Senate Bill No. 184

CHAPTER 47

An act to amend Sections 15432, 15451.5, 100800, 100820, and 100825 of, and to add Section 12534 to, the Government Code, to amend Sections 120475, 120511, 122440, 127691, 127692, 127694, 127695, 127696, 128205, 128210, 128230, and 128235 of, to amend and repeal Section 104395 of, to add Sections 1385.035, 11831.1, 11834.28, 11839.6.1, 124024, and 124110.5 to, to add Article 7 (commencing with Section 101320) to Chapter 3 of Part 3 of Division 101 of, to add Article 2.3 (commencing with Section 123451) to Chapter 2 of Part 2 of Division 106 of, to add Chapter 2.6 (commencing with Section 127500) to Part 2 of Division 107 of, and to add Article 2 (commencing with Section 128250) to Chapter 4 of Part 3 of Division 107 of, and to repeal Sections 128215, 128220, and 128225 of the Health and Safety Code, to amend, repeal, and add Section 12693.74 of, and to add Section 10181.35 to, the Insurance Code, to add Part 4.6 (commencing with Section 1490) to Division 2 of the Labor Code, to amend Sections 1001.36, 1026, 1026.2, 1369, 1370, 1370.6, 1372, 1602, 1603, 1604, 2603, and 4019 of, and to repeal Section 1369.1 of, the Penal Code, to amend Sections 18914 and 18916 of the Revenue and Taxation Code, and to amend Sections 4335.2, 4361, 5328, 5848.5, 5961.5, 7276, 7279, 7281, 7290, 14005.22, 14005.26, 14005.37, 14005.64, 14007.8, 14007.9, 14011.10, 14011.66, 14011.7, 14087.46, 14105.075, 14105.192, 14105.48, 14124.12, 14132.100, 14132.88, 14132.98, 14138.1, 14138.12, 14138.13, 14138.14, 14138.15, 14138.16, 14138.17, 14138.23, 14148, 14148.8, 14170.8, 14184.201, 14184.206, 14184.400, 14184.405, 14184.405, 14184.800, 14186.3, 14197, 14197.04, 14197.2, 15826, 15854, and 16501.3 of, to amend the heading of Article 4.1 (commencing with Section 14138.1) of Chapter 7 of Part 3 of Division 9 of, to amend, repeal, and add Sections 14005.12, 14005.13, 14105.2, 15832, and 15840 of, to add Sections 4336, 4361.7, 5325.3, 14005.255, 14105.197, 14132.57, 15849, and 15854.5 to, to add Chapter 16.5 (commencing with Section 18998) to Part 6 of Division 9 of, to add and repeal Section 4360.5 of, to repeal Sections 7284, 7285, 7286, 7287, 7291, 7292, 14005.225, 14138.11, and 14138.19 of, and to repeal and add Sections 14132.725, 14132.731, 14138.10, 14138.18, 14138.21, and 14138.22 of, the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor June 30, 2022. Filed with Secretary of State June 30, 2022.]

LEGISLATIVE COUNSEL'S DIGEST

SB 184, Committee on Budget and Fiscal Review. Health.

(1) Existing federal law, the Patient Protection and Affordable Care Act (PPACA), enacts various health care market reforms. Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law, until January 1, 2023, requires the Exchange to administer a program of health care coverage financial assistance to help low-income and middle-income Californians. Existing law exempted the program design of financial assistance and a related regulation, standard, criterion, procedure, determination, rule, notice, guideline, or any other guidance established or issued by the Exchange or Franchise Tax Board from the Administrative Procedure Act until January 1, 2022.

This bill would indefinitely extend the above-described financial assistance program and Administrative Procedure Act exemptions.

(2) Existing law generally requires the State Department of Public Health to license, inspect, and regulate health facilities, including hospitals. Existing law requires health facilities to meet specified cost and disclosure requirements, including maintaining an understandable written policy regarding discount payments and charity. Existing law establishes the Department of Health Care Access and Information (HCAI) to oversee various aspects of the health care market, including oversight of hospital facilities and community benefit plans.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires each department to develop and adopt regulations to ensure that enrollees and insureds have access to needed health care services in a timely manner. Existing law requires that health care service plans and health insurers submit rates to their regulating entity for review.

This bill would establish, within HCAI, the Office of Health Care Affordability to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, set and enforce cost targets, and create a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers. The bill would also establish the Health Care Affordability Board , composed of 8 members, appointed as prescribed, and the Health Care Affordability Advisory Committee.

The bill would require the board to establish statewide health care cost targets for per capita total health care expenditures by the 2025 calendar year and specific targets for each health care sector it defines, including fully integrated delivery system systems, geographic regions, and individual health care entities, as appropriate. The bill, commencing in 2026, would require the office to take progressive actions against health care entities for failing to meet the cost targets, including performance improvement plans and escalating administrative penalties. The bill would establish the Health

Care Affordability Fund for the purpose of receiving and, upon appropriation by the Legislature, expending revenues collected pursuant to the provisions of the bill.

The bill would require the office to set standards for various health care metrics, including health care quality and equity , alternative payment models , primary care and behavioral health investments , and health care workforce stability. The bill would require the office to gather data and present a report on baseline health care spending trends and underlying factors on or before June 1, 2025. On or before June 1, 2027, the bill would require the office to prepare and publish annual reports concerning health care spending trends and underlying factors, along with policy recommendations to control costs and the other stated metrics. The bill would require the office to present the report's findings to the board and the broader public at a public meeting of the board and would provide for public comment and feedback on the report, as specified.

The bill would require the office to monitor cost trends in the health care market and to examine health care mergers, acquisitions, corporate affiliations, or other transactions that entail material changes to ownership, operations, or governance of health care service plans, insurers, hospitals or hospital systems, physician organizations, providers, pharmacy benefit managers, and other health care entities. The bill would require the health care entities to provide the office with written notice, as specified, of agreements and transactions that would sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of assets, or that would transfer control, responsibility, or governance of a material amount of the assets or operations to one or more entities. The bill would require the office to conduct a cost and market impact review, as specified, if it finds that the change is likely to have a risk of a significant impact on market competition, the state's ability to meet cost targets, or costs for purchasers and consumers. The bill would prohibit an agreement or transaction for which a cost and market impact review proceeds to be implemented without a written waiver from the office or until 60 days after the office issues its final report. The bill would require the health care entity to pay specified costs associated with that review and completing the report.

The bill would require health care service plans and health insurers, in submitting rates for review, to demonstrate the impact of any changes in the rate of growth of health care costs resulting from the health care cost targets. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

(3) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

The federal Medicaid program prohibits payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color

of law. Existing law, after the Director of the State Department of Health Care Services has communicated the determination to the Department of Finance that systems have been programmed for the implementation of these purposes, but no sooner than May 1, 2022, extends Medi-Cal eligibility for the full scope of Medi-Cal benefits to an individual who is 50 years of age or older, and who does not have satisfactory immigrant status or is unable to establish satisfactory immigration status, as specified, if they are otherwise eligible for those benefits. Existing law makes the effective date of enrollment for those individuals the same day that systems are operational to begin processing new applications pursuant to the director's determination. Existing law provides that a person enrolled in the Medi-Cal program under these provisions is not required to file a new application for the Medi-Cal program, requires the enrollment to be conducted pursuant to a prescribed eligibility and enrollment plan, and requires the department to provide monthly updates to the Legislature, as specified.

This bill would extend Medi-Cal eligibility for the full scope of Medi-Cal benefits to an individual who is 26 to 49 years of age, inclusive, and who does not have satisfactory immigrant status if they are otherwise eligible for those benefits. The bill would make the expansion after the director has determined and communicated the determination to the Department of Finance, that systems have been programmed for the implementation of these purposes, but no later than January 1, 2024. The bill would, as described above, make the effective date of enrollment the same day that systems are operational, would not require a new application, and would require the department to include these individuals in monthly updates to the Legislature. Because counties are required to make Medi-Cal eligibility determinations and this bill would expand Medi-Cal eligibility to specified individuals who are 26 to 49 years of age, inclusive, the bill would impose a state-mandated local program.

This bill would require the eligibility and enrollment plan to enable, to the maximum extent possible, as determined by the department, an individual to maintain their primary care provider or medical home. The bill would require the department to work with counties, Medi-Cal managed care health plans, health care providers, and consumer advocations, among others, to identify and maintain such linkage.

(4) Existing law, to the extent federal financial participation is available, requires the State Department of Health Care Services to exercise its option under federal law to implement a program for individuals who are 65 years of age or older or are disabled , without a share of cost, if they meet certain financial eligibility criteria, including not exceeding 138% of the federal poverty level in their countable income or as specified. Under existing law, certain medically needy persons with higher incomes qualify for Medi-Cal with a share of cost, if they meet specified criteria. Under existing law, the share of cost for those persons is generally the total after deducting an amount for maintenance from the person's monthly income. Existing law requires the department to establish income levels for maintenance at the lowest levels that reasonably permit a medically needy person to meet their

basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. Under existing law, for a single individual, the amount of the income level for maintenance per month is based on a calculation of 80% of the highest amount that would ordinarily be paid to a family of 2 persons, without any income or resources, under specified cash assistance provisions, multiplied by the federal financial participation rate, adjusted as specified.

This bill, to the extent that any necessary federal authorization is obtained, would increase the above-described income level for maintenance per month to be equal to the income limit for Medi-Cal without a share of cost for individuals who are 65 years of age or older or are disabled, generally totaling 138% of the federal poverty level. The bill would make these provisions operative on January 1, 2025, or the date certified by the department, whichever is later. The bill would repeal related provisions as part of conforming changes.

(5) Existing law requires the State Department of Health Care Services ,to the extent federal financial participation is available, to exercise a federal option to extend continuous eligibility to children 19 years of age and younger until the earlier of either the end of a 12-month period following the eligibility determination or the date the child exceeds 19 years of age.

Under this bill, a child under 5 years of age would be continuously eligible for Medi-Cal, including without regard to income, until the child reaches 5 years of age. The bill would prohibit the redetermination of Medi-Cal eligibility before the child reaches 5 years of age, unless the department or county possesses facts indicating that the family has requested the child's voluntary disenrollment, the child is deceased, the child is no longer a state resident, or the child's original enrollment was based on a state or county error or on fraud, abuse, or perjury, as specified. The bill would require the department to implement those provisions on January 1, 2025, or a date specified by the direction, whichever is later.

(6) Under existing law, a pregnant woman is eligible for Medi-Cal benefits if her income is less than or equal to 109% of the federal poverty level, as specified, and meets all other eligibility requirements, subject to receipt of any necessary federal approvals and the availability of federal financial participation.

This bill would instead make a pregnant individual eligible for full-scope Medi-Cal benefits if their income, effective January 1, 2022, is less than or equal to 208% of the federal poverty level before the application of the 5% income disregard, as specified. The bill would delete certain reporting provisions and would make conforming changes to related provisions. To the extent that the bill would create new duties for counties relating to Medi-Cal eligibility determinations, the bill would impose a state-mandated local program.

Existing law requires the department to seek any state plan amendments or federal waivers necessary to provide full-scope Medi-Cal benefits without a share of cost to pregnant women during their pregnancy and for 60 days

thereafter if their income is over 109% of, and is up to and including 138% of, the federal poverty level, as specified.

This bill would repeal those provisions.

(7) Existing law requires that Medi-Cal benefits be provided to optional targeted low-income children based on a certain income eligibility threshold. Existing law establishes the Medi-Cal Access Program , which provides health care services to a woman who is pregnant or in her postpartum period and whose household income is between certain thresholds, and to a child under 2 years of age who is delivered by a mother enrolled in the program, as specified. Existing law requires a subscriber to provide income information at the end of 12 months of coverage under the Medi-Cal Access Program, and requires that the infant be disenrolled from the program if the annual household income exceeds 317% of the federal poverty level or if the infant is eligible for full-scope Medi-Cal with no share of cost. Existing law also establishes a program under which certain employed persons with disabilities are eligible for Medi-Cal benefits based on income and other criteria.

Existing law creates the County Health Initiative Matching Fund in the State Treasury, administered by the State Department of Health Care Services for the purpose of providing matching state funds and local funds received by the fund through intergovernmental transfers to a county agency, a local initiative, or a county organized health system in order to provide health insurance coverage to certain children and adults in low-income households who do not qualify for health care benefits through the Healthy Families Program or Medi-Cal. Existing law requires the department to exercise the option , available to the state under federal law, to impose specified monthly premiums, based on income level, for the above-described children and employed persons with disabilities. Existing law requires the department to determine schedules for subscriber contribution amounts for persons enrolled in the Medi-Cal Access Program.

This bill would authorize the department, to the extent allowable under federal law, to elect not to impose premiums on specified individuals whose family income has been determined to be above 160% and up to and including 261% of the federal poverty level for the above-described programs. The bill would require the department to specify that election or reinstatement of premiums in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation in the annual Budget Act.

Beginning January 1, 2025, or the date certified by the State Department of Health Care Services, as specified, this bill would remove the requirement for providing income information at the end of the 12 months of enrollment in the Medi-Cal Access Program, and would instead require that the infant remain continuously eligible for the Medi-Cal program until they are 5 years of age, as specified. The bill would also make conforming changes.

(8) Existing law requires the State Department of Health Care Services to administer the Child Health and Disability Prevention (CHDP) Program. Under the CHDP Program , certain health and disability prevention treatment

services are provided to eligible children. Existing law requires the governing board of a county to establish a community CHDP program for the purpose of providing early and periodic assessments of the health status of children in the county.

Under this bill, all qualified providers enrolled in the CHDP Program as of June 30, 2024, instead, would be automatically enrolled as providers under the Children's Presumptive Eligibility Program on July 1, 2024. The bill would require the department, before July 1, 2024, to take various steps, including developing a transition plan to transition the CHDP Program, conducting a stakeholder engagement process to inform the department in the development and implementation of the transition plan, and requiring the department to seek federal approval to implement the transition plan. The bill would make the CHDP Program inoperative on July 1, 2024, or on the date that the department certifies that all the steps have been taken to implement the transition plan, whichever date is later.

(9) Existing law created the Healthy Families Program for the provision of health, vision, and dental benefits to eligible children pursuant to the federal Children's Health Insurance Program. Existing law requires the department and the former Managed Risk Medical Insurance Board to implement a program for preenrollment of children into the Medi-Cal program and the former Healthy Families Program. Existing law requires that subscribers continue to be eligible for the Healthy Families Program for a period of 12 months from the month eligibility is established. Existing law requires the State Department of Health Care Services to develop an electronic application to serve as the application into these programs and the CHDP Program, and authorizes the department to designate CHDP Program providers as qualified entities who are authorized to determine eligibility for the CHDP Program and for preenrollment into the Medi-Cal program and the former Healthy Families Program.

This bill, beginning January 1, 2025, or on a date certified by the State Department of Health Care Services, as specified, would require that a child be continuously eligible for the Healthy Families Program at up to five years of age. The bill would delete obsolete provisions relating to the former Healthy Families Program and the former Managed Risk Medical Insurance Board, and would make technical, nonsubstantive changes.

(10) Existing law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits. Existing law conditions implementation of the redetermination provisions on the availability of federal financial participation and receipt of any necessary federal approvals. In response to a change in circumstances, if a county cannot obtain sufficient information to redetermine eligibility, existing law requires the county to send to the beneficiary a form developed by the department that is prepopulated with the information that the county has obtained and that states the information needed to renew eligibility. If the individual will provide the form by mail or in person, existing law requires

them to sign the form. If, within 90 days of termination of a Medi-Cal beneficiary's eligibility or a change in eligibility status, the beneficiary submits the form or needed information to the county, existing law requires the county to redetermine eligibility. If the beneficiary is found eligible, or the beneficiary's eligibility status has not changed, whichever applies, existing law requires the termination to be rescinded as though the form were submitted in a timely manner.

This bill would remove the requirement on the county to prepopulate the form with the obtained information to redetermine eligibility in response to a change in circumstances. Under the bill, the beneficiary would not be required to sign and return the form. The bill would require the department to develop future revisions to the form. The bill would require that the eligibility redetermination be performed in a timely manner without requiring a new application. The bill would remove the requirement of rescinding the preceding termination as though the form were submitted in a timely manner. To the extent that the bill would modify county duties relating to the redetermination of Medi-Cal eligibility, the bill would impose a state-mandated local program.

(11) Existing law provides that routine health care costs related to the treatment of a beneficiary who is diagnosed with cancer and accepted in a clinical trial are covered under the Medi-Cal program, if certain requirements are met. Under existing federal law, medical assistance covered by the Medicaid program includes, among other services, routine patient costs for items and services furnished in connection with participation in a qualifying clinical trial, which is defined as a clinical trial, in any clinical phase of development, that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease, as specified.

This bill, effective July 1, 2022, would expand the coverage requirements for qualifying clinical trials for purposes of the Medi-Cal program, to conform with the Medicaid definition of a qualifying clinical trial.

(12) Under existing law, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for health care services provided by the modality of asynchronous store and forward, as defined, to the extent that federal financial participation is available.

This bill would also provide that face-to-face contact is not required when covered health care services are provided by video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. The bill would require a provider furnishing services through video synchronous interaction or audio-only synchronous interaction to also offer those services through in-person face-to-face contact or arrange for a referral to in-person care, except as specified. The bill would authorize a provider to establish a new patient relationship with a Medi-Cal beneficiary through video synchronous interaction, as specified, and would prohibit a provider from doing so through the other modalities, except as specified.

The bill would set forth other requirements on the State Department of Health Care Services or a Medi-Cal provider relating to the use of those telehealth modalities, including requirements concerning fee schedules and minimum reimbursement limits, services in border communities, as defined, consent standards, privacy and security compliance, informational notices, and a research and evaluation plan.

(13) Under existing law, federally qualified health center (FQHC) services and rural health clinic (RHC) services are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is available, to providers on a per-visit basis. "Visit " is defined as a face-to-face encounter between an FQHC or RHC patient and any of specified health care professionals.

This bill would expand "visit" to include an encounter between an FQHC or RHC patient and any of specified health care professionals using video synchronous interaction, audio-only synchronous interaction, or asynchronous store and forward modality when the applicable standard of care and other conditions are met. The bill would set forth other requirements on an FQHC or RHC relating to the use of those telehealth modalities, including requirements concerning reimbursement rates, consent standards, privacy and security compliance, the establishment of new patient relationships, and in-person services or referrals.

(14) Existing law establishes, until January 1, 2023, certain time and distance and appointment time standards for specified services to ensure that Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner.

This bill would extend those provisions to January 1, 2026.

Existing law authorizes the State Department of Health Care Services to allow a Medi-Cal managed care plan to use clinically appropriate telecommunications technology as a means of determining annual compliance with the time and distance standards or to approve alternative access to care, including telehealth, e-visits, or other evolving and innovative technological solutions that are used to provide care from a distance.

This bill would delete those provisions and would instead authorize the department to allow a Medi-Cal managed care plan to use clinically appropriate video synchronous interaction as a means of demonstrating compliance with the time or distance standards, and as part of an alternative access standard request. The bill would authorize the department to develop policies for granting credit, as specified.

If a Medi-Cal managed care plan cannot meet the time and distance standards, existing law requires the plan to submit a request for alternative access standards to the department, as specified.

This bill would make changes to the frequency of those request submissions. The bill would also require the plan to close out any corrective action plan deficiencies in a timely manner to ensure beneficiary access is adequate and to continually work to improve access in its provider network.

(15) Existing law requires a Medi-Cal managed care plan to comply with a minimum 85% medical loss ratio (MLR) consistent with specified federal

regulations. Existing law excludes certain health care service plans and dental managed care plans from those provisions.

This bill would remove those exclusions commencing on specified dates. The bill would also require the department to post on its internet website certain MLR-related and remittance-related information regarding subcontractor plans or other delegated entities.

(16) Existing federal law authorizes a state plan to provide for payment in any fiscal year to an FQHC for specified services in an amount that is determined under an alternative payment methodology (APM) if it is agreed to by the state and the FQHC and results in a payment to the FQHC of an amount that is at least equal to the amount otherwise required to be paid to the FQHC. Existing state law requires the department to authorize an APM pilot project for FQHCs that agree to participate, for implementation with respect to a county for a period of up to 3 years.

This bill would make various changes to the APM methodology for FQHCs, with implementation of the new provisions under the APM project to begin no sooner than January 1, 2024, subject to any necessary federal approvals, and no longer limited to a period of up to 3 years.

Existing law requires the department to establish a risk corridor structure for principal health plans, as defined, and to construct the risk sharing of the costs, as specified, and requires that certain responsibility-sharing terms apply and be incorporated into the contracts of each affected principal health plan.

This bill would remove those responsibility-sharing terms and would instead require the department to develop and specify the terms of the risk corridor in a form and manner specified by the department through all-plan letters or other technical guidance that would be incorporated into the contracts between each affected principal health plan and the department.

Existing law requires the department to establish a payment adjustment structure for the duration of the APM pilot project. Under existing law, an adjustment to payments in the case of higher than expected utilization is triggered when utilization exceeds projections by specified percentages, through which a participating FQHC site receives an aggregate payment adjustment from the principal health plan or applicable subcontracting payer that is based upon certain formulas involving the actualization utilization and projected utilization.

This bill would remove those formulas and would instead specify that, if an adjustment is required in a given year, the participating FQHC site would receive an aggregate payment adjustment from the principal health plan or applicable subcontracting payer that is based upon the difference between its actual utilization for the year and the projected utilization for the year. The bill would make conforming changes to related provisions.

Under existing law, participating FQHCs have the flexibility to experience a lower than expected visit utilization of up to 30% of projected utilization. If an FQHC site's actual utilization is at a level above that threshold, existing law requires the department to conduct a review and determine whether to

allow the participating FQHC site to retain all or a portion of the payments, as specified.

This bill would remove those provisions relating to the determination when the threshold is exceeded, and would require the department to develop objective criteria to ensure minimum standards for access and quality. If an FQHC site does not meet those standards, the bill would require the participating FQHC to return a portion of revenue based on a formula developed by the department, as specified.

Existing law authorizes the department to modify any methodology, process, or provision specified above to the extent necessary to comply with federal law or to obtain any necessary federal approvals.

This bill would condition the modification on not violating the spirit, purposes, and intent of the APM provisions, and would require the department to notify affected FQHCs, principal health plans, and certain legislative committees within 10 business days of the modification.

Existing law authorizes the department to make payment adjustments in response to an epidemic or similar catastrophic occurrence, as specified. Existing law requires the department to contract with an independent entity to perform an evaluation of the APM pilot project, and requires that certain reports be submitted to the Legislature.

This bill would repeal those provisions. The bill would also make conforming changes to other APM-related provisions concerning FQHCs.

(17) Existing law, the Children and Youth Behavioral Health Initiative , requires the State Department of Health Care Services to develop and select evidence-based interventions and community-defined promising practices, with a competitive grant process , to improve outcomes for children and youth with, or at high risk for, behavioral health conditions. Existing law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative to, among other things, improve quality outcomes, reduce health disparities, and increase flexibility. Existing law requires the department, subject to an appropriation, to establish the Behavioral Health Quality Improvement Program to provide grants to qualified Medi-Cal behavioral health delivery systems for purposes of implementing CalAIM behavioral health components and the Children and Youth Behavioral Health Initiative, as specified.

This bill would instead specify that those grants be provided for purposes of implementing CalAIM behavioral health components and for other purposes related to Medi-Cal behavioral health delivery systems, as specified. The bill would make conforming changes to related provisions.

(18) Existing law sets forth coverage for certain nonspecialty mental health services by Medi-Cal managed care plans or the Medi-Cal fee-for-service delivery system, and coverage for specialty mental health services by county mental health plans, as specified. Existing law requires the State Department of Health Care Services to continue to implement the Specialty Mental Health Services Program as a component of CalAIM.

This bill would authorize the department, as a component of the Specialty Mental Health Program, to seek federal approval for a demonstration project

to receive federal financial participation for services furnished to Medi-Cal beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as institutions for mental diseases, as defined.

(19) Under the Medi-Cal program, qualified low-income individuals receive health care services pursuant to a schedule of benefits. Existing law requires the State Department of Health Care Services to standardize those applicable covered Medi-Cal benefits provided by Medi-Cal managed care plans under comprehensive risk contracts with the department on a statewide basis and across all models of Medi-Cal managed care in accordance with specified requirements and the CalAIM Terms and Conditions. Existing law, commencing January 1, 2023, subject to CalAIM implementation, requires the department to include, or continue to include, institutional long-term care services as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan.

This bill would instead require the department, commencing July 1, 2023, and subject to CalAIM implementation, to include or continue to include institutional long-term care services not described in the above-described provision, as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan, as specified.

(20) Existing law, subject to CalAIM implementation, authorizes a Medi-Cal managed care plan to cover those services or settings approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services, including, among others, housing transition navigation services or recuperative care. Existing law requires the department, beginning no later than January 1, 2024, to conduct an independent evaluation of the effectiveness of in lieu of services.

This bill would rename in lieu of services or settings as community supports. The bill would remove the above-described deadline and would instead require the department to conduct the evaluation in accordance with the parameters and timeframes specified in the CalAIM Terms and Conditions.

(21) Existing federal law provides for the suspension of Medi-Cal benefits to an inmate of a public institution and provides that the suspension ends, as specified, for an individual who is defined as a Juvenile under federal law. Under existing state law, the suspension of Medi-Cal benefits to an inmate of a public institution ends, for someone who is not a juvenile, on the date the individual is no longer an inmate of a public institution or one year from the date the individual becomes an inmate of a public institution, whichever is sooner, and ends, for a juvenile, as defined, as specified in federal law or one year from the date the individual becomes an inmate of a public institution, whichever is sooner.

This bill would instead provide, commencing January 1, 2023, for the suspensions of those benefits on the day the person becomes an inmate of a public institution, except as specified for an individual who is a juvenile

or for a person who is not a juvenile to the extent permissible under federal law.

Existing law makes a qualifying inmate of a public institution eligible, commencing no sooner than January 1, 2023, to receive targeted Medi-Cal services for 90 days, or the number of days approved in the CalAIM Terms and Conditions if fewer than 90 days, before the date they are released from a public institution, as specified.

This bill would change the duration of eligibility for targeted Medi-Cal services to 90 days or the number of days approved in the CalAIM Terms and Conditions with respect to an eligible population of qualifying inmates if different than 90 days, before the date they are released from a public institution. To the extent that the bill would create new duties for counties relating to Medi-Cal eligibility determinations, the bill would impose a state-mandated local program.

(22) Existing regulation requires facilities that provide specialty mental health services and community mental health services to maintain a written record of a voluntarily admitted patient's consent to receive antipsychotic medications, including the patient's signature.

This bill would eliminate the requirement that a facility's written record include the patient's signature.

(23) Existing law, the Hospital Presumptive Eligibility program, provides Medi-Cal benefits to certain individuals who have been determined eligible on the basis of preliminary information by a qualified hospital, as specified.

This bill would authorize qualified hospitals to make presumptive eligibility determinations for individuals who are 65 years of age or older, blind, or disabled, who meet certain income criteria.

(24) Existing law authorizes the State Department of Health Care Services to provide health care services to beneficiaries through various models of managed care, including geographic managed care and prepaid health plans, and requires the department to implement a dental managed care program. Dental services are provided under geographic managed care in the County of Sacramento and prepaid health plans in the County of Los Angeles. Existing law requires the department to extend dental managed care contracts to December 31, 2022, and to secure the extensions on a sole source basis, as specified.

This bill would require the department to conduct a competitive bid and procurement process to award new dental managed care contracts, commencing January 1, 2024, as specified. The bill would extend the above-described existing dental managed care contracts through December 31, 2023, or through the calendar day immediately preceding the effective date for the new contracts to the extent that effective date is later than January 1, 2024. The bill would condition implementation of these provisions on receipt of any necessary federal approvals. The bill would require the department, if new dental managed care contracts have not taken effect on or before July 1, 2024, to provide an update to the Legislature detailing the specific circumstances that contributed to the delay and an expected commencement date for the new contracts.

This bill would require that covered dental benefits and accompanying criteria be identified in the Medi-Cal Dental Manual of Criteria, and would require the State Department of Health Care Services to evaluate all covered dental benefits for evidence-based practices consistent with the American Academy of Pediatric Dentistry and the American Dental Association guidelines.

Existing law sets forth different dental services as covered benefits based on whether the beneficiary is under 21 years of age or is older. Under existing law, for persons 21 years of age or older, laboratory-processed crowns on posterior teeth are not a covered benefit except when a posterior tooth is necessary as an abutment for any fixed or removable prosthesis.

This bill would, for those persons, instead cover laboratory-processed crowns on posterior teeth when medically necessary to restore a posterior tooth back to normal function based on the criteria specified in the Medi-Cal Dental Manual of Criteria.

Existing law requires the department to reduce the rate of subgingival curettage and root planing by 41% for all beneficiaries except those residing in a skilled nursing facility or an intermediate care facility for the developmentally disabled, as specified.

This bill would repeal that provision relating to the rate reduction.

(25) Existing law requires the State Department of Health Care Services to audit amounts paid for services provided to Medi-Cal beneficiaries, as specified. Existing law requires every primary supplier of pharmaceuticals, medical equipment, or supplies to maintain specified accounting records for 3 years subject to audit by the department.

This bill would instead require every primary supplier of pharmaceuticals, medical equipment, or supplies to maintain those accounting records for 10 years.

