requires OSHPD, before agreeing to a work progress plan, to determine all of the following:

- The work progress plan contains a milestone timeline that is feasible and should reasonably result in the completion of work necessary to meet the January 1, 2013, structural performance deadline;
- The work progress plan gives priority to replacing or relocating services in those buildings determined by a seismic evaluation report to be of greatest potential risk of collapse, or to pose a significant risk of loss of life.

Requires, for any general acute care inpatient hospital that exercises its option pursuant to above, to file by January 1, 2003, a work progress plan that includes the anticipated date of completion of each milestone.

Requires OSHPD, in reviewing work progress plans and milestones for hospitals in the same geographic area, to identify the effect of potential service disruptions due to the interaction of work progress plans and advise the affected hospitals.

Requires that specified milestones, exclusive of proprietary information and trade secrets, be incorporated in the hospital's work progress plan.

Requires a hospital owner, commencing January 1st of the year subsequent to the establishment of a work progress plan, to file an annual progress report with OSHPD.

Requires OSHPD to be authorized, for any general acute care inpatient hospital subject to above that fails to comply with its milestones, to assess a penalty for each milestone missed in an amount between \$50 and \$100 per general acute care inpatient hospital staffed bed in the hospital. Caps the amount of the penalty at \$50,000 for the first milestone missed and \$100,000 for each subsequent milestone. Requires, in the event a milestone is missed, OSHPD to notify the hospital, and requires the hospital to have an additional 30 days following receipt of the notice to achieve the milestones without penalty. Permits a hospital to apply for a waiver of the penalty if the hospital demonstrates that the failure to comply was due to events not within its control or the control of its contractors. Requires all penalties collected be deposited into the Hospital Building Fund.

Requires OSHPD to report to the Legislature annually on the status of hospital compliance with seismic requirements and specifies information that must be included in the report.

Requires this bill to become operative on January 1, 2002, if two hospital seismic safety bond acts are enacted by the Legislature in 2001 and submitted to the voters at elections to be held in the 2004 calendar year and the 2006 calendar year.

Status: Provisions Removed from Original Version Heard in Committee in 2001

SB 928 (Dunn) – Health Facilities: Seismic Safety Financing

(Adds Chapter 1.5, commencing with Section 130075, to Part 7 of Division 107 of the Health and Safety Code)

Finds a vital public interest in maintaining the operations of hospitals following an earthquake. Finds compliance costs estimated to exceed \$24 billion, construction improvement costs approximately the value of the existing hospital structures, and finds hospitals unable to finance mandated construction. States legislative intent to form a state/hospital partnership to enable hospitals to comply with seismic safety standards.

Creates the Hospital Seismic Safety Bond Act of 2002 and authorizes the issuance of general obligation bonds totaling an unspecified amount. Finds and declares it necessary to establish a cost-sharing formula through which hospitals bear two-thirds of the costs of compliance and the state provides one-third through bond proceeds or other financing mechanisms.

Establishes the 2002 Hospital Seismic Safety Bond Fund in the State Treasury. Makes the fund available for appropriation by the Legislature for the purposes of this chapter which are necessary to meet seismic standards for the year 2008. Permits up to 1.5 percent of bond proceeds to be available for administration.

Directs the Office of Statewide Health Planning and Development (OSHPD) to classify each acute care hospital into one of six financial capacity categories based on the overall financial capacity of the individual hospital system of which the hospital is a member. Requires the OSHPD to contract with an independent entity to evaluate the financial capacity of the individual hospital to be paid by the hospital seeking the assistance.

States that priority shall be given to those hospitals that provide care to uninsured patients without expectation of compensation, that provide essential medical services in isolated communities, and those that provide essential community services not provided by other geographically proximate facilities and county and University of California Hospitals.

Exempts recipient hospitals from eligibility standards for other state and federal hospital construction/capital development programs but shall be subject to standards established to ensure the hospital is capable of repaying bonds.

Authorizes an unspecified bond issue for the purposes of this chapter. Makes such bonds a binding obligation of the state ensured by the full faith and credit of California.

Provides that no funds shall be created by this bill, no bonds issued or sold and no appropriation made.

Status: Provisions Removed from Original Version Heard in Committee in 2001

SB 1135 (Polanco) – Tissue Banks

(Amends Section 1639 of the Health and Safety Code)

Requires the Department of Health Services (DHS) to adopt, on or before July 1, 2004, rules and regulations governing licensed tissue banks engaged in the collection of human musculoskeletal tissue, skin, and veins for transplantation in humans.

Requires the regulations to be substantially based upon the criteria used by tissue bank trade associations in their respective accreditation process including, but not limited to, those of the Eye Bank Association of America and the American Association of Tissue Banks, and the scientific and technical data submitted by individual tissue banks.

Requires, rather than permits under current law, regulations adopted by DHS to include minimum standards for the following: safe preservation, transportation, storage, and handling of tissue acquired or used for transplantation; testing of donors to determine compatibility when appropriate; testing or assessment of donors to prevent the spread of disease through transplantation; equipment; methods; personnel qualifications; and, any other area concerning the operation or maintenance of a tissue bank, not inconsistent with this chapter, as may be necessary to carry out this chapter.

Requires DHS, on or before July 1, 2003, to report to the appropriate policy and fiscal committees of the Legislature regarding the status of the proposed regulations.

Status: Chapter 929, Statutes of 2002

SB 1394 (Ortiz) - Statewide Health Planning And Development: Hospitals: Charity Care Policies And Reporting Requirements

(Amends Sections 128735 of, and adds Article 3, commencing with Section 127400, to Chapter 2 of Part 2 of Division 107 of, the Health and Safety Code)

Defines "charity care" as medical treatment and diagnostic services delivered by a hospital for which a third party payer is not responsible and the patient has the inability to pay. Charity care shall not include bad debt, debt that has been referred to collectors, contractual shortfalls from government programs or care paid for by private third parties except for insurance co-payments or deductibles, or both.

Requires each hospital to develop a charity care policy that is in accordance with the requirements established by the Office of Statewide Health Planning and Development (OSHPD).

Requires hospitals to provide patients a notice of their charity care policy and to post their charity care policy in specified locations within the hospital.

Requires hospitals to attempt to obtain from patients whether they have insurance coverage that, at a minimum, would provide partial coverage for services received.

Requires that hospitals, as part of any billing include: a statement of charges for services rendered; a request that patients inform the hospital of their insurance coverage; a statement that patients without insurance may be eligible for specified public health insurance programs; information about how patients can obtain applications for public health insurance programs; information regarding the hospital's charity care application; and if at the time care was provided, the patient did not provide proof of insurance, an application for the charity care program.

Prohibits referral to collection for 120 days. During this delay the hospital can: bill patients, attempt to negotiate a payment plan, attempt to collect payment from third party payers, assist the patient in obtaining Medi-Cal or Healthy Families, and make a final determination regarding the patient's eligibility for charity care. At the time the hospital commences collection, the patient must be provided a notice that: outlines the patient's rights, provides information about non-profit counseling services in the area, and states that the patient can receive emergency care from the hospital regardless of the collection procedures.

Requires that hospitals make a reasonable effort to negotiate a payment plan prior to beginning collection, reporting bad debt to a credit-reporting agency, or suing the patient.

Requires hospitals to establish a reduced payment schedule, which specifies payment levels, general terms, and payment policies in relation to the family income of patients. Requires that the schedule be consistent with criteria established by OSHPD and take into consideration low-income patients' ability to pay. Specifies criteria OSHPD must consider when reviewing reduced payment schedules.

Establishes that the maximum payment a hospital can require from uninsured patient be consistent with the reduced payment schedule established by the hospital and approved by OSHPD.

Requires hospitals to report specified information to OSHPD regarding hospital charity care policies, the number of people who received charity care, and to report organizations a hospital is affiliated with.

Authorizes OSHPD to enforce charity care requirements. Defines penalties that OSHPD can impose to include: administrative penalties of not more than \$100 per day and for hospital overbilling of patients, an amount equal to the amount billed in error to the patient except as specified.

Status: Died on the Senate Floor

SB 1824 (Ortiz) - Long-Term Health Care Facilities: Status Changes and Patient Transfers

(Amend Section 1336.2 of the Health and Safety Code)

Requires the facility to obtain a medical, and a social and physical functioning assessment of each patient, prior to giving the patient notice of the transfer. The medical

assessment must be completed by the patient's attending physician. The social and physical functioning assessment must be completed by the facility nursing staff and activity director based on the minimum data set. The social and physical functioning assessment must also include recommendations for preventing adverse health consequences in the event of transfer, a recommendation for the type of facility that would best meet the resident's needs, and may be amended because of a change in the resident's health care needs.

Permits patients to remain in the facility for up to sixty days after the approved written notification of transfer if an appropriate placement has not been made, and imposes staffing requirements upon facilities under these conditions in order to ensure the well-being of the remaining patients.

Clarifies that the transfer plan submitted by the facility to the department becomes effective upon the date that the department grants its approval. If the department finds that the relocation plan does not comply with requirements, then the department must promptly notify the facility of its determination of non-compliance. Without an approved plan, the facility may not issue a notice of transfer.

Requires the department to monitor the facility's staging of transfers, and if the department determines that the staging is causing a detrimental impact on those patients being transferred, then the department must limit the number of patients being transferred per day until the department determines that it would be safe to increase the numbers.

Requires the facility's licensee to reimburse the Department of Health Services (DHS) for the cost of providing the relocation services, if the individual facility is not able to reimburse DHS.

Requires the department to request that the Attorney General seek injunctive relief and damages against a facility that fails to provide the specified relocation services.

Status: Died in the Assembly Health Committee. However, provisions were amended into SB 339 – not heard in this Committee.

HEALTH PERSONNEL

SB 317 (Ortiz) – Nursing Education

(Adds Chapter 6, commencing with Section 128500, to Part 3 of Division 107 of the Health and Safety Code)

Finds and declares that the current shortage of nurses is critical, and that without action, will jeopardize the public health. Finds California has the lowest ratio of nurses in the nation, finds nursing education at capacity, and finds that the state will experience a shortage of 26,000 nurses in the next four years. States intent of Legislature to expand the capacity of the educational system to train nurses and to support nurses through educational loans.

Creates the Registered Nursing Enhancement Grant Program to increase the number of nurse training positions and to provide additional medical services in underserved communities.

Directs the Commission to make recommendations on expenditures to ensure use of the funds exclusively for the education of nurses. The Commission is to create recommended criteria for award of grants and must consider costs, mentoring, clinical training opportunities, commitment to lower income and minority communities and criteria for special programs and evaluation. Requires the recommendations give priority to programs reaching students from all social and ethnic backgrounds, mentoring programs and sites with integrated clinical practice opportunities. Requires the Director of OSHPD to assure program quality and perform program evaluations in addition to administering the programs.

Creates the Registered Nursing Loan Forgiveness Program within OSHPD. The program forgives loans to recipient registered nursing students who agree to work for five years in medically underserved areas of this state. Authorizes OSHPD to accept private donations and to monitor and administer the program. Directs that loans be made available based on scholastic ability, financial need, geographic considerations, and willingness of student to work in underserved areas.

Appropriates \$122,300,000 from the General Fund to OSHPD. \$120,000,000 is appropriated for additional training slots, \$2,300,000 for student loans.

Status: Died in the Senate Appropriations Committee

SB 760 (Murray) – Medical Education

(Adds Article 5, commencing with Section 128050, to Chapter 2 of Part 3 of Division 107 of the Health and Safety Code)

Establishes the California Health Service Corps Loan Repayment Program within the Office of Statewide Health Planning and Development which shall operate in conjunction with the federal National Health Service Corps State Loan Repayment Program.

Permits a professional to participate in the program only if he or she provides full-time primary health services in a health professional shortage area or an area of the state where unmet priority needs for primary care family physicians exist. Provides that no matching funds are required from any entity in the practice site area.

Status: Vetoed by the Governor

AB 668 (Chan) – California Dentist Loan Forgiveness Program

(Adds Section 128040 to the Health and Safety Code)

Finds very serious unmet medical needs among California's children, noting that one half of this State's children have untreated tooth decay and two-thirds have periodontal disease. Finds current programs to place dentists in underserved areas to be ineffective and inadequate.

Requires the Office of Statewide Health Planning and Development (OSHPD) to report to the Legislature by June 30, 2002, on the feasibility of establishing a California Dentist Loan Forgiving Program (CDLFP) utilizing the same general guidelines applicable to the federal National Health Service Corps State Loan Repayment Program, as specified, except as follows:

- Requires a dentist to be eligible to participate in CDLFP if he or she provides full-time or half-time dental services in either a dental health professional shortage area, as defined by federal law, or an area of the State where unmet priority needs for dentists exist as determined by the Health Manpower Policy Commission, as specified.
- Requires matching funds to repay a portion of the dentist's outstanding loan amount to come from the practice site areas or from other private nonprofit sources;
- Requires a qualifying practice site to include a private dental practice.

Requires OSHPD to include in its report a projection of the dentist-to-population ratio to 2001; a determination of future dental needs in underserved communities; barriers to utilization of tuition loan repayment programs; and projected costs of dental education; recommendations on whether a CDLFP should be established and, if so, suggested funding sources. Requires OSHPD, in making its recommendations, to consider the impact of the program on access to dental services in areas of the State that currently have a shortage of dentists.

Status: Chapter 249, Statutes of 2001

AB 2194 (Jackson) - Obstetrics and Gynecology Residency Requirements

(Adds Section 123418 to the Health and Safety Code)

Requires all residency programs in obstetrics and gynecology, subject to all other provisions of the act, to comply with the program requirements for residency education in obstetrics and gynecology of the Accreditation Council for Graduate Medical Education.

Specifies that in addition to education and training in in-patient care, the program in obstetrics-gynecology be geared toward the development of competence in the provision of ambulatory primary health care for women, including, but not limited to, training in the performance of abortion services.

Status: Chapter 384, Statutes of 2002

MEDI-CAL, HEALTHY FAMILIES, AND OTHER PUBLIC HEALTH INSURANCE PROGRAMS

SB 59 (Escutia) – Healthy Families Program Demonstration Projects

(Adds Section 12693.915 to the Insurance Code)

Requires the Department of Health Services (DHS) and the Managed Risk Medical Insurance Board (MRMIB) to develop up to five new demonstration projects in urban or

rural areas that expand on the Rural Health Demonstration Projects. The purpose of these demonstration projects would be to fund health care providers and collaborative health care networks to target special populations experiencing health disparities.

Requires one demonstration project to target vulnerable populations including the immigrant population, the homeless population, populations living with HIV/AIDS, as well as other populations currently experiencing health disparities. Requires the providers who are funded to commit to assisting eligible individuals to enroll in Medi-Cal and the Healthy Families Program (HFP).

Requires one demonstration project to include a mechanism for compensating HFP providers for enabling services, which would include translation/interpretive services, child care, case management, mobile services, or eligibility assistance.

Requires one demonstration project to organize providers into organized networks to provide health care services to migrant populations as they move through the "migrant stream" during different seasons of the year.

Requires MRMIB and DHS to develop administrative processes, seek any federal waivers necessary, and implement emergency regulations to implement the bill, as specified.

Specifies that the contracts may include funds for purchasing equipment, making capital expenditures, and providing infrastructure; and title to any equipment or capital improvement shall vest in the grantee for the public good, and not the state.

Status: Chapter 800, Statutes of 2002

SB 98 (Kuehl) - Medicaid: Services for Persons with Dual Diagnoses

(Adds Section 14021.45 to the Welfare and Institutions Code)

Authorizes counties and cities to establish an integrated mental health/alcohol and drug treatment program for dually diagnosed Medi-Cal beneficiaries.

Specifies that those Medi-Cal beneficiaries residing in a participating city or county, who have a dual diagnosis of mental illness and alcohol and drug dependence, shall be eligible to receive specified treatment services, including inpatient and outpatient services and other diagnostic, screening, preventative, or remedial rehabilitative services, in either a clinic or community setting.

Requires that the integrated treatment services provided must be medically necessary and recommended by a physician or other licensed practitioner of the healing arts.

Requires the Department of Health Services (DMH) to submit by July 1, 2002, an amendment to the state's Medi-Cal plan to seek federal financial participation (federal matching funds) for the new dual diagnosis treatment services described in this bill.

Status: Died in the Senate Appropriations Committee

SB 146 (Haynes) – Medi-Cal: Prescription Drug Co-Payment and Billing Process

(Adds Sections 14105.46 and 14105.47 to the Welfare and Institutions Code)

Requires the Department of Health Services (DHS) to use an on-line process to determine Medi-Cal recipient eligibility, drug coverage, and whether payment will be covered when a pharmacy requests payment for any prescription or over-the-counter drug under the Medi-Cal program.

Directs DHS the Medi-Cal program to pay the copayments for drugs and office visits of persons eligible for both Medicare and Medi-Cal.

Status: Died in the Senate Appropriations Committee

SB 276 (Speier) – Schools to Provide Information on Free or Low-Cost Health Insurance

(Adds Section 48217 to the Education Code)

Requires school districts that are selected pursuant to a process implemented by each county office of education to ask the parent or guardian of each pupil each year, as part of the process for updating parental and pupil information, whether or not they would like the school to provide information and assistance in obtaining free or low-cost health insurance.