(26) Existing law requires the Medi-Cal reimbursement rate for intermediate care facilities for the developmentally disabled or facilities providing continuous skilled nursing care to developmentally disabled individuals, for dates of service on or after August 1, 2021, to July 31, 2022, inclusive, to be the greater of the rate published by the State Department of Health Care Services or the rate, including Proposition 56 supplemental payments, if available, or the approved Medi–Cal State Plan reimbursement rate, inclusive of the temporary increased Medicaid payments associated with the COVID–19 Public Health Emergency, plus the Proposition 56 supplemental payment amount, in effect for that facility, as specified.

This bill would require the Medi-Cal reimbursement rate for the above-described facilities and services, for dates of service on or after August 1, 2021, to be the greater of the rate published by the department or the rate, including Proposition 56 supplemental payments, if available, or the approved Medi–Cal State Plan reimbursement rate, inclusive of the temporary increased Medicaid payments associated with the COVID-19 Public Health Emergency, plus the Proposition 56 supplemental payment amount, in effect for that facility, on the last day of the COVID-19 Public Health Emergency.

(27) Existing law requires that Medi-Cal provider payments and payments for specified non-Medi-Cal programs be reduced by 10% for dates of service on and after June 1, 2011, and conditions implementation of those payment reductions on receipt of any necessary federal approvals. Existing law exempts certain services, facilities, and payments from those payment reductions.

This bill would make additional exemptions, for dates of service on and after July 1, 2022, or the effective date of any necessary federal approvals, whichever is later, for specified services and providers, and would exempt podiatrists and prosthetists for dates of service on and after January 1, 2023, or the effective date of any necessary federal approvals, whichever is later. The bill would condition implementation of these provisions on receipt of federal approval. The bill would make other conforming changes.

The bill would, for the above-described dates, authorize the maintenance of the reimbursement rates or payments for specified services and providers, using General Fund or other state funds appropriated to the department as the state share, at the payment levels in effect on December 31, 2021, as specified, under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 that were implemented with funds from the Healthcare Treatment Fund.

The bill would condition implementation of the maintenance provision on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would authorize the department to implement the provision through provider bulletins or similar instructions. The bill would require the department to develop the eligibility criteria, methodologies, and parameters for the payments and rate increases maintained, and would authorize revisions, as specified.

(28) Existing law requires the State Department of Health Care Services to establish a list of covered services and maximum allowable reimbursement rates for durable medical equipment, as defined. Existing law requires reimbursement for oxygen delivery systems and oxygen contents to utilize certain national codes, and to be the lesser of specified amounts.

This bill would, effective July 1, 2022, require that reimbursement for oxygen and respiratory equipment, as determined by the department, not to exceed 100% of the lowest maximum allowance for California established by the federal Medicare Program for the same or similar item or service.

(29) Under the Medi-Cal program, existing law prohibits the allowable markup payable for the dispensing of medical supplies, generally, by assistive device and sickroom supply dealers and pharmacies, from exceeding 23% of the estimated acquisition cost of the item dispensed, as defined by the State Department of Health Care Services. Existing law requires that payment for diabetic testing supplies not exceed the estimated acquisition cost of the item dispensed, as defined by the department, plus a fee, as specified.

This bill would clarify that, beginning July 1, 2022, the allowable markup described above applies to diabetic testing supplies dispensed by assistive

device and sickroom supply dealers and pharmacies except for diabetic test strips, lancets, and insulin syringes.

(30) Existing law, for the duration of the COVID-19 emergency period, requires the department to implement any federal Medicaid program waiver or flexibility approved by the federal Centers for Medicare and Medicaid Services related to that emergency and to exercise its option under prescribed law to extend medical assistance to uninsured individuals, as specified, for the duration of that emergency period.

This bill would require the department to reimburse the administration of a COVID-19 vaccine at 100% of the Medicare national equivalent rate in effect at the time of administration without geographic adjustment.

(31) Existing law establishes the Drug Medi-Cal Treatment Program (Drug Medi-Cal), under which the State Department of Health Care Services is authorized to enter into contracts with each county, or enter into contracts directly with certified providers, for the provision of various alcohol and drug use treatment services to Medi-Cal beneficiaries. Existing law requires, to the extent federal financial participation is available and any necessary federal approvals have been obtained, that a Drug Medi-Cal certified provider receive reimbursement for individual counseling services provided through telehealth by a licensed practitioner of the healing arts or a registered or certified alcohol or other drug counselor, when medically necessary and in accordance with the Medicaid state plan.

This bill would expand reimbursement for other medically necessary Drug Medi-Cal services and to other authorized individuals, as specified, when those services are delivered through video synchronous interaction or audio-only synchronous interaction. The bill would similarly set forth certain requirements relating to privacy and security compliance and the establishment of new patient relationships through telehealth modalities. The bill would require the department to adopt regulations by July 1, 2024, to implement these provisions.

(32) Existing law charges the State Department of Health Care Services with administering prevention, treatment, and recovery services for alcohol and drug abuse. Existing law authorizes the department to conduct various activities to alleviate problems related to alcohol and other drug use, including providing funds to counties for the implementation of local programs, reviewing and certifying alcohol and other drug programs, and licensing and regulating adult alcoholism or drug abuse recovery or treatment facilities.

This bill would require alcohol and other drug programs and alcoholism or drug abuse recovery or treatment facilities to either offer medications for addiction treatment (MAT) directly to clients, or have an effective referral process in place with narcotic treatment programs, community health centers, or other MAT providers. The bill would require these programs and facilities to implement and maintain a MAT policy approved by the department, as specified.

Existing law requires the department to license narcotic treatment programs to use narcotic replacement therapy and medication-assisted treatment in the treatment of addicted persons.

This bill would require the department to establish a program for the operation and regulation of mobile narcotic treatment programs. The bill would require those programs to meet specified requirements, including that they operate under the license of a primary narcotic treatment program and receive approval from the department before operating a mobile narcotic treatment program.

(33) Existing federal law authorizes a state to provide medical assistance for qualifying community-based mobile crisis intervention services during a specified 5-year period ending on March 31, 2027.

This bill would require the State Department of Health Care Services to seek all necessary federal approvals to provide qualifying community-based mobile crisis intervention services to eligible Medi-Cal beneficiaries experiencing a mental health or substance use disorder crisis. Under the bill, these services would be available exclusively through a Medi-Cal behavioral health delivery system. The bill would require the department to establish requirements for the receipt of the services by eligible Medi-Cal beneficiaries and for authorized service providers, and to oversee and enforce the requirements and guidelines. The bill would authorize the department to enter into exclusive or nonexclusive contracts, or to amend existing contracts, for purposes of implementing these provisions, as specified. Under the bill, these provisions would be implemented no sooner than January 1, 2023, up to the end of the 5-year period specified under federal law.

(34) Existing law prohibits a person from being tried or adjudged to punishment while that person is mentally incompetent. Existing law establishes a process by which a defendant's mental competency is evaluated. Existing law requires the court to appoint a psychiatrist or licensed psychologist to examine the defendant, and requires the psychiatrist or licensed psychologist to inform the court of their opinion regarding the defendant's ability to understand the proceedings and to assist counsel in their defense, and their opinion regarding the suitability of antipsychotic medication to treat the defendant, as specified. Existing law requires a court, before ordering a defendant to be committed to the State Department of State Hospitals or other treatment facility, to hear and determine whether the defendant lacks the capacity to make decisions regarding the administration of antipsychotic medication, as specified.

This bill would revise the respective roles of a licensed psychologist or psychiatrist in this process, and would revise the requirements for the hearing regarding the defendant's capacity and administration of antipsychotic medication.

Existing law requires a court, when ordering commitment to the State Department of State Hospitals or other treatment facility, to provide copies of certain documents to the facility, including a commitment order. Existing law requires a court to order a mentally incompetent defendant to be

delivered to a State Department of State Hospitals facility or to any other available public or private treatment facility, as specified.

This bill would require additional documentation to be provided when ordering commitment. The bill would, commencing on July 1, 2023, require that a defendant first be considered for placement in an outpatient treatment program, a community treatment program, or a diversion program, if available, unless the court finds that the clinical needs of the defendant or the risk to community safety, warrant placement in a State Department of State Hospitals facility, as specified.

Existing law authorizes the State Department of State Hospitals to conduct reevaluations of defendants who have been found mentally incompetent to stand trial and have been awaiting admission to the department for 60 days or more.

This bill would instead authorize the department to conduct reevaluations of those defendants awaiting admission any time after commitment has been ordered. The bill would authorize a court to order the involuntary administration of antipsychotic medication based upon a reevaluation, as specified. The bill would also require local county jails to cooperate with evaluators, as specified. This bill would, subject to an appropriation, authorize the State Department of State Hospitals to contract for medical, evaluation, and other services for felony defendants in county jail deemed incompetent to stand trial.

Existing law defines a treatment facility to include a county jail, as specified, and authorizes the administration of antipsychotic medications in a county jail, subject to specified limitations.

This bill would repeal this provision and make conforming changes.

Existing law requires each county, acting singly or in combination with other counties, to contract with the State Department of State Hospitals for the number and types of state hospital beds that the department will make available to the county or counties during the year.

This bill would require the department to implement a cap for the number of mentally incompetent persons committed in each county per year and would assess a penalty rate for commitments exceeding that cap. The bill would create the Mental Health Diversion Fund, a continuously appropriated fund, and would require the penalty funds to be collected by the department and deposited into the fund. The bill would require the penalty funds to be dispersed to each county in amounts equal to the penalty payments made for the purpose of supporting county mental health services and activities, as specified. By requiring counties to utilize county funds for specified purposes, this bill would impose a state-mandated local program. By creating a continuously appropriated fund, the bill would make an appropriation.

Existing law establishes the Forensic Conditional Release Program to provide outpatient and community-based treatment to persons committed to the State Department of State Hospitals.

This bill would, until June 30, 2026, establish a statewide panel of independent evaluators, as specified, to identify and evaluate state hospital

patients that are appropriate for participation in the Forensic Conditional Release Program.

Under existing law, patient records of the State Department of State Hospitals are confidential.

This bill would authorize disclosure of these records to parties in specified judicial and administrative proceedings and to district attorneys in commitment, recommitment, or petition for release proceedings.

(35) Existing law, the Investment in Mental Health Wellness Act of 2013, provides that funds appropriated by the Legislature to the California Health Facilities Financing Authority for the purposes of the act be made available to selected counties or counties acting jointly, except as otherwise provided, and used to increase capacity for client assistance and services in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. The act, through appropriations in the annual Budget Act, authorizes the authority and the Mental Health Services Oversight and Accountability Commission to administer competitive selection processes for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, and specified personnel resources.

This bill would authorize the authority and the commission to use a sole-source contracting processes to increase capacity for those services.

The act requires funds allocated to the commission to be allocated selected counties, counties acting jointly, or city mental health departments for triage personnel to provide intensive case management and linkage services for individuals with mental health disorders at various points of access. Existing law requires the commission to distribute these funds through a competitive selection process.

This bill, instead, would require funds appropriated to the commission to be allocated to various entities, including community-based organizations or local government entities, to support crisis prevention, crisis early intervention, and crisis response strategies. The bill would authorize the commission to utilize a sole-source process to allocate funds when it determines, during a public hearing, that it is in the public interest to do so and would address barriers to participation for local government agencies and community-based organizations, as specified.

(36) Existing law requires the State Department of Public Health to develop and review plans and participate in a program for the prevention and control of venereal disease. Existing law requires the department to allocate funds to local health jurisdictions for sexually transmitted disease prevention and control activities. In awarding these funds, existing law requires the department to authorize local health jurisdictions to include innovative and impactful prevention and control activities, including, among other things, community-based testing and disease investigation.

This bill would expand these activities to include, among other things, integrated services for sexually transmitted infections (STIs), viral hepatitis,

human immunodeficiency virus infection, and drug overdose to the extent they improve health outcomes for people living with, or at risk for, STIs.

Existing law requires, if funds are explicitly appropriated in the annual Budget Act for these purposes, the State Department of Public Health to allocate funds to local health jurisdictions to provide hepatitis C virus (HCV) activities, including monitoring, prevention, testing, and linkage to and retention in care activities for the most vulnerable and underserved individuals living with, or at high risk for, HCV infection. Existing law requires no less than 50% of the funds allocated to local health jurisdictions to be provided to community-based organizations if the community-based organizations are able to provide these activities and demonstrate expertise, history, and credibility working successfully in engaging the most vulnerable and underserved individuals living with, or at high risk for, HCV infection.

This bill would, contingent on funding, expand the activities that the department may allocate funding for including, among other things, integrated services for human immunodeficiency virus (HIV) infection and sexually transmitted infections. The bill would authorize local health jurisdictions and community-based organizations to use funds to provide material support, including, among other things, sleeping bags and clothing items. The bill would also authorize the department to use funds to support capacity building assistance, including, among other things, integrated services for HIV and sexually transmitted infections, to the extent they improve health outcomes for the most vulnerable and underserved individuals living with, or at high risk for, HCV infection.

(37) Existing law, the California Uniform Controlled Substances Act, classifies opioids as Schedule II controlled substances and imposes various restrictions on the prescription of those drugs. Existing law requires the State Department of Public Health, subject to an appropriation in the Budget Act of 2016, to award grant funding for naloxone, or another approved opioid antagonist, to local health departments, local government agencies, or other specified entities to reduce the rate of fatal overdose from opioid drugs.

Existing law establishes the Litigation Deposits Fund , under the control of the Department of Justice and consisting of moneys received as litigation deposits where the state is a party to the litigation, as specified. The State of California is a party to certain opioid-related settlements, through which the state receives funds for opioid remediation.

This bill would create the Opioid Settlements Fund (OSF), to be administered by the State Department of Health Care Services. The bill would, upon appropriation by the Legislature, require the moneys in the OSF to be used for opioid remediation in accordance with the terms of the judgment or settlement from which the funds were received. The bill would funds certain opioid settlements and funds from any future judgments or settlements that are not deposited in the Litigation Deposits Fund to be transferred to the OSF. The bill would require the State Department of Health Care Services to oversee those activities funded by the OSF, including preparing periodic written reports. The bill would authorize the department

to implement these provisions through information notices or other similar instructions, and to enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis for purposes of implementing those activities funded by the OSF, as specified.

(38) Existing law establishes the State Department of State Hospitals within the California Health and Human Services Agency, and provides the department with jurisdiction over specified facilities for the care and treatment of persons with mental health disorders. Existing law authorizes the Director of State Hospitals to reduce, cancel, or remit the amount to be paid by the estate liable for the care and treatment of a person at the state hospital who is an alcoholic or who has a mental health disorder and who is a patient at a state hospital, on satisfactory proof that the estate is unable to pay the cost of that care and treatment or that the amount is uncollectible.

This bill would, among other things, additionally authorize the director's designee to reduce, cancel, or remit the amount to be paid by the estate, and would no longer include under that provision the care and treatment of a person who is an alcoholic. The bill would require the department to develop and implement a financial assistance program that may reduce or cancel the amount that a patient owes for the cost of care and treatment at a state hospital, as specified, and would require the department to make its financial assistance program policy available to the public on the department's internet website. The bill would also authorize the department to develop reasonable payment plans suitable to the patient's ability to pay.

Existing law, if at any time there is not sufficient money on hand in the estate of a committed person to pay the claim of a state mental hospital for their care, support, maintenance, and expenses therein, authorizes the court to make an order directing the guardian or conservator to sell as much of the other personal or real property, or both, of the person as is necessary to pay for the care, support, maintenance, and expenses of the person at the state hospital, and use those proceeds to pay the amount due. Under existing law, if a person who lacks legal capacity to make decisions, who has no guardian or conservator of the estate, and who has been admitted or committed to the department for placement in a state hospital, is the owner of any property, the department may apply to the superior court of the proper county for its appointment as guardian or conservator of the person's estate. Existing law also authorizes the department to invest funds held as executor, administrator, or conservator of estates, or trustee, in specified bonds or obligations, and to establish one or more common trusts for investment of those funds. Existing law authorizes the department, upon the death of a person under its jurisdiction, to make proper disposition of the remains and pay for the disposition of the remains, as specified.

This bill would delete the above-described provisions.

(39) Existing law establishes the California Health Workforce Education and Training Council to help coordinate California's health workforce education and training in order to develop a health workforce that meets the state's health care needs. Existing law establishes the membership of the council.

This bill would revise and recast those provisions, and additionally include the Secretary of Labor and Workforce Development on the council.

(40) Under existing law, HCAI is responsible for, among other things, administering various health professions training and development programs.

Existing law, the Song-Brown Health Care Workforce Training Act, establishes a state medical contract program with accredited medical schools, hospitals, and other programs and institutions to increase the number of students and residents receiving quality education and training in specified primary care specialties and maximize the delivery of primary care and family physician services to underserved areas of the state. Existing law requires the director of HCAI to take specified actions regarding this program, including, among others, developing application and contract criteria based on health care workforce needs and the priorities of the council.

This bill would instead require the director of HCAI to develop application and contract criteria based on health care workforce needs and priorities. The bill would add programs that train midwives to the list of programs eligible to contract with the state under the Song-Brown Health Care Workforce Training Act, and would add midwifery to the list of specified primary care specialties under that act. The bill would make conforming changes.

The bill would establish the Abortion Practical Support Fund, a continuously appropriated fund, and would require HCAI to administer the fund for the purpose of providing grants to nonprofit organizations that either specialize in assisting pregnant people who are low income, or who face other financial barriers, with direct practical support services to access and obtain an abortion or that provide abortion services to those persons. By creating a continuously appropriated fund, the bill would make an appropriation.

This bill would require HCAI, on or before July 1, 2023, to develop and approve statewide requirements for community health worker certificate programs and to approve the curriculum required for programs to certify community health workers. The bill would require HCAI, on or before July 1, 2023, to review, approve, or renew evidence-based curricula and community-defined curricula for core competencies, specialized programs, and training. The bill would require an organization that seeks approval or renewal of a community health worker certificate program to submit a community health worker certificate program plan, submit to periodic reviews, and submit annual community health worker certificate program reports, as specified. The bill would authorize HCAI, in consultation with stakeholders, to request that an individual who is either enrolled in, or who has completed, a community health worker certificate program submit specified workforce data.

This bill would require the State Department of Health Care Services, subject to appropriation by the Legislature, to provide funding to specified employers for retention payments to their eligible employees or physicians for the public purpose of promoting stability and retention in California's health care workforce. The bill would define a qualifying work period as a

91-day period identified by the department beginning no later than 30 days after the enactment of the bill and would require employers to submit to the department information related to its eligible employees and their hours of compensated work during that period, among other information. The bill would authorize the department to provide funding to the employers up to $1,500 per employee, subject to pro rata reductions based on the aggregate appropriation. The bill would require employers to provide the funding to their employees within 60 days, to attest to the department that the payments were made within that time period, to return any unspent funds to the department, and to report to the department within 90 days the payments made to the employees, as specified. Because the bill would require the employer to attest to the payments being made under penalty of perjury, the bill would establish a new crime and would create a state-mandated local program.

(41) Existing law recognizes the Legislature's intent to further the provision of necessary public health services by granting financial assistance to local health departments and enabling them to meet present and future health needs in an efficient and effective manner.

This bill would require the State Department of Public Health to develop and implement a program to fund and support vital public health activities and services provided by local health jurisdictions. The bill would condition funding on a local health jurisdiction's submission of a public health plan, as specified. The bill would specify how funds under this program are to be allocated and would require the funds to be used to supplement, rather than supplant, existing levels of services provided by qualifying local health jurisdictions. The bill would provide, for the 2022–23 fiscal year, that each local health jurisdiction may use the funds to develop the required public health plans.

This bill would require the State Public Health Officer, on or before February 1 of every other year, to submit a report to the Governor and Legislature on the state of public health in California. The bill would require the report to include, among other things, data on the prevalence of morbidity and mortality related to mental illness and substance abuse. The bill would also require, as condition of the funding, local health jurisdictions to present annual updates on the public health status to the city council or board of supervisors, including an update on the progress addressing these issues through the strategies and programs identified by the local health jurisdiction.

(42) Existing law requires the State Department of Social Services to establish a program of public health nursing in the child welfare services program, and requires counties to use the services of the foster care public health nurse under this program. Existing law requires the foster care public health nurse to work with the appropriate child welfare services workers to coordinate health care services and to serve as a liaison with health care professionals, and requires the foster care public health nurse to have access to the child's medical, dental, and mental health care information to fulfill these duties. Existing law limits the implementation of those provisions to

the extent that the State Department of Social Services determines that federal financial participation is available.

This bill would limit the implementation of those provisions to the extent that the State Department of Health Care Services determines that federal financial participation is available. The bill would require the State Department of Social Services, the State Department of Health Care Services, and counties and cities, to maximize the use of federal funds in implementing those provisions. The bill would, among other things, authorize the State Department of Health Care Services to enter into contracts, or amend existing contracts, with a California county, city, or city and county to facilitate local administration of those provisions, as specified.

(43) Existing law, the California Affordable Drug Manufacturing Act of 2020, requires the California Health and Human Services Agency (CHHSA) to enter into partnerships, in consultation with other state departments as necessary, to increase patient access to affordable drugs, among other things. Existing law requires CHHSA to report to the Legislature on or before July 1, 2022, with a description of the status of the drugs targeted for manufacture and an analysis of how CHHSA's activities have impacted competition, access, and costs for those drugs, and also requires CHHSA, upon appropriation by the Legislature, to submit a report to the Legislature on or before July 1, 2023, that assesses the feasibility and advantages of directly manufacturing generic prescription drugs and selling generic prescription drugs at a fair price. Existing law exempts all nonpublic information and documents obtained under this program from disclosure under the California Public Records Act.

For purposes of implementing the California Affordable Drug Manufacturing Act of 2020, this bill would authorize CHHSA or its departments to enter into to enter into exclusive or nonexclusive contracts on a bid or negotiated basis and would exempt these contracts from review or approval by the Department of General Services until December 31, 2027, as specified. The bill would extend the deadline for the report describing the status of the drugs targeted for manufacture and the related impacts until December 31, 2022, and would extend the deadline for the report assessing the feasibility of directly manufacturing generic prescription drugs until December 31, 2023. The bill would additionally exempt all nonpublic information and documents prepared under the California Affordable Drug Manufacturing Act of 2020 from disclosure under the California Public Records Act.

(44) Existing law, the Personal Income Tax Law, authorizes an individual to contribute amounts in excess of their personal income tax liability for the support of specified funds. Existing law establishes the Suicide Prevention Voluntary Tax Contribution Fund in the State Treasury, as a continuously appropriated fund, and requires the Franchise Tax Board to revise the tax return to include a space for this fund when another voluntary contribution designation is removed or space becomes available. Existing law requires moneys contributed to the fund on the tax return to be allocated to the Franchise Tax Board, the Controller, and the Mental Health Services

Oversight and Accountability Commission for administrative costs and to the commission for disbursement to crisis centers located in the state that are active members of the National Suicide Prevention Lifeline. Existing law requires 50% of the funds disbursed to crisis centers to be awarded through a project-specific grant process to fund programs that are designed to provide suicide prevention services to rural and desert communities. Existing law requires the other 50% of those funds to be disbursed to crisis centers for the sole purpose of providing suicide prevention services and requires those funds to be disbursed to each crisis center in an amount proportional to the proportion that the annual number of calls the crisis center answers bears to the annual number of calls answered by all crisis centers located in the state, as specified. Existing law requires the commission to report on its internet website information regarding the award of funds and the administrative costs of the program.

This bill would require the State Department of Health Care Services, instead of the commission, to administer the funds disbursed to crisis centers. The bill would eliminate the requirement that 50% of those funds be awarded as grants to provide suicide prevention services to rural and desert communities and that 50% of the funds be disbursed on a proportional basis to crisis centers based on the number of calls answered by the crisis centers. The bill would instead require the money to be disbursed to crisis centers located in the state that are active members of the National Suicide Prevention Lifeline, with priority given to those crisis centers located in rural and desert communities. By changing the purposes for which the moneys in a continuously appropriated fund may be expended, the bill would make an appropriation.

This bill would eliminate the commission's reporting requirement and would prohibit money in the fund from being used to supplant administrative funding for other specified mental health programs. The bill would authorize the department, in administering the funds, to enter into exclusive or nonexclusive contracts, or amend existing contracts. The bill would make other conforming changes.

(45) The California Health Facilities Financing Authority Act authorizes the California Health Facilities Financing Authority to, among other things, make loans from the continuously appropriated California Health Facilities Financing Authority Fund to participating health institutions for financing or refinancing the acquisition, construction, or remodeling of health facilities. Under existing law, participating health institutions are specified entities authorized by state law to provide or operate a health facility and undertake the financing or refinancing of the construction or acquisition of a project or of working capital, as defined. Existing law defines "working capital" as moneys to be used by or on behalf of a participating health institution for specified expenses in connection with the ownership or operation of a health facility, including interest not to exceed one year on any loan for working capital made pursuant to these provisions. Existing law requires a participating health institution that is a private nonprofit corporation or

association and that borrows money to finance working capital to repay and discharge the loan within 15 months of the loan date.

This bill would change the definition of "working capital" to include 2 years' worth of interest on any loan for working capital. The bill would also extend the time for a participating health institution that is a private nonprofit corporation or association to repay and discharge a loan for working capital to 24 months.

(46) Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

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

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

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

Appropriation: yes.

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

SECTION 1. Section 12534 is added to the Government Code, to read:

12534. (a) The Opioid Settlements Fund is hereby created in the State Treasury.

(b) Upon order of the Director of Finance, the Controller shall transfer funds received in the Litigation Deposits Fund from the settlement of People v. McKinsey & Company, Inc. (Alameda County Superior Court, No. RG21087649, Feb. 4, 2021) to the Opioid Settlements Fund. Funds received from this settlement that are not deposited in the Litigation Deposits Fund shall be deposited into the Opioid Settlements Fund.

(c) Upon order of the Director of Finance, the Controller shall transfer funds received in the Litigation Deposits Fund allocated to the state for state opioid remediation from the 2022 opioid settlements with Johnson & Johnson, Janssen Pharmaceuticals, McKesson, Cardinal Health, and AmerisourceBergen to the Opioid Settlements Fund. Funds received from these settlements and any future judgments or settlements for these purposes that are not deposited in the Litigation Deposits Fund shall be deposited into the Opioid Settlements Fund.

(d) Upon appropriation by the Legislature, moneys in the Opioid Settlements Fund shall be used for opioid remediation in accordance with the terms of the judgment or settlement from which the funds were received.

(e) The State Department of Health Care Services shall administer the Opioid Settlements Fund and shall oversee those activities funded by the Opioid Settlements Fund. This shall include, but not be limited to, designating additional high-impact abatement activities, conducting related stakeholder engagement, monitoring the California participating subdivisions for compliance, and preparing periodic written reports.

(f) Under the terms of the California State-Subdivision Agreement Regarding Distribution and Use of Settlement Funds executed pursuant to the 2022 opioid settlements, any settlement funds received by a California participating subdivision that are not expended or encumbered within the time period specified in the California State-Subdivision Agreement Regarding Distribution and Use of Settlement Funds shall be transferred to the state. These transferred funds shall be deposited into the Opioid Settlements Fund.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1, the State Department of Health Care Services may implement, interpret, or make specific this section, in whole or in part, by means of information notices or other similar instructions, without taking further regulatory action.

(h) The State Department of Health Care Services may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis for purposes of implementing those activities funded by the Opioid Settlements Fund. Contracts entered into or amended pursuant to this section are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5, Section 19130, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, the State Administrative Manual, and the State Contracting Manual, and are exempt from the review or approval of any division of the Department of General Services.

(i) For purposes of this section, ”California participating subdivision” means a city, county, or political subdivision participating in the 2022 settlement agreements listed in subdivision (c) that is either identified as a Plaintiff Subdivision, or identified as a Primary Subdivision with a population equal to or greater than 10,000 residents.

SEC. 2. Section 15432 of the Government Code is amended to read:

15432. As used in this part, the following words and terms shall have the following meanings, unless the context clearly indicates or requires another or different meaning or intent:

(a) “Act” means the California Health Facilities Financing Authority Act.

(b) “Authority” means the California Health Facilities Financing Authority created by this part or any board, body, commission, department, or officer succeeding to the principal functions thereof or to which the powers conferred upon the authority by this part shall be given by law.

(c) "Cost," as applied to a project or portion of a project financed under this part, means and includes all or any part of the cost of construction and acquisition of all lands, structures, real or personal property, rights, rights-of-way, franchises, easements, and interests acquired or used for a project, the cost of demolishing or removing any buildings or structures on land so acquired, including the cost of acquiring any lands to which those buildings or structures may be moved, the cost of all machinery and equipment, financing charges, interest prior to, during, and for a period not to exceed the later of one year or one year following completion of construction, as determined by the authority, the cost of insurance during construction, the cost of funding or financing noncapital expenses, reserves for principal and interest and for extensions, enlargements, additions, replacements, renovations and improvements, the cost of engineering, service contracts, reasonable financial and legal services, plans, specifications, studies, surveys, estimates, administrative expenses, and other expenses of funding or financing, that are necessary or incident to determining the feasibility of constructing any project, or that are incident to the construction, acquisition, or financing of any project.

(d) "Health facility" means a facility, place, or building that is licensed, accredited, or certified and organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, or physical, mental, or developmental disability, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, and includes, but is not limited to, all of the following types:

(1) A general acute care hospital that is a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services.

(2) An acute psychiatric hospital that is a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for mentally disordered, incompetent, or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services.

(3) A skilled nursing facility that is a health facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability or skilled nursing care on an extended basis.

(4) An intermediate care facility that is a health facility that provides the following basic services: inpatient care to ambulatory or semiambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability or continuous skilled nursing care.

(5) A special health care facility that is a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical or dental staff that provides inpatient or outpatient, acute or nonacute care, including, but not limited to, medical, nursing, rehabilitation, dental, or maternity.

(6) A clinic that is operated by a tax-exempt nonprofit corporation that is licensed pursuant to Section 1204 or 1204.1 of the Health and Safety Code or a clinic exempt from licensure pursuant to subdivision (b) or (c) of Section 1206 of the Health and Safety Code.

(7) An adult day health center that is a facility, as defined under subdivision (b) of Section 1570.7 of the Health and Safety Code, that provides adult day health care, as defined under subdivision (a) of Section 1570.7 of the Health and Safety Code.

(8) A facility owned or operated by a local jurisdiction for the provision of county health services.

(9) A multilevel facility is an institutional arrangement where a residential facility for the elderly is operated as a part of, or in conjunction with, an intermediate care facility, a skilled nursing facility, or a general acute care hospital. "Elderly," for the purposes of this paragraph, means a person 62 years of age or older.

(10) A child day care facility operated in conjunction with a health facility. A child day care facility is a facility, as defined in Section 1596.750 of the Health and Safety Code. For purposes of this paragraph, "child" means a minor from birth to 18 years of age.

(11) An intermediate care facility/developmentally disabled habilitative that is a health facility, as defined under subdivision (e) of Section 1250 of the Health and Safety Code.

(12) An intermediate care facility/developmentally disabled-nursing that is a health facility, as defined under subdivision (h) of Section 1250 of the Health and Safety Code.

(13) A community care facility that is a facility, as defined under subdivision (a) of Section 1502 of the Health and Safety Code, that provides care, habilitation, rehabilitation, or treatment services to developmentally disabled or mentally impaired persons.

(14) A nonprofit community care facility, as defined in subdivision (a) of Section 1502 of the Health and Safety Code, other than a facility that, as defined in that subdivision, is a residential facility for the elderly, a foster family agency, a foster family home, a full service adoption agency, or a noncustodial adoption agency.

(15) A nonprofit accredited community work activity program, as specified in subdivision (e) of Section 4851 and Section 4856 of the Welfare and Institutions Code.

(16) A community mental health center, as defined in paragraph (3) of subdivision (b) of Section 5667 of the Welfare and Institutions Code.

(17) A nonprofit speech and hearing center, as defined in Section 1201.5 of the Health and Safety Code.

(18) A blood bank, as defined in Section 1600.2 of the Health and Safety Code, licensed pursuant to Section 1602.5 of the Health and Safety Code, and exempt from federal income taxation pursuant to Section 501(c)(3) of the Internal Revenue Code.

(19) A residential facility for persons with developmental disabilities, as defined in Sections 4688.5 and 4688.6 of the Welfare and Institutions Code, which includes, but is not limited to, a community care facility licensed pursuant to Section 1502 of the Health and Safety Code and a family teaching home as defined in Section 4689.1 of the Welfare and Institutions Code.

(20) A nonpublic school that provides educational services in conjunction with a health facility, as defined in paragraphs (1) to (19), inclusive, that otherwise qualifies for financing pursuant to this part, if the nonpublic school is certified pursuant to Sections 56366 and 56366.1 of the Education Code as meeting standards relating to the required special education and specified related services and facilities for individuals with physical, mental, or developmental disabilities.

"Health facility" includes a clinic that is described in subdivision (*l*) of Section 1206 of the Health and Safety Code.

"Health facility" includes information systems equipment and the following facilities, if the equipment and facility is operated in conjunction with or to support the services provided in one or more of the facilities specified in paragraphs (1) to (20), inclusive, of this subdivision: a laboratory, laundry, a nurses or interns residence, housing for staff or employees and their families or patients or relatives of patients, a physicians' facility, an administration building, a research facility, a maintenance, storage, or utility facility, an information systems facility, all structures or facilities related to any of the foregoing facilities or required or useful for the operation of a health facility and the necessary and usual attendant and related facilities and equipment, and parking and supportive service facilities or structures required or useful for the orderly conduct of the health facility.

"Health facility" does not include any institution, place, or building used or to be used primarily for sectarian instruction or study or as a place for devotional activities or religious worship.

(e) "Participating health institution" means a city, city and county, or county, a district hospital, or a private nonprofit corporation or association, or a limited liability company whose sole member is a nonprofit corporation or association authorized by the laws of this state to provide or operate a health facility or a nonprofit corporation that controls or manages, is controlled or managed by, is under common control or management with, or is affiliated with any of the foregoing, and that, pursuant to this part, undertakes the financing or refinancing of the construction or acquisition of a project or of working capital as provided in this part. "Participating health institution" also includes, for purposes of the California Health Facilities Revenue Bonds (UCSF-Stanford Health Care) 1998 Series A, the Regents of the University of California.

(f) "Project" means construction, expansion, remodeling, renovation, furnishing, or equipping, or funding, financing, or refinancing of a health facility or acquisition of a health facility to be financed or refinanced with funds provided in whole or in part pursuant to this part. "Project" may include reimbursement for the costs of construction, expansion, remodeling, renovation, furnishing, or equipping, or funding, financing, or refinancing of a health facility or acquisition of a health facility. "Project" may include any combination of one or more of the foregoing undertaken jointly by any participating health institution with one or more other participating health institutions.

(g) "Revenue bond" or "bond" means a bond, warrant, note, lease, or installment sale obligation that is evidenced by a certificate of participation or other evidence of indebtedness issued by the authority.

(h) "Working capital" means moneys to be used by, or on behalf of, a participating health institution to pay or prepay maintenance or operation expenses or any other costs that would be treated as an expense item, under generally accepted accounting principles, in connection with the ownership or operation of a health facility, including, but not limited to, reserves for maintenance or operation expenses, interest for not to exceed two years on any loan for working capital made pursuant to this part, and reserves for debt service with respect to, and any costs necessary or incidental to, that financing.

SEC. 3. Section 15451.5 of the Government Code is amended to read:

15451.5. A participating health institution that is a private nonprofit corporation or association and that borrows money to finance working capital pursuant to this part, other than as part of the cost of a project, shall be required to repay and discharge the loan within 24 months of the loan date.

SEC. 4. Section 100800 of the Government Code is amended to read:

100800. (a) The Exchange shall administer a program of financial assistance to help low-income and middle-income Californians access affordable health care coverage through the Exchange.

(b) The program may provide financial assistance to California residents with household incomes at or below 600 percent of the federal poverty level, and may provide other appropriate subsidies designed to make health care coverage more accessible and affordable for individuals and households.

(c) The Exchange shall adopt, and may amend, an annual program design for each coverage year to implement this section by resolution of the board of the Exchange. The resolution shall be adopted at a duly noticed meeting.

(1) A resolution adopted pursuant to this section shall not take effect until approved by the Director of Finance following 10 days notification in writing to the Joint Legislative Budget Committee.

(2) The requirements of paragraph (1) may be waived by the joint written consent of the Director of Finance and the Chair of the Joint Legislative Budget Committee to adopt a resolution that is deemed urgent. A resolution adopted pursuant to this paragraph shall take immediate effect.

(3) The Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) shall not apply to the program design or a resolution adopted pursuant to this section.

(d) The program design adopted for a coverage year shall be based on funds appropriated to the program for that coverage year. An appropriation made for the program shall contain provisional language directing the Exchange to provide a certain proportion of the funds to specified income ranges as determined by the Legislature and may provide other parameters guiding the design of the program.

(e) The Exchange shall provide appropriate opportunities for stakeholders and the public to consult in the design of the program.

SEC. 5. Section 100820 of the Government Code is amended to read:

100820. (a) The Exchange may, in consultation with the Franchise Tax Board, promulgate rules and regulations as necessary to implement this title that are consistent with the program design adopted pursuant to Section 100800.

(b) The Franchise Tax Board may, in consultation with the Exchange, adopt regulations that are necessary and appropriate to implement Section 100810 and that are consistent with the program design adopted pursuant to Section 100800 and regulations adopted by the Exchange pursuant to this section.

(c) The Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) shall not apply to a regulation, standard, criterion, procedure, determination, rule, notice, guideline, or any other guidance established or issued by the Exchange or Franchise Tax Board pursuant to this title.

(d) In construing this title, the regulations promulgated by the Exchange under Title 10 of the California Code of Regulations shall apply to the extent that those regulations do not conflict with this title, the program design adopted pursuant to Section 100800, regulations promulgated by the Exchange pursuant to this section, and regulations promulgated by the Franchise Tax Board pursuant to this section.

(e) It is the intent of the Legislature that, in construing this title, the regulations promulgated under Section 36B of the Internal Revenue Code shall apply to the extent that those regulations do not conflict with this title or regulations promulgated by the Exchange pursuant to subdivision (a) or Franchise Tax Board pursuant to subdivision (b).

SEC. 6. Section 100825 of the Government Code is amended to read:

100825. This title shall not be construed to create an entitlement program of any kind, to appropriate any funds, to require the Legislature to appropriate any funds, or to increase or decrease taxes owed by a taxpayer.

SEC. 7. Section 1385.035 is added to the Health and Safety Code, to read:

1385.035. (a) It is the intent of the Legislature in enacting this section to ensure that enrollees and subscribers benefit from reductions in the rate

of growth in health care costs as a result of the establishment of the Office of Health Care Affordability.

(b) In submitting rates for review consistent with this article, a health care service plan shall demonstrate the impact of any changes in the rate of growth in health care costs resulting from the health care cost targets set pursuant to Chapter 2.6 (commencing with Section 127500) of Part 2 of Division 107.

(c) In determining whether a rate is unreasonable or not justified, the director shall consider the impact on changes in health care costs as a result of the health care cost targets set pursuant to Chapter 2.6 (commencing with Section 127500) of Part 2 of Division 107.

SEC. 8. Section 104395 of the Health and Safety Code is amended to read:

104395. The department shall expand the Child Health and Disability Prevention (CHDP) Program contained in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 as follows:

(a) Any child between birth and 90 days after entrance into first grade, all persons under 21 years of age who are eligible for the California Medical Assistance Program, and any person under 19 years of age whose family income is not more than 200 percent of the federal poverty level shall be eligible for services under the program in the county of which they are a resident. The department shall adopt regulations specifying which age groups shall be given certain types of screening tests and recommendations for referral.

(b) The first source of referral under the program shall be the child's usual source of health care. If referral is required and no regular source of health care can be identified, the facility or provider providing health screening and evaluation services shall provide a list of three qualified sources of care, without prejudice for or against any specific source.

(c) The department shall issue protocols for an antitobacco education component of the child health and disability prevention medical examination. The protocols shall include the following: dissuading children from beginning to smoke, encouraging smoking cessation, and providing information on the health effects of tobacco use on the user, children, and nonsmokers. The protocols shall also include a focus on health promotion, disease prevention, and risk reduction, utilizing a "wellness" perspective that encourages self-esteem and positive decisionmaking techniques, and referral to an appropriate community smoking cessation program.

(d) Notwithstanding any other provision of law, the department shall ensure that a portion of the funds in the Child Health Disability Prevention Program budget is used to facilitate the integration of the medical and dental components of all aspects of that program.

(e) The department shall expand its support and monitoring of county child health and disability prevention program efforts to provide all of the following:

(1) Review of a representative, statistically valid, randomly selected sample of child health and disability prevention health assessments,

including, but not limited to, dental assessments, which result in the discovery of conditions which require followup diagnosis and treatment, including but not limited to dental treatment, and which qualify for services under this section. The purpose of the survey and followup reviews of local programs is to determine whether necessary diagnosis and treatment services are being provided, and the degree to which those services comply with the intent of the act that added this subdivision. These survey reviews shall include all counties and shall be conducted at least three times a year.

(2) At least once a year, as part of regular visits to county child health and disability prevention programs to provide technical assistance, support services and monitoring and evaluation of program performance, department staff shall review the effectiveness of the mandated treatment program. The purpose of this review is to assure that the county is providing appropriate followup services for conditions discovered during child health and disability prevention health assessments. This review shall be done in conjunction with the ongoing survey activity of the Child Health and Disability Prevention Branch of the department and shall utilize data resulting from that activity.

(3) If the department establishes that a county has failed to provide treatment services mandated by the act that added this subdivision, the department shall require the county to submit a plan of correction within 90 days. If the department finds that substantial correction has not occurred within 90 days following receipt of the correction plan, it may require the county to enter into a contract pursuant to Section 16934.5 of the Welfare and Institutions Code for the remainder of the fiscal year and the following fiscal year, and for this purpose shall withhold the same percentage of funds as are withheld from other counties participating in the program pursuant to Section 16934.5 of the Welfare and Institutions Code.

(f) This section shall become inoperative on July 1, 2024, or on the date certified by the department pursuant to subdivision (d) of Section 124024, whichever date is later, and shall be repealed on January 1 of the year following the inoperative date.

SEC. 9. Section 11831.1 is added to the Health and Safety Code, to read:

11831.1. (a) No sooner than July 1, 2022, alcohol and other drug programs that are certified in accordance with Section 11831.5 shall either offer medications for addiction treatment (MAT) directly to clients, or have an effective referral process in place with narcotic treatment programs, community health centers, or other MAT providers.

(b) An effective referral process shall include an established relationship with a MAT provider and transportation to appointments for MAT. Providing contact information for a MAT provider does not meet the requirement of an effective referral.

(c) Certified alcohol and other drug programs shall implement and maintain a MAT policy approved by the department. The MAT policy shall do all of the following:

(1) Explain how a client receives information about the benefits and risks of MAT.

(2) Describe the availability of MAT at the program, if applicable, or the referral process for MAT.

(3) Identify an evidence-based assessment for determining a client's MAT needs.

(4) Address administration, storage, and disposal of MAT, if applicable.

(5) Outline training for staff about the benefits and risks of MAT.

(6) Outline training for staff on the MAT policy.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section through the use of all-county letters, provider bulletins, or similar instructions, without taking any further regulatory action.

SEC. 10. Section 11834.28 is added to the Health and Safety Code, to read:

11834.28. (a) No sooner than July 1, 2022, an alcoholism or drug abuse recovery or treatment facility shall either offer medications for addiction treatment (MAT) directly to clients, or have an effective referral process in place with narcotic treatment programs, community health centers, or other MAT providers.

(b) An effective referral process shall include an established relationship with a MAT provider and transportation to appointments for MAT. Providing contact information for a MAT provider does not meet the requirement of an effective referral.

(c) An alcoholism or drug abuse recovery or treatment facility shall implement and maintain a MAT policy approved by the department. The MAT policy shall do all of the following:

(1) Explain how a client receives information about the benefits and risks of MAT.

(2) Describe the availability of MAT at the program, if applicable, or the referral process for MAT.

(3) Identify an evidence-based assessment for determining a client's MAT needs.

(4) Address administration, storage, and disposal of MAT, if applicable.

(5) Outline training for staff about the benefits and risks of MAT.

(6) Outline training for staff on the MAT policy.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section through the use of all-county letters, provider bulletins, or similar instructions, without taking any further regulatory action.

SEC. 11. Section 11839.6.1 is added to the Health and Safety Code, to read:

11839.6.1. (a) No sooner than July 1, 2022, the department shall establish a program for the operation and regulation of mobile narcotic treatment programs. A mobile narcotic treatment program established pursuant to this section shall do all of the following:

(1) Operate under the license of a primary narcotic treatment program with which it is affiliated and associated.

(2) Provide opioid addiction treatment in a motor vehicle.

(3) Comply with any applicable federal requirements.

(4) Receive approval from the department prior to operating a mobile narcotic treatment program.

(b) The department shall do all of the following:

(1) Establish the requirements for approval of a mobile narcotic treatment program.

(2) Oversee and enforce the requirements developed pursuant to this section.

(c) (1) The primary narcotic treatment program shall be subject to action under Section 11839.9 for any violation by its mobile narcotic treatment program of any requirements imposed under this section or any regulations promulgated under this article.

(2) The department may terminate the operation of a mobile narcotic treatment program for failing to comply with this section.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section through the use of all-county letters, provider bulletins, or similar instructions, without taking any further regulatory action.

(e) The following definitions apply for purposes of this section:

(1) "Mobile narcotic treatment program" means a narcotic treatment program operating from a motor vehicle that serves as a mobile component and is operating under a primary narcotic treatment program, and engages in treatment of opioid addiction, including maintenance or detoxification treatment, at a location or locations remote from the primary narcotic treatment program, but within California.

(2) "Motor vehicle" means a vehicle propelled under its own motive power and lawfully used on public streets, roads, or highways with more than three wheels in contact with the ground. This term does not include a trailer.

SEC. 12. Article 7 (commencing with Section 101320) is added to Chapter 3 of Part 3 of Division 101 of the Health and Safety Code, to read:

Article 7. Support for Vital Public Health Activities

101320. (a) Upon appropriation by the Legislature for this purpose, the department shall develop and implement a program to fund and support vital public health activities and services provided by the 61 local health jurisdictions in California.

(b) As a condition of funding, each local health jurisdiction shall, by December 30, 2023, and by July 1 every three years thereafter, be required to submit a public health plan to the department consistent with the requirements of subdivision (c). Each local public health plan shall be

informed by the jurisdiction's most recent community health assessment, community health improvement plan, or strategic plan, and shall include proposed evaluation methods and metrics.

(c) The funds provided for this program shall be used to supplement, rather than supplant, existing levels of the services provided by qualifying local health jurisdictions. Each local health jurisdiction receiving funds through this article shall annually certify to the department that its portion of this funding shall be used to supplement and not supplant all other specific local county funds, including, but not limited to, local realignment and county general fund resources utilized for local health jurisdiction purposes, and excluding federal funds in this determination. In addition, each local health jurisdiction shall certify that 70 percent of funds will be used to support staff, including benefits and training, and that remaining funds, not to exceed 30 percent, may be used for equipment, supplies, and other administrative purposes, such as facility space, furnishings, travel, and similar activities.

(d) Notwithstanding subdivision (c), in the 2022–23 fiscal year, each local health jurisdiction may use funds to develop the plan required by subdivision (b), including contracting for services to support the development of the public health plans, community health assessments, community health improvement plans, and strategic plans.

(e) Each participating local health jurisdiction shall receive a base grant of three hundred fifty thousand dollars ($350,000). The remaining balance of the funding shall be provided to local health jurisdictions proportionally as follows: (1) 50 percent based on 2019, or most recent, population data, (2) 25 percent based on 2019, or most recent, poverty data, and (3) 25 percent based on the 2019, or the most recent, portion of the population that is Black/African American, Latinx, or Native Hawaiian or Pacific Islander.

(f) A participating local health jurisdiction that does not have a completed community health needs assessment, community health improvement plan or strategic plan, shall commence coordination and planning activities by no later than October 1, 2022, and complete its triennial public health plan by December 30, 2023.

(g) In addition to local evaluation plans and metrics, the department shall work in collaboration with the County Health Executives Association of California, California Conference of Local Health Officers, and Service Employees International Union to determine any minimum requirements for the funding and to establish statewide metrics to evaluate the impact of the investment of these funds on public health outcomes.

(h) A local health jurisdiction may, upon submission of a letter of support to the department with a description of the regional capability being provided, direct a portion of its funds to another local health jurisdiction in support of regional capacity.

101320.3. (a) On or before February 1 of every other year, beginning in calendar year 2024, the State Public Health Officer shall submit a written report to the Governor and the Legislature on the state of public health in California. The State Public Health Officer shall present an update annually

to the Assembly Committee on Budget and Senate Committee on Budget and Fiscal Review, or relevant subcommittees, during legislative budget hearings.

(b) The written report shall include all of the following:

(1) Information on key public health indicators that California is experiencing, as determined to be relevant by the State Public Health Officer.

(2) Information on health disparities identified as part of the indicators and trends, if any.

(3) The leading causes of morbidity and mortality in California and evidence of increasing or decreasing rates of morbidity and mortality over the prior three to five years, inclusive.

(4) Data on the incidence and prevalence of communicable and noncommunicable chronic diseases and conditions.

(5) Data on the incidence and prevalence of intentional and unintentional injuries, including data specific to suicides and gun violence.

(6) Data on the prevalence of morbidity and mortality related to mental illness and substance abuse.

(c) The department shall annually seek input from stakeholders, including legislative staff, on which public health issues to address in a written report.

101320.5. (a) As a condition of the funding authorized pursuant to subdivision (a) of Section 101320, a local health jurisdiction administered by a city shall annually present updates on the public health status to its city council on the state of the city's public health. The presentation shall identify the city's most prevalent current causes of morbidity and mortality, causes of morbidity and mortality with the most rapid three-year growth rate, and health disparities. The presentation shall also provide an update on progress addressing these issues through the strategies and programs identified in the local health jurisdiction's triennial public health planning document, as well as identify policy recommendations for addressing these issues.

(b) As a condition of the funding authorized pursuant to subdivision (a) of Section 101320, a local health jurisdiction administered by a county, or a city and county, shall annually present updates to its board of supervisors on the state of the county's public health. The presentation shall identify the county's most prevalent current causes of morbidity and mortality, causes of morbidity and mortality with the most rapid three-year growth rate, and health disparities. The presentation shall also provide an update on progress addressing these issues through the strategies and programs identified in the local health jurisdiction's triennial public health planning document, as well as identify policy recommendations for addressing these issues.

SEC. 13. Section 120475 of the Health and Safety Code is amended to read:

120475. On or before March 15 on a biennial basis, the department shall submit a report to the Legislature on all of the following issues:

(a) The immunization status of young children in the state, based on available data.

(b) The steps taken to strengthen immunization efforts.

(c) The steps taken to improve immunization levels among currently underserved minority children, young children in family day care and other child care settings, and children with no health insurance coverage.

(d) The improvements made in ongoing methods of immunization outreach and education in communities where immunization levels are disproportionately low.

(e) Its recommendations for a comprehensive strategy for fully immunizing all California children and its analysis of the funding necessary to implement the strategy.

SEC. 14. Section 120511 of the Health and Safety Code is amended to read:

120511. (a) The department shall allocate funds to local health jurisdictions for sexually transmitted disease prevention and control activities in accordance, to the extent possible, with the following:

(1) Local health jurisdictions shall be prioritized based on population and incidence of sexually transmitted diseases.

(2) Funds shall be allocated to prioritized local health jurisdictions in a manner that balances the need to spread funding to as many local health jurisdictions, community-based organizations, and nonprofit health care providers as possible and the need to provide meaningful activities to each recipient. No less than 50 percent of the funds allocated to local health jurisdictions shall be provided to, or used to support activities in partnership with, community-based organizations or nonprofit health care providers, provided that there are community-based organizations or nonprofit health care providers in the jurisdiction that can conduct the activities and provide these services consistent with this section.

(3) Each local health jurisdiction shall demonstrate to the department that the community-based organization or nonprofit health care provider that receives funding under this section has done all of the following:

(A) Identified priority target populations.

(B) Satisfactorily described its outreach protocols.

(C) Included community resources for prevention and control activities.

(D) Engaged representatives from impacted communities in the development of outreach activities.

(4) Local health jurisdiction shall use these funds to facilitate expanded access to sexually transmitted infection (STI) clinical services, including, but not limited to, LBGTQ+ populations, including those who face confidentiality barriers in using their health coverage to receive STI testing, treatment, and related care.

(5) The department shall develop measures for each local health jurisdiction funded pursuant to this section to demonstrate accountability.

(b) In awarding funds pursuant to subdivision (a), the department shall authorize local health jurisdictions to include innovative and impactful prevention and control activities, including, but not limited to, the following:

(1) Voluntary screening for sexually transmitted diseases among inmates and wards of county adult and juvenile correctional facilities. The department

may provide assistance or guidance to the local health jurisdiction if necessary to secure participation by other county agencies.

(2) Technology, telehealth, and digital platforms and applications to enhance immediate access to screening, testing, and treatment, as well as partner activities in order to speed activities and to reduce administrative costs.

(3) State-of-the-art testing modalities that ensure swift and accurate screening for, and diagnosis of, sexually transmitted diseases.

(4) Community-based testing and disease investigation.

(5) Integrated services for STIs, viral hepatitis, human immunodeficiency virus (HIV) infection, and drug overdose, to the extent they improve health outcomes for people living with, or at risk for, STIs.

(6) Material support, including, but not limited to, sleeping bags, tarps, shelter, clothing items, and hygiene kits, to people living with, or at risk for, STIs for purposes consistent with this section.

(c) The department may use funds to support capacity building assistance for purposes consistent with this section, including integrated services for STIs, viral hepatitis, HIV, and drug overdose, to the extent they improve health outcomes for people living with, or at risk for, STIs.

(d) The department shall monitor activities in funded local health jurisdictions, based on the accountability measures required under paragraph(5) of subdivision (a), in order to assess the effectiveness of prevention and control activities efforts.

(e) It is the intent of the Legislature that the activities identified in this section are to enhance the activities that are already provided. Therefore, nothing in this section shall be construed to require the department to replace existing activities with the activities provided for in subdivision (a) or to prevent the department from adding new activities as may be appropriate.

(f) This section shall be operative only if funds are explicitly appropriated in the annual Budget Act specifically for purposes of this section.

SEC. 15. Section 122440 of the Health and Safety Code is amended to read:

122440. (a) (1) (A) The State Department of Public Health shall allocate funds to local health jurisdictions to provide hepatitis C virus (HCV) activities and other activities that improve HCV health outcomes, including, but not limited to, monitoring, prevention, testing, and linkage to and retention in care activities for the most vulnerable and underserved individuals living with, or at high risk for, HCV infection. Activities may include integrated services for viral hepatitis, human immunodeficiency virus (HIV) infection, sexually transmitted infections, and drug overdose to the extent they improve health outcomes for the most vulnerable and underserved individuals living with, or at high risk for, HCV infection.

(B) Local health jurisdictions shall be prioritized based on factors that indicate a need for HCV monitoring, prevention, testing, and linkage to and retention in care activities.

(C) Funds shall be allocated to prioritized local health jurisdictions in a manner that balances the need to spread funding to as many local health

jurisdictions and community-based organizations as possible and the need to provide meaningful activities to each recipient. No less than 50 percent of the funds allocated to local health jurisdictions shall be provided to, or used to support activities in partnership with, community-based organizations for purposes consistent with this section, provided that there are community-based organizations in the jurisdiction that are able to provide these activities and demonstrate expertise, history, and credibility working successfully in engaging the most vulnerable and underserved individuals living with, or at high risk for, HCV infection.

(D) The department shall develop measures for each local health jurisdiction funded pursuant to this section to demonstrate accountability.

(E) Local health jurisdictions and community-based organizations may use funds to provide material support, including, but not limited to, sleeping bags, tarps, shelter, clothing items, and hygiene kits, to individuals described in subparagraph (A) for purposes consistent with this section.

(2) The department may use funds to support capacity building assistance for purposes consistent with this section, including integrated services for viral hepatitis, HIV, sexually transmitted infections, and drug overdose, to the extent they improve health outcomes for the most vulnerable and underserved individuals living with, or at high risk for, HCV infection.

(b) This section shall not be construed to require the department to replace existing activities with the activities provided for in subdivision (a) or to prevent the department from adding new activities as appropriate.

(c) This section shall be operative only if funds are explicitly appropriated in the annual Budget Act specifically for purposes of this section.

SEC. 16. Article 2.3 (commencing with Section 123451) is added to Chapter 2 of Part 2 of Division 106 of the Health and Safety Code, to read:

Article 2.3. Abortion Practical Support Fund

123451. (a) As used in this article, the following definitions apply:

(1) “Abortion” has the same meaning as defined in Section 123464.

(2) “Department” means the Department of Health Care Access and Information.

(3) “Fund” means the Abortion Practical Support Fund.

(4) “Grantee” means a qualifying nonprofit organization in California that assists pregnant people with direct practical support for the purposes of obtaining an abortion.

(5) “Practical support” means direct assistance, in-state travel, dependent childcare, doula support, and translation services, to help a person access and obtain an abortion in California. For purposes of this paragraph, “in-state travel“ means airfare, lodging, ground transportation, gas money, and meals.

(b) The Abortion Practical Support Fund is hereby established in the State Treasury for the purpose of providing grants described in Section 123452. Notwithstanding Section 13340 of the Government Code, moneys in the Abortion Practical Support Fund are continuously appropriated to the

department for providing grants described in Section 123452 and administrative costs as described in subdivision (d).

(c) Notwithstanding any other law, the department may receive and deposit moneys in the fund from the following entities:

(1) Nonstate entities, such as private sector or philanthropic entities.

(2) Local and federal government agencies.

(d) The department shall administer the fund. No more than 5 percent of the moneys in the fund shall be available for the department's administrative activities related to planning and production of grants.

(e) Beginning no later than July 1, 2022, the fund shall be available to receive moneys from nonstate entities.

123452. (a) The department, or its contracted vendor, shall use moneys in the fund to administer grants to nonprofit organizations in California that are exempt from taxation under Section 501(c) of the Internal Revenue Code and that either specialize in assisting pregnant people who are low income, or who face other financial barriers, with direct practical support services to access and obtain an abortion or that provide abortion services to those persons. Grants awarded pursuant to this subdivision shall be used for activities that increase patient access to abortion in California, including, but not limited to, any of the following:

(1) Practical support services.

(2) Abortion navigators, patient navigators, and community health workers services based in California.

(3) Case management support.

(4) Costs associated with training volunteers and staff in the provision of practical support services to abortion patients in California.

(5) Costs associated with enabling grantees that meet the requirements of this section to assist pregnant people with practical support services, including staffing and administrative costs.

(6) Costs associated with coordinating practical support services, abortion providers, and other support services in California.

(b) (1) Unless otherwise specified by the department, grants under this article are for a period of one year.

(2) An application for a grant shall be made on a form to be developed by the department or its contracted vendor.