Requires parents and guardians in participating districts to be advised of specified information relative to the free and low-cost health insurance options available to families and the legal protections for information provided when applying for these programs.

Requires that all information provided by parents and guardians in applying for health insurance in participating districts is confidential and not to be used for any other purpose.

Requires participating school districts to provide information and assistance in obtaining low-cost health insurance through certified application assistants who may be employees of the district or a community-based organization working in partnership with the school district. Requires that information and assistance to be provided in the family's chosen language.

Requires the Department of Education to provide a method for distributing available funds to the 58 county offices of education.

Requires county offices of education to then implement an application and selection process in order to determine which school districts will be able to participate in the program.

Status: Provisions Removed from Original Version Heard in Committee in 2001

SB 285 (Soto) – Medi-Cal: Estate Claims

(Adds Section 366.4 to the Code of Civil Procedure, amends Sections 215 and 9202 of the Probate Code, and amends Section 14009.5 of the Welfare and Institutions Code)

Specifies that action to recover Medi-Cal costs from a deceased Medi-Cal recipient's estate or against a recipient of the property of that decedent must begin within one year after the recipient's death.

Prevents the Department of Health Services (DHS) from filing a claim against the estate of a surviving spouse after his/her death to pay for prior services to a deceased Medi-Cal recipient.

Clarifies that a DHS estate claim must be waived for undue hardship to dependents, heirs, distributees, or survivors, who have submitted an application for waiver or reduction of DHS' claim, based on published criteria that the state must establish.

Requires that waivers be granted consistent with DHS regulations that must, at a minimum, define "undue hardship" and consider specified criteria.

Requires DHS to consider it an undue hardship when a sibling, son, or daughter of a deceased Medi-Cal recipient lawfully resides in the recipient's home on a continuous basis, as specified.

Specifies that various disputes are subject to appeal by administrative law hearing or judicial review, as described.

Prevents DHS from taking action to enforce a recovery claim until final determination of a hardship application or other appeals.

Prohibits interest from accruing on any recovery claim until final adjudication of the claim.

Eliminates the requirement in the Probate Code that the estate attorney, or if there is no estate attorney, the beneficiary, the personal representative, or the person in possession of property of the decedent, shall give the Director of DHS notice of the decedent's death within 90 days of the death if the deceased person was the surviving spouse of a person who received health care under the Medi-Cal program.

Specifies that the bill's provisions apply to instances where the Medi-Cal recipient died on or after January 1, 2002.

Status: Died in the Senate Appropriations Committee

SB 344 (Ortiz) – Medi-Cal: Health Care Data Reporting

(Adds Article 1.3, commencing with Section 11024, to Chapter 1 of Part 3 of Division 9 of the Welfare and Institutions Code)

Requires, commencing March 1, 2002, the Department of Health Services (DHS) to post, monthly, on the Internet website maintained by DHS, 10 tables on the number of persons enrolled in the Medi-Cal program, including the number of children enrolled in all categories of the Medi-Cal program, by ethnicity, age and gender, to the extent collected, for 12 months of data. Requires the tables to provide different breakdowns of the Medi-Cal population by the various aid code categories. Requires some tables to differentiate between the family-based Medi-Cal programs where eligibility is conditioned on the presence of a child or pregnancy, and non-family based Medi-Cal programs where eligibility is conditioned on the presence of aged, blindness, or disability. Requires some tables to provide enrollment levels for the family-based programs, differentiating between beneficiaries in cash-related Medi-Cal programs and beneficiaries in non-cash-related Medi-Cal programs. Requires DHS to display on its web site the information required above by both statewide totals and county-by-county breakdowns, and requires the percentage increase or decrease in each county by month and by year to be shown.

Requires the information to be posted in a format that is simple, not technical, does not require downloading, and is likely to be easily understood by the general public.

Requires, commencing March 1, 2002, in addition to the information described above, DHS to post on its Internet web site in a format that may be easily understood by the general public, all of the following data:

- All county letters and county information notices prepared after January 1, 2002;
- Application forms for the following programs, to the extent available in computerized form: the Medi-Cal program; the California Children's Services Program; the Child Health and Disability Prevention Program; and, the Family Planning, Access, Care and Treatment Waiver Program, as specified.

Status: Chapter 276, Statutes of 2001

SB 443 (Perata) – Medi-Cal: Substance Abuse Programs

(Amends Section 11758.46 of the Health and Safety Code, and to amend Section 14021 of, and adds Section 14021.45 to, the Welfare and Institutions Code)

Expands the definition of drug Medi-Cal services to include outpatient drug-free services provided in a community setting, residential and day care rehabilitative services for clients other than pregnant and parenting women, and medication management.

Changes the drug Medi-Cal program from the clinic option to the rehabilitation option under federal Medicaid law. Limits the addition of the rehabilitation option to drug Medi-Cal providers who are certified.

Requires the Department of Drug and Alcohol Programs (DADP) to prepare by an unspecified date, amendments to the medical assistance state plan to expand the location

including home, school, and community-based sites, and type of therapeutic services offered under drug Medi-Cal available to states under the category of "other diagnostic, screening, preventative, and rehabilitative services"; expand federal financial participation (FFP) in alcohol and drug treatment services; expand FFP for services that meet the rehabilitation needs of alcohol or other drug dependent persons; and improve fiscal systems and accountability structures for drug Medi-Cal costs and rates.

Requires the above drug Medi-Cal state plan revision to be completed with review and comments by the County Alcohol and Drug Program Administrators Association of California and other appropriate groups.

Requires the Department of Health Services (DHS) to review DADP's state plan revision and submit it for federal approval if DHS approves it. If DHS does not approve it, requires DHS to report to the Joint Legislative Budget Committee by an unspecified date.

Specifies that the state and local funds required to match FFP may include, but not be limited to, drug Medi-Cal and other nonfederal funds at county discretion. Additional state General Fund monies shall be subject to appropriation in the annual Budget Act.

States legislative intent that the rehabilitation option become operative only after federal approval and a correction plan approved by DADP for audit issues identified for the Medi-Cal Drug Treatment Program has been submitted and the requirements of the section have been fully satisfied.

Requires DADP to review and revise the quality assurance standards and guidelines, as specified, if the plan is submitted for federal approval

Status: Died in the Senate Appropriations Committee

SB 493 (Sher) - Health Programs: Eligibility

(Adds Section 18925 to the Welfare and Institutions Code)

Finds that 1.3 million of California's 1.8 million uninsured children are eligible for the Medi-Cal or Healthy Families programs, that lack of insurance results in reduced access to medical and preventive services and increased reliance on emergency rooms, and that at least 50 percent of eligible but not enrolled children participate in public programs with similar eligibility guidelines, including the Food Stamp Program.

Declares the intent of the Legislature to create outreach and enrollment linkages between the Medi-Cal and Healthy Families programs and the Food Stamp Program to efficiently target eligible children and make the health insurance enrollment process more efficient for those in need of care.

Directs the Department of Health Services, in conjunction with the Department of Social Services, to implement a simplified eligibility process as part of the Food Stamp Program to expedite Medi-Cal and Healthy Families enrollment for food stamps beneficiaries who are eligible for but not enrolled in those programs.

Directs each county welfare department to:

- Develop a data list of family members residing in eligible food stamp households who are not enrolled in the Medi-Cal program or the Healthy Families Program.
- Develop a notice informing those individuals that they may be entitled to receive benefits under the two programs.
- To send notice to the individuals at the time of the food stamp household's annual recertification. Requires the notice is to include a request for permission to use the information in the food stamp recipient's case file to make a determination of eligibility for the Medi-Cal program and the Healthy Families program.

Requires the notice to be written in culturally and linguistically appropriate language and at an appropriate literacy level and include information on the Medi-Cal program, the Healthy Families Program, and a telephone number that food stamp recipients may call for additional information.

Requires the county welfare department to, using information in the food stamp case file, determine the Medi-Cal or Healthy Families eligibility of individuals who return the notice and express interest in being considered for the Medi-Cal program. Requires the county welfare department to request either orally or in writing any additional information necessary to establish Medi-Cal eligibility. Specifies that the Medi-Cal program application date shall be the date the notice is received by the county welfare department.

Status: Chapter 897, Statutes of 2001

SB 534 (Ortiz) – Medi-Cal for Independent Adults

(Adds Section 14005.41 to the Welfare and Institutions Code)

Expands the Medi-Cal program to provide no-cost Medi-Cal to independent adults whose income is below 200 percent of the federal poverty level.

Provides that the benefits and services and the definition of income and resources would mirror those currently provided to parents in the Medi-Cal 1931 program, the program that provides for eligibility for low-income families with children.

Defines independent adults as persons who are over 18 years of age and under 65 years of age, not pregnant, neither a parent nor a caretaker relative, and not eligible for the SSI/SSP program.

Requires the department to maximize federal reimbursement including seeking a waiver under Section 1115 of the Social Security Act.

Status: Died in the Senate Appropriations Committee

SB 599 (Chesbro) - Health Care Coverage: Substance Related Disorders

(Amends Section 1367.2 of the Health and Safety Code, and amends Section 10123.14 of the Insurance Code)

Requires every health plan that provides hospital, medical, or surgical expenses on a group or individual basis to provide coverage for the medically necessary treatment of substance-related disorders, with the exception of caffeine-related disorders, as listed in the Diagnostic and Statistical Manual of Mental Disorders IV, published by the American Psychiatric Association, in a nondiscriminatory manner on the same basis as any other medical care.

Requires health plans to provide the continuum of clinically effective and appropriate services and continuing treatment in a licensed facility or by a licensed physician, a licensed psychologist, a licensed marriage and family therapist or other provider licensed or certified in the treatment of substance related disorders.

Requires coverage and funding to be the same as benefits covering other physical illness, including medications, with the same cost-sharing provisions, deductibles, appropriate caps or limits on number of outpatient visits, residential or inpatient treatment days, payments, lifetime benefits, and catastrophic coverage.

Requires every health plan to communicate the availability of this coverage to all enrollees and to all prospective subscribers with whom they are negotiating.

Requires every health plan and its contracting entities to provide an augmentation for reimbursement to the providers of services required by this bill for any mandate for coverage contained in existing law regulating health plans that has been enacted after the date that a contract has been signed between the provider and the health plan or its contracting entity.

Prohibits a disability health insurer from seeking indemnity from its contracting providers or otherwise transferring to its contracting providers financial responsibility for any mandate set forth in this bill.

Prohibits a health care service plan that directly contracts with an individual provider or provider organization from delegating the risk-adjusted treatment cost of providing services under this bill unless specified requirements are met. Permits a health plan to limit nonhospital residential care to 60 days per calendar year. Defines "nonhospital residential care" as the provision of medical, nursing, counseling, or therapeutic services to patients suffering from substance-related disorders in a residential environment, according to individualized treatment plans.

Permits a health plan to provide coverage for all or part of the substance-related services required by this bill through a separate specialized health care service plan or substance abuse plan and prohibits the health plan from being required to obtain an additional or specialized license for this purpose.

Exempts from the provisions of this bill Medi-Cal, vision-only, dental-only, accident-only, hospital indemnity, Medicare supplement, specified disease, or long-term care coverage.

Status: Died on the Assembly Floor Inactive File

SB 615 (Ortiz) - Medi-Cal and Healthy Families Program: Temporary Eligibility

(Adds Section 100132 to the Welfare and Institutions Code)

Creates an expedited enrollment mechanism to increase beneficiary participation in Medi-Cal and Healthy Families.

Directs the Department of Health services (DHS) to develop a screening instrument that hospitals which operate an emergency services department and community clinics may use to determine a patient's temporary eligibility for the Medi-Cal or Healthy Families program.

Specifies that the screening instrument must be simple and comprehensible to consumers must be easy to administer, and shall be available in languages spoken by a significant number of persons served by the provider. Requires that the screening instrument contain inquiries about factors that necessarily affect a person's Medi-Cal or Healthy Families program eligibility.

Permits hospitals that operate an emergency services department and community clinics to use the screening instrument developed by DHS. Requires participating providers to screen any person seeking care from a participating entity who chooses to be screened and to grant temporary eligibility to persons who meet the screening criteria. Requires that the screening be conducted after initial stabilizing services have been provided.

Requires that participating providers inform uninsured persons that they may be eligible for free or low-cost health insurance, that they can be screened for Medi-Cal or Healthy Families eligibility and that the screen may result in their temporary eligibility. Participating providers shall inquire if the person would like to be screened, and obtain the individual's written consent to the screening information being shared with the local Medi-Cal program or the entity that screens applications for the Healthy Families program.

Grants 60 days of temporary eligibility to each person who meets screening criteria. Considers the date of the screen as the date of application for purposes of determining Medi-Cal or Healthy Families eligibility.

Requires that participating providers forward information provided on the person's screen to the local agency that administers the Medi-Cal program or the entity that screens applications for the Healthy Families program within three days.

Authorizes the appropriate entities to contact applicants to request any additional necessary information. Requires providers to assist in the collection of necessary

information. Prohibits the use of information contained in the screening instrument for any purpose other than determining eligibility and specifies who may access this information.

Specifies that persons granted temporary eligibility pursuant to this bill shall not be charged for any services received during the temporary period of eligibility.

Requires DHS to monitor participating providers to ensure they are appropriately granting temporary eligibility. Entities that demonstrate a pattern of inappropriately qualifying applicants shall be ineligible for compensation for unqualified applicants from any fiscal source and shall be barred from conducting eligibility screens until the department reinstates the entity's ability to do so.

Status: Died in the Senate Appropriations Committee

SB 622 (Ortiz) - Dental Services

(Adds Section 123281 to the Health and Safety Code)

Finds that oral diseases are the most prevalent diseases among California's children, that 27 percent of California's preschool children have untreated tooth decay and nine percent are in urgent need of dental treatment, that 55 percent of California's six to eight year olds suffer from untreated tooth decay and that children in ethnic and racial minorities have ever higher rates of tooth decay. Finds that over 51 million school hours and 164 million work hours are lost in the United States due to dental related illnesses.

Directs the Women, Infants, and Children (WIC) Special Nutrition Branch of the State Department of Health Services (DHS) to implement the Early Childhood Oral Health Program for WIC participants through grants to local programs administering WIC to augment services under the local WIC. Requires the use of grants to compensate staff time relating to enhanced interventions, supplies and equipment related to oral health services, and to reimburse personnel providing on-site screening and preventive services to WIC participants. Requires grantees to provide enhanced education and counseling, referrals and simple preventative treatments to WIC participants.

Requires DHS to provide, thorough training and technical assistance to grantees, updated information related to the prevention and recognition of early childhood caries (cavities), oral health practices that focus on prevention of oral diseases, referral sources for early childhood caries, conducting simple oral screenings of very young children, and providing basic preventive service onsite.

Requires DHS to conduct an evaluation of the early childhood dental outreach, education and preventive services program to determine the number of adults and children who received a dental screening, a referral to dental services and preventive dental services.

Status: Died in the Assembly Human Services Committee. However, provisions of this bill amended into SB 460--not heard in this committee.

SB 833 (Ortiz) - Medi-Cal Program: Eligibility

(Amends Section 14008.85 of the Welfare and Institutions Code)

Requires the Department of Health Services (DHS), by March 1, 2002 to submit a state plan amendment basing the definition of unemployment for purposes of Medi-Cal eligibility on the net nonexempt earned income of the principal wage earner only, and increasing the income level to 200 percent of the federal poverty level. Requires DHS to implement this definition of unemployment on the first day of the month following the second month after federal approval of the state plan amendment is received.

Requires implementation of above to be contingent upon receipt of approval of the State Child Health Insurance Program waiver described in a specified provision of law relating to providing coverage to uninsured parents and responsible adults.

Status: Vetoed by the Governor

SB 1413 (Chesbro) – Medi-Cal

(Amends Section 14087.325 of, and adds Section 14132.100 to, the Welfare and Institutions Code)

Prohibits the Department of Health Services (DHS), in calculating the capitation rates to be paid to specified entities, from including the additional dollar amount applicable to cost-based or prospective payment reimbursement, or that would otherwise be paid, absent cost-based or prospective payment reimbursement, to federally qualified health centers (FQHCs) and rural health clinics (RHCs) in the Medi-Cal fee-for-service program.

States that FQHC and RHC services are a Medi-Cal benefit.

Requires FQHCs and RHCs to be reimbursed on a per-visit basis as specified.

Requires that, effective October 1, 2003, and on each October 1, thereafter, FQHC and RHC per-visit rates be increased by the Medicare Economic Index (MEI) applicable to primary care services as specified in federal law. Requires that, prior to January 1, 2003, FQHC and RHC per visit rates to be adjusted by the MEI in accord with the methodology set forth in the state plan in effect on January 1, 2001.

Permits an FQHC or RHC to apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the center or clinic. Requires that rate changes based on a change in the scope of services provided by a center or clinic to be evaluated in accordance with Medicare reasonable cost principles, as specified. Defines the meaning of a change in scope of service. Permits providers to submit requests for scope of service changes once at any time during the clinic's fiscal year.

Requires providers to have the right to request a rate reconsideration if extraordinary circumstances beyond the control of the provider occur, and prospective payment system payments are insufficient due to these extraordinary circumstances. Defines meaning of

extraordinary circumstances. Defines the meaning of FQHC or RHC "visit" as specified. States that multiple visits on the same day are independently reimbursable if a clinic or center patient sees more than one health care professional of a different discipline or specialty, if a patient is treated for a different diagnosis.