(3) Decisions regarding the grants and the funding level of the grant shall be made after consideration of all relevant factors, such as the grantee's anticipated level of need and the availability of funds.

(c) To administer this section, the department, or its contracted vendor, shall use moneys in the fund to pay direct and indirect costs of the department, or its contracted vendor, including hiring or administrative costs.

(d) The department, or its contracted vendor, shall use moneys in the fund to maintain a system of financial reporting on all aspects of the fund. The financial reporting shall include, but is not limited to, information from the grantees on their expenditures and activities using grant funds associated with this article as the department deems necessary to ensure the use of the

funds are consistent with the purposes of this article and the terms of any grant award.

(e) For purposes of this section, the department, or its contracted vendor, shall not require the submission of any identifying personal information about individuals receiving practical support services as part of an application for a grant or reporting of expenditures and activities using grant funds under this article. Information required by the department, or its contracted vendor, may only include information in summary, statistical, or other forms that do not identify particular individuals.

(f) An application for a grant under this article and financial reporting by grantees are exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(g) Contracts entered into or amended pursuant to this article are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and are exempt from the review or approval of any division of the Department of General Services.

SEC. 17. Section 124024 is added to the Health and Safety Code, immediately preceding Section 124025, to read:

124024. (a) Before July 1, 2024, the department shall take the following steps:

(1) Conduct a stakeholder engagement process to inform the department in the development and implementation of a transition plan and defined milestones to guide the transition of Child Health and Disability Prevention (CHDP) to other existing Medi-Cal delivery systems or services.

(A) The stakeholder engagement process shall include representatives of the State Department of Social Services, the State Department of Public Health, the County Health Executives Association of California, the County Welfare Directors Association of California, the California Dental Association, the American Academy of Pediatrics California, the Service Employees International Union, Medi-Cal managed care plans, children's advocates, and subject-matter experts as identified by the department.

(B) The department shall strive to ensure the stakeholder engagement process reflects participation from the various regions throughout the state, including large urban and rural jurisdictions.

(C) The department shall launch the stakeholder engagement process by convening the first meeting no later than October 1, 2022.

(2) Develop a transition plan that shall include, at a minimum, all of the following:

(A) A posttransition oversight and monitoring plan for Medi-Cal children currently served through CHDP, including those in fee-for-service and foster youth.

(B) A plan for how managed care plans will monitor providers serving children for adherence to the Bright Futures Guidelines from the American Academy of Pediatrics and the Early and Periodic Screening, Diagnostic,

and Treatment (EPSDT) Program standards, including, but not limited to, requirements for site reviews, provider training and audits, and coordination of care to needed services, including to dental and behavioral health providers.

(C) A plan to fund the administrative and services costs of the Health Care Program for Children in Foster Care to meet statutory requirements.

(D) An analysis and plan for retaining existing local CHDP positions through the exploration of new partnerships and roles, or through bolstering existing programs that can leverage CHDP expertise, or through both.

(3) Provide an update to the Legislature during the 2023—24 budget hearings on the proposed transition plan.

(4) Take actions necessary to continue Medi-Cal presumptive eligibility for children under 19 years of age, including expanding access within the Children's Presumptive Eligibility Program to include all eligible Medi-Cal providers.

(5) Take actions necessary, in consultation with the State Department of Social Services, to continue the Health Care Program for Children in Foster Care, including entering into contracts pursuant to subdivision (f) of Section 16501.3 of the Welfare and Institutions Code.

(6) Take actions necessary, in consultation with the State Department of Public Health, to continue the Childhood Lead Poisoning Prevention Program activities.

(7) Seek any federal approvals the department deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and the department determines that federal financial participation is available and is not otherwise jeopardized.

(b) All qualified providers enrolled in the CHDP Program as of June 30, 2024, will be automatically enrolled as providers under the Children's Presumptive Eligibility Program on July 1, 2024. Medi-Cal providers not enrolled in the CHDP Program as of June 30, 2024, must follow all prescribed departmental rules and guidance in order to enroll as a Presumptive Eligibility qualified entity.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of all-county letters, plan letters, provider bulletins, numbered letters, information notices, or other similar instructions, without taking any further regulatory action.

(d) The department shall issue a declaration certifying the date that all activities required pursuant to subdivision (a) have been completed. The department shall post the declaration on its internet website and provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

SEC. 18. Section 124110.5 is added to the Health and Safety Code, to read:

124110.5. This article shall become inoperative on July 1, 2024, or on the date certified by the department pursuant to subdivision (d) of Section 124024, whichever date is later, and shall be repealed on January 1 of the year following the inoperative date.

SEC. 19. Chapter 2.6 (commencing with Section 127500) is added to Part 2 of Division 107 of the Health and Safety Code, to read:

Chapter 2.6. Health Care Affordability

Article 1. General Provisions and Definitions

127500. This chapter shall be known, and may be cited, as the California Health Care Quality and Affordability Act.

127500.2. As used in this chapter, the following definitions apply:

(a) (1) "Administrative costs and profits" means the total sum of all expenses not included in the numerator of the medical loss ratio calculation under state or federal law, including, but not limited to, all of the following:

(A) All categories of administrative expenditures.

(B) Net additions to reserves.

(C) Rate dividends or rebates.

(D) Profits or losses.

(E) Taxes and fees.

(2) For purposes of this chapter, "administrative costs and profits" for a fully integrated delivery system means those associated with its nonprofit health care services plan.

(b) "Affordability for consumers" means considering the totality of costs paid by consumers for covered benefits, including the enrollee share of premium and cost-sharing amounts paid towards the maximum out-of-pocket amount, including deductibles, copays, coinsurance, and other forms of cost sharing for public and private health coverage.

(c) "Affordability for purchasers" means considering the cost to purchasers, including, but not limited to, health plans and health insurers, employers purchasing group coverage, and the state, for health coverage and shall include premium costs, actuarial value of coverage for covered benefits, and the value delivered on health care spending in terms of improved quality and cost efficiency.

(d) "Alternative payment model" means a state or nationally recognized payment approach that financially incentivizes high-quality and cost-efficient care.

(e) "Board" means the Health Care Affordability Board established by Section 127501.10.

(f) "Director" means the Director of the Department of Health Care Access and Information.

(g) (1) "Exempted provider" means a provider that meets standards established by the board for exemption from either of the following:

(A) The statewide health care target.

(B) Specific targets set for health care sectors, including fully integrated delivery systems, geographic regions, and for individual health care entities.

(2) The factors used in setting standards for exemption may include, but are not limited to, annual gross and net revenues, patient volume, and high-cost outliers in a given service or geographic region.

(3) In determining whether a provider is an exempted provider, the board shall also consider any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the provider or that are subject to the control, governance, or financial control of the provider.

(4) A physician practice that does not meet the definition in subdivision (p) is an exempted provider.

(h) "Fully integrated delivery system" means a system that includes a physician organization, health facility or health system, and a nonprofit health care service plan that provides health care services to enrollees in a specific geographic region of the state through an affiliate hospital system and an exclusive contract between the nonprofit health care service plan and a single physician organization in each geographic region to provide those medical services.

(i) "Geographic region" may either be the regions specified in Section 1385.01 or may be otherwise defined by the board.

(j) "Health care cost target" means the target percentage for the maximum annual increase in per capita total health care expenditures.

(k) "Health care entity" means a payer, provider, or a fully integrated delivery system.

(*l*) "Insurance market" means the public and private health insurance markets.

(m) "Line of business" means the different individual, small, and large group business lines, as defined in Section 1348.95 of this code and Section 10127.19 of the Insurance Code, as well as Medi-Cal, Medicare, Covered California, or self-insured public employee health plans.

(n) "Material change" means any change in ownership, operations, or governance for a health care entity, involving a material amount of assets of a health care entity.

(o) "Payer" means private and public health care payers, including all of the following:

(1) A health care service plan or a specialized mental health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2) or a Medi-Cal managed care plan contracted with the State Department of Health Care Services to provide full scope benefits to a Medi-Cal enrollee pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

(2) A health insurer licensed to provide health insurance or specialized behavioral health-only policies, as defined in Section 106 of the Insurance Code.

(3) A publicly funded health care program, including, but not limited to, Medi-Cal and Medicare.

(4) A third-party administrator.

(5) Any other public or private entity, other than an individual, that pays for or arranges for the purchase of health care services on behalf of employees, dependents, or retirees.

(p) "Physician organization" includes any of the following:

(1) An organization described in paragraph (2) of subdivision (g) of Section 1375.4.

(2) A risk-bearing organization, as defined in Section 1375.4.

(3) A restricted health care service plan and limited health care service plan under subdivision (a) of Section 1300.49 of Title 28 of the California Code of Regulations. The inclusion of restricted health care service plans and limited health care service plans in the definition of "physician organization" does not narrow, abrogate, or otherwise alter the regulatory authority of the Department of Managed Health Care over these entities.

(4) A medical foundation exempt from licensure pursuant to subdivision (*l*) of Section 1206.

(5) A medical group practice, a professional medical corporation, a medical partnership, or any lawfully organized group of physicians and surgeons that provides, delivers, furnishes, or otherwise arranges for health care services and is comprised of 25 or more physicians.

(6) Notwithstanding paragraph (5), an organization of less than 25 physicians, but that is a high-cost outlier whose costs for the same services provided are substantially higher compared to the statewide average, as identified through data sources that include, but are not limited to, data from state and federal agencies, other relevant supplemental data, such as financial data on providers that is submitted to state agencies, or data reported to HCAI under the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671). The cost of delivering the same services in a geographic region shall be considered to the extent that cost substantially deviates from the statewide average and reflects higher costs in that region unrelated to the market dominance of providers in that region or unrelated to the ownership, management, or asset structure chosen by the organization.

(q) "Provider" means any of the following that delivers or furnishes health care services:

(1) A physician organization.

(2) A health facility, as defined in Section 1250, including a general acute care hospital.

(3) A clinic conducted, operated, or maintained as an outpatient department of a hospital, as described in subdivision (d) of Section 1206.

(4) A clinic described in subdivision (*l*) of Section 1206.

(5) A clinic described in subdivision (a) of Section 1204.

(6) A specialty clinic, as described in paragraphs (1) to (3), inclusive, of subdivision (b) of Section 1204.

(7) An ambulatory surgical center or accredited outpatient setting.

(8) A clinical laboratory licensed or registered with the State Department of Public Health under Chapter 3 (commencing with Section 1200) of the Business and Professions Code.

(9) An imaging facility that employs or contracts with persons that are subject to the Radiation Control Law (Chapter 8 (commencing with Section 114960) of Part 9 of Division 104), or the Radiologic Technologists Act (Article 5 (commencing with Section 106955) of Chapter 4 of Part 1, or Article 6 (commencing with Section 107150) of Chapter 4 of Part 1 of Division 104).

(r) "Purchaser" means an individual, organization, or business entity that purchases health care services, including, but not limited to, trust funds, trade associations, and private and public employers who provide health care benefits to their employees, members, and dependents.

(s) "Total health care expenditures" means all health care spending in the state by public and private sources, including all of the following:

(1) All claims-based payments and encounters for covered health care benefits.

(2) All non-claims-based payments for covered health care benefits, such as capitation, salary, global budget, other alternative payment methods, or supplemental provider payments pursuant to the Medi-Cal program.

(3) All cost sharing for covered health care benefits paid by residents of this state, including, but not limited to, copayments, coinsurance, and deductibles.

(4) Administrative costs and profits.

(5) Pharmacy rebates and any inpatient or outpatient prescription drug costs not otherwise included in this subdivision.

127500.5. (a) The Legislature finds and declares all of the following:

(1) It is in the public interest that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal.

(2) While California has reduced the uninsured share of its population to a historic low of 7 percent through implementation of the federal Patient Protection and Affordable Care Act (PPACA: Public Law 111-148) and other state efforts, affordability has reached a crisis point as health care costs continue to grow.

(3) As costs rise, employers are increasingly shifting the cost of premiums and deductibles to employees, negatively impacting the potential for wage growth. Between 2010 and 2018, wages in the state kept pace with inflation by increasing by 19 percent. Meanwhile, families with job-based coverage experienced a 45 percent increase in premiums, or more than twice the rate of wage growth. During the same period, families experienced a 70 percent increase in PPO deductibles, or nearly four times the rate of wage growth. While health insurance premium increases for 2021 may be considered moderate due to lower utilization of preventive, routine, and nonemergency services as a result of the novel coronavirus (COVID-19) pandemic, this abatement in health care cost growth is expected to be temporary.

(4) Escalating health care costs are being driven primarily by high prices and the underlying factors or market conditions that drive prices, particularly

in geographic areas and sectors where there is a lack of competition due to consolidation, market power, venture capital activity, the role of profit margins, and other market failures. Consolidation through acquisitions, mergers, or corporate affiliations is pervasive across the industry and involves health care service plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities. Further, market consolidation occurs in various forms, including horizontal, vertical, and cross industry mergers, transitions from nonprofit to for-profit status or vice versa, and any combination involving for-profit and nonprofit entities, such as a nonprofit entity merging with, acquiring, or entering into a corporate affiliation with a for-profit entity or vice versa.

(5) Californians of color experience health disparities, including barriers to accessing care, receiving lower quality of care, lack of access to culturally and linguistically competent care, and experiencing worse health outcomes. Certain communities, including low-income, Black, Latino, Pacific Islander, and essential workers, have been disproportionately impacted by COVID-19 in terms of higher rates of infection, hospitalizations, and deaths. These negative health outcomes further highlight a public health imperative to reduce racial and ethnic disparities in health care.

(6) The COVID-19 pandemic has exposed vulnerabilities within the current system with regard to provider payments. Physician fee-for-service payment has increased over the past decade, while the use of population-based prepayment has decreased in the employer-sponsored coverage market. As Californians stayed home, the loss of fee-for-service (FFS) payment revenue for providers has downstream impacts on access to care and for health care workers' economic security. Beyond exposing providers to considerable financial instability, FFS payments may not be the most effective way to incentivize providers to deliver high-quality and cost-efficient care or offer the flexibility to make practice changes that enable improved access, care coordination, patient engagement, and quality.

(7) Primary care is foundational to an effective health care system and evidence supports that greater use of primary care has been associated with lower costs, higher patient satisfaction, reduced low birth weight, fewer hospitalizations and emergency department visits, and lower mortality, among other key outcomes. However, the United States as a whole spends a far lower share of health care expenditures on primary care and experiences worse outcomes in life expectancy and mortality than other countries.

(8) Behavioral health needs are common among Californians, with most who need it not receiving treatment. National research finds that persons with mental health or substance use disorders have approximately two to three times higher medical costs than those with no behavioral health diagnosis. This research also shows that total health care spending on mental health and substance use disorder services have remained relatively flat between 2012 and 2017. Models that integrate primary care and behavioral health services have been shown to improve access to effective behavioral health services that improve health outcomes, as well as deliver a return on investment by reducing downstream health care costs.

(9) Surveys show that people are delaying or going without care due to concerns about cost, or are getting care but struggling to pay the resulting bill. In California, one in four people report problems paying or being unable to pay their medical bills, with two-thirds cutting back on basic household items like food and clothing to pay those bills. Concerns about affordability of coverage and care are expected to be exacerbated during the economic recession related to the COVID-19 pandemic, particularly among lower-wage workers.

(10) High drug prices contribute significantly to health care costs. Prescription drugs account for nearly one-fifth of health care spending. The Centers for Medicare and Medicaid Services project that prescription drug spending will grow faster and outpace other categories of health care spending in the years to come. Cost-effectiveness analyses often find that drugs are priced in excess of the value they deliver to patients.

(11) The State of California has a substantial public interest in the price and cost of health care coverage. California is a major purchaser through the Public Employees' Retirement System, the State Department of Health Care Services, the Department of General Services, the Department of Corrections and Rehabilitation, and other entities acting on behalf of a state purchaser. The government also provides major tax expenditures through the tax exclusion of employer-sponsored coverage and tax deductibility of coverage purchased by individuals, as well as tax deductibility of excess health care costs for individuals and families.

(b) It is the intent of the Legislature to have a comprehensive view of health care spending, cost trends, and variation to inform actions to reduce the overall rate of growth in health care costs while maintaining quality of care, with the goal of improving affordability, access, and equity of health care for Californians.

(c) It is the intent of the Legislature to encourage policies, payments, and initiatives that improve the affordability, quality, equity, efficiency, access, and value of health care service delivery, with a particular focus on ensuring health equity and reducing disparities in care, access, and outcomes across California.

(d) It is the intent of the Legislature to recognize and consider the unique health care needs of people with disabilities and chronic illnesses and the associated challenges with access, affordability, equity, quality, and delivery of health care.

(e) It is the intent of the Legislature for the State of California to achieve more affordable health care and better outcomes by consistently measuring and promoting sustained systemwide investment in primary care and behavioral health.

(f) It is the intent of the Legislature to facilitate increased adoption of alternative payment models that reward high-quality and cost-efficient care, including strategies for shared savings and downside risk arrangements and population-based payments.

(g) It is the intent of the Legislature to promote the goal of health care affordability while recognizing the need to maintain and increase the supply

of trained, culturally and linguistically competent health care workers, and to monitor the effects of cost containment efforts on health care workforce stability, high-quality health care jobs, and the training needs of health care workers. It is the intent of the Legislature that cost containment does not constrain the health care workforce that California needs, including the competitive wages and benefits of frontline health care workers.

(h) It is the intent of the Legislature that health care cost targets not be used to place a floor or ceiling on health care workforce compensation.

(i) It is the intent of the Legislature to increase transparency on mergers, acquisitions, and corporate affiliations involving health care service plans, health insurers, hospitals or hospital systems, physician organizations, pharmacy benefit managers, and other health care entities that may impact market competition and affordability for consumers and purchasers.

(j) It is the intent of the Legislature to analyze cost and quality trends in the pharmaceutical sector, study the impact of drug prices and pharmaceutical market failures on affordability, and inform policy interventions to improve competition and lower consumer costs.

(k) It is the intent of the Legislature in enacting this chapter to provide accountability to the State of California for the affordability and cost of health care in California.

(*l*) It is the intent of the Legislature in enacting this chapter that the setting of health care cost targets distinguish between health care entities that deliver cost-efficient, high quality care and those that deliver high-cost care without commensurate improvements in overall quality.

(m) It is the intent of the Legislature in enacting this chapter that enforcement actions to address growth in per capita total health care expenditures are implemented in a progressive manner, such that health care entities are assisted to come into compliance with cost targets, including through technical assistance and performance improvement plans, before assessing administrative penalties unless there are egregious violations as specified in Section 127502.5.

(n) To avoid duplication of efforts and to avoid inconsistency between federal and state laws, it is the intent of the Legislature that collaboration occur between relevant regulatory agencies regarding whether a health care entity is in compliance or noncompliance with the cost targets.

(o) It is the intent of the Legislature, therefore, to establish a single entity within state government charged with doing all of the following:

(1) Developing a comprehensive strategy for cost containment in California, including measuring progress towards reducing the rate of growth in per capita total health care spending and ultimately lowering consumer spending on premiums and out-of-pocket costs, while maintaining quality, access, and equity of care, as well as promoting workforce stability and maintaining high-quality health care jobs.

(2) Addressing cost increases in excess of health care cost targets through public transparency, opportunities for remediation, and other progressive enforcement actions to achieve cost targets that optimize value in health care spending.

(3) Referring transactions that may reduce market competition or increase costs to the Attorney General for further review.

Article 2. Office of Health Care Affordability

127501. (a) There is hereby established, within the Department of Health Care Access and Information, the Office of Health Care Affordability. The Director of the Department of Health Care Access and Information shall be the director of the office and shall carry out all functions of that position, including enforcement.

(b) The office shall be responsible for analyzing the health care market for cost trends and drivers of spending, developing data-informed policies for lowering health care costs for consumers and purchasers, creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers, and enforcing cost targets.

(c) The office shall do all of the following:

(1) Increase cost transparency through public reporting of per capita total health care spending and factors contributing to health care cost growth.

(2) Support the board, through data collection and analysis and recommendations, to establish a statewide health care cost target for per capita total health care spending.

(3) Support the board, through data collection and analysis and recommendations, to establish specific health care cost targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate.

(4) Collect and analyze data from existing and emerging public and private data sources that allow the office to track spending, set cost targets, approve performance improvement plans, monitor impacts on health care workforce stability, and carry out all other functions of the office.

(5) Analyze cost and quality trends for drugs covered by pharmaceutical and medical benefits. The office shall consider the data in the reports required pursuant to Section 1367.243 and Section 10123.205 of the Insurance Code and pharmaceutical data reported in the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671).

(6) Oversee the state's progress towards meeting the health care cost target by providing technical assistance, requiring public testimony, requiring submission of and monitoring compliance with performance improvement plans, and assessing administrative penalties through enforcement actions, including escalating administrative penalties for noncompliance.

(7) Promote, measure, and publicly report performance on quality and health equity through the adoption of a priority set of standard quality and equity measures for health care entities, with consideration for minimizing administrative burden and duplication.

(8) Advance standards for promoting the adoption of alternative payment models.

(9) Measure and promote sustained systemwide investment in primary care and behavioral health.

(10) Advance standards for health care workforce stability and training, as these relate to costs.

(11) Disseminate best practices from entities that comply with the cost target, including a summary of affordability efforts that enable the entity to meet the cost target.

(12) Review and evaluate consolidation, market power, and other market failures through cost and market impact reviews of mergers, acquisitions, or corporate affiliations involving health care service plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities.

(13) Analyze trends in the price of health care technologies.

(14) Analyze trends in the cost of labor for both management and administration, as well as nonsupervisorial health care workforce, as well as analyzing the profits of health care entities, if that data is available.

(15) Conduct ongoing research and evaluation on payers, fully integrated delivery systems, and providers, including physician organizations, to determine whether the definitions or other provisions of this chapter include those entities that significantly affect health care cost, quality, equity, and workforce stability.

(16) Adopt and promulgate regulations for the purpose of carrying out this chapter.

(17) Establish advisory or technical committees, as necessary.

(d) For purposes of implementing this chapter, including hiring staff and consultants, through the procurement authority and processes of the department, facilitating and conducting meetings, conducting research and analysis, and developing the required reports, the office may enter into exclusive or nonexclusive contracts on a bid or negotiated basis. Until January 1, 2026, contracts entered into or amended pursuant to this chapter are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and are exempt from the review or approval of any division of the Department of General Services.

127501.2. (a) Until January 1, 2027, any necessary rules and regulations for the purpose of implementing this chapter may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of emergency regulations pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, including subdivisions (e) and (h) of Section 11346.1, an emergency regulation adopted pursuant to this section shall be repealed by operation of law unless the

adoption, amendment, or repeal of the regulation is promulgated by the office pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code within five years of the initial adoption of the emergency regulation.

(c) Any rule or regulation adopted pursuant to this section shall be discussed by the board during at least one board meeting before the office adopts the rule or regulation.

127501.3. (a) The office shall be responsive to requests for additional information from the Legislature, including providing testimony during hearings and commenting on proposed legislation or policy issues.

(b) The Legislature finds and declares that activities, including, but not limited to, responding to legislative or executive inquiries, tracking and commenting on legislation and regulatory activities, and preparing reports on the implementation of this chapter and the performance of the office, are necessary state requirements.

127501.4. (a) (1) Notwithstanding any other state or local law, the office shall collect data and other information it determines necessary from health care entities, except exempted providers, to carry out the functions of the office. To the extent consistent with federal law and to the greatest extent possible, the office may use existing and emerging public and private data sources to minimize administrative burdens and duplicative reporting, including data or information from federal agencies as well as state agencies. The office may request data and information from, or enter into a data sharing agreement with, the State Department of Health Care Services, Covered California, the Department of Managed Health Care, the Department of Insurance, the Labor and Workforce Development Agency, the Business, Consumer Services, and Housing Agency, and other relevant state agencies that monitor compliance of plans and providers with access standards, including timely access, language access, geographic access, and other access standards as provided by law and regulation. The office may also enter into a data sharing agreement with these state agencies that collect payer and provider financial data or other data or information about the health care workforce.

(2) In furtherance of this chapter, and with the intent to reduce administrative burdens, the office shall coordinate with the State Department of Health Care Services on data and other information necessary to report both of the following:

(A) Total health care expenditures and per capita total health care expenditures for Medi-Cal services.

(B) Medical loss ratios required under applicable state and federal laws.

(C) Quality and equity measures to assess performance for the Medi-Cal program or other programs administered by the State Department of Health Care Services.

(3) (A) The office shall obtain from the Department of Managed Health Care and the Department of Insurance information about health care services plans, as defined in subdivision (b) of Section 1345, and insurers offering policies of health insurance, as defined in subdivision (b) of Section 106 of

the Insurance Code. The information shall be for coverage in the individual, small group, and large group markets for both grandfathered and nongrandfathered products. The information shall include, but not be limited to, all of the following:

(i) Information on premiums, cost sharing, benefits, and other information required under Article 6.2 (commencing with Section 1385.01) of Chapter 2.2 of Division 2 of this code and Article 4.5 (commencing with Section 10181) of Chapter 1 of Part 2 of Division 2 of the Insurance Code.

(ii) Trend factors by benefit category, such as inpatient hospitalization and physician services, including price, utilization, and cost as a percentage of Medicare, as required by Section 1385.045 of this code and Section 10181.45 of the Insurance Code.

(iii) Medical loss ratio for each health care service plan or health insurer under applicable state and federal laws.

(iv) Cost containment and quality improvement efforts reported consistent with Sections 1385.03 and 1385.045 of this code and Sections 10181.3 and 10181.45 of the Insurance Code.

(v) Prescription drug costs consistent with Section 1367.243 and Article 6.1 (commencing with Section 1385.001) of Chapter 2.2 of Division 2 of this code and Section 10123.205 of the Insurance Code.

(vi) Information regarding health equity and quality required under Article 11.9 (commencing with Section 1399.870) of Chapter 2.2 of Division 2, including data and results.

(B) The Department of Managed Health Care and the Department of Insurance shall provide the above information in the initial submission of data to the office for the five years prior to 2023, to the extent that information is available, and annually thereafter.

(b) The office shall establish requirements for payers and fully integrated delivery systems to submit data and other information necessary to do all of the following:

(1) Measure total health care expenditures and per capita total health care expenditures.

(2) Determine whether health care entities met health care cost targets.

(3) Identify the annual change in health care costs of health care entities.

(4) Approve and monitor implementation of performance improvement plans.

(5) Assess performance on quality and equity measures.

(c) The office shall, in a manner prescribed by the office, establish requirements for providers to submit data in support of this section as necessary to carry out the functions of the office.

(d) (1) For the purpose of the baseline health care spending report published pursuant to subdivision (a) of Section 127501.6, payers and fully integrated delivery systems shall submit data on total health care expenditures for the 2022 and 2023 calendar years on or before September 1, 2024. Enforcement shall not be implemented pursuant to this baseline report, except any enforcement actions necessary to ensure compliance with the deadline for submitting data.

(2) For the first annual report, published pursuant to subdivision (b) of Section 127501.6, payers and fully integrated delivery systems shall submit data on total health care expenditures for the 2024 and 2025 calendar years based on a reporting schedule established by the office. For subsequent annual reports, payers and fully integrated delivery systems shall submit data for the relevant calendar years according to the reporting schedule established by the office.

(e) (1) The office shall require health care entities to submit data and other information as necessary to fulfill its functions and measure total health care expenditures and per capita total health care expenditures by sectors.

(2) For the calculation of total health care expenditures and per capita total health care expenditures by sectors, the office shall use the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671), to the greatest extent possible, to minimize reporting burdens for health care entities, and may also use data from federal agencies.

(f) The office shall require payers, fully integrated delivery systems, hospitals, and physician organizations to report data and other information, as necessary, for the single set of standard quality measures pursuant to Section 127503.

(g) (1) The office shall require payers, fully integrated delivery systems, restricted health care service plans, and limited health care service plans, as defined in Section 1300.49 of Title 28 of the California Code of Regulations, to submit data and other information to measure the adoption of alternative payment models pursuant to Section 127504.

(2) The office shall establish requirements for payers, fully integrated delivery systems, restricted health care service plans, and limited health care service plans, as defined in Section 1300.49 of Title 28 of the California Code of Regulations, to report data and other information, including, but not limited to, the types of payment models, adoption by line of business, the number of members covered by alternative payment models, the percent of budget dedicated to alternative payments, or cost and quality performance measures tied to those payment models.

(h) (1) The office shall require payers, fully integrated delivery systems, restricted health care service plans, and limited health care service plans, as defined in Section 1300.49 of Title 28 of the California Code of Regulations, to submit data and other information to measure the percentage of total health care expenditures allocated to primary care and behavioral health pursuant to Section 127505.

(2) For the calculation of total health care expenditures allocated to primary care and behavioral health, the office shall do all of the following:

(A) Use the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671), to the greatest extent possible, to minimize reporting burdens for health care entities.

(B) Determine the categories of health care professionals who should be considered primary care and behavioral health providers and consider existing state and national approaches, as appropriate.

(C) Determine specific procedure codes that should be considered primary care and behavioral health services and consider existing state and national approaches, as appropriate.

(D) Determine the categories of payments to primary care or behavioral health care providers and practices, including non-claims-based payments, such as alternative payment models, that should be included when determining the total amount spent on primary care and behavioral health.

(i) (1) With consideration to minimizing reporting burdens and expenses, the office shall require providers and any physician organizations that are part of a fully integrated delivery system to submit audited financial reports, similar to those required in paragraphs (a) to (e), inclusive, of Section 128735. This paragraph does not apply to exempted providers.