Permits entities that first qualify as an FQHC or RHC in a center or clinic fiscal year ending in the year 2001 or later, and other specified FQHCs and RHCs, to have their rates calculated on a per-visit basis that is equal to the average of the per-visit rates of three comparable centers or clinics located in the same or adjacent area with a similar caseload.

Requires visits occurring at an intermittent clinic site, as specified, of an existing FQHC or RHC to be billed by and reimbursed at the same rate as the center or clinic establishing the intermittent clinic site, subject to the right of the center or clinic to request a scope of service adjustment to the rate.

Permits an FQHC or RHC to elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. Requires these costs to be adjusted out of the center or the clinic base rate as scope of service changes.

Permits FQHCs and RHCs to appeal a grievance or complaint concerning rate-setting, scope of service changes, settlement of cost report audits, payment of amounts due under this provision, or the processing or payment of money alleged by a provider of services to be payable as specified, notwithstanding any other provision of law.

Status: *Vetoed by the Governor*

SB 1414 (Speier) – Health Care Coverage

(Adds Division 100, commencing with Section 100000, to the Health and Safety Code, adds Section 12693.705 to the Insurance Code, amends Sections 14005.30 and 14011 of, adds Section 14005.41 to, and adds Sections 14005.41 and 14005.42 to the Welfare and Institutions Code)

Expands publicly funded health care coverage to provide health care benefits to all citizens and legal immigrants residing in California, and creates the Healthy California Program (HCP) to provide this coverage. Designates the Managed Risk Medical Insurance Board to administer HCP, conduct outreach programs, determine eligibility of applicants and monitor the quality of the program.

Proposes to expand coverage in two stages. The first includes consolidation and simplification of Medi-Cal, the Healthy Families Program and the Access for Infants and Mothers Program, and a federal waiver request to expand coverage to noncustodial adults with incomes up to 150 percent of the federal poverty level. The second stage would expand health insurance coverage to all uninsured citizens and legal residents.

Status: *Died in the Senate Appropriations Committee*

SB 1567 (Chesbro) – Medi-Cal

(Amends Section 14005.30 of, and adds Section 14005.42 to, the Welfare and Institutions Code)

Directs the Department of Health Services to exercise federal options to simplify Medi-Cal eligibility by exempting all resources in the determination of eligibility for all Medi-Cal programs serving parents, caretaker relatives and children up to age 21, as long as the applicants have incomes at or below 200% of the federal poverty level.

Status: Died in the Senate Appropriations Committee

AB 32 (Richman) – Health Care Coverage: Cal-Health Program

(Adds Part 6.25, commencing with Section 12694, to Division 2 of, the Insurance Code and to amend Section 14005.30 of, and to add Section 14005.42 to, the Welfare and Institutions Code)

Creates Cal-Health to coordinate Medi-Cal and Healthy Families Program (HFP) for the purpose of reducing administrative costs by simplifying and streamlining income and resource methodologies and other eligibility rules and application, enrollment, retention, and seamless bridging procedures between the two programs to ensure no disruption in coverage for eligible individuals. The duties and functions of Cal-Health would be carried out by the Department of Health Services (DHS) personnel and the Managed Risk Medical Insurance Board (MRMIB).

Requires, by July 1, 2002, the state to seek a Section 1115 federal waiver or exercise federal options that may be available to use federal Medicaid funds for Medi-Cal coverage for adults under 65 years of age who are not disabled and do not have a deprived child in the home and who have a family income at or below 250 percent of the federal poverty level (FPL).

Modifies the Cal-Health application and enrollment processes:

- In addition to any electronic application process, there would be a simple, uniform mail-in application and enrollment process.
- Participating providers would screen and temporarily enroll eligible individuals and initiate an accelerated enrollment process. The procedures governing the 60-day presumptive eligibility program for pregnant women would be used to implement the temporary enrollment of children.
- By July 1, 2002, the state would submit a federal waiver to permit providers to screen and temporarily enroll children, parents, and other adults who meet initial screening requirements into Medi-Cal and HFP for 90 days pending submission of an application and a final eligibility determination by DHS and MRMIB, using procedures that are similar to the accelerated enrollment procedures of the Family Planning, Access, Care and Treatment (PACT) waiver program.

Requires DHS and MRMIB to implement a pilot project by January 1, 2003, to assist small businesses in learning about health insurance products and costs, administering employer-sponsored coverage, and enrolling eligible individuals in Cal-Health.

Requires all medically necessary health care services rendered to individuals in Cal-Health by health care providers be reimbursed at rates applicable to those programs as otherwise required by law.

Requires MRMIB by January 1, 2003, to identify the benefits and suggest the design of a privately sold and marketed standard uniform benefit package that is more affordable and less expensive than products currently available in the private market.

Simplifies eligibility for Medi-Cal by exempting all resources and increase the income limit from 100% FPL to 133% FPL.

Requires the state to seek a waiver to provide any California resident who is an independent adult and whose income is at or below 250% FPL health care benefits and services.

Status: Died in the Senate Appropriations Committee

AB 59 (Cedillo) - Health Programs: Eligibility

(Amends Sections 49075, 49557, and 49558 of, and adds Section 49557.2 to, the Education Code, and adds Sections 10618.5 and 14005.41 to, the Welfare and Institutions Code)

Establishes a statewide pilot project to expedite Medi-Cal enrollment for children receiving free lunches through the National School Lunch Program, effective July 1, 2002. Creates a process to authorize consent for the release of information on applications for free lunches to county welfare departments, and authorizes them to quickly enroll children in Medi-Cal upon receipt of such information from school districts.

Authorizes immediate Medi-Cal enrollment of children, who are in families with incomes less than 100 percent of the federal poverty level, and require simplified additional information to determine if children in families over 100 percent are eligible for either Medi-Cal or the Healthy Families Program.

Requires county welfare departments to assist Food Stamp applicants with applying for Medi-Cal and provide information on the Healthy Families program to families that don't qualify for Medi-Cal.

Status: Chapter 894, Statutes of 2001

AB 482 (Cedillo) – Healthy Families Program

(Amends Sections 12693.02, 12693.14, and 12693.77 of, and adds Sections 12693.03 and 12693.435 to, the Insurance Code)

Expands the Healthy Families Program (HFP) to small employers under specified conditions.

Establishes for employees with a household income up to 250 percent of the federal poverty level (FPL), at or below \$21,475 for an individual, a state contribution equal to one-half of the premium for the health care coverage of the enrollee. Requires the employee to pay the same premium as adults who qualify under the proposed Healthy Families Program waiver, and requires the employer to pay for the remaining costs of the premium.

Defines "small employer" as a person, propriety or nonprofit firm, corporation, partnership, public agency, or association that is actively engaged in business or service that, on at least 50 percent of its working days during the preceding calendar quarter, or preceding calendar year, employed at least two, but not more than 50 eligible employees.

Allows a small employer to purchase coverage through the Healthy Families Program under specified conditions.

Specifies that it is an unfair labor practice and contrary to public policy for any employer to change an employee's salary or wages, or the employee-employer share-of-cost ratio based upon the employee's wage base or job classification, in order that the employee becomes eligible for the state share of premium provided by the HFP.

Permits the Managed Risk Medical Insurance Board (MRMIB) to establish enrollee co-payment levels for non-Medi-Cal or Access for Infants and Mothers Program (AIM) enrollees.

Requires MRMIB to coordinate the enrollment of eligible employees and dependents that have a household income at or below 250 percent FPL into Medi-Cal, Healthy Families, or AIM, whichever is applicable. Requires eligibility for those programs to be determined under the provisions of those programs. Requires the program to ensure that enrollees are not eligible for no-cost full-scope Medi-Cal.

States that any person who intentionally makes false declarations as to his or her or another's eligibility for which that person is not eligible shall be guilty of a misdemeanor.

States that any person who intentionally makes false declarations as to his or her or another person's eligibility may be denied coverage for up to one year from the date of the denial of coverage.

Implements the provisions of this bill only to the extent that funds are appropriated in the Budget Act for this purpose.

Status: Died in the Senate Insurance Committee

AB 495 (Diaz) – Health Care Coverage

(Adds Part 6.4, commencing with Section 12699.50, to Division 2 of the Insurance Code)

Establishes the Fund in the State Treasury. Requires the Fund and the provisions of this bill to be administered by the Managed Risk Medical Insurance Board (MRMIB), in

collaboration with the Department of Health Services (DHS). Requires the Fund to accept intergovernmental transfers (such as from a local government entity) as the nonfederal match required by the federal government for the Healthy Families Program (HFP).

Permits a county agency, a local initiative, or a county organized health system that will provide an intergovernmental transfer, to submit a proposal to MRMIB for funding for the purpose of providing comprehensive health insurance coverage to any child, under age 19, who meets citizenship and immigration status requirements and whose family income is at or below 300 percent of the federal poverty level (FPL) in specific geographic areas and who does not qualify for either Healthy Families or Medi-Cal. Permits the proposal to include an administrative mechanism for outreach and eligibility.

Permits the applicant to include in its proposal reimbursement for medical, dental, vision or mental health services delivered to Healthy Families-eligible children, if these services are part of an overall program with the measurable goal of enrolling served children in the HFP.

Provides that if a child is found eligible for benefits for the treatment of a medical condition by the California Children's Services Program, then a local or county entity applying for grant funding will not be responsible for the provision of this treatment.

Permits MRMIB, upon its approval of a proposal, to provide the applicant reimbursement in an amount equal to the amount that the applicant will contribute to implement the program described in its proposal, plus the appropriate and allowable amounts of federal State Child Health Insurance Program (SCHIP) funds (SCHIP funds are the federal funds matched for the Healthy Families Program).

Requires reimbursement provided from the Fund to consist of intergovernmental transfers from applicants and the appropriate and allowable federal SCHIP funds. Prohibits more than 10 percent of the Children's Health Initiative Matching Fund from being expended for administrative costs as well as the cost to the state to administer the proposal. Provides that reasonable start up costs for the program shall be reimbursed by those entities applying for grants. Defines "administrative costs" as those expenses that are not incurred for the direct provision of health benefits.

Permits MRMIB to audit the expenses incurred by the applicant in implementing its program to ensure that the expenditures comply with the provisions of this bill.

Requires each applicant that is provided funds under this bill to submit to MRMIB a plan to limit initial and continuing enrollment in its program in the event the amount of moneys for its program is insufficient to maintain health insurance coverage for those participating in the program.

Requires each health care service plan and specialized health care service plan that contracts to provide health care benefits under this bill to be licensed by the State Department of Managed Health Care, or be a county organized health system.

Permits MRMIB, in administering the provisions of this bill, to do all of the following:

- Administer the expenditure of moneys from the fund;
- Adopt regulations, including the adoption of emergency regulations, in accordance with the Administrative Procedure Act.

Requires all expenses incurred by MRMIB and DHS in administering the provisions of this bill to be paid from the fund.

States that nothing in this bill creates a right or an entitlement to the provision of health insurance coverage or health care benefits.

Requires the Governor, in collaboration with MRMIB and DHS, to apply for a federal waiver, or in coordination with MRMIB and DHS, to allow a county agency, local initiative, county organized health system, to apply for matching funds through the federal SCHIP program using local funds for the state match.

Implements the provisions of this bill only if all of the following conditions are met:

- Federal funds are appropriated for this purpose;
- Federal participation is approved;
- MRMIB determines that federal SCHIP funds will remain available in the relevant fiscal year after providing funds to all current enrollees and eligible children and parents that are likely to enroll in the Healthy Families Program in that fiscal year and rollover funds are determined to be available from the SCHIP.

Specifies that the state shall be held harmless for any federal disallowance, as specified.

Status: Chapter 648, Statutes of 2001

AB 574 (Salinas) – Medi-Cal: Overpayment Forgiveness

(Adds Sections 14176.5 and 14176.6 to the Welfare and Institutions Code)

Authorizes the Department of Health Services (DHS), whenever it has been determined by an audit conducted by DHS, that an overpayment for Medi-Cal services has been made to a hospital for services rendered from January 1, 1992, to December 31, 1997, to forgive all or part of the debt arising from the overpayment and interest, if the hospital meets all of the following criteria:

- Is a disproportionate share hospital (generally, a hospital that serves a large number of Medi-Cal and low-income patients);
- Is located in Kern County or Monterey County; and,
- Meets either of the following: is a nonprofit hospital, defined as a general acute care hospital or an acute psychiatric hospital owned and operated by a fund, foundation, or

corporation in which no part of the net earnings inure to the benefit of any private shareholder or individual; or, is not affiliated with a hospital system.

Status: Chapter 649, Statutes of 2001

AB 843 (Chan) - Medi-Cal: Newborn Children: Electronic Enrollment

(Adds Section 14001.45 to the Welfare and Institutions Code)

Directs the State Department of Health Services (DHS), when sufficient funding is available, to develop an electronic enrollment process to confirm, and enter into the Medi-Cal eligibility data system, information regarding the eligibility of a newborn child whose mother was eligible for and receiving Medi-Cal benefits on the date of the birth of the child, to the extent the child may be deemed eligible pursuant to federal law.

Authorizes DHS to designate, as necessary, those hospitals and other providers that may have access to the electronic process.

Requires, upon confirmation by DHS of whether or not a newborn child is deemed to be eligible for Medi-Cal benefits, the parent or parents of the child to be informed of one of the following:

- If the child meets the requirements of deemed eligibility, the parent or parents shall be informed of the newborn child's individual Medi-Cal number.
- If the child does not meet the requirements of deemed eligibility, the parent or parents shall be informed of the process by which to apply for Medi-Cal benefits for the newborn child.

Requires DHS to secure all necessary federal approvals in order to maximize federal financial participation.

Creates the Newborn Children Electronic Confirmation Fund in the State Treasury consisting of the following accounts:

- The Nonstate Public Funds Account, which shall consist of all public moneys from nonstate sources.
- The Special Funds Account, which shall consist of all funds received by the Controller from foundations and other nongovernmental sources and interest accrued thereon.

Provides that moneys in the fund may be expended by the department, upon appropriation by the Legislature, for the purposes of this section.

Authorizes DHS, to the extent permitted by law, to contract with qualified consultants to assist with the development of the electronic system.

Requires DHS to implement the provisions of this bill only to the extent allowable under federal law.

Status: Vetoed by the Governor

AB 915 (Frommer) – Hepatitis A: Immunizations

(Amends Section 120335 of, and adds Sections 1596.794, 120326.5, and 120327 to, the Health and Safety Code)

Makes findings and declarations, including:

- The Legislature's intent to prevent the spread of hepatitis A through the use of a vaccine.
- California's hepatitis A rates are "five times higher than the national average and disproportionately affects Latino and Native American populations..."
- Seasonal and migrant agricultural workers, food service workers, military veterans, and children are at particular risk.
- To not seek to prevent the spread of hepatitis A is to increase the risk to Californians already infected with hepatitis B or C, and others who are otherwise immunocompromised.
- Children between 5 and 14 years of age have the highest rates of disease and often pose a significant risk to adults by being asymptomatic carriers of the disease.
- The Center for Disease Control identified California as one of the 11 states where the hepatitis A rate is more than twice the national average, and recommends the routine vaccination of children in those states.

Requires children, in the Counties of Imperial, Los Angeles, Orange, Riverside, San Bernardino, and San Diego, to be immunized against hepatitis prior to entering kindergarten, beginning July 1, 2003, if funds are appropriated for this purpose.

Requires children, in counties in which the average annual rate of hepatitis A exceeds the minimum threshold for a community with high rates of the disease, to be immunized against hepatitis prior to entering kindergarten, beginning July 1, 2004, if funds are appropriated for this purpose.

Requires the director of the Department of Health Services (DHS) to develop and implement a public education and outreach program on hepatitis A and the importance of immunization of high-risk groups, as specified. Requires that the program:

- Coordinate with national public education efforts on hepatitis A;
- Stimulate public interest in, work with community-based organizations, to sponsor community forums and other community outreach activities;
- Include hepatitis A counseling and education, into local state-funded programs, including those on hepatitis C; and
- Report to the health committees of the Legislature on the effectiveness of the program and the prevalence of hepatitis A by July 1, 2004.

Creates the Hepatitis A Child Vaccination Services Fund in the state treasury to receive donations to the state to be used by DHS to reimburse costs incurred by health care providers who provide hepatitis A vaccines to children ineligible for the federal Vaccines for Children program, and are not covered by private insurance, Medi-Cal, Healthy Families, or the Child Health and Disability Prevention Program.

Prohibits the implementation of Section 3 of the bill (noted above) without sufficient funds for these purposes appropriated from the new Fund created by the bill, and prohibits the use of new General Fund money for these purposes.

Reinstates an exemption for "drop-in" day care centers from the requirement to maintain files regarding, and to verify, children's immunizations and tuberculosis testing.

Status: Provisions Removed from Original Version Heard in Committee in 2001

AB 969 (Chan) – Medi-Cal: In-Home Supportive Services

(Amends Section 14005.12 of the Welfare and Institutions Code)

Revises the income maintenance needs level (MNL) for the medically needy program (MNP), commencing April 1, 2002, by establishing the following amounts as the need level:

- For an aged, blind, or disabled person as defined under the SSI/SSP, a child in foster care or receiving adoption assistance, the MNL is 120 percent of the federal poverty level (FPL). (For a household of 1, this is equivalent to \$10,308 annual income);
- For a medically needy family person that includes a parent or caretaker relative who meets the deprivation requirement, child, or a pregnant woman, the MNL is 100 percent of the FPL. (For a household of 2, this equivalent to \$11,610 annual income);
- For family of two adults, the income level applicable to a family of three for both of the categories of individuals described above.

Provides for work incentive deductions for a medically needy person who is aged, disabled or blind person, in a medical institution or nursing facility or participating in a specified demonstration project for frail elderly persons, as specified. States that these earned income deductions, for purposes of determining the amount of a person's personal and incidental needs do not apply when the employer is the facility in which the Medi-Cal recipient lives. Provides that the amount disregarded shall constitute the amount by which the person's personal and incidental needs have been increased that month.

Provides, for the population in long-term care described above, deductions for personal and incidental expenses, may deduct mandatory fees and costs, such as checking account or check-writing fees, up to a maximum of \$10 per month.

Provides, for the population in long-term care described above, deductions for personal and incidental expenses, to include reasonable court approved guardian or conservatorship fees to the same extent allowed for Medi-Cal recipients not in long-term care. Provides that the amount disregarded shall constitute the amount by which the person's personal and incidental needs have been increased that month.

Requires the Department of Health Services (DHS) or other departments as required to seek federal approvals for federal financial participation for implementation of portions of this bill, as specified. Specifies that provisions of this bill can only be implemented to the extent federal financial participation is available.

Gives DHS or other state departments emergency regulation authority to implement the changes described above.

Requires the California Health and Human Services Agency to submit a report to the Legislature by January 1, 2003, on the feasibility of adopting a pilot project for a sliding-scale system of universal eligibility for in-home supportive services in counties that have adopted public authorities for the provision of those services, with services to be provided either through the In-Home Supportive Services Program or as personal care option services under the Medi-Cal Program.

Status: Died in the Senate Appropriations Committee

AB 1807 (Richman) - Medi-Cal: Healthy Families Program: Temporary Qualification: Accelerated Enrollment

(Adds Section 100133 to the Health and Safety Code)

Requires the Department of Health Services (DHS) to develop a one-page joint application form for the Health Families Program (HFP) and Medi-Cal to grant children presumptive eligibility. Specifies that the form must require applicants to provide the following information: the child's name and contact information, the name of the child's parent or guardian, specified income information, the child's and parent's or guardian's social security number if the child is applying for Medi-Cal, and that the child has not enrolled by this method within the last 12 months.

Requires the one-page form to request that a standard application to participate in HFP or Medi-Cal be completed on the child's behalf within 60 days after the date the one-page form is submitted to a health care provider.

Requires that HFP and Medi-Cal reimburse health care providers for services, and pharmacies for prescribed drugs, provided to children enrolled through the one-page form to the same extent and in the same manner as they would be reimbursed for a child who is fully enrolled and eligible, if the one-page form has been completed and declares an income that meets the HFP or Medi-Cal eligibility criteria.

Requires children who are temporarily qualified for HFP or Medi-Cal using this one-page form to be eligible for benefits for 60 days; limits children's eligibility using the one-page form to once during any 12-month period.

Requires health care providers to have access to the electronic application process and allows providers to screen, temporarily qualify, and initiate the accelerated enrollment of an individual. Requires providers who utilize this process to forward the one-page form to the Single Point of Entry within five days and to provide applicants with the complete Healthy Families and Medi-Cal applications.

Requires HFP and counties that receive the one-page form to conduct an eligibility determination. Authorizes the county and the HFP to contact the applicant to request additional information necessary to determine eligibility. Permits enrollment without

requiring a full application if the qualifying entity has all the necessary information to determine eligibility without requiring the applicant to complete a full program application.

Requires DHS to include the capacity to establish presumptive eligibility for children within any statewide electronic application process for Medi-Cal or Healthy Families.
Status: Died in the Senate Appropriations Committee

AB 2197 (Koretz) - Medi-Cal: Benefits For Persons Infected with HIV Who Are Not Disabled

(Adds Article 4.9, commencing with Section 14149, to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code)

States legislative intent to expand eligibility for Medi-Cal benefits, with the exception of prescription drug benefits provided by the AIDS Drug Assistance Program (ADAP), to persons with HIV who are not disabled.

Grants eligibility to individuals who are, and remain, enrolled in ADAP and who are not disabled, but who, if disabled, would qualify for Medi-Cal benefits.

States legislative intent to provide Medi-Cal benefits to at least 1,000 persons with HIV by the end of the first year of implementation of this bill.

Requires any person who is eligible for enrollment in Medi-Cal under this program to elect a Medi-Cal managed care plan in those counties in which a managed care plan is available except as specified.

Requires DHS to develop a program allocation method so those eligible individuals can be enrolled in Medi-Cal on a first-come, first-served basis.

Requires DHS to begin enrolling HIV patients into this program on July 1, 2003, or the date that all necessary federal waivers have been obtained, whichever is later.

Requires DHS to meet federal revenue neutrality requirements through the savings generated by the voluntary enrollment into Medi-Cal managed care of persons who are disabled as a result of AIDS, and who are either receiving Medi-Cal benefits on a fee-for-service basis as of January 1, 2003 or who become eligible to receive Medi-Cal benefits on or after January 1, 2003.

Authorizes DHS to implement other means of meeting the federal revenue neutrality requirements.

Requires DHS to encourage the voluntary enrollment into Medi-Cal managed care of persons who are disabled as a result of AIDS.

Requires DHS to conduct all outreach and awareness necessary to implement this bill.

Requires that DHS use the savings generated by increased voluntary enrollments in Medi-Cal managed care to fund enrollment in the program created by this bill.

Requires DHS to establish capitation rates to be paid to Medi-Cal Managed Care plans for services provided pursuant to this bill. Prohibits capitation rates from exceeding 95% of the FFS equivalent costs to the Medi-Cal program for medical services for persons with HIV.

States that DHS may not provide the Medi-Cal expansion until DHS can ensure sufficient savings equal to the cost of providing benefits to newly enrolled HIV patients.

Requires DHS to seek appropriate waivers from federal government. Requires the provisions of this bill to be implemented only if, and to the extent that, DHS determines that federal financial participation is available.

Status: Chapter 684, Statutes of 2002

AB 2674 (Chu) - Medi-Cal: Federally Qualified Health Centers: Primary Care Providers

(Amends Sections 14087.325 and 14105 of the Welfare and Institutions Code)

Requires any Medi-Cal Managed Care (MCMC) enrollee who selects, or is assigned to, a federally qualified health center (FQHC) or rural health clinic (RHC) to be assigned directly to the FQHC or RHC, and not to any individual provider performing services on behalf of the FQHC or RHC.

Requires Medi-Cal beneficiaries to be entitled to affirmatively select, or to be assigned by default to, any primary care provider as defined.

Requires when a Medi-Cal beneficiary is assigned to a primary care physician, and that primary care physician is an employee of a primary care provider, as defined, the assignment constitutes an assignment to the primary care provider.

Repeals requirement that FQHCs and RHCs must waive their rights to cost based reimbursement to participate in MCMC Risk contracts.

Indicates in statute that FQHCs and RHCs are capable and eligible for receiving Medi-Cal enrollee assignments and referrals. It allows assignment of a beneficiary to a clinic rather than an individual clinic provider. This proposal is intended to clarify the actual provider arrangement and ensure continuity of care for patients assigned to a clinic.

Clarifies that Medi-Cal beneficiaries can be assigned to FQHC/RHCs. It states that beneficiaries are entitled to affirmatively select, or to be assigned by default to, any primary care provider. It also requires that when a Medi-Cal beneficiary is assigned to a primary care physician, and that primary care physician is an employee of a primary care provider, that the assignment constitutes an assignment to the primary care provider. A

beneficiary who has established an on-going professional relationship with a clinic physician may be assigned to the physician rather than the clinic.

Repeals the requirement that FQHCs and RHCs must waive their rights to cost based reimbursement to participate in Medi-Cal Managed Care Risk contracts. This change brings California into compliance with federal law and reflects the change in clinic reimbursement methodologies following the introduction of the prospective payment system.

Status: Chapter 756, Statutes of 2002

AB 2739 (Chan) - Health Care Coverage: Multilingual Information and Services

(Repeals and adds Section 12693.30 of the Insurance Code, and to add Section 14093.06 to the Welfare and Institutions Code)

Requires the Managed Risk Medical Insurance Board (MRMIB), in the case of Health Families Program (HFP) and the Department of Health Services (DHS), in the case of Medi-Cal Managed Care (MCMC), to ensure that each contracting health plan provides language assistance services in threshold languages.

Defines threshold languages as follows:

- For the Healthy Families Program: Spanish, any language representing the preferred mode of communication for the lesser of 5% of the contracting plan's enrollment or 3,000 subscribers, and any other language, as determined by MRMIB, that meets a threshold below the lesser of 5% of enrollment or 3,000 subscribers.
- For the Medi-Cal Program: Primary languages spoken by limited English proficient population groups meeting a numeric threshold of 3,000 eligible limited English proficient (LEP) beneficiaries residing in a county, 1,000 eligible LEP beneficiaries residing in a single ZIP Code, or 1,500 LEP beneficiaries residing in two contiguous ZIP Codes.

Requires each health plan that contracts with HFP or MCMC to do all of the following:

- Develop and implement written policies and procedures for ensuring access to interpretation services for all its LEP beneficiaries or subscribers and require compliance by any network providers with these requirements;
- Provide 24-hour access to interpretation services for all LEP subscribers or beneficiaries seeking health services within the plan's network by either assigning the LEP subscriber or beneficiary to a provider able to provide health care services in the individual's primary language, or using onsite interpreters. Authorizes the provision of interpreting services by phone when other options are not feasible;
- Provide access to interpretation services at all key medical and non-medical points of contact;
- Implement written procedures to ensure that LEP beneficiaries are not subject to unreasonable delays in receiving health care services;
- Encourage the use of health care interpreters at all medical points of contact;

- Prohibit the use of minors as interpreters, except for only the most extraordinary circumstances, such as medical emergencies;
- Prohibit any requirement for any LEP beneficiary to, or suggestion that an LEP beneficiary must, provide his or her own interpreter; inform LEP beneficiaries in their primary language of the availability of language assistance services;
- Establish a system to record the language needs of subscribers or beneficiaries;
- Monitor and evaluate the effectiveness of its language assistance program;
- Translate all newly developed documents into Spanish and each threshold language within 90 days after the English version is approved by the board;
- Develop, implement, and maintain community linkages through the formation of a community advisory clinic; and
- Conduct a group needs assessment to develop and implement effective health education programs and C/L services and programs. Submit to MRMIB or DHS a summary report of the group needs assessment findings, which must examine specified topics.

Requires each contracting plan to report to the MRMIB annually, on or before February 1 of each year, regarding the linguistically and culturally appropriate services provided and proposed to be provided to meet the needs of LEP applicants and subscribers in the plan. Requires the report to address types of services, including, but not limited to, linguistically and culturally appropriate providers and clinics, interpreters, marketing materials, information packets, translated written materials, and referrals to culturally and linguistically appropriate community services and programs that are available to subscribers from the contracting plan, and also training and education activities for providers. Requires the report to also address the contracting plan's efforts to evaluate cultural and linguistic services and outcomes of cultural and linguistic activities, as part of the contracting plan's ongoing quality improvement efforts, through member complaints and grievances, membership satisfaction information, and other supplemental information. Requires the board to make the contracting plans' reports available to the public upon request.

Status: Vetoed by the Governor

MENTAL HEALTH

SB 30 (Chesbro) - Mental Health: Realignment Review Task Force

(An act relating to mental health)

Requires the Health and Human Services Agency (HHS) Task Force to examine the relationship between the state and counties as it relates to the delivery of mental health services, health services, and social services and related programs, with a goal of improving the ability of counties to provide these services. Requires this examination to include:

- Changes in the target population of these programs;

- The statutory, regulatory, or legal requirements that have been imposed on the affected programs since 1991;
- The inequity between available resources and service needs, any strategies for improving access to services; and,
- The sources of additional revenue to finance these services.

Requires the Task Force to be composed of the following members:

- The Secretary of HHSa or his or her designee;
- The Director of Mental Health or his or her designee;
- The Director of Social Services or his or her designee;
- The Director of Health Services or his or her designee;
- The Director of Finance or his or her designee;
- The Legislative Analyst or his or her designee;
- Two members of the Senate appointed by the Senate Committee on Rules;
- Two members of the Assembly appointed by the Speaker of the Assembly;
- One representative of a urban county and one representative of a rural county selected by the California State Association of Counties; and,
- Three representatives from counties, representing administrators in each of the following three disciplines; health services, mental health services, and social services. Requires these representatives to be selected by HHSa from persons recommended by the California State Association of Counties.

Requires the Task Force to establish a process, including the establishment of workgroups, through which system stakeholders have input to the Task Force deliberations. Requires the group of stakeholders to include, but not be limited to, statewide organizations representing primary consumers, family members, advocacy organizations, and service providers.

Requires the Task Force to present options regarding realignment to the Governor and the Legislature on or before April 1, 2002.

Status: Vetoed by the Governor

SB 98 (Kuehl) - Medicaid: Services for Persons with Dual Diagnoses

(Adds Section 14021.45 to the Welfare and Institutions Code)

Authorizes counties and cities to establish an integrated mental health/alcohol and drug treatment program for dually diagnosed Medi-Cal beneficiaries.

Specifies that those Medi-Cal beneficiaries residing in a participating city or county, who have a dual diagnosis of mental illness and alcohol and drug dependence, shall be eligible to receive specified treatment services, including inpatient and outpatient services and other diagnostic, screening, preventative, or remedial rehabilitative services, in either a clinic or community setting.

Requires that the integrated treatment services provided must be medically necessary and recommended by a physician or other licensed practitioner of the healing arts.

Requires the Department of Health Services to submit by July 1, 2002, an amendment to the state's Medi-Cal plan to seek federal financial participation (federal matching funds) for the new dual diagnosis treatment services described in this bill.

Requires DMH and the Department of Alcohol and Drug Program to jointly develop, by July 1, 2002, standards and guidelines for the integrated treatment services.

Status: Provisions Removed from Original Version Heard in Committee in 2001

SB 414 (Perata) - Mental Health: Dual Diagnosis

(Adds Part 3.5, commencing with Section 5820, to Division 5 of the Welfare and Institutions Code)

Requires the Department of Mental Health (DMH) to establish a Dual Diagnosis Competitive Grant Program for the purpose of awarding grants to both existing and new treatment programs for individuals with co-occurring disorders of mental illness and substance abuse.

States the goal of the grant program is to encourage successful and innovative programs aimed at patients with a dual diagnosis.

Requires DMH to establish criteria for awarding the grants, using the department's current request for assistance criteria or other criteria deemed appropriate by DMH. Requires the State Department of Alcohol and Drug programs to be consulted in the development of the criteria.

Specifies that the grants will be for a three-year time period and grantees shall be selected from diverse geographical areas throughout the state.

Requires DMH to evaluate the programs or contract for an evaluation and submit the findings in a report to the Legislature by March 30, 2004.

Status: Died in the Assembly Health Committee

SB 620 (Ortiz) – Suicide Treatment and Prevention

(Adds and repeals Section 4028 of the Welfare and Institutions Code)

Establishes the California Suicide Prevention Act of 2001, which requires the Department of Mental Health (DMH) to develop a comprehensive statewide plan (Plan) on the prevention of suicide. Permits DMH to use consultant services for this purpose. Requires the council to consider, as a model for the California strategy, the United States Surgeon General's National Suicide Prevention Strategy.

Requires DMH or the entity developing the Plan under contract with DMH, in order to ensure the involvement of diverse stakeholders in the development of the plan, to

convene a council of mental health and suicide prevention organizations. Requires DMH, in consultation with the council, to develop and submit to the Governor and the Legislature, by May 1, 2002, a statewide comprehensive suicide prevention strategic plan that is required to include specific measurable goals and proposed timelines for reaching those goals.

Permits the council, in the development of the strategic plan, to review the missions, as provided in statute, of major state mental health, health, aging, and school mental health programs and recommend, as necessary and appropriate, statutory changes to include suicide prevention in the mission statement of those programs.

Permits the membership of the council to include representatives of the following: Departments of Health Services, Alcohol and Drug Programs, Social Services, Education, and Aging, Board of Corrections; Department of the Youth Authority; County mental health and health departments; and, Local law enforcement.

Status: Died in the Assembly Appropriations Committee

SB 639 (Ortiz) - Alzheimer's Disease/Mental Health: Demonstration Projects

(Adds and repeals Chapter 7, commencing with Section 4099, to Part 1 of Division 4 of the Welfare and Institutions Code)

Makes findings and declarations that 70 percent of persons with Alzheimer's disease reside at home or in the community.

Makes findings and declarations that the progression of Alzheimer's disease and related dementia, may lead to acute psychiatric symptoms (such as anxiety, depression, hallucinations and agitation) that may cause the individual to be inappropriately incarcerated, hospitalized or prematurely moved to a higher level of institutional care.