(2) For physician organizations defined in paragraph (5) of subdivision (p) of Section 127500, and providers that do not routinely prepare audited financial reports, the office shall require a comprehensive financial statement that includes details regarding annual costs, annual receipts, realized capital gains and losses, and accumulated surplus and accumulated reserves using the standard accounting method routinely used by the physician organization or provider. The comprehensive financial statement shall be supported by sworn written declarations by the chief financial officer, chief executive officer, or other officer who has financial management and oversight responsibilities for the physician organization or provider, certifying that the financial statement is complete, true, and correct in all material matters to the best of their knowledge, and that the provider does not routinely prepare audited financial reports. This paragraph does not apply to exempted providers and physician organizations that are part of a fully integrated delivery system.

(3) The board, members of the board, the office, the department, and the employees, contractors, and advisors of the office and the department shall keep the audited financial reports and comprehensive financial statements confidential, and shall use the confidential information and documents only as necessary for the function of the office.

(4) This subdivision does not apply to providers that are already required to report under Section 128735 or risk bearing organizations (RBOs) that are required to file quarterly and annual financial statements under Section 1375.4 of this code and Section 1300.75.4.2 of Title 28 of the California Code of Regulations.

(5) Notwithstanding any other law, all information and documents obtained under this subdivision shall not be required to be disclosed pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) or any similar local law requiring the disclosure of public records.

(j) (1) Consistent with subdivision (a), the office shall obtain data from existing state and federal data sources and from regulated entities to effectively monitor impacts to health care workforce stability and training needs.

(2) In order for an adjustment to cost targets to be made under paragraph (7) of subdivision (d) of Section 127502, a provider, a fully integrated delivery system, or other associated party shall produce actual or projected nonsupervisory employee organized labor costs, including increased expenditures related to compensation, and any other supporting information to validate the adjustment, as may be requested by the office pertaining to the actual or projected organized labor costs.

(3) The office may collect all of the following types of data and make it accessible to the public:

(A) Overall trends in the health care workforce, including, but not limited to, statewide and regional workforce supply, unemployment and wage data, trends and projections of wages and compensation, projections of workforce supply by region and specialty, training needs, and other future trends in the health care workforce.

(B) The number and classification of workers in internship, clinical placements, apprenticeships, and other training programs sponsored by an employer.

(C) The percentage of employees employed through a registry or casual employment.

(D) The number of workers at health care entities that were retrained through established public training programs.

(E) Investments by health care entities in private training and retraining programs.

(F) The number of workers subject to relocation, termination, or mass layoff as described in Chapter 4 (commencing with Section 1400) of Part 4 of Division 2 of the Labor Code.

(4) The office may request additional data from health care entities if it finds that the data is needed to effectively monitor impacts to health care workforce stability and training needs.

(5) The office may annually request from health care entities that are in compliance with the cost target, a summary of best practices used for improving health care affordability, if any.

(k) In furtherance of this section, the office shall promulgate regulations to collect data and other information it determines necessary from health care entities, except exempted providers, to carry out the functions of the office. The regulations may include, but are not limited to, detailed reporting schedules, technical specifications, and other resources to ensure the submission of accurate data in a standardized format within the specified timeframes. Prior to adopting regulations and approving the reporting schedules, technical specifications, and other resources, the office shall engage relevant stakeholders, hold a public meeting to solicit input, and provide a response to input received.

127501.6. (a) For data submitted to the office under paragraph (1) of subdivision (d) of Section 127501.4, the office shall prepare a report on baseline health care spending consistent with subparagraph (A) of paragraph (2) of subdivision (b) on or before June 1, 2025.

(b) (1) On or before June 1, 2027, the office shall prepare and publish its first annual report concerning health care spending trends and underlying factors, for the 2024 and 2025 calendar years, along with policy recommendations to control costs and improve quality performance and equity of the health care system, while maintaining access to care and high-quality jobs and workforce stability. The report shall be based on the office's analysis of data and other information collected pursuant to this chapter.

(2) The annual report shall include all of the following:

(A) Total health care expenditures, per capita total health care expenditures, and, as appropriate, disaggregated data by categories such as service category, consumer out-of-pocket spending, and health care sector or geographic region, as specified in Section 127502.

(B) The state's progress towards achieving the health care cost target and improving affordability for consumers and purchasers of health care, while improving quality, reducing health disparities, and maintaining access to care and high-quality jobs and workforce stability.

(C) Upon implementation of the Health Care Payments Data Program pursuant to Chapter 8.5 (commencing with Section 127671), or the availability of an alternative source of health care spending data for payers and fully integrated delivery systems required to report to the office, drivers of overall cost and cost growth, including cost trends by health care sector, such as type of provider or service type. Alternative sources of data shall include, but not be limited to, data provided to existing multipayer claims databases or other state or federal agencies. Any analysis of cost trends in the pharmaceutical sector shall account for the effect of drug rebates and other price concessions in the aggregate, without disclosing any product- or manufacturer-specific rebate or price concession information, and without limiting or otherwise affecting the confidential or proprietary nature of any rebate or price concession agreement.

(D) Factors that contribute to cost growth within the state's health care system.

(E) Access, quality, and equity of care measures and data, as available. Access includes timely access, language access, geographic access, and other measures of access reported through available data.

(F) Performance improvement plans required, administrative penalties imposed and assessed, and the amount returned to consumers and purchasers, if any.

(G) A summary of best practices for improving affordability while maintaining access, quality, and equity of care, as well as any concerns regarding impacts on the health care workforce stability and training needs of health care workers, as feasible.

(c) (1) Prior to and following the completion of the report on baseline health care spending, the office shall present the report's findings to the board and the broader public at a public meeting of the board.

(2) On or before July 1, 2027, and at least 30 days after posting the annual report, and each year thereafter, the office shall present the annual report at

a public meeting of the board to inform the board, policymakers, including the Governor and the Legislature, and the broader public about implementation of this chapter, including health care cost targets, cost trends, and actionable recommendations for mitigating cost growth.

(3) (A) The office shall seek comments on the findings of the annual report from health care entities, purchasers, consumer advocacy organizations, organizations representing employers who purchase health coverage, representatives of trust funds and other self-insured purchasers of health benefits, and experts on matters relevant to health care affordability, costs, quality, access, and equity of care, workforce stability, and administrative simplification. The office shall also solicit and collect comments from the public, submitted orally, electronically, or in writing, regarding the impacts of health care affordability efforts on health care workforce stability or training needs. All comments may be posted on the office's internet website to the extent that they are in compliance with state guidelines for the appropriateness of communications.

(B) The office shall notify the relevant regulatory agency and the Attorney General if a health care entity is impacting health care workforce stability or quality jobs, lowering quality, or reducing access or equity of care.

(d) The annual report and the report on baseline health care spending shall be submitted to the Governor and the Legislature and shall be made available to the public on the office's internet website, along with key data and statistics supporting its findings. The reports submitted pursuant to this section shall be submitted in compliance with Section 9795 of the Government Code.

(e) The public meetings shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

127501.7. (a) (1) Notwithstanding any other law regarding the confidentiality of data submitted by health care service plans or other entities to the Department of Managed Health Care, the office and the Department of Managed Health Care may enter into an interagency agreement for the transfer of data pursuant to Section 127501.4 and any other data maintained by the Department of Managed Health Care deemed necessary by the office to implement this chapter.

(2) The interagency agreement shall specify that the office shall comply with any confidentiality requirements of the data that would otherwise apply to the Department of Managed Health Care with respect to disclosure. When confidentiality of data applies, the office may aggregate data for disclosure so that it does not reveal information specific to any particular health care service plan or other entity.

(b) (1) Notwithstanding any other law regarding the confidentiality of data submitted by health insurers or other entities to the Department of Insurance, the office and the Department of Insurance may enter into an interagency agreement for the transfer of data pursuant to Section 127501.4 and any other data maintained by the Department of Insurance deemed necessary by the office to implement this chapter.

(2) The interagency agreement shall specify that the office shall comply with any confidentiality requirements of the data that would otherwise apply to the Department of Insurance with respect to disclosure. When confidentiality of data applies, the office may aggregate data for disclosure so that it does not reveal information specific to any particular health insurer or other entity.

(c) (1) Notwithstanding any other law regarding the confidentiality of data submitted by health plans or other entities to the State Department of Health Care Services, the office and the State Department of Health Care Services may enter into an interagency agreement for the transfer of data pursuant to Section 127501.4 and any other data maintained by the State Department of Health Care Services deemed necessary by the office to implement this chapter.

(2) The interagency agreement shall specify that the office shall comply with any confidentiality requirements of the data that would otherwise apply to the State Department of Health Care Services with respect to disclosure. When confidentiality of data applies, the office may aggregate data for disclosure so that it does not reveal information specific to any particular Medi-Cal managed care plan or other entity.

(d) (1) Notwithstanding any other law regarding the confidentiality of data submitted by qualified health plans or other entities to Covered California, the office and Covered California may enter into an interagency agreement for the transfer of data pursuant to Section 127501.4 and any other data maintained by Covered California deemed necessary by the office to implement this chapter.

(2) The interagency agreement shall specify that the office shall comply with any confidentiality requirements of the data that would otherwise apply to Covered California with respect to disclosure. When confidentiality of data applies, the office may aggregate data for disclosure so that it does not reveal information specific to any particular qualified health plan or other entity.

(e) (1) Notwithstanding any other law regarding the confidentiality of data submitted to a state agency, the office may enter into an interagency agreement for the transfer of data pursuant to Section 127501.4 and any other data maintained by the state agency deemed necessary by the office to implement this chapter.

(2) The interagency agreement shall specify that the office shall comply with any confidentiality requirements of the data that would otherwise apply to the state agency with respect to disclosure. When confidentiality of data applies, the office may aggregate data for disclosure so that it does not reveal specific confidential information.

(f) For the purposes of this section, information that is otherwise publicly available, or that has not been confidentially maintained by the source, shall not be considered nonpublic information.

127501.8. (a) There is hereby established in the State Treasury the Health Care Affordability Fund for the purpose of receiving and expending

revenues collected pursuant to this chapter. This fund is subject to appropriation by the Legislature.

(b) All moneys in the fund shall be expended in a manner that prioritizes the return of the moneys to consumers and purchasers.

(c) The office may identify any opportunities to leverage existing public and private financial resources to provide technical assistance to health care entities and support to the office. Any private or public moneys obtained may be placed in the Health Care Affordability Fund, for use by the office upon appropriation by the Legislature.

127501.10. (a) There is hereby established, within the office, the Health Care Affordability Board. The board shall be composed of eight members, as follows:

(1) Four members shall be appointed by the Governor and confirmed by the Senate.

(2) One member shall be appointed by the Senate Committee on Rules.

(3) One member shall be appointed by the Speaker of the Assembly.

(4) The Secretary of Health and Human Services or their designee.

(5) The CalPERS Chief Health Director or their deputy shall serve as a nonvoting member of the board.

(b) Members of the board who are appointed shall be appointed for a term of four years, except that the initial appointment by the Senate Committee on Rules shall be for a term of five years, the initial appointment by the Speaker of the Assembly shall be for a term of two years, and one of the initial appointments by the Governor shall be for a term of three years. A member of the board may continue to serve until the appointment and qualification of a successor. Vacancies shall be filled by appointment for the unexpired term.

(c) (1) Each person appointed to the board shall have demonstrated and acknowledged expertise in at least one of the following areas: health care economics; health care delivery; health care management or health care finance and administration, including payment methodologies; health plan administration and finance; health care technology; research and treatment innovations; competition in health care markets; primary care; behavioral health, including mental health and substance use disorder services; purchasing or self-funding group health care coverage for employees; enhancing value and affordability of health care coverage; or organized labor that represents health care workers.

(2) Appointing authorities shall consider the expertise of the other members of the board and attempt to make appointments so that the board's composition of members reflects a diversity of expertise on health care entities, purchasers, and consumer advocacy groups, who also meet the requirements of paragraph (1).

(3) In making appointments to the board, the appointing authorities shall take into consideration the state's diversity in culture, race, ethnicity, sexual orientation, gender identity, and geography so that the board's composition reflects the communities of California. Appointing authorities shall consider the experience the board member has as a patient or caregiver of a patient

with a chronic condition requiring ongoing health care, which may include behavioral health care or a disability.

(4) (A) An appointee to the board shall not receive financial compensation from, or be employed by, a health care entity that is subject to the cost targets, an entity subject to cost and market impact reviews, or an exempted provider.

(B) For purposes of this paragraph, an appointee's prohibited financial compensation and employment does not include employment by a health care entity solely as a tenured academic instructor with duties and compensation unrelated to the health care operations of the entity.

(C) For purposes of this paragraph, financial compensation does not include compensation received pursuant to a retirement plan.

(D) For purposes of this paragraph, financial compensation does not include clinical volunteer services if all of the following conditions are met:

(i) The board member is a health care professional who was actively participating in that profession prior to appointment to the board.

(ii) The board member does not receive compensation for performing volunteer services and does not have an ownership interest or other financial interest in the entity, facility, clinic, or provider group.

(iii) The clinical volunteer services are performed at the University of California or a nonprofit educational institution; a facility, clinic, or provider group operated by, or affiliated with, an academic medical center of either the University of California or a nonprofit educational institution; or a facility, clinic, or provider group operated by a state agency or county health system that does not directly contract with the office.

(E) For purposes of subparagraph (D), compensation and financial interest for a health care professional who performs clinical volunteer services does not include either of the following:

(i) A contribution to a professional liability insurance program made by the entity, facility, clinic, or provider group for the member or staff.

(ii) The provision of physical space, equipment, support staff, or other supports made by the entity, facility, clinic, or provider group for the member or staff necessary for the performance of clinical volunteer services described in subparagraph (D).

(5) The board shall elect a chair.

(d) (1) Each member of the board shall receive a per diem of five hundred dollars ($500) for each day actually spent in the discharge of official duties, not to exceed 30 days per year, and shall be reimbursed for traveling and other expenses necessarily incurred in the performance of official duties. After June 30, 2026, the per diem shall be one hundred dollars ($100) per day.

(2) Notwithstanding any other law, a public officer or employee shall not receive per diem salary compensation for serving on the board on any day when the officer or employee also received compensation for their regular public employment.

(e) (1) The board shall meet at least quarterly or at the call of the chair.

(2) The board shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code), except that the board may hold closed sessions when considering matters related to the office assessing administrative penalties, requiring performance improvement plans under Section 127502.5, and discussing nonpublic information and documents received by the office and board under this chapter.

(3) The board shall be subject to Article 3 (commencing with Section 87300) of Chapter 7 of Title 9 of the Government Code, and the regulations promulgated thereunder.

127501.11. (a) After receiving input, including recommendations, from the office and the advisory committee, and receiving public comments, the board shall establish all of the following:

(1) A statewide health care cost target.

(2) The definitions of health care sectors, which may include geographic regions and individual health care entities, as appropriate, except fully integrated delivery systems as defined in subdivision (h) of Section 127500.2, and specific targets by health care sector, which may include fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate.

(3) The standards that need to be met for exemption from health care cost targets or submitting data directly to the office, including the definition of exempted providers.

(b) The board shall approve all of the following:

(1) Methodology for setting cost targets and adjustment factors to modify cost targets when appropriate.

(2) The scope and range of administrative penalties and the penalty justification factors for assessing penalties.

(3) The benchmarks for primary care and behavioral health spending.

(4) The statewide goals for the adoption of alternative payment models and standards that may be used between payers and providers during contracting.

(5) The standards to advance the stability of the health workforce that may apply in the approval of performance improvement plans.

(c) The director shall present to the board for discussion all of the following:

(1) Options for statewide health care cost targets, specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate.

(2) The collection, analysis, and public reporting of data for the purposes of implementing this chapter.

(3) The risk adjustment methodologies for the reporting of data on total health care expenditures and per capita total health care expenditures.

(4) Review and input on performance improvement plans prior to approval, including delivery of periodic updates about compliance with performance improvement plans to inform any adjustment to the standards for imposing those plans.

(5) Review and input on administrative penalties to inform any adjustments to the scope and range of administrative penalties and the penalty justification for assessing penalties.

(6) Factors that contribute to cost growth within the state's health care system, including the pharmaceutical sector.

(7) Strategies to improve affordability for both individual consumers and purchasers of health care, including data collection, targets, and other steps.

(8) Recommendations for administrative simplification in the health care delivery system.

(9) Approaches for measuring access, quality, and equity of care.

(10) Recommendations for updates to statutory provisions necessary to promote innovation and to enable the increased adoption of alternative payment models.

(11) Methods of addressing consolidation, market power, and other market failures.

(d) (1) To support the board's decisionmaking, the board may request data analysis to be conducted or collected by the office.

(2) The office may establish advisory or technical committees, as necessary. The office shall establish advisory or technical committees at the request of the board. These committees may be standing committees or time-limited workgroups, at the discretion of the board. Members of these committees shall comply with the requirements in paragraph (1) of subdivision (c) of Section 127501.10. A committee established by the board may include members who are health care entities, consumer organizations representing health care consumers or patients, organized labor representing health care workers, or patients or caregivers of patients with a chronic condition requiring ongoing health care, which may include behavioral health care or a disability.

127501.12. (a) (1) The board shall establish a Health Care Affordability Advisory Committee to provide input, including recommendations, to the board and the office on a range of areas, including, but not limited to, all of the following:

(A) A statewide health care cost target and specific targets by health care sector and geographic region.

(B) The methodology for setting cost targets and adjustment factors to modify cost targets when appropriate.

(C) Definitions of health care sectors.

(D) Benchmarks for primary care and behavioral health spending.

(E) Statewide goals for the adoption of alternative payment models and standards.

(F) Quality and equity metrics.

(G) Standards to advance the stability of the health care workforce.

(H) Other areas requested by the board or the office.

(2) The advisory committee may provide input, including recommendations, to the board regarding board requests for data analysis performed by the office, but does not have authority to direct data analysis or any other work performed by the office.

(b) (1) The board shall appoint the members of the advisory committee. Appointments shall be made by a majority vote of the voting members of the board. When appointing members to the advisory committee, the board shall aim for broad representation, including, at a minimum, representatives of consumer and patient groups, payers, fully integrated delivery systems, hospitals, organized labor, health care workers, medical groups, physicians, and purchasers, and shall apply the same considerations of demonstrated knowledge, expertise, diversity, and personal experience outlined in paragraphs (1) to (3), inclusive, of subdivision (c) of Section 127501.10.

(2) Each appointed member shall serve at the discretion of the board and may be removed at any time by a majority vote of the voting members of the board.

(3) The advisory committee members shall not have access to confidential, nonpublic information that is accessible to the board and office. Instead, the advisory committee shall only have access to information that is publicly available. Neither the board nor the office shall disclose any confidential, nonpublic information to the advisory committee members.

(4) Advisory committee members shall receive reimbursement for travel and other actual costs.

(c) (1) The advisory committee shall meet at least four times per year or when requested by the board.

(2) At least one member of the board shall attend the advisory committee meetings.

(3) Advance notice of any advisory committee meetings shall be posted on the office's internet website to allow for public participation at the meetings. Meeting minutes of all advisory committee meetings and input, including recommendations, on proposed cost targets shall be posted on the office's internet website.

(d) The board shall consider input, including recommendations, from the advisory committee, along with public comments, in the board's deliberation and decisionmaking.

Article 3. Health Care Cost Targets

127502. (a) The board shall establish a statewide health care cost target.

(b) (1) The board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate. The board shall define health care sectors, which may include geographic regions and individual health care entities, as appropriate, except for fully integrated delivery systems, and the office shall promulgate regulations accordingly.

(2) The board may adjust cost targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, when warranted to account for the baseline costs in comparison to other health care entities in the health care sector and geographic region.

(3) The setting of different targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, shall be informed by historical cost data and other relevant supplemental data, such as financial data on health care entities submitted to state agencies and the Health Care Payments Data Program, as well as consideration of access, quality, equity, and health care workforce stability and quality jobs pursuant to Section 127506.

(c) The health care cost targets shall meet all of the following requirements:

(1) Promote a predictable and sustainable rate of change in per capita total health care expenditures.

(2) (A) Be based on a target percentage, with consideration of economic indicators or population-based measures, and be developed based on a methodology that is available and transparent to the public.

(B) Economic indicators may include established measures reflecting the broader economy, the labor markets, and consumer cost trends.

(C) Population-based measures may include changes in the state's demographic factors that may influence demand for health care services, such as aging.

(3) Be set for each calendar year, with consideration of multiyear targets to provide health care entities with consistency, be updated periodically, and shall consider relevant adjustment factors.

(4) Be developed, applied, and enforced.

(5) Promote the goal of improved affordability for consumers and purchasers of health care, while maintaining quality and equitable care, including consideration of the impact on persons with disabilities and chronic illness.

(6) Promote the stability of the health care workforce, including the development of the future workforce, such as graduate medical education teaching, training, apprenticeships, and research.

(7) Be adjusted for a provider or fully integrated delivery system's cost target, as appropriate, upon a showing that nonsupervisory employee organized labor costs are projected to grow faster than the rate of any applicable cost targets.

(d) (1) Consistent with paragraph (1) of subdivision (b) of Section 127501.11, the office shall develop a methodology, for approval by the board, to set health care cost targets. The methodology shall be available and transparent to the public.

(2) The methodology shall review historical trends and projections for economic indicators and population-based measures.

(3) The methodology shall review historical trends in costs for Medi-Cal, Medicare, and commercial health care coverage. The methodology shall provide differential treatment of the 2020 and 2021 calendar years due to the impacts of COVID-19 on health care spending and health care entities.

(4) The methodology shall review potential factors to adjust future cost targets, including, but not limited to, the health care employment cost index, labor costs, the consumer price index for urban wage earners and clerical

workers, impacts due to known emerging diseases, trends in the price of health care technologies, provider payer mix, state or local mandates such as required capital improvement projects, and any relevant state and federal policy changes impacting covered benefits, provider reimbursement, and costs.

(5) (A) With respect to Medi-Cal, the methodology shall consider provision of nonfederal share, determined to be appropriate by the Director of Health Care Services, associated with Medi-Cal payments, such as expenditures by providers or provider-affiliated entities that serve as the nonfederal share associated with Medi-Cal reimbursement.

(B) The methodology may also consider all of the following:

(i) Supplemental payments to qualifying providers who provide services to Medi-Cal and underinsured patients.

(ii) Provisions of nonfederal share or reimbursement of state costs not associated with specific Medi-Cal reimbursement, but that supports the Medi-Cal program, and any other reimbursements and fees assessed by the State Department of Health Care Services, as determined appropriate by the Director of Health Care Services.

(iii) Health care-related taxes or fees that, in whole or in part, provide the nonfederal share associated with Medi-Cal payments or support the Medi-Cal program, as determined appropriate by the Director of Health Care Services.

(C) The methodology shall allow the board, to the extent necessary for the Medi-Cal program to comply with federal requirements to help ensure that full federal financial participation is available and not otherwise jeopardized related to services, programs, benefits, and contracts that involve funds disbursed by the State Department of Health Care Services, including but not limited to funds authorized pursuant to Title XIX (42 U. S.C. Sec. 1396 et seq.) of the Social Security Act or Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.), to adjust any targets, when warranted, as they pertain to health care entities in the Medi-Cal program, upon the request of the Director of Health Care Services.

(6) (A) The methodology shall allow the board to adjust cost targets downward, when warranted, for health care entities that deliver high-cost care that is not commensurate with improvements in quality, and upward, when warranted, for health care entities that deliver low cost, high quality care.

(B) Data sources on cost and quality performance of health care entities may include, but are not limited to, all of the following:

(i) Cost and quality performance data reported by or sourced from recognized quality improvement and transparency initiatives.

(ii) Any other relevant supplemental data, such as financial data on health care entities, submitted to state agencies, and data on costs, payments, and quality from the Health Care Payments Data Program established pursuant to Chapter 8.5 (commencing with Section 127671).

(iii) Any relevant federal, state, or local data.

(7) The methodology shall require the board to adjust cost targets, as appropriate, for a provider or a fully integrated delivery system to account for actual or projected nonsupervisory employee organized labor costs, including increased expenditures related to compensation. For an adjustment to be effectuated, the provider, the fully integrated delivery system, or other associated party shall submit a request with supporting documentation in a format prescribed by the office. To validate the basis for the requested adjustment, the office may request or accept further information, such as any single labor agreement that is final and reflects the actual or projected increased nonsupervisory employee organized labor costs. The office may audit the submitted data and supporting information as necessary.

(e) The methodology for setting a sector target for an individual health care entity shall be developed taking into account the following:

(1) Allow for the setting of cost targets based on the entity's status as a high-cost outlier.

(2) Allow for the setting of cost targets that encourage an individual health care entity to serve populations with greater health care risks by incorporating all of the following:

(A) A risk factor adjustment reflecting the health status of the entity's patient mix, consistent with risk adjustment methodology developed under subdivision (f).

(B) An equity adjustment accounting for the social determinants of health and other factors related to health equity for the entity's patient mix, consistent with subdivision (g).

(C) A geographic cost adjustment reflecting the relative cost of doing business, including labor costs in the communities the entity operates.

(f) (1) In consultation with the board, the office shall establish risk adjustment methodologies for the reporting of data on total health care expenditures and may rely on existing risk adjustment methodologies. The methodology shall be available and transparent to the public.

(2) To select appropriate risk adjustment methodologies or inform the way any adjustments are applied to unadjusted data to account for the underlying health status of the population, the office may convene technical committees, as necessary.

(3) The risk adjustment methodologies selected or used to inform any adjustments shall take into account the impact of perverse incentives that may inflate the measurement of population risk, such as upcoding. The office may audit submitted data and make periodic adjustments to address those issues as necessary.

(g) In consultation with the board, the office shall establish equity adjustment methodologies to take into account social determinants of health and other factors related to health equity, to the extent data is available and methodology has been developed and validated.

(h) (1) Targets set for payers shall also include targets on administrative costs and profits to deter growth in administrative costs and profits.

(2) The targets established for a payer's administrative costs and profits under this subdivision may be subject to annual adjustment, but shall not

increase to the extent the costs for the medical care portion of the medical loss ratio exceed a target.

(3) The office shall consult with the Department of Managed Health Care, the State Department of Health Care Services, and the Department of Insurance to ensure any targets for payers established by the office consider actuarial soundness and rate review requirements imposed by or upon those departments.

(i) (1) Until the board approves sector targets for fully integrated delivery systems, fully integrated delivery systems shall comply with the statewide cost target.

(2) Targets set for fully integrated delivery systems shall include all health care services, costs, and lines of business managed by that system in each separately administered geographic service area of the state. The system shall provide sufficient data and information, comparable to other unintegrated payers and providers, including patient risk mix, to the office to enable analysis and public reporting of performance, including by sector, insurance market, line of business, and separately administered geographic service area.

(3) Targets for fully integrated delivery systems shall include targets on payer administrative costs and profits.

(4) After the board approves sector targets for fully integrated delivery systems, a fully integrated delivery system shall be subject to a target for each of its geographic service areas in which a single medical group is responsible for providing, or arranging for the provision of, all professional services to the payer's enrollees.

(j) The office shall direct the public reporting of performance on the health care cost targets, which may include analysis of changes in total health care expenditures on an aggregate and per capita basis for all of the following:

(1) Statewide.

(2) By geographic region.

(3) By insurance market and line of business, including for each payer.

(4) For health care entities, both unadjusted and using a risk adjustment methodology against the covered lives or patient populations, as applicable, for which they serve.

(5) For impact on affordability for consumers and purchasers of health care.

(k) The office shall direct the analysis and public reporting of contributions of health care entities to cost growth in the state using data that includes, but is not limited to, data submitted to the office, data from state and federal agencies, other relevant supplemental data, such as financial data on health care entities, that is submitted to state agencies, and the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671).

(*l*) (1) The board shall establish a statewide health care cost target for the 2025 calendar year and for each calendar year thereafter. The 2025 baseline target shall be a reporting year only and shall not be subject to

enforcement pursuant to Section 127502.5. The targets established for the 2026 calendar year, and each calendar year thereafter, shall be enforced for compliance pursuant to Section 127502.5.

(2) (A) On or before October 1, 2027, the board shall define initial health care sectors, which may include geographic regions and individual health care entities, as appropriate, except fully integrated delivery systems, considering factors such as delivery system characteristics. Sectors may be further defined over time.

(B) Not later than June 1, 2028, the board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, in accordance with this chapter.

(C) The development of sector targets shall be done in a manner that minimizes fragmentation and potential cost shifting and that encourages cooperation in meeting statewide and geographic region targets.

(D) Sector targets adopted under this subdivision shall specify which single sector target is applicable if a health care entity falls within two or more sectors.

(m) (1) The board shall hold a public meeting to discuss the development and adoption of recommendations for statewide cost targets, or specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities. The board shall deliberate and consider input, including recommendations from the office, the advisory committee, and public comment. Cost targets and other decisions of the board consistent with this section shall not be adopted, enforced, revised, or updated until presented at a subsequent public meeting. The meetings shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code) consistent with paragraph (2) of subdivision (e) of Section 127501.10.

(2) The office shall publish on its internet website its recommendations for proposed cost targets for the board's review and consideration. The board shall discuss recommendations at a public meeting for proposed targets on or before March 1 of the year prior to the applicable target year.

(3) The board shall receive and consider public comments for 45 days after the board meeting.

(4) The board shall adopt final targets on or before June 1, at a board meeting. The board shall remain in session, and members shall not receive per diem under Section 127501.10, until the board adopts all required cost targets for the following calendar year.

(n) The adoption of cost targets under this section is exempt from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(o) For purposes of this section, "individual health care entity" does not include an exempted provider.