Requires the California Health and Human Services Agency to develop a strategic plan for improving access to mental health services by persons with Alzheimer's disease or related disorders, for treatable mental health conditions.

Requires the plan to be developed with consultation and collaboration with the agency's Alzheimer's Disease and Related Disorders Advisory Committee, the California Mental Health Planning Council, the State Department of Mental Health, the California Department of Aging, the State Department of Health Services, the California Mental Health Directors Association, the California Council of the Alzheimer's Association, and other departments and organizations, as deemed appropriate by the agency, with expertise and experience in the unique needs of this population.

Requires the plan to be completed and a report submitted to the Legislature and the Governor no later than January 1, 2003.

Status: Chapter 692, Statutes of 2001 (Item Veto)

SB 931 (Burton) - Mental Health: Local Treatment Programs

(Adds Article 9, commencing with Section 5345, to Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code)

Requires the Department of Mental Health (DMH) to award grants to counties to improve the delivery and coordination of comprehensive services, supports and treatment for persons with mental illness who are discharged from a period of involuntary commitment, or are at risk of becoming involuntarily committed. The grants would be awarded for a four-year period to enable counties to develop local plans, then implement and evaluate programs.

Requires DMH to establish minimum standards and procedures for awarding grants and develop an equitable formula for allocating funds among eligible counties. In establishing the formula, DMH would consider an eligible county's number of clients potentially at risk of involuntary commitment and encourage multi-county collaborations. Specifies that grant funds must supplement, not supplant, funding for existing programs.

Requires that a county, to be eligible for a grant, would establish a local committee that includes, at a minimum, the county mental health director and representatives from law enforcement, drug and alcohol programs, health and social services, and client and advocacy organizations, and a superior court judge. The committee would evaluate existing services, identify service gaps (including unserved and underserved populations), develop a cost-effective and culturally competent expenditure plan for improving the delivery and coordination of comprehensive services, supports, and treatment to persons with mental illness who are discharged from involuntary commitment, or are at risk of involuntary commitment.

Allows counties in their expenditure plans to include funding for acquisition, renovation, or construction of needed facilities or infrastructure, or other one-time needs. Expenditure plans also would be required to include programs that maximize empowerment, recovery, voluntary engagement, noninstitutional settings and approaches, and independent and integrated living. Components of programs could include, but are not limited to: discharge planning, including the use of advance directives; peer counseling and self-help programs; family advocate services; emergency response teams and crisis residential programs; outreach workers; respite care; case management, money management assistance, assistance in obtaining eligibility for local, state, and federal programs for which the client is entitled; substance abuse treatment; suicide prevention; supportive and other housing assistance; transportation; vocational rehabilitation, and supportive employment services; social skills development programs; medically necessary medications to treat severe mental illnesses; patient rights advocates; clinical and treatment support for persons requiring long-term care; and any other treatment service or support that contributes to the ability of persons with mental illness to live successfully in the community.

Requires counties seeking grants to include in their plans, training for mental health providers, including but not limited to, mental health professionals, law enforcement

officials, and certification hearing officers involved in making treatment and involuntary commitment. The training would emphasize each patient's right to provide informed consent to assistance and would include:

- Information relative to legal requirements for detaining a person for involuntary in-patient treatment;
- Methods for ensuring that decisions regarding involuntary treatment, as provided for under the Lanterman-Petris-Short law, direct patients towards the most effective treatment.

Requires DMH to identify specific outcome and performance measures for programs and services funded through the 4-year grants. DMH would be required to submit to the Legislature a preliminary report on the effectiveness of the grant program no later than March 1, 2003, and to submit a final report no later than March 1, 2006. Requires DMH to establish consistent data reporting requirements regarding the involuntary treatment of persons with mental illness.

Status: Died in the Assembly Health Committee

SB 1448 (Chesbro) – Deceased Residents of State Hospitals and Developmental Centers

(Adds Section 4015 to the Welfare and Institutions Code)

Requires the Department of Mental Health (DMH) to conduct various inventories regarding persons who have died while residing at a state hospital or a state developmental center, including, within existing resources, identifying the location of gravesites on existing state hospital and developmental center lands or gravesites located on other lands designated by the state for burial of state hospital or developmental center residents. The inventories would also include the names and location of the remains of persons whose remains were donated for medical research.

Requires DMH to conduct the required inventories in coordination with a task force of specified organizations representing persons with disabilities and with other state entities including, but not limited to, the departments of General Services, Developmental Services, the Secretary of State, and the California State Library.

Requires DMH, in coordination with other state entities and the task force, to assist and cooperate with the California Memorial Project in conducting research regarding the records of deaths and burials of persons at state hospitals or developmental centers, and to grant access to state records as necessary to perform the inventories described in the bill.

Requires notwithstanding specified provisions of law relating to requiring specified patient information to be confidential, or any other provision of law regarding confidentiality of patient records, the information described in this section shall be limited to the name, date of birth, date of death, and photographic images of any person who died while in residency at any state hospital or developmental center to be made available for the purposes of the implementation of this bill.

Requires DMH to assist the California Memorial Project in developing a plan for the restoration of the gravesites and cemeteries on state hospital and developmental center grounds (or located on other lands designated by the state for burial of state hospital or developmental center residents). Requires DMH to develop a protocol for the future interment of patients who die while residing in a state hospital or developmental center and whose remains are not claimed by a family member. Permits DMH to develop a protocol to coordinate the efforts of the state entities described in the bill.

Requires DMH to establish a task force, with specified members, to provide direction in carrying out the requirements of this bill. Requires DMH to submit a progress report to the Legislature regarding the implementation of the bill, no later than January 31, 2004.

Status: Chapter 440, Statutes of 2002

SB 1911 (Ortiz) – Children’s Mental Health

(An act relating to mental health)

Requires the State Department of Mental Health (DMH) to develop (in consultation with the state departments of Health Services, Education, and Social Services, county welfare departments, county mental health departments, and advocates for children with mental health care needs) an analysis of the increased federal funding, and savings to the General Fund and the county mental health system, by applying for a federal Medicaid waiver or by adopting a state option to provide home- and community-based services, to children with mental health care needs. The waiver would apply to children for whom there has been a determination that, but for provision of home-and community-based services, the children would require the level of care provided in a hospital (due to the severity of their mental health care needs) the cost of which could be reimbursed under the state plan. Permits the State Department of Health Services (DHS) to also consider children who would require the level of care provided in a skilled nursing facility or intermediate care facility, to the extent permitted under federal law.

Requires the analysis to be submitted to the Legislature no later than 12 months after DHS receives sufficient funds to develop the analysis. Requires the analysis to do all of the following:

- Identify the number and diagnoses of the children that can be served under a federal Medicaid waiver or option;
- Identify services that can be provided to the population to be served under the federal Medicaid waiver or state option;
- Specify the eligibility criteria for obtaining services under the federal Medicaid waiver or state option;
- Discuss, to the extent possible, whether a waiver or state option could improve interagency coordination between foster care, juvenile justice, county mental health, and local educational agency programs;
- Determine whether a home- and community-based Medicaid option or waiver would provide cost benefits to the General Fund. Requires, in making this determination, DMH, in consultation, with the entities specified above, to consider (to the extent

relevant data is reasonably available) the nonfederal mental health treatment costs borne by state and local governmental agencies, including, but not limited to: mental health departments, foster care programs, local educational agencies, and juvenile justice programs;

- State whether a Medicaid home- and community-based services option, or waiver, will provide cost benefits to the General Fund. Requires, if DMH determines that the option or waiver will not provide cost benefits to the General Fund, the analysis to specify the reasons for the determination.

Specifies that the cost savings to be considered above for juvenile justice programs include, but are not limited to, the savings that would accrue by avoidance of juvenile justice placement, by the use of discharge planning, and by the provision of post-release services that would reduce future institutionalization, risk of out-of-home placement, or incidence of recommitment or reincarceration as a result of juvenile delinquency or criminal proceedings.

Permits DMH to contract with a nonprofit entity with a demonstrated history of expertise in analyzing and publishing data on California's public mental health system, to develop the analysis described in this bill. Permits DMH or contractor to also contract with a consultant for assistance in the development of the fiscal data necessary to complete the analysis, and in the preparation of a draft federal Medicaid waiver application for the State.

Authorizes, but does not require, DHS to submit to the appropriate federal agency a home- and community-based waiver application, or adopt a state home-and community-based services option, as appropriate, to provide services to the target population, if DMH, in consultation with DHS, the State Department of Finance, and the entities identified above determines based on the analysis developed pursuant to this bill that a Medicaid home-and community-based services option or a federal waiver will provide cost benefits to the General Fund.

Permits DMH to accept private nonstate donations to support the activities specified in this bill.

Status: Chapter 887, Statutes of 2002

SR 31 (Chesbro) – Relative to Psychiatric Facilities

States the intent of the Legislature to enact legislation to protect citizens from injuries, trauma and death when they are being held, often involuntarily, in isolation and/or restraints in a psychiatric facility.

Requires the Senate on Developmental Disabilities and Mental Health Select Committee to conduct hearings into California's existing standards governing the use of seclusion and restraints, oversight and reporting practices.

Requires the committee to conduct hearings regarding injuries, deaths and trauma cause by the use of seclusion and restraints in psychiatric facilities and the best practices developed in other states to reduce the use of seclusion and restraint.

Requires the committee to prepare a report on its findings and recommendations and submit the report to the Legislature by March 1, 2003.

Status: Adopted 2002

AB 328 (Salinas) – Mental Health Realignment: Reports

(An act relating to human services)

Requires the State Department of Mental Health (DMH) to work cooperatively with the California Mental Health Directors Association and other relevant parties to submit data on the current status of the county mental programs.

Requires this data, at a minimum, to address all of the following:

- The current structure and status of the financing of mental health services established in the statutes effected by Chapters 89, 91, and 611 of the Statutes of 1991, commonly referred to as realignment.
- Changes the current service delivery system of mental health programs that have occurred since the enactment of Chapters 89, 91, and 611 of the Statutes of 1991.
- Trends in the financial status and service delivery systems within county mental health programs.

Requires DMH, by April 1, 2002, to submit the data to the Legislature.

Status: Chapter 367, Statutes of 2001

AB 334 (Steinberg) - Mental Health Funding: Local Grants

(Amends Sections 5806, 5811, 5814, and 5814.5 of the Welfare and Institutions Code)

Clarifies that all the specified service standards established for the county demonstration grant program be met by counties.

Specifies that recipients of outreach services may include families; the public; primary care physicians; and others likely to come into contact with individuals who may be suffering from an untreated severe mental illness who would likely become homeless if the illness continued to be untreated for a substantial period of time.

Permits outreach to adults voluntarily or involuntarily hospitalized as a result of a severe mental illness.

Revises service standards to include provision of services to clients who have been suffering from an untreated severe mental illness for less than one year, and who do not require the full range of services, but who are at risk of becoming homeless unless a comprehensive individual and family support services plan is implemented. Requires these clients to be served in a manner that is designed to meet their needs.

Expands the training, consultation, and technical assistance of the Department of Mental Health (DMH) is currently required to provide to counties participating in the grant program to include:

- Efforts to ensure that all of the different programs are operating as well as they can;
- Information on which programs are having particular success in particular areas so that they can be replicated in other counties; and
- Technical assistance to the counties in their first two years of participation to ensure quality and cost-effective service.

Requires the DMH grant program advisory committee to annually provide written comments on the performance of each county program and, if requested by DMH, requires each participating county to provide a written response to the advisory committee's comments.

Adds to the information DMH must include in the annual report to the Legislature the extent to which county grant programs funded for three or more years are making a measurable and significant difference on the street, in hospitals, and in jails, as compared to other counties or as compared to those counties in previous years.

Requires, before a city or county submits a proposal to the state to establish or expand a grant program, that the proposal must be reviewed by a local advisory committee or mental health board (which may be an existing advisory body). Also, requires the local advisory committee to include clients, family members, private providers of services, and other relevant stakeholders.

Makes various legislative declarations and findings relating to the efficacy of providing mental health and related services to persons who are mentally ill and homeless.

Status: Chapter 454, Statutes of 2001

AB 470 (Chu) - Mental Health: Involuntary Confinement: Psychologists

(Amends Sections 5152, 5154, 5257, 5259.3, 5264, 5267, 5270.35, and 5309 of the Welfare and Institutions Code)

Adds psychologists to various provisions of law, currently applicable to psychiatrists, that permit release of persons from involuntary commitment, before the end of the maximum time period the person may be held without additional court action (i.e., before the end of the "up to" 72-hour, 14-day period of intensive treatment, or 30 days of treatment, etc.). As with current law applicable to psychiatrists, the early release would be permitted when the psychologist directly responsible for the person's treatment believes, as a result of his or her personal observations, that the person is no longer a danger to self or others or is no longer gravely disabled, or if the person agrees to voluntarily accept treatment or agrees to remain in the facility on a voluntary basis.

Prohibits psychologists, in addition to psychiatrists, from being held civilly or criminally liable for any action by a person released before the end of the maximum commitment

period (72 hours, 14-days, 30-days, etc.), if the provisions of law relating to the release of a person who has been admitted for treatment and evaluation have been met.

Makes various other technical non-substantive amendments.

Status: Referred back to Assembly Health Committee. Died in Committee.

AB 1156 (Aroner) - Mental Health: Community Treatment Facilities: Program Standards: Seclusion And Restraints

(Amends Sections 4094 and 4094.1 of the Welfare and Institutions Code)

Makes various findings and declarations related to the use of emergency interventions in group homes and Community Treatment Facilities (CTFs), the goals and the role of CTFs in treating severely emotionally disturbed youth, and the scope of work to be completed by the Senate Select Committee on Developmental Disabilities and Mental Health on the use of seclusion and restraints in California.

Specifies that until legislation is enacted resulting from the report on seclusion and restraint by the Senate Select Committee on Developmental Disabilities and Mental Health, or until January 1, 2004, whichever occurs first, the following conditions will apply for CTFs:

- The State Department of Mental Health (DMH) is prohibited from adopting or enforcing regulations on the use of emergency interventions in CTFs that are in addition to, or more stringent than, the regulations applicable to the use of emergency interventions in group homes.
- CTFs that use emergency interventions are not required to have 24-hour onsite licensed nursing staff, but must retain at least one full-time registered nurse on staff.
- The use of mechanical restraints is prohibited in CTFs.

Other nursing staff will be available on call to provide nursing services, when necessary, within one hour. Declares the intent of the Legislature that DMH and the State Department of Social Services (DSS), in consultation with CTF providers and pertinent stakeholders, review existing reporting requirements related to the use of seclusion and restraints to ensure that they are clear, consistent, and accurate.

Declares the intent of the Legislature that DMH and DSS, in consultation with CTF providers and pertinent stakeholders, review existing training requirements related to the use of seclusion and restraint to ensure that they protect and promote the health of children.

Status: Vetoed by the Governor

AB 1347 (Pescetti) – Dementia Caregiver Training

(Adds Section 1263 to the Health and Safety Code)

Requires Certified Nurse Assistants (CNAs) employed by a skilled nursing facility (SNF) or intermediate care facility (ICF) to complete at least two hours of dementia-specific training as part of the facility's orientation program.

Requires SNF and ICF facilities to develop a dementia-specific training component within the existing orientation program, to be implemented no later than July 1, 2002.

Requires the Department of Health Services to review each facility's modified orientation program in a phase-in schedule that begins no later than July 1, 2002, and is completed no later than July 1, 2005.

Requires CNAs employed by a SNF or ICF to complete five hours of dementia-specific in-service training per year, as part of the facility's in-service training requirements.

Exempts free-standing and hospital-based pediatric SNFs with exclusively pediatric occupancy from these requirements.

Status: *Chapter 339, Statutes of 2001*

AB 1421 (Thomson) – Mental Health: Involuntary Treatment

(Adds and repeals Article 9, commencing with Section 5345, of Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code)

Authorizes, in participating counties, a court to order a person age 18 or older into assisted outpatient treatment (AOT) if the court finds by clear and convincing evidence that all of the following criteria are met: The person is suffering from a serious mental illness, as defined in existing law, and is unlikely to survive safely in the community without supervision, based on a clinical determination:

- The person has a history of lack of compliance with treatment for mental illness that has: at least twice within the last 36 months been a substantial factor in necessitating hospitalization, treatment in a mental health unit of a correctional facility, or incarceration (not including any hospitalization or incarceration immediately preceding the filing of the petition); or resulted in one or more acts, attempts, or threats of serious violent behavior toward self or others, within the last 48 months (not including any hospitalization or incarceration immediately preceding the filing of the petition).
- The county mental health director or designee has offered the person an opportunity to participate in a treatment plan, the person continues to fail to engage in treatment, and the person's condition is substantially deteriorating.
- In view of the person's treatment history and current behavior, the person is in need of AOT in order to prevent a relapse or deterioration which would be likely to result in grave disability or serious harm to the person or others as defined in Section 5150.
- Assisted outpatient treatment would be the least restrictive placement necessary to ensure the person's recovery and stability, and the person is likely to benefit from the treatment.

Allows a request for the filing of a petition for an AOT order to be made to the county mental health department by (1) an adult living with the person who is the subject of the petition; (2) the parent, spouse, sibling, or adult child of that person; or (3) specified mental health and law enforcement personnel. Requires the county mental health director

or designee to investigate the request, including conducting an examination of the person who is the subject of the petition, and to file the petition only upon a determination that there is a reasonable likelihood that all the necessary elements to sustain the petition can be proved by clear and convincing evidence.

Requires the court to hold a hearing within five court days of receipt of the petition (conducted in accordance with the rules of evidence), and would permit the court to conduct the hearing in the person's absence, if the person fails to appear after appropriate notice. Provides that, if the person refused to be examined during the petition examination, the court may request that the person consent to such an examination, and if the person still refuses and the court believes an examination is warranted, the court may order the person to be taken into custody for up to 72 hours for examination by a licensed mental health provider as soon as is practicable. Provides that the person who is the subject of an AOT petition would have the rights to (1) adequate notice of the hearing; (2) a copy of the court ordered evaluation; (3) legal representation at all stages of the proceedings (by the public defender, if the person has not retained counsel); and (4) at the hearing, to be present, to call or cross-examine witnesses, and to appeal decisions.

Requires the court, if it finds that the person meets the AOT criteria, to order the person to receive AOT services, set forth in a written treatment plan as specified, for an initial period not to exceed six months.

Provides that AOT services shall not be ordered unless the court finds, in consultation with the mental health director or designee, that the specified services are available in the county.

Provides that, if in the clinical judgment of a licensed mental health treatment provider, a person ordered into an AOT program has failed or refused to comply with the order, efforts were made to solicit compliance, and the person may be in need of involuntary admission to a hospital pursuant to this bill, the provider may request that person be detained up to 72 hours for evaluation by a licensed mental health treatment provider to determine if the person is in need of involuntary treatment pursuant to Section 5150.

Requires that, if at any time during the 72-hour hold the person is determined not to meet the criteria for a 72-hour hold, and does not agree to stay in the hospital as a voluntary patient, the person shall be released, and any subsequent involuntary retention in a hospital shall be pursuant to Section 5150. Failure to comply with an AOT order alone shall not be grounds for involuntary civil commitment or a finding of contempt of court. Provides that, if the person refuses to begin the AOT program as ordered, the court shall order the person to meet with the treatment team. Only after that attempt to gain cooperation with the treatment team fails may the person be subject to a 72-hour hold as provided by this section.

Requires that if the director of the assisted outpatient treatment program determines that the condition of the patient requires further assisted outpatient treatment, the director to apply to the court, prior to the expiration of the period of the initial assisted outpatient

treatment order, for an order authorizing continued assisted outpatient treatment for a period not to exceed 180 days. Provides that, at 60-day intervals during an AOT program, the director of the program shall file an affidavit with the court confirming that the person continues to meet the AOT criteria. The person shall have a right to dispute the affidavit at a hearing, with the burden of proof on the director; and during each 60-day period, the person may file a petition for a writ of habeas corpus requiring the director to prove the person continues to meet the AOT criteria.

Provides that any person ordered to undergo assisted outpatient treatment who was not present at the hearing at which the order was issued, may immediately petition the court for a writ of habeas corpus. Treatment under the order for assisted outpatient treatment may not commence until the resolution of that petition.

Provides that after a petition is filed, but before the conclusion of the hearing, a person who is the subject of the petition may enter into a settlement agreement approved by the court that shall have the same effect as an order for AOT services issued pursuant to Section 5346.

Prohibits involuntary medication absent a separate order by the court under the provisions of existing law.

Is operative only in any county where the board of supervisors has authorized its application, and has made a finding that any additional costs incurred by the assisted outpatient treatment program will not result in reductions in the county's current voluntary mental health programs.

Requires counties implementing the AOT procedure to provide specified services, which also would be available on a voluntary basis, and would require persons subject to AOT orders to be provided services by trained mobile mental health teams with no more than 10 clients per team member.

Requires counties implementing its provisions to provide specified data related to its use and effects, and would require the State Department of Mental Health to summarize this data in a report to the Legislature by May 1 of each year in which the county provides services.

Requires implementing counties to work with other interested parties to develop a training and education program to improve delivery of services to mentally ill individuals affected by this bill, which shall include education as to the legal requirements for commitment, and methods to ensure effective treatment and to encourage individuals' informed consent to assistance.

Status: Chapter 1017, Statutes of 2002

AB 1422 (Thomson) – Mental Health Advocacy

(Adds and repeals Article 1.5, commencing with Section 5505, of Chapter 6.2 of Part 1 of Division 5 of the Welfare and Institutions Code)

Establishes a Mental Health Advocacy Commission for a six-year period ending January 1, 2008, and composed of 13 members, including the Attorney General, the Superintendent of Public Instruction, and the Secretaries of Health and Human Services, and Business, Transportation and Housing, five members appointed by the Governor and two each appointed by the Speaker and the Senate Rules Committee.

Requires the Governor, by February 1, 2003, to appoint a task force of three individuals from the private sector, which shall be responsible for seeking private funding for commission startup operations and staff, developing an application process for commission membership, and soliciting qualified nominations from stakeholders, and for soliciting nominations from public and private statewide interests that are significantly affected by mental health policy. Requires a complete list of applicants and task force recommendations to be provided to the Governor, the Speaker of the Assembly, and the Senate Committee on Rules within 60 days of appointment of the task force.

Requires the proposed Mental Health Advocacy Commission to perform the following duties:

- Determine the prevalence of mental health needs throughout California.
- Assess the capacity of the public and private mental health system.
- Define the fiscal impact and identify the ways in which the costs of unaddressed mental health needs are shifted to other public sector budgets.
- Define the fiscal impact and identify the ways in which the private sector bears the costs of unaddressed mental health needs.
- Document the human and social costs of unaddressed mental health needs.
- Document the extent to which adequate and available mental health care can improve the quality of life for all community members.
- Propose appropriate strategies to overcome the stigma associated with mental illness.
- Seek creative and technical assistance to develop and release a public information campaign to effectively promote understanding of and reduce discrimination against persons with mental illness.
- Increase awareness within the business and labor communities of the value of mental health services to reduce costs, improve productivity, and improve the overall quality of life.
- Propose mechanisms for improving the availability and application of research and clinical and field-based knowledge to improve the quality, efficiency, and effectiveness of mental health services.
- Report to the Governor and the Legislature on the costs to the public and private sector of unaddressed mental health needs and the individual, social, and fiscal benefits of effective, accessible systems of care for children, adults, and older adults. Requires the report to include recommendations on methods and means of establishing the appropriate balance of responsibility between the private and public

sector for the provision of quality mental health services. Establish policies and procedures for operation of the commission including employment practices, maintenance of records, and accounting of revenue and expenditures.

Requires the commission to establish a Mental Health Policy Advisory Committee, which shall serve as a resource on stigma and discrimination, experiences with accessing public and private mental health services, system administration, acquisition of statistical and fiscal data and other research, as may be reasonably available, and the impact of unaddressed mental health needs. Provides that both the California Mental Health Advocacy Commission, including the policy advisory committee, and the task force shall be funded exclusively through private donations, grants, gifts, or other private funding sources and no state general funds shall be used for that purpose.

Requires the commission to provide annual reports to the Legislature including a measure of the success of education and outreach efforts and documentation of progress toward goals.

Status: Vetoed by the Governor

AB 1424 (Thomson) - Mental Health: Involuntary Treatment

(Adds Section 1374.51 to the Health and Safety Code, adds Section 10144.6 to the Insurance Code, and amends Sections 5008.2, 5328, and 5332 of, and adds Sections 5012, 5013, 5150.05, and 14021.8 to, the Welfare and Institutions Code)

Information on patient's medical history

Expands the list of "historical course" information that a hearing officer, court, or jury must consider, in specified commitment and conservatorship proceedings, to include the patient's medical records, including psychiatric records, and information voluntarily presented by the patient. Requires that treatment facilities make "every reasonable effort" to make information provided by a patient's family available to the court. Also, clarifies that information provided by family members is voluntary.

Requires (rather than permits as under current law) the hearing officer, court or jury to exclude from consideration "historical course" evidence it determines to be irrelevant because of remoteness of time or dissimilarity of circumstances.

Requires (rather than permits as under current law) that, when determining if probable cause exists to take, or cause to be taken, a person into custody for a 72-hour hold for psychiatric evaluation and treatment, any person with the legal authority to make that determination must consider "available relevant information about the historical course of the person's mental disorder". Such information must be considered if the authorized person making the determination finds that the information has a reasonable bearing on the determination as to whether the person is a danger to others, or to himself or herself, or is gravely disabled as a result of the mental illness. Requires that an agency or facility providing mental health treatment to an individual who is subject to a 72-hour hold, 14-day certification, second 14-day certification for suicidal persons, or a 30-day

certification for gravely disabled persons, must obtain his or her medication history, if possible.

Confidentiality requirement

Provides that the existing statute governing the confidentiality of mental health information and records [WIC Section 5328] is not limited by (i.e., applies to) the provisions described above.

Insurance coverage/reimbursement for mental health treatment

Prohibits a disability insurer or health care service plan or, under the Medi-Cal program, the State Department of Health Services, from utilizing any information regarding whether a person's psychiatric inpatient admission was made on a voluntary or involuntary basis for the purpose of determining eligibility for claim reimbursement. Similarly, provides that the fact that a person has been taken into custody under the existing involuntary commitment procedures (Lanterman-Petris-Short Act) may not be used by such entities doing business in California, in the determination of the person's eligibility for payment or reimbursement for mental health or other health care services.

Status: Chapter 506, Statutes of 2001

AB 2057 (Steinberg) – Mental Health Services

(Amends Section 5814 of the Welfare and Institutions Code)

Requires the Department of Mental Health to include the following in its annual report to the Legislature on the effectiveness of the Integrated Services for Homeless Adults program:

- For those who have been enrolled in the program for at least two years and who were enrolled in Medi-Cal prior to, and at the time they were enrolled in, this program, a comparison of their Medi-Cal hospitalizations and other Medi-Cal costs for the two years prior to enrollment and the two years after enrollment in this program.
- The number of persons served who were and were not receiving Medi-Cal benefits in the 12-month period prior to enrollment and, to the extent possible, the number of emergency room visits and other medical costs for those not enrolled in Medi-Cal in the prior 12-month period.

Provides that, to the extent that state savings associated with providing integrated services for the mentally ill are quantified, it is the intent of the Legislature to capture those savings in order to provide integrated services to additional adults.

Status: Chapter 337, Statutes of 2002

PUBLIC HEALTH

SB 351 (Ortiz) –Hexavalent Chromium Drinking Water Standards

(Adds Section 116365.5 to the Health and Safety Code)

Requires the Department of Health Services (DHS) to report to the Legislature on its development of a primary drinking water standard for hexavalent chromium (chromium VI) by January 1, 2003 and to adopt the standard by January 1, 2004.

Requires DHS to adopt a secondary drinking water standard for chromium VI by July 1, 2003.

Status: Chapter 602, Statutes of 2001

SB 406 (Ortiz) - Bioterrorism Preparedness and Other Public Health Threats: Federal Funding

(Adds Chapter 3.5, commencing with Section 101315, to Part 3 of Division 101 of the Health and Safety Code)

Prohibits a local health jurisdiction from eligibility to receive funding from appropriations under this bill when that local health jurisdiction directly receives federal funding for the same purpose. Further prohibits appropriated funds pursuant to this bill from being used to supplant funding for existing levels of service.

Requires, for fiscal year (FY) 2003-04 and subsequent fiscal years, a basic allotment of \$100,000, subject to the availability of funds to be appropriated in the annual Budget Act or some other act, to be distributed to the administrative bodies of each local health jurisdiction.

Requires, for FY 2002-2003, the basic allotment of \$100,000 to be reduced by the amount of federal funding allocated as part of a basic allotment, as specified.

Requires the population estimates used for the calculation of the per capita allotment to be based on the Department of Finance's E-1 Report, "City/County Populations Estimates with Annual Percentage Changes" as of January 1 of the previous year. Requires, if within a local health jurisdiction there are one or more city health jurisdictions, the local health jurisdiction to subtract the population of the city or cities from the local health jurisdiction total population for purposes of calculating the per capita total.

Requires, if the amounts appropriated in the annual Budget Act are insufficient to fully fund the allocations specified above, the Department of Health Services (DHS) to prorate and adjust each local health jurisdiction's allocation so that the total amount allocated equals the amount appropriated.

Requires for FY 2002-03 and subsequent FYs, in cases where the federally approved collaborative state-local plan identifies an allocation method, other than the basic allotment and per capita method, that specific funding to a local public health jurisdiction

be paid to the administrative bodies of those local health jurisdictions in accordance with the federally approved collaborative state-local plan for bioterrorism preparedness and other public health threats in the state.

Requires DHS to disburse funds quarterly to local health jurisdictions beginning July 1, 2002, using the following process:

Requires DHS, each fiscal year, upon the submission of an application for funding by the administrative body of a local health jurisdiction to make the first quarterly payment to each eligible local health jurisdiction. Requires the application to include a plan and budget for the local program that is in accordance with DHS' plans and priorities for bioterrorism preparedness and response, and other public health threats and emergencies. Requires a certification by either the chairperson of the board of supervisors or, in the case of a city with a local health department, the mayor that the funds received will not be used to supplant other funding sources;

Requires DHS to establish procedures and a format for the submission of the local health jurisdiction's plan and budget. Requires the local health jurisdiction's plan to be consistent with DHS' plans and priorities for bioterrorism preparedness and response, and other public health threats and emergencies, in accordance with requirements specified in DHS' federal grant award. Requires payments to local health jurisdictions beyond the first quarter to be contingent upon the approval of the department of the local health jurisdiction's plan and the local health jurisdiction's progress in implementing the provisions of the local health jurisdiction's plan, as determined by DHS.

Permits, if a local health jurisdiction does not apply or submits a noncompliant application for its allocation, funds to be redistributed to the remaining local health jurisdictions.

Requires funds to be used for activities to improve and enhance local health jurisdictions' preparedness for and response to bioterrorism and other public health threats and emergencies, and for any other purposes, as determined by DHS, that are consistent with the purposes for which the funds were appropriated.

Requires a local health jurisdiction that receives funds to deposit them in a special Local Public Health Preparedness Trust Fund established solely for this purpose. Requires the interest earned on monies in the fund to accrue to the benefit of the fund and to be expended for the same purposes as other moneys in the fund.

Requires a local health jurisdiction that receives funds to submit reports that display cost data and the activities funded by moneys deposited in its Local Public Health Preparedness Trust Fund to DHS on a regular basis in a form and according to procedures prescribed by DHS.

Requires DHS, in consultation with local health jurisdictions, to develop required content for the reports required above that include, but are not limited to, data and information

needed to implement this bill and to satisfy federal reporting requirements. Requires the chairperson of the board of supervisors or the mayor of a city with a local health department to certify the accuracy of the reports and verify that the moneys appropriated for the purposes of this bill have not been used to supplant other funding sources.

Permits the administrative body of a local health jurisdiction to enter into a contract with DHS whereby DHS administers all or a portion of the moneys allocated to the local health jurisdiction. Permits DHS to recoup from a local health jurisdiction any moneys allocated pursuant to this bill that are unspent or that are not expended for required purposes. Permits DHS to withhold quarterly payments of moneys to a local health jurisdiction if the local health jurisdiction is not in compliance with this bill or the terms of that local health jurisdiction's plan as approved by DHS. Requires, before any funds are recouped or withheld from a local health jurisdiction, DHS to meet with local health officials to discuss the status of the unspent moneys or the disputed use of the funds, or both.

Requires funds appropriated for purposes of this bill to be allocated through the use of agreements and not to be subject to existing law regarding state contracts.

Appropriates \$50,800,000 from the Federal Trust Fund to the department, half of which would be used for purposes of implementing these provisions and the other half of which would be used for purposes of allocating federal bioterrorism and public health preparedness funds to local health jurisdictions and overseeing that process, implementing state-level provisions of the federally approved collaborative state-local plan, and for hospital bioterrorism preparedness activities.

Status: Chapter 931, Statutes of 2002

SB 622 (Ortiz) - Dental Services

(Adds Section 123281 to the Health and Safety Code)

Finds that oral diseases are the most prevalent diseases among California's children, that 27 percent of California's preschool children have untreated tooth decay and nine percent are in urgent need of dental treatment, that 55 percent of California's six to eight year olds suffer from untreated tooth decay and that children in ethnic and racial minorities have ever higher rates of tooth decay. Finds that over 51 million school hours and 164 million work hours are lost in the United States due to dental related illnesses.

Directs the Women, Infants, and Children (WIC) Special Nutrition Branch of the State Department of Health Services (DHS) to implement the Early Childhood Oral Health Program for WIC participants through grants to local programs administering WIC to augment services under the local WIC. Requires the use of grants to compensate staff time relating to enhanced interventions, supplies and equipment related to oral health services, and to reimburse personnel providing on-site screening and preventive services to WIC participants. Requires grantees to provide enhanced education and counseling, referrals and simple preventative treatments to WIC participants.

Requires DHS to provide, through training and technical assistance to grantees, updated information related to the prevention and recognition of early childhood caries (cavities), oral health practices that focus on prevention of oral diseases, referral sources for early childhood caries, conducting simple oral screenings of very young children, and providing basic preventive service onsite.