(p) (1) Statewide and sector-specific health care cost targets do not apply to exempted providers. Upon approval by the board, the office shall promulgate regulations defining who is an exempted provider.

(2) This section does not exempt claims and non-claims-based payments for exempted providers, and associated cost-sharing amounts paid by consumers, from inclusion in the calculation of total health care expenditures and per capita total health care expenditures that uses data submitted by payers.

127502.5. (a) The director shall enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets, allows each health care entity opportunities for remediation, and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access, quality, equity, or workforce stability. The director shall consider each entity's contribution to cost growth in excess of the applicable target and any actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target. The director shall review information and other relevant data from additional sources, as appropriate, including data from the Health Care Payments Data Program, to determine the appropriate health care entity that may be subject to enforcement actions under this section. Commensurate with the health care entity's offense or violation, the director may take the following progressive enforcement actions:

(1) Provide technical assistance to the entity to assist it to come into compliance.

(2) Require or compel public testimony by the health care entity regarding its failure to comply with the target.

(3) Require submission and implementation of performance improvement plans, including input from the board.

(4) Assess administrative penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

(b) Prior to taking any enforcement action, the office shall do all of the following:

(1) Notify the health care entity that it has exceeded the health care cost target.

(2) Give the health care entity not less than 45 days to respond and provide additional data, including information in support of a waiver described in subdivision (i).

(3) If the office determines that the additional data and information meets the burden established by the office to explain all or a portion of the entity's cost growth in excess of the applicable target, the office may modify its findings, as appropriate.

(4) The director shall consult with the Director of Managed Health Care, the Director of Health Care Services, or the Insurance Commissioner, as applicable, prior to taking any of the enforcement actions specified in this

section with respect to a payer regulated by the respective department to ensure any technical assistance, performance improvement plans, or other measures authorized by this section are consistent with laws applicable to regulating health care service plans, health insurers, or a Medi-Cal managed care plan contracted with the State Department of Health Care Services.

(c) (1) If a health care entity exceeds an applicable cost target, the office shall notify the health care entity of their status and provide technical assistance. The office shall make public the extent to which the health care entity exceeded the target. The office may require a health care entity to submit and implement a performance improvement plan that identifies the causes for spending growth and shall include, but not be limited to, specific strategies, adjustments, and action steps the health care entity proposes to implement to improve spending performance during a specified time period. The office shall request further information, as needed, in order to approve a proposed performance improvement plan. The director may approve a performance improvement plan consistent with those areas requiring specific performance or correction for up to three years. The director shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode access, quality, equity, or workforce stability. The standards developed under Article 7 (commencing with Section 127506) may be considered in the approval of a performance improvement plan.

(2) The office shall monitor the health care entity for compliance with the performance improvement plan. The office shall publicly post the identity of a health care entity implementing a performance improvement plan and, at a minimum, a detailed summary of the entity's compliance with the requirements of the performance improvement plan while the plan remains in effect and shall transmit an approved performance improvement plan to appropriate state regulators for the entity.

(3) A health care entity shall work to implement the performance improvement plan as submitted to, and approved by, the office. The office shall monitor the health care entity for compliance with the performance improvement plan.

(4) The board, the members of the board, the office, the department, and employees, contractors, and advisors of the office and the department shall keep confidential all nonpublic information and documents obtained under this subdivision, and shall not disclose the confidential information or documents to any person, other than the Attorney General, without the consent of the source of the information or documents, except in an administrative penalty action, or a public meeting under this section if the office believes that disclosure should be made in the public interest after taking into account any privacy, trade secret, or anticompetitive considerations. Prior to disclosure in a public meeting, the office shall notify the relevant party and provide the source of nonpublic information an opportunity to specify facts documenting why release of the information is damaging or prejudicial to the source of the information and why the public interest is served in withholding the information. Information that is otherwise publicly available, or that has not been confidentially maintained

by the source, shall not be considered nonpublic information. This paragraph does not limit the board's discussion of nonpublic information during closed sessions of board meetings.

(5) Notwithstanding any other law, all nonpublic information and documents obtained under this subdivision shall not be required to be disclosed pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records.

(d) (1) If the director determines that a health care entity is not compliant with an approved performance improvement plan and does not meet the cost target, the director may assess administrative penalties commensurate with the failure of the health care entity to meet the target. An entity that has fully complied with an approved performance improvement plan by the deadline established by the office shall not be assessed administrative penalties. However, the director may require a modification to the performance improvement plan until the cost target is met.

(2) The administrative penalty shall be deposited into the Health Care Affordability Fund.

(3) Prior to assessing an administrative penalty against a health care entity, the director may consider related provision of nonfederal share, determined to be appropriate by the Director of Health Care Services, associated with Medi-Cal payments, such as expenditures by providers or provider-affiliated entities that serve as the nonfederal share associated with Medi-Cal reimbursement.

(4) To the extent that an administrative penalty is related to a Medi-Cal expenditure, including federal financial participation, the office shall coordinate with the State Department of Health Care Services to ensure appropriate treatment and return of any federal funds pursuant to Subpart F commencing with Section 433.300 of Part 433 of Title 42 of the Code of Federal Regulations.

(5) If, after the implementation of one or more performance improvement plans, the health care entity is repeatedly noncompliant with the performance improvement plan, the director may assess escalating administrative penalties that exceed the penalties imposed under paragraphs (1) and (2) of this subdivision and paragraph (4) of subdivision (a).

(6) The director shall consider all of the following to determine the penalty:

(A) The nature, number, and gravity of the offenses.

(B) The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity.

(C) The market impact of the entity.

(e) Administrative penalties shall not constitute expenditures for the purpose of meeting cost targets. The imposition of administrative penalties shall not alter or otherwise relieve the health care entity of the obligation

to meet a previously established cost target or a cost target for subsequent years.

(f) (1) For payers and fully integrated delivery systems, the director also shall enforce cost targets established by Section 127502 against the cost growth for administrative costs and profits.

(2) If a payer exceeds the target for per capita growth in total health care expenditures, but has met its target for administrative costs and profits, the payer shall submit relevant documentation or supporting evidence for the drivers of excess cost growth.

(3) This subdivision does not relieve a payer of its obligation to meet targets for per capita growth in total health care expenditures established by Section 127502, and does not limit enforcement actions for payers under this section.

(g) If data indicate adverse impacts on cost, access, quality, equity, or workforce stability from consolidation, market power, or other market failures, the director may, at any point, require that a cost and market impact review be performed on a health care entity, consistent with Section 127507.2.

(h) (1) The director may directly assess administrative penalties when a health care entity has failed to comply with this chapter by doing any of the following:

(A) Willfully failing to report complete and accurate data.

(B) Repeatedly neglecting to file a performance improvement plan with the office.

(C) Repeatedly failing to file an acceptable performance improvement plan with the office.

(D) Repeatedly failing to implement the performance improvement plan.

(E) Knowingly failing to provide information required by this section to the office.

(F) Knowingly falsifying information required by this section.

(2) The director may call a public meeting to notify the public about the health care entity's violation and declare the entity as imperiling the state's ability to monitor and control health care cost growth.

(i) The office may establish requirements for health care entities to file for a waiver of enforcement actions due to reasonable factors outside the entity's control, such as changes in state or federal law or anticipated costs for investments and initiatives to minimize future costly care, such as increasing access to primary and preventive services, or under extraordinary circumstances, such as an act of God or catastrophic event. The entity shall submit documentation or supporting evidence of the reasonable factors, anticipated costs, or extraordinary circumstances. The office shall request further information, as needed, in order to approve or deny an application for a waiver.

(j) As applied to the administrative penalties for acts in violation of this chapter, the remedies provided by this section and by any other law are not exclusive and may be sought and employed in any combination to enforce this chapter.

(k) Following an administrative hearing, a health care entity adversely affected by a final order imposing an administrative penalty authorized by this chapter may seek independent judicial review by filing a petition for a writ of mandate in accordance with Section 1094.5 of the Code of Civil Procedure.

(*l*) After an order imposing an administrative penalty becomes final, and if a petition for a writ of mandate has not been filed within the time limits prescribed in Section 11523 of the Government Code, the office may apply to the clerk of the appropriate court for a judgment in the amount of the administrative penalty. The application, which shall include a certified copy of the final order of the administrative hearing officer, shall constitute a sufficient showing to warrant the issuance of the judgment. The court clerk shall enter the judgment immediately in conformity with the application. The judgment so entered has the same force and effect as, and is subject to all the provisions of law relating to, a judgment in a civil action, and may be enforced in the same manner as any other judgment of the court in which it is entered.

Article 4. Quality and Equity Performance

127503. (a) (1) The office shall adopt a single set of standard measures for assessing health care quality and equity across payers, fully integrated delivery systems, hospitals, and physician organizations. Performance on quality and health equity measures shall be included in the annual report required in Section 127501.6.

(2) The standard quality and equity measures shall use recognized clinical quality, patient experience, patient safety, and utilization measures for health care service plans, health insurers, hospitals, and physician organizations.

(3) The standard quality and equity measures shall reflect the diversity of California in terms of race, ethnicity, sex, age, language, sexual orientation, gender identity, and disability status. The standard quality and equity measures shall be appropriate for a population under 65 years of age, including children and adults.

(4) The standard quality and equity measures shall consider available means for reliable measurement of disparities in health care, including race, ethnicity, sex, age, language, sexual orientation, gender identity, and disability status.

(5) The office shall reduce administrative burden by selecting quality and equity measures that simplify reporting and align performance measurement with other payers, programs, and state agencies, including leveraging existing voluntary and required reporting to the greatest extent possible. The office shall further reduce administrative burden by encouraging other payers and programs to use the same reporting mechanisms.

(6) Public reporting developed pursuant to this article shall consider differences among payers, fully integrated delivery systems, hospitals, and

physician organizations, including factors such as plan or network design or line of business, provider payer mix, and the risk mix associated with the covered lives or patient population for which they are primarily responsible.

(b) In implementing this section, the office shall coordinate with the Department of Managed Health Care to align with requirements under Article 11.9 (commencing with Section 1399.870) of Chapter 2.2 of Division 2. The office shall also coordinate with the State Department of Health Care Services, Covered California, and the Public Employees' Retirement System, and shall consult with state departments, external quality improvement organizations and forums, payers, physicians, other providers, and consumer advocates or stakeholders with expertise in quality or equity measurement.

(c) The office shall annually review and update the priority set of standard measures for assessing the quality and equity of care pursuant to subdivision (a).

Article 5. Alternative Payment Models

127504. (a) The office shall promote the shift from payments based on fee-for-service to alternative payment models that provide financial incentive for equitable high-quality and cost-efficient care. In furtherance of this goal, the office shall convene health care entities and organize an alternative payment model working group, set statewide goals for the adoption of alternative payment models, and measure the state's progress toward those goals. With input from the working group, the office shall set benchmarks that include, but are not limited to, increasing the percentage of total health care expenditures delivered through alternate payment models or the percentage of membership covered by an alternative payment model.

(b) (1) To advance statewide goals for adoption of alternative payment models, the office shall consider existing alternative payment models and work with the working group to develop standards for alternative payment models that may be used during contracting between health care entities. The office shall adopt the standards for alternative payment models on or before July 1, 2024.

(2) The standards for alternative payment models shall focus on encouraging and facilitating multipayer participation and alignment, improving affordability, efficiency, equity, and quality by considering the current best evidence for strategies such as investments in primary care and behavioral health, shared risk arrangements, or quality-based or population-based payments.

(3) The standards shall include minimum criteria for what is considered an alternative payment model, but be flexible enough to allow for innovation and evolution over time. The standards shall be consistent, and align, to the extent possible, with the quality and equity measures outlined in Article 4 (commencing with Section 127503) to encourage physicians and other providers to make investments and aim to see year-over-year improvement.

(4) The standards shall address appropriate incentives to physicians and other providers and balanced measures, including, but not limited to, total cost of care and quality, access, and equity requirements and shared savings models, to protect against perverse incentives and unintended consequences.

(5) The standards shall attempt to reduce administrative burden by incorporating alternative payment models that facilitate multipayer participation and align with other state payers and programs or national models.

(6) The office shall review the standards at least every five years or more frequently, as appropriate, in order to determine whether the standards are rewarding high-quality, cost-efficient, and equitable care.

(c) The office shall include an analysis of alternative payment model adoption in the annual report required in Section 127501.6.

(d) In implementing this section, the office shall consult with state and federal departments to ensure consistency with state and federal laws, and shall also consult with external organizations promoting alternative payment models and other entities and individuals with expertise in health care financing and quality and equity measurements.

Article 6. Primary Care and Behavioral Health Investments

127505. (a) (1) The office shall measure and promote a sustained systemwide investment in primary care and behavioral health. In furtherance of this goal, the office shall measure the percentage of total health care expenditures allocated to primary care and behavioral health and set spending benchmarks. Spending benchmarks for primary care shall consider current and historic underfunding of primary care services.

(2) The intent of the spending benchmarks is to build and sustain infrastructure and capacity, specifically methods of reimbursement that shift greater health care resources and investments away from specialty care and toward supporting and facilitating innovation and care improvement in primary care and behavioral health. It is intended that increased support for primary care and behavioral health will not increase costs to consumers or increase the total costs of health care. However, shifting resources may take time and not be associated with immediate savings.

(3) Benchmarks and public reporting developed pursuant to this article shall consider differences among payers and fully integrated delivery systems, including factors such as plan or network design or line of business, the diversity of settings and facilities through which primary care can be delivered, including clinical and nonclinical settings, the use of both claims-based and non-claims-based payments, and the risk mix associated with the covered lives or patient population for which they are primarily responsible.

(4) In addition to measuring performance of health care entities with the spending benchmarks, the office shall promote improved outcomes for primary care and behavioral health, including, but not limited to, health care

entities making investments in, or adopting models that do, any or all of the following:

(A) Promote the importance of primary care and adopt practices that give consumers a regular source of primary care.

(B) Increase access to advanced primary care models and adoption of measures that demonstrate their success in improving quality and outcomes.

(C) Integrate primary care and behavioral health services, including screenings for behavioral health conditions in primary care settings or delivery of behavioral health support for common behavioral health conditions, such as anxiety, depression, or substance use disorders.

(D) Leverage alternative payment models that provide resources at the practice level to enable improved access and team-based approaches for care coordination, patient engagement, quality, and population health. Team-based approaches support the sharing of accountability for delivery of care between physicians and nurse practitioners, physician assistants, medical assistants, nurses and nurse case managers, social workers, pharmacists, and traditional and nontraditional primary and behavioral health care providers, such as peer support specialists, community health works, and others.

(E) Deliver higher value primary care and behavioral health services with an aim toward reducing disparities.

(F) Leverage telehealth and other digital health solutions to expand access to primary care and behavioral health services, care coordination, and care management.

(G) Implement innovative approaches that integrate primary care and behavioral health with broader social and public health services.

(b) The office shall include an analysis of primary care and behavioral health spending and growth, and relevant quality and equity performance measures, in the annual report required pursuant to Section 127501.6.

(c) In implementing this section, the office shall consult with state departments, external organizations promoting investment in primary care and behavioral health, and other entities and individuals with expertise in primary care, behavioral health, and health equity.

Article 7. Health Care Workforce Stability

127506. (a) The intent of this section is to monitor the effects of cost targets on health care workforce stability, high-quality jobs, and training needs of health care workers, in addition to adjustments to cost targets pertaining to nonsupervisory employee organized labor costs pursuant to paragraph (7) of subdivision (d) of Section 127502. The Legislature intends that the office use a transparent process that allows for public input to monitor how health care entities achieve the cost targets and highlight best practices and discourage practices harmful to workers and patients.

(b) The office shall monitor health care costs while promoting health care workforce stability, including the competitive wages and benefits of

frontline health care workers, and the professional judgment of health professionals acting within their scope of practice. The office shall monitor health care workforce stability with the goal that workforce shortages do not undermine health care affordability, access, quality, equity, and culturally and linguistically competent care. The office shall also promote the goal of health care affordability, while recognizing the need to maintain and increase the supply of trained health care workers.

(c) To assist health care entities in implementing cost-reducing strategies that advance the stability of the health care workforce, and without exacerbating existing health care workforce shortages, the office, on or before July 2024, in consultation with the board and with input from organized labor representing health care workers, health care entities, and other entities and individuals with expertise in the health care workforce, shall develop standards to advance the stability of the health care workforce. The standards may be considered in the setting of cost targets pursuant to Section 127502 or in the approval of performance improvement plans imposed pursuant to Section 127502.5.

Article 8. Health Care Market Trends

127507. (a) The office shall monitor cost trends, including conducting research and studies on the health care market, including, but not limited to, the impact of consolidation, market power, venture capital activity, profit margins, and other market failures on competition, prices, access, quality, and equity. In a manner supportive of the efforts of the Attorney General, the Department of Managed Health Care, and the Department of Insurance, as appropriate, the office shall promote competitive health care markets by examining mergers, acquisitions, corporate affiliations, or other transactions that entail a material change to ownership, operations, or governance structure involving health care service plans, health insurers, hospitals or hospital systems, physician organizations, providers, pharmacy benefit managers, and other health care entities. The office shall prospectively analyze those transactions likely to have significant effects, seek input from the parties and the public, and report on the anticipated impacts to the health care market. The role of the office is to collect and report information that is informative to the public.

(b) This article does not apply to an exempted provider unless that provider is being acquired by, or affiliating with, an entity that is not an exempted provider. If an entity that is not an exempted provider is acquiring or affiliating with an exempted provider, the entity that is not an exempted provider shall meet the requirements of this article.

(c) (1) A health care entity shall provide the office with written notice of agreements or transactions that will occur on or after April 1, 2024, that do either of the following:

(A) Sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of its assets to one or more entities.

(B) Transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities.

(2) Written notice pursuant to paragraph (1) shall be provided to the office at least 90 days prior to entering into the agreement or transaction. If the conditions in paragraph (1) of subdivision (a) of Section 127507.2 apply, the office shall make the notice of material change publicly available, including all information and materials submitted to the office for review with regard to the material change.

(3) The office shall adopt regulations for proposed material changes that warrant a notification, establish appropriate fees, and consider appropriate thresholds, including, but not limited to, annual gross and net revenues and market share in a given service or region.

(d) The requirement to provide notice of a material change pursuant to subdivision (c) does not apply to any of the following:

(1) Agreements or transactions involving health care service plans that are subject to review by the Director of the Department of Managed Health Care for cost impact or market consolidation under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2).

(2) Agreements or transactions involving health insurers that are subject to review by the Insurance Commissioner under Article 14 (commencing with Section 1091) of Chapter 1 of Part 2, of Division 1 of the Insurance Code.

(3) Agreements or transactions where a county is purchasing, acquiring, or taking control, responsibility, or governance of an entity to ensure continued access in that county.

(4) Agreements or transactions involving nonprofit corporations that are subject to review by the Attorney General under Article 2 (commencing with Section 5914) of Chapter 9 of Part 2, Division 2 of Title 1 of the Corporations Code.

(e) Agreements or transactions exempted under subdivision (d) from the requirement to provide a notice of material change may be referred to the office for a cost and market impact review by the reviewing authority.

(f) This article does not limit the Attorney General's review of the conversion or restructuring of charitable trusts held by a nonprofit health facility or by an affiliated nonprofit health system or the Attorney General's review of any health care agreement or transaction under any state or federal law.

(g) This article does not narrow, abrogate, or otherwise alter the corporate practice of medicine doctrine, which expressly prohibits the practice of medicine or control of medicine, medical corporations, medical partnerships, or physician practices by entities or individuals other than licensed physicians and surgeons.

127507.2. (a) (1) If the office finds that a material change noticed pursuant to Section 127507 is likely to have a risk of a significant impact on market competitions, the state's ability to meet cost targets, or costs for purchasers and consumers, the office shall conduct a cost and market impact

review that examines factors relating to a health care entity's business and its relative market position, including, but not limited to, changes in size and market share in a given service or geographic region, prices for services compared to other providers for the same services, quality, equity, cost, access, or any other factors the office determines to be in the public interest. The office also may conduct cost and market impact reviews on any health care entity based on a determination by the director under subdivision (g) of Section 127502.5, or in association with agreements or transactions referred to the office by a reviewing authority listed in paragraphs (1) to (4), inclusive, of subdivision (d) of Section 127507.

(2) In conducting the review, the office shall consider the benefits of the material change to consumers of health care services, where those benefits could not be achieved without that transaction, including, but not limited to, increased access to health care services, higher quality, and more efficient health care services where consumers of health care services benefit directly from those efficiencies. The party subject to the review may provide information demonstrating the benefits of the material change or information demonstrating the benefits of an integrated organization where the material change would increase those benefits, and where the benefits involve cost, quality, or access to care for consumers of health care services.

(3) (A) Within 60 days of receipt of a notice of material change, the office shall either advise the noticing health care entity of the office's determination to conduct a cost and market impact review or provide a written waiver from the review. An agreement or transaction for which a cost and market impact review proceeds shall not be implemented until 60 days after the office issues a final report.

(B) The office may adopt regulations that expedite these timelines, as warranted, depending on the nature of the agreement or transaction.

(4) In furtherance of this article, the office shall conduct investigations, including, but not limited to, compelling, by subpoena, health care entities and other relevant market participants to submit data and documents.

(5) Upon completion of the cost and market impact review, the office shall make factual findings and issue a preliminary report of its findings. After allowing for the affected parties and the public to respond in writing to the findings in the preliminary report, the office shall issue its final report.

(b) The office shall adopt regulations for notification to affected parties for the basis of the review, factors considered in the review, requests for data and information from affected parties, the public, and other relevant market participants, and relevant timelines.

(c) (1) The office, the department, employees, contractors, and advisors of the office and the department, the board, and the board members shall keep confidential all nonpublic information and documents obtained under this article that were not required with the notice of material change or from the parties to the transaction, and shall not disclose the confidential information or documents to any person, other than the Attorney General, without the consent of the source of the information or documents, except in a preliminary report or final report under this section if the office believes

that disclosure should be made in the public interest after taking into account any privacy, trade secret, or anticompetitive considerations. Prior to disclosure in a report, the office shall notify the relevant party and provide the source of nonpublic information an opportunity to specify facts documenting why release of the information is damaging or prejudicial to the source of the information and why the public interest is served in withholding the information. Information that is otherwise publicly available, or that has not been confidentially maintained by the source, shall not be considered nonpublic information.

(2) Notwithstanding any other law, all nonpublic information and documents obtained under this article shall not be required to be disclosed pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records.

(d) (1) The office may refer its findings, including the totality of documents gathered and data analysis performed, to the Attorney General for further review of any unfair methods of competition, anticompetitive behavior, or anticompetitive effects.

(2) This section does not limit the authority of the Attorney General to protect consumers in the health care market or to protect the economy of the state, or any significant part thereof, insofar as health care is concerned, under any state or federal law. The authority of the Attorney General to maintain competitive markets and prosecute state and federal antitrust and unfair competition violations shall not be narrowed, abrogated, or otherwise altered by this section.

127507.4. In furtherance of this article, the office may do all of the following:

(a) Contract with, consult, and receive advice from any state agency on terms and conditions that the office deems appropriate.

(b) Contract with experts or consultants to assist in reviewing a proposed agreement or transaction.

(1) Contract costs shall not exceed an amount that is reasonable and necessary to conduct the review and complete the report.

(2) The office shall be entitled to reimbursement from the health care entity subject to review for all actual, reasonable, and direct costs incurred in reviewing, evaluating, and making the determination referred to in Section 127507.2, including administrative costs. The health care entity subject to review shall promptly pay the office, upon request, for all of those costs.

127507.6. In addition to any legal remedies, the office shall be entitled to specific performance, injunctive relief, and other equitable remedies a court deems appropriate for enforcement of any of the requirements of this article and shall be entitled to recover its attorney’s fees and costs incurred in remedying each violation.

SEC. 20. Section 127691 of the Health and Safety Code is amended to read:

127691. For purposes of this chapter, the following definitions apply:

(a) "Generic drug" means a drug that is approved pursuant to subdivision (j) of Section 355 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. Sec. 301 et seq.), or a biosimilar, as defined under the federal Public Health Service Act (42 U.S.C. Sec. 262).

(b) "Partnerships" include, but are not limited to, agreements for the procurement of generic prescription drugs by way of contracts, grant agreements, or purchasing by a payer, state governmental agency, group purchasing organization, nonprofit organization, or other entity.

SEC. 21. Section 127692 of the Health and Safety Code is amended to read:

127692. (a) The California Health and Human Services Agency (CHHSA) or its departments shall enter into partnerships, consistent with subdivision (b) of Section 127693, in consultation with other state departments as necessary, to increase competition, lower prices, and address shortages in the market for generic prescription drugs, to reduce the cost of prescription drugs for public and private purchasers, taxpayers, and consumers, and to increase patient access to affordable drugs.

(b) Until December 31, 2027, for purposes of implementing this chapter, CHHSA and its departments, including the Department of Health Care Access and Information, may enter into exclusive or nonexclusive contracts on a bid or negotiated basis. Contracts entered into or amended pursuant to this section are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and are exempt from the review or approval of any division of the Department of General Services.

(c) CHHSA shall have the ability to hire staff to oversee and project-manage the partnerships for manufacturing or distribution of generic prescription drugs, contingent upon an appropriation by the Legislature for this purpose.

SEC. 22. Section 127694 of the Health and Safety Code is amended to read:

127694. (a) On or before December 31, 2023, CHHSA shall submit a report to the Legislature that assesses the feasibility of directly manufacturing generic prescription drugs and selling generic prescription drugs at a fair price. The report shall include an analysis of governance structure options for manufacturing functions, including chartering a private organization, a public-private partnership, or a public board of directors.

(b) This section shall only go into effect if the Legislature appropriates funds for this purpose in the annual budget.

(c) The report shall be submitted in compliance with Section 9795 of the Government Code.

(d) This section shall remain in effect only until January 1, 2028, and as of that date is repealed.

SEC. 23. Section 127695 of the Health and Safety Code is amended to read:

127695. (a) On or before December 31, 2022, CHHSA shall report to the Legislature on both of the following:

(1) A description of the status of all drugs targeted under this chapter.

(2) An analysis of how the activities of CHHSA may impact competition, access to targeted drugs, the costs of those drugs, and the costs of generic prescription drugs to public and private purchasers.

(b) This section shall remain in effect only until January 1, 2028, and as of that date is repealed.

SEC. 24. Section 127696 of the Health and Safety Code, as added by Section 1 of Chapter 207 of the Statutes of 2020, is amended to read:

127696. In order to protect proprietary, confidential information regarding manufacturer or distribution costs and drug pricing, utilization, and rebates, it is necessary that this act limit the public's right of access to that information. Notwithstanding any other provision of law, all nonpublic information and documents obtained or prepared under this chapter shall not be required to be disclosed pursuant to the California Public Records Act, Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, or any similar local law requiring the disclosure of public records.

SEC. 25. Section 127696 of the Health and Safety Code, as amended by Section 289 of Chapter 615 of the Statutes of 2021, is amended to read:

127696. In order to protect proprietary, confidential information regarding manufacturer or distribution costs and drug pricing, utilization, and rebates, it is necessary that this act limit the public's right of access to that information. Notwithstanding any other provision of law, all nonpublic information and documents obtained or prepared under this chapter shall not be required to be disclosed pursuant to the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records.

SEC. 26. Section 128205 of the Health and Safety Code is amended to read:

128205. As used in this article, and Article 2 (commencing with Section 128250), the following terms have the following meanings:

(a) "Family physician" means a primary care physician and surgeon who is prepared to and renders continued comprehensive and preventative health care services to individuals and families and who has received specialized training in an approved family medicine residency for three years after graduation from an accredited medical school.

(b) "Primary care physician" means a physician who is prepared to and renders continued comprehensive and preventative health care services, and has received specialized training in the areas of internal medicine, obstetrics and gynecology, or pediatrics.

(c) "Council" means the California Health Workforce Education and Training Council.

(d) “Graduate medical education” means residency programs for education or training in one or more specialties or subspecialties following graduation from medical school.

(e) “Health professions education and training” means any formal organized education or training undertaken for the purpose of gaining knowledge and skills necessary to practice a specific health profession or to provide a role in a health care setting. Health professions education and training includes any type of health professions training program, including shadowing programs, participating in rotations, affiliation agreements, and accredited or accreditation-eligible programs, at any educational level, including certificate, undergraduate, graduate, professional, or postgraduate, and in any clinical discipline, excluding graduate medical education.

(f) “Programs that train primary care physician’s assistants” means a program that has been approved for the training of primary care physician assistants pursuant to Section 3513 of the Business and Professions Code.

(g) “Programs that train primary care nurse practitioners” means a program that is operated by a California school of medicine or nursing, or that is authorized by the Regents of the University of California or by the Trustees of the California State University, or that is approved by the Board of Registered Nursing.

(h) “Programs that train registered nurses” means a program that is operated by a California school of nursing and approved by the Board of Registered Nursing, or that is authorized by the Regents of the University of California, the Trustees of the California State University, or the Board of Governors of the California Community Colleges, and that is approved by the Board of Registered Nursing.

(i) “Programs that train midwives” means programs that train certified nurse-midwives and programs that train licensed midwives, as those terms are defined in Section 128297.

(j) “Teaching health center” means a community-based ambulatory patient care center that operates a primary care residency program. Community-based ambulatory patient care settings include, but are not limited to, federally qualified health centers, community mental health centers, rural health clinics, health centers operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization, and entities receiving funds under Title X of the federal Public Health Service Act (Public Law 91-572).