Requires DHS to conduct an evaluation of the early childhood dental outreach, education and preventive services program to determine the number of adults and children who received a dental screening, a referral to dental services and preventive dental services.

Status: Died in Assembly Human Services Committee. Provisions of this bill amended into SB 460 - not heard in this committee.

SB 634 (Murray) - Lead Poisoning Prevention

(Adds Sections 124166 and 124167 to the Health and Safety Code)

Requires the Department of Health Services (DHS) to develop a community-based lead hazard "preliminary assessment" training program, in coordination with local health departments, including preparation of training materials. Requires the training workshops to train parents and community volunteers to conduct preliminary assessments to identify conditions that indicate potential for exposure of children under 5 years of age to lead hazards. The program would include a standardized format for identifying and assessing lead hazards in preschools, day care centers, school facilities, residences, and housing projects.

Requires DHS to develop a program, as specified, to train and certify lead "clearance technicians" qualified to perform lead clearance examinations and conduct preliminary assessments. The certification program would be required to meet provisions in federal law pertaining to curriculum.

Requires DHS to report to the Legislature on the resources required to fully implement the existing state Lead Safe Schools Protection Act, and the provisions of SB 634, including recommendations for increases in fees for entities responsible for identifiable sources of lead contributing to environmental lead contamination. The recommendations would include funds needed to ensure sufficient funding to prevent exposure, provide early screening of high risk children, and to identify and abate exposure to lead of children under age 5.

Requires DHS to report to the Legislature by January 1, 2003 specified information on a program of monitoring and reducing lead levels in drinking water in schools and preschools, and the cost of implementing such a lead-free school drinking water plan by January 2, 2004. Requires DHS to report to the Legislature between January 1, 2006 and January 1, 2007 recommendations regarding continuation of the community-based training program counties would be required to implement under the provisions of this bill.

Status: Died in the Senate Appropriations Committee

SB 732 (Ortiz) - Toxic Mold

(Amends Section 1102.6 of the Civil Code, and adds Chapter 18, commencing with Section 26100, to Division 20 of the Health and Safety Code)

Requires sellers of commercial or industrial real property and residential and commercial landlords who know or, in the case of residential landlords, have reasonable cause to believe, that mold affects the unit or building and either exceeds permissible exposure limits or poses a health threat according to the Department of Health Services' (DHS) guidelines to disclose this fact to prospective buyers and current and prospective tenants.

Provides that these sellers and landlords are exempted from the bill's disclosure requirements if the presence of mold was remediated according to the mold remediation guidelines adopted by DHS.

Requires that the required written disclosure be provided to both prospective and current tenants and provides that the bill's disclosure requirements do not apply until the first January 1 or July 1 that occurs at least six months after DHS adopts standards and develops guidelines.

Requires commercial tenants who know that mold is present in specified locations in the building to inform the landlord of this knowledge and requires the commercial landlord to conduct any necessary remedial action.

Requires DHS to consider the feasibility of adopting permissible exposure limits to mold in indoor environments and to adopt such standards if feasible and requires DHS to adopt practical guidelines to assess the health threat posed by the presence of mold in an indoor environment and determine whether the presence of mold constitutes mold infestation.

Specifies that a commercial, industrial or residential landlord may not be required to conduct air or surface testing to determine whether the presence of molds exceeds permissible exposure limits to mold or constitutes mold infestation.

Adds mold to the list of substances, materials or products which may be an environmental hazard and which must be disclosed to a prospective purchaser of residential property as part of the standard "Real Estate Transfer Disclosure Statement."

Authorizes the enforcement of all conditions of this bill including the disclosure provisions by specified enforcement officers and provides that the implementation of the bill is dependent upon the extent to which DHS determines that funds are available. Requires DHS to develop public education materials on the health effects of exposure to molds and means to address mold contamination.

Requires the Department of Consumer Affairs to assess the need for education and certification standards for mold testing and mold remediation professionals and to report its findings to the Legislature.

Status: Chapter 584, Statutes of 2001

SB 977 (Battin) - Condoms: Warning Label

(Adds Chapter 6.3, commencing with Section 25050, to Division 20 of the Health and Safety Code)

Requires each manufacturer of condoms to place, or cause to be placed, within each retail package of one or more condoms offered for sale or distributed in California on or after January 1, 2003, a label that states the following:

IMPORTANT: If used properly, latex condoms will help reduce the risk of the transmission of HIV infection (AIDS) and many other sexually transmitted diseases (STDs). While condoms help decrease the risk of contracting STDs such as chlamydia, genital herpes, genital warts (HPV), gonorrhea, hepatitis B, and syphilis, they do not fully guard against the transmission of HPV (genital warts). Having genital warts is an important risk factor in having cervical cancer. To help prevent cervical cancer, all women who are 18 years of age or older, or who are sexually active, or who have had genital warts (HPV) or any of these STDs, should have annual checkups that include Pap tests and pelvic examinations.

Requires that if the required label is printed as a separate package insert, it shall be printed in both English and Spanish.

Status: Died in the Assembly Health Committee

SB 1610 (Bowen) - Food: Nutritional Labeling: Fatty Acids

(Adds Section 110808 to the Health and Safety Code)

Requires any manufacturer or producer of a food product or dietary supplement, for which the product label claims (in accordance with federal law) a low quantity of saturated fat, to provide in the labeling of the product information on the amount of trans fatty acids present in the food.

Requires that the required information on trans fatty acids be displayed in a conspicuous and legible, boldface print in contrast to other matter on the package, and in compliance with specifications set forth in the Code of Federal Regulations.

Defines the terms: "hydrogenation" and "trans fatty acids."

Status: Failed Passage in the Assembly Agriculture Committee

SB 2043 (Bowen) - Preservation of Antibiotics for Human Treatment Act of 2002

(Adds Chapter 6.5 (commencing with Section 111657) to Part 5 of Division 104 of the Health and Safety Code)

Requires the Director of the Department of Health Services (DHS), in consultation with the California Department of Food and Agriculture (CDFA), to conduct a study to evaluate the extent to which the use of antimicrobial drugs in agricultural animals may lead to the development of antimicrobial-resistant diseases in humans. The study must address the health risks of providing humans and animals with the same classes of

antimicrobial drugs and explore the potential impact of antibiotic resistance in humans on the state's ability to protect its population from future acts of biological terrorism.

Makes the following legislative findings and declarations:

- Several antibiotics that are either used in or are related to antibiotics used in humans to treat infectious diseases are also routinely administered to agricultural animals, generally in their feed or water, in order to promote the animal's growth or prevent disease.
- Mounting scientific evidence shows the use of antibiotics in animals, including growth promoting antibiotics, can lead to the development of antibiotic-resistant bacteria that can be transferred to humans, making it more difficult to treat certain infections.
- In 1997, the World Health Organization recommended antibiotics used to treat humans should not be used to promote animal growth, although the antibiotics in question could be used to treat animal illnesses.
- In July 1998, the National Academy of Sciences concluded there is a link between the use of animals used for human consumption and the development of bacterial resistance to these drugs.
- In December 1998, health ministers for countries of the European Union voted to ban the four remaining human use antibiotics still in use to promote animal growth. The ban on using virginiamycin, tylosin, spiramycin, and bacitracin in animal feed became effective for the 15 member states of the EU on July 1, 1999. Prior to that action the United Kingdom, Denmark, Finland, and Sweden had banned the use of specific antibiotics in animal feed.
- An April 1999 study by the General Accounting Office concluded that resistant strains of salmonella, campylobacter, and E. coli are linked to the use of antibiotics in animals.
- In 1999, the National Association of State Public Health Veterinarians adopted a policy recommending the discontinuation of antimicrobial drugs used to promote the growth of food animals if they are also used in human medicine.
- In October 2000, the Food and Drug Administration (FDA) issued a notice announcing its intention to withdraw approval for the use of flouroquinolone antibiotics in poultry, in light of the fact that increased resistance to flouroquinolones in certain bacteria followed approval of those antibiotics for that use in the mid 1990's. Previous proceedings by the FDA to withdraw approval of animal drugs have taken substantial amounts of time following initiation of formal action by the FDA. The procedure to withdraw approval took six years in one instance and 20 years in another.
- In June 2001, the American Medical Association adopted a resolution opposing the nontherapeutic use of antimicrobial drugs that are medically important in animal agriculture. The American College of Preventative Medicine, the American Public Health Association, and the Council of State and Territorial Epidemiologists have taken similar positions.

Status: Died in the Assembly Agriculture Committee

SJR 49 (Ortiz) – Human Exposure to Environmental Chemicals

(Relative to human exposure to environmental chemicals)

Memorializes the President and the Secretary of Health and Human Services, the Director of the Centers for Disease Control and Prevention (CDC), and the California Congressional delegation to seek the release of California-specific findings from a federal study, the 1999 CDC National Report on Human Exposure to Environmental Chemicals, to the California DHS.

Memorializes the CDC to release the California-specific data from the forthcoming 2002 National Report on Human Exposure to Environmental Chemicals, due to be released December 2002.

Status: Resolution Chapter 137, Statutes of 2002

AB 182 (Vargas) - Hepatitis A: Mandatory Immunization for Children

(Amends Sections 120325 and 120335 of, and to add Section 1596.794 to, the Health and Safety Code)

Makes findings and declarations related to the Legislature's intent to prevent the spread of hepatitis A through the use of a vaccine, and the fact that California's hepatitis A rates are higher than the national average.

Adds hepatitis A to the list of childhood diseases for which the Legislature intends the eventual achievement of immunization.

Adds hepatitis A to the list of diseases that require documentation of immunization prior to admission to kindergarten, on or after July 1, 2003.

Reinstates an exemption from the requirement to maintain files regarding, and to verify, children's immunizations and tuberculosis testing for "drop-in" child care centers.

Status: Failed Passage in the Senate Health and Human Services Committee

AB 791 (Strom-Martin) – Transgenic Seafood

(Adds Section 110373 to the Health and Safety Code)

Requires the retail sale of any unpackaged seafood, other than by a restaurateur, containing any transgenic fish or transgenic shellfish, including, but not limited to, any species of salmon, to be accompanied by a notice that clearly discloses that fact to the consumer, including the definition of transgenic fish and transgenic shellfish for that purpose.

Defines "transgenic fish" or "transgenic shellfish" to mean fish or shellfish that is altered at the molecular level by means that are not possible under natural conditions or processes, including recombinant DNA and RNA techniques, cell fusion, gene deletion, and doubling, introducing a foreign gene, and changing the positions of the gene, but not

including chromosome manipulation for the sole purpose of sterilization or creation of triploid fish.

Authorizes the Department of Health Services to adopt guidelines to implement provisions of the bill.

Status: Referred back to the Assembly Agriculture Committee. Died in Committee.

AB 945 (Wright) - Lead Inspections: Certified Industrial Hygienists

(Adds Section 105291 to the Health and Safety Code)

Requires, in addition to any other providers determined to be eligible by the Department of Health Services (DHS), certified industrial hygienists (CIHs) or other qualified professionals who are certified by DHS as inspector/assessors to be eligible to provide environmental investigation services as a part of case management services under the Childhood Lead Poisoning Prevention Program (CLPPP).

Requires these services, performed by CIHs or others certified as inspector/assessors, to be funded under CLPPP.

Status: Chapter 524, Statutes of 2001

AB 1452 (Cox - Vaccinations: Meningococcal Disease

(Adds Chapter 1.7 (commencing with Section 120395) to Part 2 of Division 105 of the Health and Safety Code)

Requires the Department of Health Services (DHS), by April 1, 2002, to develop information about meningococcal disease, that includes the following:

- Information about meningococcal disease, including symptoms, risks, and treatment; and,
- Notice of the availability, benefits, risks and limitations of a meningococcus vaccination, with specific information as to those persons at higher risk for the disease.

Requires DHS to make available to each degree-granting public and private postsecondary institution, upon the request of that institution, information developed by DHS on meningococcal disease.

Requires DHS to notify each school district of the availability of information developed by DHS, and to make the information available to any school district upon request.

Permits DHS to use the information developed to design and implement a public awareness campaign about meningococcal disease to reach members of the population identified as being at high risk for contracting the disease.

Requires each degree granting public postsecondary educational institution that provides on-campus housing in the state to, beginning with the 2002-03 school year, do all of the following:

- Provide information on meningococcal disease developed by DHS to each incoming freshman who has been accepted for admission and will be residing in on-campus housing. Requires the information to include a response form with space in which to indicate that the incoming freshman has received the information about meningococcal disease and the availability of the vaccine to prevent one from contracting the disease. Requires the form to include space for the incoming freshman to indicate whether or not he or she has chosen to receive the vaccination, and a space for his or her signature;
- Require each incoming freshman to return to the postsecondary educational institution a form with a response as to whether the person received the information, and whether or not the person chooses to receive the vaccination; and,
- Maintain the completed forms received from students in accordance with the institution's health care records policy.

Requires each degree granting private postsecondary educational institution that provides on-campus housing in the state to adopt a policy to notify all incoming students about meningococcal disease and the availability of the vaccination, beginning with the 2002-03 school year. Exempts the University of California (UC) from the provisions of this bill except to the extent that the Regents of UC, by appropriate resolution, make the provisions of this bill applicable.

Status: Chapter 372, Statutes of 2001

AB 2261 (Cardenas) - Childhood Lead Poisoning Prevention Enforcement

(Adds Chapter 3.7, commencing with Section 105240, to Part 5 of Division 103 of the Health and Safety Code)

Authorizes the Department of Health Services (DHS) and local health departments to enforce requirements of the federal Lead-Based Paint Hazard Reduction Act and the state the Childhood Lead Poisoning Prevention Act (CLPPA).

Authorizes the enforcement of lead-hazard assessment testing, work practice, interim control, abatement and disposal standards adopted pursuant to the federal and state lead poisoning prevention acts.

Authorizes inspections in public and residential buildings, the issuance of stop-work and abatement orders and the imposition of civil penalties of up to \$2,000 per site visit for violations of any requirement related to the interim control and abatement of covered lead hazards.

Permits inspections of public and residential buildings when there is a lead hazard risk or significant possibility that a building or premises poses a risk of a lead hazard.

Requires occupant consent for inspections of residences outside of normal working hours. Prohibits inspections of the nondwelling portions of residential buildings without the consent of the owner or occupant. Prohibits inspections of dwelling units in the absence of the occupant without an appropriate court order.

Authorizes the issuance of stop-work orders when lead abatement or lead-related construction work is being carried out in an unsafe manner or in violation of applicable standards and guidelines.

Status: Died in the Senate Health and Human Services Committee

SCHOOL HEALTH

SB 19 (Escutia) – Pupil Health

(Adds Article 2.5, commencing with Section 49430, to Chapter 9 of Part 27 of the Education Code)

Requires a school to follow the United States Department of Agriculture's (USDA) Enhanced Food Based Meal Pattern, the USDA Nutrient Standard Meal Planning, California's SHAPE Menu Patterns, or the USDA Traditional Meal Pattern in order to qualify for an increased reimbursement for free and reduced-price meals and for a reimbursement for meals sold at full price.

Requires food sold to pupils at elementary schools during breakfast and lunch periods to be sold as a full meal, which is defined as any combination of food items that meet a USDA-approved meal pattern. Exempts the sale of fruits, nonfried vegetables, legumes, beverages, dairy products, or grain products from this requirement if they meet specified requirements.

Requires individual food items sold to pupils at elementary schools during morning and afternoon breaks at elementary schools to meet the following standards: a) not more than 35% of its total calories from fat. Exempts the sale of nuts or seeds from this requirement; b) not more than 10% of its total calories from saturated fat; and c) not more than 35% of its total weight composed of sugar. Exempts the sale of fruits and vegetables from this provision.

Limits the types of beverages that may be sold to pupils at an elementary school, regardless of the time of day, to water, milk, and 100% fruit juices or fruit-based drinks that are composed of no less than 50% fruit juice and that have no added sweeteners.

Prohibits, in middle schools, carbonated beverages from being sold to pupils from one-half hour before the start of the schoolday until after the end of the last lunch period.

Allows an elementary school to permit the sale of food items that do not comply with the provisions of this bill as part of a school fundraising event: if the sale of those items takes place off of school premises or at least one-half hour after the end of the schoolday.

Requires the State Department of Education (SDE) to establish a three-year pilot program in which not less than 10 high schools, middle schools, or any combination thereof, voluntarily adopt the provisions of this bill.

Requires a school district participating in the pilot program to comply with specified requirements including prohibiting entree items and side dish serving sizes from being larger than the portions of those foods served as part of the federal school meal program.

Permits a school district maintaining at least one elementary, middle, or high school that is participating in the pilot program established by this bill, to convene a Child Nutrition and Physical Activity Advisory Committee to develop and recommend to the governing board of the school district for its adoption, school district policies on nutrition and physical activity addressing specified issues and goals, including increasing the availability of organic fruits and vegetables and school gardens.

Permits a school district to apply to SDE for a grant to offset the costs of developing and adopting policies pursuant to this bill. Requires these grants to be one-time grants and available to applicant school districts by March 1, 2002.

Requires a participating school district to receive a grant of no less than \$4,000, and no more than \$25,000, depending upon the size of the school district, for the purpose of offsetting the costs of developing the school district nutrition and physical activity policies.

Requires SDE to provide technical support and assistance to school districts in implementing above, including, highlighting model nutrition programs, disseminating information to assist in the financial management of the food service programs and for pupil activities that encourage healthy eating habits among pupils, and providing information regarding best practices in school nutrition programs.

Status: Chapter 913, Statutes of 2001 (Item Veto)

SB 231 (Ortiz) – Medi-Cal: Local Education Agency Services

(Adds Section 14115.8 to the Welfare and Institutions Code)

Requires the Department of Health Services (DHS) to amend the Medicaid state plan with respect to the billing option for services by Local Education Agencies (LEAs) to ensure that schools are reimbursed for all eligible services they provide that are not precluded by federal requirements. Requires DHS to examine methodologies for increasing school participation in the Medi-Cal billing option for LEAs. Requires DHS, to the extent possible, to simplify claiming processes for LEAs.

Requires DHS to eliminate and modify state plan and regulatory requirements that exceed federal requirements when they are unnecessary.

Requires DHS in consultation with stakeholders to implement the recommendations from that study to the extent feasible and appropriate, if a rate study for the LEA Medi-Cal billing option is completed pursuant to a specified statute relating to the budget implementation of health services.

Requires DHS to regularly consult with the following entities to assist in the development of the state plan amendments: the State Department of Education; representatives of urban, rural, large and small school districts and county offices of education; the Local Education Consortium; LEAs; the LEA technical assistance project; the federal Centers for Medicare and Medicaid Services; experts from the fields of both health and education; and state legislative staff.

Requires DHS to file an annual report with the Legislature that includes the following:

- A state-by-state comparison of school-based Medicaid total and per eligible child claims and federal revenues;
- A summary of DHS activities and an explanation of how each activity contributed toward narrowing the gap between California's per eligible student federal fund recovery and the per student recovery of the top three states;
- A listing of all school-based services, activities, and providers approved for reimbursement by the federal Centers for Medicare and Medicaid Services in other state plans that are not yet approved for reimbursement in California's state plan and the service unit rates approved for reimbursement;
- A one-year timetable for state plan amendments and other actions necessary to obtain reimbursement for those items, as specified;
- Identification of any barriers to LEA reimbursement, that are not imposed by federal requirements, and a description of the actions that have been, and will be, taken to eliminate them.

Requires these activities to be funded and staffed by proportionately reducing federal Medi-Cal payments allocable to LEAs for the provision of benefits funded by the federal Medi-Cal program under the LEA billing option. Caps the annual amount funded at \$1.5 million.

Status: Chapter 655, Statutes of 2001

SB 391 (McPherson) – Education: Health Delivery Services: Consulting Nurse

(Adds Sections 49428 and 49429 to the Education Code)

Makes findings and declarations establishing the need for more school nurses and consultants in California public schools.

Requires each county office of education, to the extent funds are available, to employ a credentialed school nurse as its consultant to provide leadership and coordination of mandated and appropriate health services to pupils, including to:

- Ensure cost-effective continuity of health services to pupils;
- Provide advice, consultation, coordination and training to school administrators and parents;
- Design and develop in-service training formats, programs, instructional materials, and staff development programs for health services personnel;
- Plan and develop health education curriculum;
- Develop public awareness and community relations programs;

- Set up programs on tobacco prevention, immunizations, screening for scoliosis, tuberculosis, dental disease, vision and hearing acuity.

Establishes the Tobacco Settlement Fund in the State Treasury with funds received from the tobacco litigation Master Settlement Agreement of 1998. Appropriates \$4 million from the Tobacco Settlement Fund for these purposes.

Status: Died in the Assembly Appropriations Committee

SB 1520 (Ortiz) – Schools: Pupil Nutrition: Carbonated Beverages
(Amends Section 49431 of the Education Code)

Prohibits, commencing on January 1, 2004, the sale of beverages other than the following on elementary school campuses between one half hour before the start of the regular schoolday to one half hour after the end of the regular school day:

- Fruit-based drinks that are composed of no less than 50 percent fruit juice and that have no added sweeteners.
- Drinking waters.
- Milk, including but not limited to chocolate milk, soymilk, rice milk, and other similar dairy or nondairy milk.
- Electrolyte replacement beverages which do not contain more than 42 ounces per 20 ounces per serving.

Requires that, commencing on January 1, 2005, no beverages other than those shown above be sold on middle and junior high school campuses.

Requires that, commencing on January 1, 2007, no beverages other than those shown above be sold on high school campuses.

Requires that no beverage that exceeds 12 ounces be sold to students from one-half hour before the start of the regular schoolday until one-half hour after the end of the regular schoolday. Exempts water, milk, and electrolyte replacement beverages under 20 ounces from this requirement.

Allows beverages to be sold on campuses as fundraisers if 1) that sale is by pupils of the school and the sale of those items takes place off of school premises, or 2) if the sale is by pupils of the school and the sale takes place at least one-half hour after the end of the schoolday.

States that contracts entered into prior to the operative date of the act may remain in effect, but may not be renewed if they are in conflict with the act.

Deletes the current prohibition, commencing on January 1, 2004 (and contingent on appropriation of specified funding), on the sale of carbonated beverages at middle schools from one-half hour before the start of the schoolday until after the last lunch period.

Deletes the current requirement that at middle schools, commencing on January 1, 2004 (and contingent on appropriation of specified funding), vending machines containing beverages not meeting specified standards be locked or rendered inoperable until after the last lunch period.

Status: Failed Passage in the Senate Education Committee

AB 2741 (Chan) - Children's School Readiness and Health Council

(Adds Part 3.5, commencing with Section 15800, to Division 9 of the Welfare and Institutions Code)

Requires the Secretary of the Health and Human Services Agency to establish and staff an interdepartmental and interagency Children's School Readiness and Health Council to:

- Coordinate school readiness, health policy and program operations;
- Develop a strategic plan for children's school readiness and health policy; and
- Gather research and provide leadership in the development of a school readiness and health system.

Requires that the council hold open meetings at least quarterly and specifies the leadership and makeup of the council to include the directors (or their designees) of several state departments and the state Proposition 10 commission, as specified.

Outlines the following duties of the council in relation to school readiness and health:

- Promote coordinated planning and policy development in the provision of children's services;
- Develop strategies to improve quality and accessibility of consumer information on available state administered programs;
- Develop strategies to enhance overall availability and quality of programs;
- Provide a study to the Legislature, by January 1, 2004, which assesses coordination and funding streams;
- Establish priorities and develop timelines for completion of its duties, with development of methods for improving consumer access to information required to be among its first priorities;
- Review and make departmental budget recommendations prior to submission of these budgets to the Department of Finance; and
- Beginning January 2004, annually report to the Legislature the council's progress in fulfilling its duties, and identify any additional legislation or resources needed.

Requires the Legislative Analyst Office to include a summary of spending and population served by school readiness and health programs in the annual analysis of the Governor's Budget.

Requires the council to establish a standing advisory committee, to be chaired by the Superintendent of Public Instruction and to include representatives of stakeholder groups, as specified, and requires the committee to undertake various specified tasks.

Requires the bill to become inoperative on June 30, 2004 unless additional statute extends the operative dates of the program.

Status: Vetoed by the Governor

TOBACCO

SB 35 (Escutia) – Tobacco Settlement Fund Allocations

(Adds Article 1.3, commencing with Section 104485, to Chapter 1 of Part 3 of Division 103 of the Health and Safety Code)

States legislative intent to use tobacco settlement funding to diminish the public costs and human suffering caused by tobacco-related illnesses and to provide better access to health care for all Californians. The bill finds tobacco-related diseases cost Californians \$8.7 billion annually, finds that hundreds of thousands of children now living in the state will die of tobacco-related diseases, finds very high rates of uninsurance among Californians, states the proposed expenditure of these funds is consistent with the intent of the settlement agreement.

Creates the Tobacco Settlement Fund in the State Treasury and requires, commencing July 1, 2001, that the state share of all funds received pursuant to the Master Settlement Agreement be deposited in the fund.

Status: Died in the Assembly Governmental Organization Committee –Content incorporated in the 2001-2002 Budget.

SB 1700 (Peace) – Tobacco Products

(Adds Division 8.6, commencing with Section 22970, to the Business and Professions Code, and amends Sections 30166 and 30473.5 of the Revenue and Taxation Code)

Requires, beginning January 1, 2004, retailers who sell tobacco products to obtain a valid license. Specifies information to be included in the application. States retailers are qualified for a license unless the retailer has a suspended license for the same location. Authorizes the board to revoke the registration or refuse to register an application for a license for a location where there is a revoked registration unless certain conditions are met. Makes selling tobacco products without a license a misdemeanor.

Prohibits a distributor or wholesaler from selling tobacco products to a retailer, wholesaler or distributor who is not properly licensed. Requires distributors or wholesalers to provide specified information on each invoice, including the amount of excise taxes. Requires that records be maintained for four years. Makes violation a misdemeanor.

Directs the Board of Equalization (BOE) to take action against retailers who violate the STAKE Act, Penal Code Section 308 (both sales of tobacco to minors) and the provisions of this bill. Makes sale or possession of counterfeit cigarettes and tobacco products by a retailer subject to a misdemeanor, as specified. Penalties apply to the license holder rather

than employee. However, covert illegal sales of counterfeit tobacco by an employee is a defense to a licensing action. Defines counterfeit tobacco products as products with false labels or stamps.

Requires, after January 1, 2003, tobacco manufacturers selling tobacco in California to obtain a license. Requires tobacco wholesalers and distributors operating in California to obtain a license. Prohibits a manufacturer from selling tobacco products to an unlicensed distributor/wholesaler. Prohibits a distributor/wholesaler from selling tobacco products to an unlicensed retailer. Makes the sale or possession of counterfeit cigarettes and tobacco products by a manufacturer, distributor or wholesaler a misdemeanor, as specified.

Requires, after January 1, 2004, tobacco manufacturers to pay a fee of up to two cents for each pack of cigarettes sold in California in 1998. Exempts manufacturers who have not signed the tobacco master settlement agreement and sunsets this provision.

Deposits all moneys collected pursuant to this division in the Cigarette and Tobacco Products Control Fund for appropriation to: the BOE for administration and issuance of stamps and licenses; to the board for reimbursement of wholesalers for the actual costs of applying stamps and storing tobacco products; the Department of Health Services for costs associated with reducing youth access to tobacco; and the Department of Justice for criminal investigative activities; imposes specified fines or imprisonment for possessing, selling, or buying false or fraudulent cigarette tax stamps.

Status: Died in the Assembly Governmental Organization Committee

AB 1453 (Koretz) - Tobacco: Minimum Legal Age: Display and Distribution Limits

(Amends Sections 17537.3, 22952, 22956, and 22958 of, and adds Sections 22963, 22963.5, 22964, and, 22965, and 22966 to, the Business and Professions Code, and amends Section 308 of the Penal Code)

Finds tobacco the principal cause of preventable death in the United States; increasing the legal minimum age will reduce youth smoking and delay the initiation of smoking; finds 90 percent of smokers begin before age 21; and finds it in the public interest to prevent adolescent addiction to tobacco.

Prohibits furnishing tobacco to persons under the age of 21. Exempts persons born before January 1, 1985. Makes corresponding changes for prohibitions on sales to minors, notice requirements and promotion on access to tobacco products. Prohibits free sampling by mail to anyone not previously identified as a tobacco consumer at least 21 years of age. Makes corresponding changes to requirements for tobacco advertising and promotions to designate that such products are not available to persons under 21; directs the Department of Health Services to expand enforcement of prohibitions on sales to persons under 21 through the STAKE Act; and recasts penalty provisions consistent with age 21, exempting persons born prior to 1985.

Prohibits the display or provision of ashtrays or other receptacles of tobacco waste on premises where smoking is prohibited. Permits tobacco waste receptacles within five feet of public entrees, and requires such receptacles in legal, designated areas; permits sale of ashtrays to the public. Establishes a schedule of civil fines for violations of these provisions ranging from \$250 for the first violation to \$1000 for the third violation in a five-year period.

Permits local governments to enact laws with respect to the legal age to purchase tobacco, provided they are at least as stringent as state laws.

Status: Provisions Removed from Original Version Heard in Committee

AB 1527 (Frommer Wiggins) – Tobacco Products

(Adds Chapter 31, commencing with Section 22945, to Division 8 of the Business and Professions Code)

Restricts retail cigarette advertising to the interior of the store and restricts references to brand and price of the advertised product. Prohibits use of slogans, symbols, logos, graphics, and pictorial advertising. Exempts any retail tobacco outlet that excludes persons under 18 years of age. Establishes civil penalties for violation and deposits penalties in the Sale of Tobacco to Minors control account with the State Treasurer.

Makes it unlawful for a cigarette manufacturer to condition monetary payments or other inducements to a cigarette retailer or its customers to the allocation of specified portions of the retailers cigarette display, signage or advertising space. Makes it unlawful to: condition monetary payments for the allocation of other manufacturers display, signage or advertising; limit a retailers total tobacco advertising space; limit a retailer's participation in other promotions; or to set the retail price of products alone or in relation to the price charged for other products. Voids any contract that violates these terms and permits prosecution by the district attorney or city attorney. Establishes civil fines equal to the value of the illegal inducement or \$10,000 whichever is greater. Deposits fine revenue in the Sale of Tobacco to Minors Control Account.

Makes provisions of the Act severable and adds a "crimes" disclaimer.

Status: Died on the Senate Floor

AB 1830 (Frommer) – Tobacco Products: Sales to Minors

(Adds Section 22963 to the Business and Professions Code)

Prohibits the distribution or sale of tobacco products directly or indirectly to any person under the age of 18 years through the U.S. Postal Service or through any other public or private postal or package delivery service at locations, including, but not limited to, public mailboxes and mailbox stores.

Requires sellers or distributors of tobacco products sent directly to consumers through the U.S. Postal Service or any other public or private package delivery service, including orders placed by mail, telephone, facsimile or the Internet, to meet the following

requirements: Verify that tobacco product purchasers are at least 18 years of age by attempting to match their names, addresses and dates of birth by reference to an appropriate database of government records. The distributor or seller must also verify that the billing address on the check or credit card offered for payment by the purchaser matches the address listed in the data base.

- When unable to verify that a customer is at least 18 years of age, require the customer to submit a valid form of government identification such as a driver's license, state identification card, green card, or military identification. The distributor or seller must also verify that the billing address on the check or credit card provided by the customer matches the address listed in the government identification
- Impose a two-carton minimum on each order of cigarettes, and require payment for the purchase of any tobacco product to be made by either personal check or credit card. The distributor or seller must submit to each credit card acquiring company with which it has credit card sales identification information in an appropriate form and format so that the words "tobacco product" may be printed in the purchaser's credit card statement when a purchase of a tobacco product is made by credit card payment.
- Make a telephone call after 5 p.m. to the purchaser confirming the order prior to shipping the tobacco products. The telephone call may be a person-to-person call or a recorded message, and may be in the form of a message on an answering machine or by voicemail.
- Deliver the tobacco product to the purchaser's verified billing address on the check or credit card used for payment. No delivery may be made to a post office box.

Holds harmless a tobacco distributor or seller who complies with all requirements of this section.

Authorizes a district attorney, city attorney or the State Attorney General to assess penalties under this law. Provides for a \$1,000 to \$2000 penalty for the first violation, \$2,500 to \$3,500 for the second violation, \$4,000 to \$5,000 for the third penalty in a five-year period, and \$5,500 to \$6,500 for the fourth violation in a five-year period. Maximum penalty is \$10,000 fine for five violations within a five-year period.

Status: Chapter 685, Statutes of 2002

AB 2906 (Horton) – Tobacco Settlement Agreement: Escrow Compliance

(Amends Sections 30436 and 30449 of, and adds Section 30163.1 to, the Revenue and Taxation Code)

Prohibits application of tax stamps to any tobacco product and brand family which does not comply with the terms of the Master Settlement Agreement (MSA). Requires the Attorney General (AG) to annually post on his web site a list that includes: all tobacco product manufacturers that are participating manufacturers under the MSA; all tobacco product manufacturers not participating in the MSA that the AG determines have made all escrow payments required by law; and shall list the brand families of participating and

non-participating manufacturers. Requires the AG to notify tobacco distributors of manufacturers who are not in compliance.

Specifies reporting requirements for tobacco manufacturers to be included on the AG's list necessary to calculate unit volumes, market shares, and escrow payments.

Authorizes the AG to exclude or remove from the list any manufacturer who fails to make required escrow payments. Permits civil appeal of the AG determination.

Establishes that a tobacco manufacturer making false representations regarding reporting and escrow payment requirements is guilty of a misdemeanor.

Requires that no person affix, or cause to be affixed, any tax stamp or meter impression to a package of cigarettes, or pay the tax levied on a cigarette unless the brand family of the cigarettes or tobacco product, and the tobacco product manufacturer that makes or sells the cigarettes or tobacco product, are included on a list posted by the AG.

Authorizes the State Board of Equalization to revoke or suspend the license of a distributor violating (5), and to impose limited civil penalties. Specifies the conditions under which a distributor may recover costs for non-complying products.

Requires each non-participating tobacco manufacturer to identify an agent responsible to the AG, to certify payment of escrow payments, and notify distributors of such compliance.

Subjects cigarettes in violation of these provisions to forfeiture. Requires any tobacco in violation of this section to destruction.

Status: Died on the Senate Floor Inactive File