SEC. 27. Section 128210 of the Health and Safety Code is amended to read:

128210. There is hereby created a state medical contract program with accredited medical schools, teaching health centers, programs that train primary care physician’s assistants, programs that train primary care nurse practitioners, programs that train registered nurses, programs that train midwives, hospitals, and other health care delivery systems to increase the number of students and residents receiving quality education and training in the primary care specialties of family medicine, internal medicine, obstetrics and gynecology, midwifery, and pediatrics, or in nursing and to

maximize the delivery of primary care and family physician services to specific areas of California where there is a recognized unmet priority need for those services.

SEC. 28. Section 128215 of the Health and Safety Code is repealed.

SEC. 29. Section 128220 of the Health and Safety Code is repealed.

SEC. 30. Section 128225 of the Health and Safety Code is repealed.

SEC. 31. Section 128230 of the Health and Safety Code is amended to read:

128230. When funding primary care and family medicine programs or departments, primary care and family medicine residencies, and programs for the training of primary care physician assistants, primary care nurse practitioners, certified nurse-midwives, licensed midwives, or registered nurses, the department shall give priority to programs that have demonstrated success in the following areas:

(a) Graduating individuals who practice in medically underserved areas.

(b) Enrolling members of underrepresented groups in medicine to the program.

(c) Locating the program's main training site in a medically underserved area.

(d) Operating a main training site at which the majority of the patients are Medi-Cal recipients.

SEC. 32. Section 128235 of the Health and Safety Code is amended to read:

128235. Pursuant to this article and Article 2 (commencing with Section 128250), the Director of the Department of Health Care Access and Information shall do all of the following:

(a) Develop application and contract criteria based on health care workforce needs and priorities.

(b) Determine whether primary care and family medicine, primary care physician's assistant training program proposals, primary care nurse practitioner training program proposals, registered nurse training program proposals, and proposals from programs that train midwives submitted to the department for participation in the state medical contract program established by this article and Article 2 (commencing with Section 128250) meet established standards.

(c) Select and contract on behalf of the state with accredited medical schools, teaching health centers, programs that train primary care physician's assistants, programs that train primary care nurse practitioners, programs that train midwives, hospitals, and other health care delivery systems for the purpose of training undergraduate medical students and residents in the specialties of internal medicine, obstetrics and gynecology, pediatrics, and family medicine. Contracts shall be awarded to those institutions that best demonstrate the ability to provide quality education and training and to retain students and residents in specific areas of California where there is a recognized unmet priority need for primary care family physicians. Contracts shall be in conformity with the contract criteria developed by the Department of Health Care Access and Information.

(d) Select and contract on behalf of the state with programs that train registered nurses. Contracts shall be awarded to those institutions that best demonstrate the ability to provide quality education and training and to retain students and residents in specific areas of California where there is a recognized unmet priority need for registered nurses. Contracts shall be in conformity with the contract criteria developed by the Department of Health Care Access and Information.

(e) Terminate, upon 30 days' written notice, the contract of any institution whose program does not meet the standards established or that otherwise does not maintain proper compliance with this part, except as otherwise provided in contracts entered into by the director pursuant to this article and Article 2 (commencing with Section 128250).

SEC. 33. Article 2 (commencing with Section 128250) is added to Chapter 4 of Part 3 of Division 107 of the Health and Safety Code, to read:

Article 2. California Health Workforce Education and Training Council

128250. (a) The terms used in this article have the same meaning as in Section 128205.

(b) There is hereby created a California Health Workforce Education and Training Council that shall be responsible for helping coordinate California's health workforce education and training to develop a health workforce that meets California's health care needs. The council shall be composed of 18 members who, together, represent various graduate medical education and training programs, health professions, including, but not limited to, specialties for primary care and behavioral health, and consumer representatives who shall serve at the pleasure of their appointing authorities, as follows:

(1) Six members appointed by the Governor.

(2) One member who shall be the Director of the State Department of Health Care Services, or the director's designee.

(3) One member who shall be the Director of the Department of Health Care Access and Information, or the director's designee.

(4) One member who shall be the Secretary of Labor and Workforce Development, or the secretary's designee.

(5) Three members appointed by the Speaker of the Assembly.

(6) Three members appointed by the Chairperson of the Senate Committee on Rules.

(7) One member who shall be the President of the University of California, or the president's designee.

(8) One member who shall be the Chancellor of the California State University, or the chancellor's designee.

(9) One member who shall be the Chancellor of the California Community Colleges, or the chancellor's designee.

(c) Members of the council appointed under paragraphs (1), (5), and (6) of subdivision (a) shall be appointed for a term of four years, except that

the term of office of the initial members appointed under paragraph (1) shall expire at the end of two years.

128251. The members of the council, other than state employees, shall receive compensation of twenty-five dollars ($25) for each day's attendance at a council meeting, in addition to actual and necessary travel expenses incurred in the course of attendance at a council meeting.

128252. (a) The council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

(1) Develop graduate medical education and workforce training and development priorities for the state.

(2) Discuss and make recommendations to the Department of Health Care Access and Information regarding the use of health care education and training funds appropriated by the Legislature for programs administered by the department under this part.

(3) Develop standards and guidelines for residency and health professions education and training programs funded under this part.

(4) Review outcomes data from funded programs, as provided to the council by the department, to reprioritize and reassess the graduate medical education and health professions education and training needs of California's communities.

(5) Explore options for developing a broad graduate medical education and health professions education and training funding strategy.

(6) Advocate for additional funds and additional sources of funds to stimulate expansion of graduate medical education and health professions education and training in California.

(7) Provide technical assistance and support for establishing new graduate medical education and health professions education and training programs in California.

(8) Review and recommend health professions career pathways or ladders.

(b) The council shall carry out the duties imposed upon it by this chapter with primary consideration given to increasing workforce diversity and furthering improved access, quality, and equity of health care for underserved, underrepresented, and Medi-Cal populations. Further, the council shall carry out the duties imposed upon it by this chapter with a primary focus on primary care, behavioral health, oral health, and allied health.

SEC. 34. Section 10181.35 is added to the Insurance Code, to read:

10181.35. (a) It is the intent of the Legislature in enacting this section to ensure that insureds benefit from reductions in the rate of growth in health care costs as a result of the establishment of the Office of Health Care Affordability.

(b) In submitting rates for review consistent with this article, a health insurer shall demonstrate the impact of any changes in the rate of growth in health care costs resulting from the health care cost targets set pursuant to Chapter 2.6 (commencing with Section 127500) of Part 2 of Division 107 of the Health and Safety Code.

(c) In determining whether a rate is unreasonable or not justified, the commissioner shall consider the impact on changes in health care costs as a result of the health care cost targets set pursuant to Chapter 2.6 (commencing with Section 127500) of Part 2 of Division 107 of the Health and Safety Code.

SEC. 35. Section 12693.74 of the Insurance Code is amended to read:

12693.74. (a) Subscribers shall continue to be eligible for the program for a period of 12 months from the month eligibility is established.

(b) If the conditions described in paragraph (1) of subdivision (b) of Section 12693.74, as added by Section 36 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the State Department of Health Care Services pursuant to paragraph (2) of subdivision (b) of Section 12693.74, as added by Section 36 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 36. Section 12693.74 is added to the Insurance Code, to read:

12693.74. (a) To the extent federal financial participation is available, and subject to subdivision (e), the child shall remain continuously eligible for the program up to five years of age. The department shall seek any federal approvals that may be necessary to implement this subdivision.

(b) (1) Implementation of this section is contingent on all of the following conditions:

(A) All necessary federal approvals have been obtained by the department pursuant to subdivision (e).

(B) The Legislature has appropriated funding to implement this section after a determination that ongoing General Fund resources are available to support the ongoing implementation of this section in the 2024–25 fiscal year and subsequent fiscal years.

(C) The department has determined that systems have been programmed to implement this section.

(2) The department shall issue a declaration certifying the date that all conditions in paragraph (1) have been met. The department shall post the declaration on its internet website and provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(c) If at any time the director determines that the eligibility criteria established under this section for the program may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), any amendment or extension of that act, or any similar federal legislation affecting federal financial participation, the director may alter the eligibility criteria to the extent necessary for the state to receive that federal financial participation.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and Chapter 4 (commencing with Section 12693.25) and Part 6.1 (commencing with Section 12670), the department may implement, interpret, or make specific this

section, in whole or in part, through all-county letters or similar instructions, without taking any further regulatory action.

(e) This section shall be implemented only to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized.

(f) This section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (b), whichever is later.

SEC. 37. Part 4.6 (commencing with Section 1490) is added to Division 2 of the Labor Code, to read:

PART 4.6. HOSPITAL AND SKILLED NURSING FACILITY COVID-19 WORKER RETENTION PAY

1490. (a) The Legislature finds and declares that stability in the California health care workforce will further its efforts to manage the COVID-19 pandemic and address other public health issues that face Californians.

(b) The Legislature further finds and declares that providing California health care workers in 24 hour care facilities with retention payments, as appropriated and available, will advance California's effort to promote stability and retention in California's health care workforce.

1491. For purposes of this part, the following definitions apply:

(a) "Covered entity" means a person or entity that owns or operates a qualifying facility, including the Regents of the University of California.

(b) "Covered Services Employer" means a person or entity meeting both of the following:

(1) Directly employs or exercises control over the wages, hours, or working conditions.

(2) Provides onsite services such as clerical, dietary, environmental services, laundry, security, engineering, facilities management, administrative, or billing staff through a contract with a qualifying facility or provides nurse practitioners or physician assistants at a qualifying facility through a professional corporation where the professional corporation is the employer of record.

(c) "Date of record" means a date determined by the department that is no later than 45 days after end of the qualifying work period.

(d) "Department" means the State Department of Health Care Services.

(e) "Eligible full-time employee" means a person who meets both of the following:

(1) Is employed by a covered entity or covered services employer as of the date of record and is not a manager or supervisor.

(2) Was compensated for at least 400 in-person hours performed on the site of a qualifying facility during the qualifying work period for a single covered entity or covered services employer, or is considered to be a full-time

employee on the site of a qualifying facility by the covered entity or covered services employer.

(f) "Eligible part-time employee" means a person who meets both of the following:

(1) Is employed by a covered entity or covered services employer as of the date of record and is not a supervisor or manager.

(2) Was compensated for at least 100 in-person hours, but less than 400 in-person hours, performed on the site of a qualifying facility during the qualifying work period for a single covered entity or covered services employer, or is considered to be a part-time employee by the covered entity or covered services employer, and is not considered to be an eligible full-time employee on the site of a qualifying facility by the covered entity or covered services employer.

(g) "Eligible physician" means a person who meets both of the following:

(1) Is a physician or surgeon, licensed by California state law.

(2) Primarily provides in-person patient care work in a clinical or medical department, or works as a member of the patient care team during the qualifying work period and on the date of record, at a qualifying facility or is an employee under Section 2401 of the Business and Professions Code of a covered entity or physician entity working primarily in-person on the site of a qualifying facility during the qualifying work period and on the date of record.

(h) "Managers and supervisors" means persons who meet all of the following:

(1) Whose duties and responsibilities involve the management of the enterprise in which they are employed or of a customarily recognized department or subdivision thereof.

(2) Who customarily and regularly directs the work of two or more other employees of the enterprise in which they are employed or of a customarily recognized department or subdivision thereof.

(3) Who has the authority to hire or fire other employees or whose suggestions and recommendations as to the hiring or firing and as to the advancement and promotion or any other change of status of other employees will be given particular weight.

(4) Who customarily and regularly exercises discretion and independent judgment.

(5) Who is primarily engaged in duties which meet the test of the exemption. The activities constituting exempt work and nonexempt work shall be construed in the same manner as such items are construed in the following regulations under the Fair Labor Standards Act effective as of the date of this order: Sections 541.102, 541.104-111, and 541.115-116 of Title 29 of the Code of Federal Regulations. Exempt work shall include, for example, all work that is directly and closely related to exempt work and work which is properly viewed as a means for carrying out exempt functions. The work actually performed by the employee during the course of the work week must, first and foremost, be examined and the amount of time the employee spends on such work, together with the employer's

realistic expectations and the realistic requirements of the job, shall be considered in determining whether the employee satisfies this requirement.

(6) Who must earn a monthly salary equivalent to no less than two times the state minimum wage for full-time employment. Full-time employment is defined in subdivision (c) of Section 515 as 40 hours per week.

(i) "Matching retention payments" means monetary compensation other than salaries, wages, and overtime paid to an eligible full-time employee or eligible part-time employee that was paid on or after December 1, 2021, or will be paid on or before December, 31, 2022, and meets any of the following criteria:

(1) The compensation was or is paid as hazard or bonus pay as a result of the COVID-19 pandemic.

(2) The compensation was or is paid as a bonus based on performance or financial targets or a payout resulting from performance sharing programs designed to provide employees with a share in performance gains.

(3) The compensation was or is paid in response to operational needs of the covered entity or covered services employer, including, but not limited to, staffing shortages or recruitment needs.

(j) "Physician entity" means any legal entity that contracts with a qualifying facility to provide physician services, including, but not limited to, professional medical corporations and sole proprietorships.

(k) "Qualifying facility" means a health facility that is not a state facility and is licensed as one of the following:

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

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

(3) A skilled nursing facility as defined in subdivision (c) of Section 1250 of the Health and Safety Code.

(4) A clinic organized under subdivision (*l*) of Section 1206 of the Health and Safety Code that is affiliated, owned, or controlled by a person or entity that owns or operates a facility described in paragraph (1).

(5) A clinic organized under subdivision (b), (d), or (r) of Section 1206 of the Health and Safety Code that is affiliated, owned, or controlled by a person or entity that owns or operates a facility described in Paragraph (1) or Parts 405 and 491 of Title 42 of the United States Code.

(6) A physician organization that is part of a fully integrated delivery system that includes a physician organization, health facility or health system, and a nonprofit health care service plan that provides medical services to enrollees in a specific geographic region of the state through an affiliate hospital system and an exclusive contract between the nonprofit health care service plan and a single physician organization in each geographic region to provide those medical services.

(7) A designated public hospital system that is comprised of a designated public hospital, as defined in subdivision (f) of Section 14184.10 of the Welfare and Institutions Code, and its affiliated governmental health and behavioral health provider entities, including nonhospital settings. A single

designated public hospital system may include multiple designated public hospitals under common government ownership.

(*l*) "Qualifying work period" means a 91-day period identified by the department beginning no later than 30 days after the enactment of this section.

(m) "State facility" means a health facility that is owned or operated by this state or any state department, authority, bureau, commission, or officer, other than a health facility owned or operated by the Regents of the University of California. A health facility owned or operated by the Regents of the University of California is not be considered a state facility.

1492. (a) Upon appropriation by the Legislature, the department shall provide funding to participant covered entities, covered services employers, and physician entities to make retention payments to their eligible employees or eligible physicians, and shall make retention payments directly to eligible physicians who are not employees of a covered entity or physician entity, for the public purposes specified in Section 1490. The department may provide up to one thousand five hundred dollars ($1,500) for each eligible full-time employee, one thousand two hundred and fifty dollars ($1,250) for each eligible part-time employee, or one thousand dollars ($1,000) for each eligible physician, subject to the methodology described in subdivision (d) and the aggregate amount of funding available for this purpose.

(b) As a condition of receipt of funding pursuant to this section, a covered entity, covered services employer or a physician entity shall submit to the department the following information for each eligible full-time employee, eligible part-time employee, or eligible physician employed by, or otherwise affiliated with, a covered entity, covered services employer, or physician entity, by a date specified by the department:

(1) Name of the eligible full-time employee, eligible part-time employee, or, if applicable, eligible physician employed by, or otherwise affiliated with, a covered entity or physician entity.

(2) Mailing address of the eligible full-time employee, eligible part-time employee, or, if applicable, eligible physician employed by, or otherwise affiliated with, the covered entity or physician entity.

(3) The total amount of matching retention payments that the covered entity or covered services employer paid or will pay to the eligible full-time employee or eligible part-time employee. A covered entity or covered services employer is not obligated to make a matching retention payment.

(4) Number of hours for which the covered entity or covered services employer compensated the eligible full-time employee or eligible part-time employee during the qualifying work period.

(5) If a covered entity, a list of eligible physicians that are employed by the covered entity, contracted with or employed by a physician entity under contract with the covered entity, or described in subparagraph (A) of paragraph (2) of subdivision (g) of Section 1491.

(6) If a covered services employer, a list of covered entities that the covered services employer contracts with for specified services staff.

(7) Any other information as required by the department for purposes of implementing this part.

(c) Following the deadline specified by the department for submissions by a covered entity, covered services employer, or physician entity pursuant to subdivision (b), the department shall determine the amount of the retention payment to be paid by each participant covered entity, covered services employer, or physician entity to each eligible employee or eligible physician, and the amount of retention payment to be paid by the department to each eligible physician who is not an employee of a covered entity or employed by or contracted with a physician entity, based on available funding and the total number of eligible full-time employees, eligible part-time employees, and eligible physicians reported pursuant to subdivision (b). The amount of the retention payment shall be calculated as follows, subject to available funding and reduced on a pro rata basis if necessary:

(1) For an eligible full-time employee, the state payment amount shall be one thousand dollars ($1,000) plus the amount of matching retention payment paid to the eligible full-time employee by the covered entity or covered services employer, up to a total maximum state payment of one thousand five hundred dollars ($1,500).

(2) For an eligible part-time employee, the state payment amount shall be seven hundred and fifty dollars ($750) plus the amount of matching retention payment paid to the eligible part-time employee by the covered entity or covered services employer, up to a total maximum state payment of one thousand two hundred and fifty dollars ($1,250).

(3) For an eligible physician, the state payment amount shall be one thousand dollars ($1,000).

(4) The department may reduce the payment amounts described in paragraphs (1), (2), or (3) on a pro rata basis to reflect the total amount of funding appropriated to the department and the total number of eligible full-time employees, eligible part-time employees, and eligible physicians reported.

(5) To the extent feasible, the department shall adopt a methodology so that a single eligible full-time employee, eligible part-time employee, or eligible physician affiliated with multiple covered entities, covered services employers, or physician entities does not receive more than one retention payment.

(d) (1) The department shall determine the conditions and data reporting requirements for participant covered entities, covered services employers, and physician entities to be eligible to receive funding for retention payments.

(2) The covered entity, covered services employer, or physician entity shall provide all funding to their eligible employees and eligible physicians within 60 days of receipt from the department. The covered entity, covered services employer, or physician entity shall attest, in a form and manner specified by the department and under penalty of perjury, that all funding received pursuant to this section was provided within 60 days of receipt from the department.

(3) The covered entity, covered services employer, or physician entity shall immediately return to the department any funding received pursuant to this section that is not distributed within 60 days of receipt from the department. The department shall return the funds to the original appropriation and the Department of Finance may transfer any unspent or returned funds from the original appropriation to the General Fund.

(4) The covered entity, covered services employer, or physician entity shall report to the department within 90 days of receipt of funds information on the number of eligible employees or eligible physicians paid by profession type, the total amount of payments made including covered entity or covered services employer matching funds for eligible employees, and information on the timing of payments.

(5) The covered employer, covered services employer, or physician entity shall not use the funding to supplant other payments from the covered employer, covered services employer, or physician entity to the eligible full-time employee, eligible part-time employee, or eligible physician.

(e) (1) The department may make payments described in this section to covered entities and eligible physicians using the existing Medi-Cal Checkwrite system. Except as required by federal law, any payments made pursuant to this section shall be exempt from any adjustments or deductions made by the department to Medi-Cal payments made to covered entities or eligible physicians, including, but not limited to, provider withholds or provider payment reductions.

(2) Payments made pursuant to this section to covered entities, covered services employers, physician entities, or eligible physicians shall not be considered as payments for patient care or medical services.

(3) The Department of Health Care Access and Information, in consultation with appropriate stakeholders, shall release a technical letter to instruct covered entities, physician entities, and eligible physicians in how to report this revenue through the established health care financial reports, including, but not limited to, those required under Section 128810 of the Health and Safety Code, or Section 97040 of Title 22 of the California Code of Regulations.

(f) The department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis for purposes of implementing this part. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and from the State Administrative and State Contracting manuals, and shall be exempt from the review or approval of any division of the Department of General Services.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department and the Department of Health Care Access and Information may implement, interpret, or make specific this part, in whole or in part, by means of

information notices or other similar instructions, without taking any further regulatory action.

(h) The Legislature finds and declares that this section is a state law within the meaning of Section 1621(d) of Title 8 of the United States Code.

(i) This part shall be implemented only to the extent that the department determines that federal financial participation under the Medi-Cal program is not jeopardized.

1493. (a) In the event of a dispute about the status of an employee as a full-time eligible employee, part-time eligible employee, the retention payment amount, or the covered entity's or covered service employer's failure to make a retention payment, the employee or a labor organization that represents the employee may write to the employer and request a review of the employee's eligibility status, retention payment amount, or the employer's failure to make a retention payment. The employer shall have 30 days to review the employee's request, disclose to the employee the amount received from the department subject to the methodology described in subdivision (d) of Section 1492, and cure any alleged deficiency without damages.

(b) If the covered entity or covered services employer does not conclude the retention payment review described in subdivision (a) within 30 days of receipt of the review request, or the employer does not cure the alleged deficiency within 30 days of receipt of the review request, and the alleged deficiency is five hundred dollars ($500) or less the employee may file a complaint with the Labor Commissioner as provided in Section 98. If the Labor Commissioner finds that the covered entity or covered services employer is liable for failing to make a required retention payment, the covered entity or covered services employer shall be ordered to make full payment of the unpaid amount, plus interest at the rate of interest specified in subdivision (b) of Section 3289 of the Civil Code, which shall accrue from the date that the retention payment funds were transmitted to the covered entity or covered services employer by the department as provided in Section 1492. A covered entity or covered services employer that willfully fails to make a full retention payment after receiving a request for review described in subdivision (a) shall be liable to the employee for liquidated damages in an amount equal to the unpaid amount.

(c) If the covered entity or covered services employer does not conclude the retention payment review described in subdivision (a) within 30 days of receipt of the review request, or does not cure the alleged deficiency within 30 days of receipt of the review request, and the alleged deficiency is greater than five hundred dollars ($500) the employee may file a complaint with the Labor Commissioner as provided in Section 98 or the employee may file a civil action in court to recover the deficiency. If the Labor Commissioner or court finds that the covered entity or covered services employer is liable for failing to make a required retention payment, or designate an employee for such payment, the covered entity or covered services employer shall be ordered to make full payment of the unpaid amount, plus interest at the rate of interest specified in subdivision (b) of

Section 3289 of the Civil Code, which shall accrue from the date that the retention payment funds were transmitted to the covered entity or covered services employer by the department as provided in Section 1492 or from the date a covered employer or covered services employer should have designated an employee for such payment. A covered entity or covered services employer that willfully fails to make a full retention payment after receiving a request for review described in subdivision (a) shall be liable to the employee for liquidated damages in an amount equal to the unpaid amount. In any civil action brought by an employee for the nonpayment of retention payments, the court shall award reasonable attorney's fees and costs to a prevailing employee.

(d) Notwithstanding any other law, the Department shall not be liable for any payment, interest, liquidated damages or attorney's fees and costs awarded to an employee pursuant to this section, and shall not be required to indemnify a covered entity or covered services employer for any such liability they incur pursuant to this section.

(e) The Labor Commissioner shall enforce this part, including investigating an alleged violation, and ordering appropriate temporary relief to mitigate the violation or to maintain the status quo pending the completion of a full investigation or hearing through the procedures set forth in Sections 98, 98.3, or 1197.1, including by issuance of a citation against an employer who violates this article, and by filing a civil action. If a citation is issued, the procedures for issuing, contesting, and enforcing judgments for citations and civil penalties issued by the Labor Commissioner shall be the same as those set out in Section 1197.1, as appropriate.

1494. (a) In the event of a dispute about the status of an eligible physician, the retention payment amount, or the physician entity's failure to make a retention payment, the physician may write to the physician entity and request a review of the physician's eligibility status, retention payment amount, or the physician entity's failure to make a retention payment. The physician entity shall have 30 days to review the physician's request, disclose to the physician the amount received from the department subject to the methodology described in subdivision (d) of Section 1492, and cure any alleged deficiency without penalty.

(b) If the physician entity does not conclude the retention payment review described in subdivision (a) within 30 days of receipt of the review request, or the physician entity does not cure the alleged deficiency within 30 days of receipt of the review request, the employee may file a complaint with the department. If the department finds that the physician entity failed to make a required retention payment, the physician entity shall be ordered to make full payment of the unpaid amount, plus interest at the rate of interest specified in subdivision (b) of Section 3289 of the Civil Code, which shall accrue from the date that the retention payment funds were transmitted to the physician entity by the department as provided in Section 1492. A physician employer that willfully fails to make a full retention payment after receiving a request for review described in subdivision (a) shall be

liable to the employee for liquidated damages in an amount equal to the unpaid amount.

(c) Notwithstanding any other law, the department shall not be required to indemnify a physician entity for any liability it incurs pursuant to subdivision (b).

1495. (a) In serving as a conduit for the retention payments under this part, covered entities, covered services employers, and physician entities are carrying out a state program. This part does not create a private right of action in any civil litigation against covered entities, covered services employers, and physician entities regarding the administration of the retention payment program and in the receipt and transmittal of retention payment program funds.

(b) Notwithstanding any other law, retention payments described in this part are not wages as defined in Section 200.

(c) Except as provided in Sections 1493 and 1494, and notwithstanding any other law, covered entities, covered services employers, physician entities, and the department shall not be liable for damages awarded under Section 3294 of the Civil Code, Sections 2698 to 2699.5, or other damages imposed primarily for the sake of example and by way of punishing the defendant, in any civil litigation related to the retention payments described in this part.

SEC. 38. Section 1001.36 of the Penal Code is amended to read:

1001.36. (a) On an accusatory pleading alleging the commission of a misdemeanor or felony offense, the court may, after considering the positions of the defense and prosecution, grant pretrial diversion to a defendant pursuant to this section if the defendant meets all of the requirements specified in paragraph (1) of subdivision (b).

(b) (1) Pretrial diversion may be granted pursuant to this section if all of the following criteria are met:

(A) The court is satisfied that the defendant suffers from a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including, but not limited to, bipolar disorder, schizophrenia, schizoaffective disorder, or post-traumatic stress disorder, but excluding antisocial personality disorder, borderline personality disorder, and pedophilia. Evidence of the defendant's mental disorder shall be provided by the defense and shall include a recent diagnosis by a qualified mental health expert. In opining that a defendant suffers from a qualifying disorder, the qualified mental health expert may rely on an examination of the defendant, the defendant's medical records, arrest reports, or any other relevant evidence.

(B) The court is satisfied that the defendant's mental disorder was a significant factor in the commission of the charged offense. A court may conclude that a defendant's mental disorder was a significant factor in the commission of the charged offense if, after reviewing any relevant and credible evidence, including, but not limited to, police reports, preliminary hearing transcripts, witness statements, statements by the defendant's mental health treatment provider, medical records, records or reports by qualified

medical experts, or evidence that the defendant displayed symptoms consistent with the relevant mental disorder at or near the time of the offense, the court concludes that the defendant's mental disorder substantially contributed to the defendant's involvement in the commission of the offense.

(C) In the opinion of a qualified mental health expert, the defendant's symptoms of the mental disorder motivating the criminal behavior would respond to mental health treatment.

(D) The defendant consents to diversion and waives the defendant's right to a speedy trial, unless a defendant has been found to be an appropriate candidate for diversion in lieu of commitment pursuant to clause (iv) of subparagraph (B) of paragraph (1) of subdivision (a) of Section 1370 and, as a result of the defendant's mental incompetence, cannot consent to diversion or give a knowing and intelligent waiver of the defendant's right to a speedy trial.

(E) The defendant agrees to comply with treatment as a condition of diversion, unless the defendant has been found to be an appropriate candidate for diversion in lieu of commitment for restoration of competency treatment pursuant to clause (iv) of subparagraph (B) of paragraph (1) of subdivision (a) of Section 1370 and, as a result of the defendant's mental incompetence, cannot agree to comply with treatment.

(F) The court is satisfied that the defendant will not pose an unreasonable risk of danger to public safety, as defined in Section 1170.18, if treated in the community. The court may consider the opinions of the district attorney, the defense, or a qualified mental health expert, and may consider the defendant's violence and criminal history, the current charged offense, and any other factors that the court deems appropriate.

(2) A defendant may not be placed into a diversion program, pursuant to this section, for the following current charged offenses:

(A) Murder or voluntary manslaughter.

(B) An offense for which a person, if convicted, would be required to register pursuant to Section 290, except for a violation of Section 314.

(C) Rape.

(D) Lewd or lascivious act on a child under 14 years of age.

(E) Assault with intent to commit rape, sodomy, or oral copulation, in violation of Section 220.

(F) Commission of rape or sexual penetration in concert with another person, in violation of Section 264.1.

(G) Continuous sexual abuse of a child, in violation of Section 288.5.

(H) A violation of subdivision (b) or (c) of Section 11418.

(3) At any stage of the proceedings, the court may require the defendant to make a prima facie showing that the defendant will meet the minimum requirements of eligibility for diversion and that the defendant and the offense are suitable for diversion. The hearing on the prima facie showing shall be informal and may proceed on offers of proof, reliable hearsay, and argument of counsel. If a prima facie showing is not made, the court may summarily deny the request for diversion or grant any other relief as may be deemed appropriate.

(c) As used in this chapter, "pretrial diversion" means the postponement of prosecution, either temporarily or permanently, at any point in the judicial process from the point at which the accused is charged until adjudication, to allow the defendant to undergo mental health treatment, subject to all of the following:

(1) (A) The court is satisfied that the recommended inpatient or outpatient program of mental health treatment will meet the specialized mental health treatment needs of the defendant.

(B) The defendant may be referred to a program of mental health treatment utilizing existing inpatient or outpatient mental health resources. Before approving a proposed treatment program, the court shall consider the request of the defense, the request of the prosecution, the needs of the defendant, and the interests of the community. The treatment may be procured using private or public funds, and a referral may be made to a county mental health agency, existing collaborative courts, or assisted outpatient treatment only if that entity has agreed to accept responsibility for the treatment of the defendant, and mental health services are provided only to the extent that resources are available and the defendant is eligible for those services.

(2) The provider of the mental health treatment program in which the defendant has been placed shall provide regular reports to the court, the defense, and the prosecutor on the defendant's progress in treatment.

(3) The period during which criminal proceedings against the defendant may be diverted shall be no longer than two years.

(4) Upon request, the court shall conduct a hearing to determine whether restitution, as defined in subdivision (f) of Section 1202.4, is owed to any victim as a result of the diverted offense and, if owed, order its payment during the period of diversion. However, a defendant's inability to pay restitution due to indigence or mental disorder shall not be grounds for denial of diversion or a finding that the defendant has failed to comply with the terms of diversion.

(d) If any of the following circumstances exists, the court shall, after notice to the defendant, defense counsel, and the prosecution, hold a hearing to determine whether the criminal proceedings should be reinstated, whether the treatment should be modified, or whether the defendant should be conserved and referred to the conservatorship investigator of the county of commitment to initiate conservatorship proceedings for the defendant pursuant to Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code:

(1) The defendant is charged with an additional misdemeanor allegedly committed during the pretrial diversion and that reflects the defendant's propensity for violence.

(2) The defendant is charged with an additional felony allegedly committed during the pretrial diversion.

(3) The defendant is engaged in criminal conduct rendering the defendant unsuitable for diversion.

(4) Based on the opinion of a qualified mental health expert whom the court may deem appropriate, either of the following circumstances exists:

(A) The defendant is performing unsatisfactorily in the assigned program.

(B) The defendant is gravely disabled, as defined in subparagraph (B) of paragraph (1) of subdivision (h) of Section 5008 of the Welfare and Institutions Code. A defendant shall only be conserved and referred to the conservatorship investigator pursuant to this finding.

(e) If the defendant has performed satisfactorily in diversion, at the end of the period of diversion, the court shall dismiss the defendant's criminal charges that were the subject of the criminal proceedings at the time of the initial diversion. A court may conclude that the defendant has performed satisfactorily if the defendant has substantially complied with the requirements of diversion, has avoided significant new violations of law unrelated to the defendant's mental health condition, and has a plan in place for long-term mental health care. If the court dismisses the charges, the clerk of the court shall file a record with the Department of Justice indicating the disposition of the case diverted pursuant to this section. Upon successful completion of diversion, if the court dismisses the charges, the arrest upon which the diversion was based shall be deemed never to have occurred, and the court shall order access to the record of the arrest restricted in accordance with Section 1001.9, except as specified in subdivisions (g) and (h). The defendant who successfully completes diversion may indicate in response to any question concerning the defendant's prior criminal record that the defendant was not arrested or diverted for the offense, except as specified in subdivision (g).

(f) A record pertaining to an arrest resulting in successful completion of diversion, or any record generated as a result of the defendant's application for or participation in diversion, shall not, without the defendant's consent, be used in any way that could result in the denial of any employment, benefit, license, or certificate.

(g) The defendant shall be advised that, regardless of the defendant's completion of diversion, both of the following apply:

(1) The arrest upon which the diversion was based may be disclosed by the Department of Justice to any peace officer application request and that, notwithstanding subdivision (f), this section does not relieve the defendant of the obligation to disclose the arrest in response to any direct question contained in any questionnaire or application for a position as a peace officer, as defined in Section 830.

(2) An order to seal records pertaining to an arrest made pursuant to this section has no effect on a criminal justice agency's ability to access and use those sealed records and information regarding sealed arrests, as described in Section 851.92.

(h) A finding that the defendant suffers from a mental disorder, any progress reports concerning the defendant's treatment, or any other records related to a mental disorder that were created as a result of participation in, or completion of, diversion pursuant to this section or for use at a hearing on the defendant's eligibility for diversion under this section may not be

used in any other proceeding without the defendant's consent, unless that information is relevant evidence that is admissible under the standards described in paragraph (2) of subdivision (f) of Section 28 of Article I of the California Constitution. However, when determining whether to exercise its discretion to grant diversion under this section, a court may consider previous records of participation in diversion under this section.

(i) The county agency administering the diversion, the defendant's mental health treatment providers, the public guardian or conservator, and the court shall, to the extent not prohibited by federal law, have access to the defendant's medical and psychological records, including progress reports, during the defendant's time in diversion, as needed, for the purpose of providing care and treatment and monitoring treatment for diversion or conservatorship.

SEC. 39. Section 1026 of the Penal Code is amended to read:

1026. (a) If a defendant pleads not guilty by reason of insanity, and also joins with it another plea or pleas, the defendant shall first be tried as if only the other plea or pleas had been entered, and in that trial the defendant shall be conclusively presumed to have been sane at the time the offense is alleged to have been committed. If the jury finds the defendant guilty, or if the defendant pleads only not guilty by reason of insanity, the question whether the defendant was sane or insane at the time the offense was committed shall be promptly tried, either before the same jury or before a new jury in the discretion of the court. In that trial, the jury shall return a verdict either that the defendant was sane at the time the offense was committed or was insane at the time the offense was committed. If the verdict or finding is that the defendant was sane at the time the offense was committed, the court shall sentence the defendant as provided by law. If the verdict or finding is that the defendant was insane at the time the offense was committed, the court, unless it appears to the court that the sanity of the defendant has been recovered fully, shall direct that the defendant be committed to the State Department of State Hospitals for the care and treatment of persons with mental health disorders or any other appropriate public or private treatment facility approved by the community program director, or the court may order the defendant placed on outpatient status pursuant to Title 15 (commencing with Section 1600) of Part 2.

(b) Prior to making the order directing that the defendant be committed to the State Department of State Hospitals or other treatment facility or placed on outpatient status, the court shall order the community program director or a designee to evaluate the defendant and to submit to the court within 15 judicial days of the order a written recommendation as to whether the defendant should be placed on outpatient status or committed to the State Department of State Hospitals or other treatment facility. A person shall not be admitted to a state hospital or other treatment facility or placed on outpatient status under this section without having been evaluated by the community program director or a designee. If, however, it appears to the court that the sanity of the defendant has been recovered fully, the defendant shall be remanded to the custody of the sheriff until the issue of sanity has

been finally determined in the manner prescribed by law. A defendant committed to a state hospital or other treatment facility or placed on outpatient status pursuant to Title 15 (commencing with Section 1600) of Part 2 shall not be released from confinement, parole, or outpatient status unless and until the court that committed the person, after notice and hearing, finds and determines that the person's sanity has been restored, or meets the criteria for release pursuant to Section 4146 of the Welfare and Institutions Code. This section does not prohibit the transfer of the patient from one state hospital to any other state hospital by proper authority. This section does not prohibit the transfer of the patient to a hospital in another state in the manner provided in Section 4119 of the Welfare and Institutions Code.

(c) If the defendant is committed or transferred to the State Department of State Hospitals pursuant to this section, the court may, upon receiving the written recommendation of the medical director of the state hospital and the community program director, or their designee, or, pursuant to Section 4360.5 of the Welfare and Institutions Code, the recommendation of the independent evaluation panel, that the defendant be transferred to a public or private treatment facility approved by the community program director or their designee, or, pursuant to Section 4360.5 of the Welfare and Institutions Code, the independent evaluation panel, order the defendant transferred to that facility. If the defendant is committed or transferred to a public or private treatment facility approved by the community program director, the court may, upon receiving the written recommendation of the community program director, order the defendant transferred to the State Department of State Hospitals or to another public or private treatment facility approved by the community program director. If either the defendant or the prosecuting attorney chooses to contest either kind of order of transfer, a petition may be filed in the court requesting a hearing, which shall be held if the court determines that sufficient grounds exist. At that hearing, the prosecuting attorney or the defendant may present evidence bearing on the order of transfer. The court shall use the same procedures and standards of proof as used in conducting probation revocation hearings pursuant to Section 1203.2.

(d) Prior to making an order for transfer under this section, the court shall notify the defendant, the attorney of record for the defendant, the prosecuting attorney, and the community program director or a designee.

(e) If the court, after considering the placement recommendation of the community program director or independent evaluation panel required in subdivision (b), orders that the defendant be committed to the State Department of State Hospitals or other public or private treatment facility, the court shall provide copies of the following documents prior to the admission of the defendant to the State Department of State Hospitals or other treatment facility where the defendant is to be committed:

(1) The commitment order, including a specification of the charges.

(2) A computation or statement setting forth the maximum term of commitment in accordance with Section 1026.5.

(3) A computation or statement setting forth the amount of credit for time served, if any, to be deducted from the maximum term of commitment.

(4) State summary criminal history information.

(5) Any arrest reports prepared by the police department or other law enforcement agency.

(6) Any court-ordered psychiatric examination or evaluation reports.

(7) The community program director's placement recommendation report.

(8) Any medical records.

(f) If the defendant is confined in a state hospital or other treatment facility as an inpatient, the medical director of the facility shall, at six-month intervals, submit a report in writing to the court and the community program director of the county of commitment, or a designee, setting forth the status and progress of the defendant. The court shall transmit copies of these reports to the prosecutor and defense counsel.

(g) For purposes of this section and Sections 1026.1 to 1026.6, inclusive, "community program director" means the person, agency, or entity designated by the State Department of State Hospitals pursuant to Section 1605 of this code and Section 4360 of the Welfare and Institutions Code.

SEC. 40. Section 1026.2 of the Penal Code is amended to read:

1026.2. (a) An application for the release of a person who has been committed to a state hospital or other treatment facility, as provided in Section 1026, upon the ground that sanity has been restored, may be made to the superior court of the county from which the commitment was made, either by the person, or by the medical director of the state hospital or other treatment facility to which the person is committed or by the community program director where the person is on outpatient status under Title 15 (commencing with Section 1600). The court shall give notice of the hearing date to the prosecuting attorney, the community program director or a designee, and the medical director or person in charge of the facility providing treatment to the committed person at least 15 judicial days in advance of the hearing date.

(b) Pending the hearing, the medical director or person in charge of the facility in which the person is confined shall prepare a summary of the person's programs of treatment and shall forward the summary to the community program director or a designee and to the court. The community program director or a designee shall review the summary and shall designate a facility within a reasonable distance from the court in which the person may be detained pending the hearing on the application for release. The facility so designated shall continue the program of treatment, shall provide adequate security, and shall, to the greatest extent possible, minimize interference with the person's program of treatment.

(c) A designated facility need not be approved for 72-hour treatment and evaluation pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code). However, a county jail may not be designated unless the services specified in subdivision (b) are provided and accommodations are provided which ensure both the safety of the person and the safety of the general population

of the jail. If there is evidence that the treatment program is not being complied with or accommodations have not been provided which ensure both the safety of the committed person and the safety of the general population of the jail, the court shall order the person transferred to an appropriate facility or make any other appropriate order, including continuance of the proceedings.

(d) No hearing upon the application shall be allowed until the person committed has been confined or placed on outpatient status for a period of not less than 180 days from the date of the order of commitment.

(e) The court shall hold a hearing to determine whether the person applying for restoration of sanity would be a danger to the health and safety of others, due to mental defect, disease, or disorder, if under supervision and treatment in the community. If the court at the hearing determines the applicant will not be a danger to the health and safety of others, due to mental defect, disease, or disorder, while under supervision and treatment in the community, the court shall order the applicant placed with an appropriate forensic conditional release program for one year. All or a substantial portion of the program shall include outpatient supervision and treatment. The court shall retain jurisdiction. The court at the end of the one year, shall have a trial to determine if sanity has been restored, which means the applicant is no longer a danger to the health and safety of others, due to mental defect, disease, or disorder. The court shall not determine whether the applicant has been restored to sanity until the applicant has completed the one year in the appropriate forensic conditional release program, unless the community program director sooner makes a recommendation for restoration of sanity and unconditional release as described in subdivision (h). The court shall notify the persons required to be notified in subdivision (a) of the hearing date.

(f) If the applicant is on parole or outpatient status and has been on it for one year or longer, then it is deemed that the applicant has completed the required one year in an appropriate forensic conditional release program and the court shall, if all other applicable provisions of law have been met, hold the trial on restoration of sanity as provided for in this section.

(g) Before placing an applicant in an appropriate forensic conditional release program, the community program director or their designee, or, pursuant to Section 4360.5 of the Welfare and Institutions Code, the independent evaluation panel, shall submit to the court a written recommendation as to what forensic conditional release program is the most appropriate for supervising and treating the applicant. If the court does not accept the recommendation of the community program director or panel, the court shall specify the reason or reasons for its order on the court record. Sections 1605 to 1610, inclusive, shall be applicable to the person placed in the forensic conditional release program unless otherwise ordered by the court.

(h) (1) If the court determines that the person should be transferred to an appropriate forensic conditional release program, the community program director or a designee shall make the necessary placement arrangements,

and, within 21 days after receiving notice of the court finding, the person shall be placed in the community in accordance with the treatment and supervision plan, unless good cause for not doing so is made known to the court.

(2) During the one year of supervision and treatment, if the community program director is of the opinion that the person is no longer a danger to the health and safety of others due to a mental defect, disease, or disorder, the community program director shall submit a report of their opinion and recommendations to the committing court, the prosecuting attorney, and the attorney for the person. The court shall then set and hold a trial to determine whether restoration of sanity and unconditional release should be granted. The trial shall be conducted in the same manner as is required at the end of one full year of supervision and treatment.

(i) If at the trial for restoration of sanity the court rules adversely to the applicant, the court may place the applicant on outpatient status, pursuant to Title 15 (commencing with Section 1600) of Part 2, unless the applicant does not meet all of the requirements of Section 1603.

(j) If the court denies the application to place the person in an appropriate forensic conditional release program or if restoration of sanity is denied, no new application may be filed by the person until one year has elapsed from the date of the denial.

(k) In any hearing authorized by this section, the applicant shall have the burden of proof by a preponderance of the evidence.

(*l*) If the application for the release is not made by the medical director of the state hospital or other treatment facility to which the person is committed or by the community program director where the person is on outpatient status under Title 15 (commencing with Section 1600), no action on the application shall be taken by the court without first obtaining the written recommendation of the medical director of the state hospital or other treatment facility or of the community program director where the person is on outpatient status under Title 15 (commencing with Section 1600).

(m) This subdivision shall apply only to persons who, at the time of the petition or recommendation for restoration of sanity, are subject to a term of imprisonment with prison time remaining to serve or are subject to the imposition of a previously stayed sentence to a term of imprisonment. Any person to whom this subdivision applies who petitions or is recommended for restoration of sanity may not be placed in a forensic conditional release program for one year, and a finding of restoration of sanity may be made without the person being in a forensic conditional release program for one year. If a finding of restoration of sanity is made, the person shall be transferred to the custody of the California Department of Corrections to serve the term of imprisonment remaining or shall be transferred to the appropriate court for imposition of the sentence that is pending, whichever is applicable.

SEC. 41. Section 1369 of the Penal Code is amended to read:

1369. Except as stated in subdivision (g), a trial by court or jury of the question of mental competence shall proceed in the following order:

(a) (1) The court shall appoint a psychiatrist or licensed psychologist, and any other expert the court may deem appropriate, to examine the defendant. If the defendant or the defendant's counsel informs the court that the defendant is not seeking a finding of mental incompetence, the court shall appoint two psychiatrists, licensed psychologists, or a combination thereof. One of the psychiatrists or licensed psychologists may be named by the defense and one may be named by the prosecution.

(2) (A) The examining licensed psychologists or psychiatrists shall evaluate the nature of the defendant's mental disorder, if any, the defendant's ability or inability to understand the nature of the criminal proceedings or the defendant's ability to assist counsel in the conduct of a defense in a rational manner as a result of a mental disorder, and whether treatment with antipsychotic medication, as defined in subdivision (*l*) of Section 5008 of the Welfare and Institutions Code, is appropriate for the defendant. The evaluation of whether treatment with antipsychotic medication is appropriate shall be done in accordance with subparagraphs (B) and (C). The examining licensed psychologists or psychiatrists shall also opine whether the defendant lacks the capacity to make decisions regarding antipsychotic medication, as outlined in subclauses (I) and (II) of clause (i) of subparagraph (B) of paragraph (2) of subdivision (a) of Section 1370.

(B) If a licensed psychologist examines the defendant and opines that treatment with antipsychotic medication may be appropriate, their opinion shall be based on whether the defendant has a mental disorder that is typically known to benefit from that treatment. A licensed psychologist's opinion shall not exceed the scope of their license. That opinion about the potential benefit of antipsychotic medication is not a prescription for that medication.

(C) If a psychiatrist examines the defendant and opines that treatment with antipsychotic medication is appropriate, the psychiatrist shall inform the court of their opinion as to the likely or potential side effects of the medication, the expected efficacy of the medication, and possible alternative treatments, as outlined in subclause (III) of clause (i) of subparagraph (B) of paragraph (2) of subdivision (a) of Section 1370.

(3) If it is suspected the defendant has a developmental disability, the court shall appoint the director of the regional center established under Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code, or the director's designee, to examine the defendant to determine whether the defendant has a developmental disability. The regional center director or their designee shall determine whether the defendant has a developmental disability, as defined in Section 4512 of the Welfare and Institutions Code, and is therefore eligible for regional center services and supports. The regional center director or their designee shall provide the court with a written report informing the court of this determination.

(4) The regional center director shall recommend to the court a suitable residential facility or state hospital. Prior to issuing an order pursuant to this section, the court shall consider the recommendation of the regional center director. While the person is confined pursuant to order of the court under this section, they shall be provided with necessary care and treatment.

(b) (1) The counsel for the defendant shall offer evidence in support of the allegation of mental incompetence.

(2) If the defense declines to offer any evidence in support of the allegation of mental incompetence, the prosecution may do so.

(c) The prosecution shall present its case regarding the issue of the defendant's present mental competence.

(d) Each party may offer rebutting testimony, unless the court, for good reason in furtherance of justice, also permits other evidence in support of the original contention.

(e) When the evidence is concluded, unless the case is submitted without final argument, the prosecution shall make its final argument and the defense shall conclude with its final argument to the court or jury.

(f) In a jury trial, the court shall charge the jury, instructing them on all matters of law necessary for the rendering of a verdict. It shall be presumed that the defendant is mentally competent unless it is proved by a preponderance of the evidence that the defendant is mentally incompetent. The verdict of the jury shall be unanimous.

(g) Only a court trial is required to determine competency in a proceeding for a violation of probation, mandatory supervision, postrelease community supervision, or parole.

(h) (1) The State Department of State Hospitals, on or before July 1, 2017, shall adopt guidelines for education and training standards for a psychiatrist or licensed psychologist to be considered for appointment by the court pursuant to this section. To develop these guidelines, the State Department of State Hospitals shall convene a workgroup comprised of the Judicial Council and groups or individuals representing judges, defense counsel, district attorneys, counties, advocates for people with developmental and mental disabilities, state psychologists and psychiatrists, professional associations and accrediting bodies for psychologists and psychiatrists, and other interested stakeholders.

(2) When making an appointment pursuant to this section, the court shall appoint an expert who meets the guidelines established in accordance with this subdivision or an expert with equivalent experience and skills. If there is no reasonably available expert who meets the guidelines or who has equivalent experience and skills, the court may appoint an expert who does not meet the guidelines.

SEC. 42. Section 1369.1 of the Penal Code is repealed.

SEC. 43. Section 1370 of the Penal Code is amended to read:

1370. (a) (1) (A) If the defendant is found mentally competent, the criminal process shall resume, the trial on the offense charged or hearing on the alleged violation shall proceed, and judgment may be pronounced.

(B) If the defendant is found mentally incompetent, the trial, the hearing on the alleged violation, or the judgment shall be suspended until the person becomes mentally competent.

(i) The court shall order that the mentally incompetent defendant be delivered by the sheriff to a State Department of State Hospitals facility, as defined in Section 4100 of the Welfare and Institutions Code, as directed

by the State Department of State Hospitals, or to any other available public or private treatment facility, including a community-based residential treatment system approved by the community program director, or their designee, that will promote the defendant's speedy restoration to mental competence, or placed on outpatient status as specified in Section 1600.

(ii) However, if the action against the defendant who has been found mentally incompetent is on a complaint charging a felony offense specified in Section 290, the prosecutor shall determine whether the defendant previously has been found mentally incompetent to stand trial pursuant to this chapter on a charge of a Section 290 offense, or whether the defendant is currently the subject of a pending Section 1368 proceeding arising out of a charge of a Section 290 offense. If either determination is made, the prosecutor shall notify the court and defendant in writing. After this notification, and opportunity for hearing, the court shall order that the defendant be delivered by the sheriff to a State Department of State Hospitals facility, as directed by the State Department of State Hospitals, or other secure treatment facility for the care and treatment of persons with a mental health disorder, unless the court makes specific findings on the record that an alternative placement would provide more appropriate treatment for the defendant and would not pose a danger to the health and safety of others.

(iii) If the action against the defendant who has been found mentally incompetent is on a complaint charging a felony offense specified in Section 290 and the defendant has been denied bail pursuant to subdivision (b) of Section 12 of Article I of the California Constitution because the court has found, based upon clear and convincing evidence, a substantial likelihood that the person's release would result in great bodily harm to others, the court shall order that the defendant be delivered by the sheriff to a State Department of State Hospitals facility, as directed by the State Department of State Hospitals, unless the court makes specific findings on the record that an alternative placement would provide more appropriate treatment for the defendant and would not pose a danger to the health and safety of others.

(iv) (I) If, at any time after the court finds that the defendant is mentally incompetent and before the defendant is transported to a facility pursuant to this section, the court is provided with any information that the defendant may benefit from diversion pursuant to Chapter 2.8A (commencing with Section 1001.35) of Title 6, the court may make a finding that the defendant is an appropriate candidate for diversion.

(II) Notwithstanding subclause (I), if a defendant is found mentally incompetent and is transferred to a facility described in Section 4361.6 of the Welfare and Institutions Code, the court may, at any time upon receiving any information that the defendant may benefit from diversion pursuant to Chapter 2.8A (commencing with Section 1001.35) of Title 6, make a finding that the defendant is an appropriate candidate for diversion.

(v) If a defendant is found by the court to be an appropriate candidate for diversion pursuant to clause (iv), the defendant's eligibility shall be determined pursuant to Section 1001.36. A defendant granted diversion may participate for the lesser of the period specified in paragraph (1) of

subdivision (c) or two years. If, during that period, the court determines that criminal proceedings should be reinstated pursuant to subdivision (d) of Section 1001.36, the court shall, pursuant to Section 1369, appoint a psychiatrist, licensed psychologist, or any other expert the court may deem appropriate, to determine the defendant's competence to stand trial.

(vi) Upon the dismissal of charges at the conclusion of the period of diversion, pursuant to subdivision (e) of Section 1001.36, a defendant shall no longer be deemed incompetent to stand trial pursuant to this section.

(vii) The clerk of the court shall notify the Department of Justice, in writing, of a finding of mental incompetence with respect to a defendant who is subject to clause (ii) or (iii) for inclusion in the defendant's state summary criminal history information.

(C) Upon the filing of a certificate of restoration to competence, the court shall order that the defendant be returned to court in accordance with Section 1372. The court shall transmit a copy of its order to the community program director or a designee.

(D) A defendant charged with a violent felony may not be delivered to a State Department of State Hospitals facility or treatment facility pursuant to this subdivision unless the State Department of State Hospitals facility or treatment facility has a secured perimeter or a locked and controlled treatment facility, and the judge determines that the public safety will be protected.

(E) For purposes of this paragraph, "violent felony" means an offense specified in subdivision (c) of Section 667.5.

(F) A defendant charged with a violent felony may be placed on outpatient status, as specified in Section 1600, only if the court finds that the placement will not pose a danger to the health or safety of others. If the court places a defendant charged with a violent felony on outpatient status, as specified in Section 1600, the court shall serve copies of the placement order on defense counsel, the sheriff in the county where the defendant will be placed, and the district attorney for the county in which the violent felony charges are pending against the defendant.

(G) If, at any time after the court has declared a defendant incompetent to stand trial pursuant to this section, counsel for the defendant or a jail medical or mental health staff provider provides the court with substantial evidence that the defendant's psychiatric symptoms have changed to such a degree as to create a doubt in the mind of the judge as to the defendant's current mental incompetence, the court may appoint a psychiatrist or a licensed psychologist to opine as to whether the defendant has regained competence. If, in the opinion of that expert, the defendant has regained competence, the court shall proceed as if a certificate of restoration of competence has been returned pursuant to paragraph (1) of subdivision (a) of Section 1372.

(H) (i) The State Department of State Hospitals may, pursuant to Section 4335.2 of the Welfare and Institutions Code, conduct an evaluation of the defendant in county custody to determine any of the following:

(I) The defendant has regained competence.

(II) There is no substantial likelihood that the defendant will regain competence in the foreseeable future.

(III) The defendant should be referred to the county for further evaluation for potential participation in a county diversion program, if one exists, or to another outpatient treatment program.

(ii) If, in the opinion of the department's expert, the defendant has regained competence, the court shall proceed as if a certificate of restoration of competence has been returned pursuant to paragraph (1) of subdivision (a) of Section 1372.

(iii) If, in the opinion of the department's expert, there is no substantial likelihood that the defendant will regain mental competence in the foreseeable future, the committing court shall proceed pursuant to paragraph (2) of subdivision (c) no later than 10 days following receipt of the report.

(2) Prior to making the order directing that the defendant be committed to the State Department of State Hospitals or other treatment facility or placed on outpatient status, the court shall proceed as follows:

(A) (i) The court shall order the community program director or a designee to evaluate the defendant and to submit to the court within 15 judicial days of the order a written recommendation as to whether the defendant should be required to undergo outpatient treatment, or be committed to the State Department of State Hospitals or to any other treatment facility. A person shall not be admitted to a State Department of State Hospitals facility or other treatment facility or placed on outpatient status under this section without having been evaluated by the community program director or a designee. The community program director or designee shall evaluate the appropriate placement for the defendant between a State Department of State Hospitals facility or the community-based residential treatment system based upon guidelines provided by the State Department of State Hospitals.

(ii) Commencing on July 1, 2023, a defendant shall first be considered for placement in an outpatient treatment program, a community treatment program, or a diversion program, if any such program is available, unless a court, based upon the recommendation of the community program director or their designee, finds that either the clinical needs of the defendant or the risk to community safety, warrant placement in a State Department of State Hospitals facility.

(B) The court shall hear and determine whether the defendant lacks capacity to make decisions regarding the administration of antipsychotic medication. The court shall consider opinions in the reports prepared pursuant to subdivision (a) of Section 1369, as applicable to the issue of whether the defendant lacks capacity to make decisions regarding the administration of antipsychotic medication, and shall proceed as follows:

(i) The court shall hear and determine whether any of the following is true:

(I) Based upon the opinion of the psychiatrist or licensed psychologist offered to the court pursuant to subparagraph (A) of paragraph (2) of subdivision (a) of Section 1369, the defendant lacks capacity to make

decisions regarding antipsychotic medication, the defendant's mental disorder requires medical treatment with antipsychotic medication, and, if the defendant's mental disorder is not treated with antipsychotic medication, it is probable that serious harm to the physical or mental health of the defendant will result. Probability of serious harm to the physical or mental health of the defendant requires evidence that the defendant is presently suffering adverse effects to their physical or mental health, or the defendant has previously suffered these effects as a result of a mental disorder and their condition is substantially deteriorating. The fact that a defendant has a diagnosis of a mental disorder does not alone establish probability of serious harm to the physical or mental health of the defendant.

(II) Based upon the opinion of the psychiatrist or licensed psychologist offered to the court pursuant to subparagraph (A) of paragraph (2) of subdivision (a) of Section 1369, the defendant is a danger to others, in that the defendant has inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm on another while in custody, or the defendant had inflicted, attempted to inflict, or made a serious threat of inflicting substantial physical harm on another that resulted in the defendant being taken into custody, and the defendant presents, as a result of mental disorder or mental defect, a demonstrated danger of inflicting substantial physical harm on others. Demonstrated danger may be based on an assessment of the defendant's present mental condition, including a consideration of past behavior of the defendant within six years prior to the time the defendant last attempted to inflict, inflicted, or threatened to inflict substantial physical harm on another, and other relevant evidence.

(III) The people have charged the defendant with a serious crime against the person or property, and based upon the opinion of the psychiatrist offered to the court pursuant to subparagraph (C) of paragraph (2) of subdivision (a) of Section 1369, the involuntary administration of antipsychotic medication is substantially likely to render the defendant competent to stand trial, the medication is unlikely to have side effects that interfere with the defendant's ability to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a reasonable manner, less intrusive treatments are unlikely to have substantially the same results, and antipsychotic medication is diagnostically and medically appropriate in light of their medical condition.

(ii) (I) If the court finds the conditions described in subclause (I) or (II) of clause (i) to be true, and if pursuant to the opinion offered to the court pursuant to paragraph (2) of subdivision (a) of Section 1369, a psychiatrist has opined that treatment with antipsychotic medications is appropriate for the defendant, the court shall issue an order authorizing the administration of antipsychotic medication as needed, including on an involuntary basis, to be administered under the direction and supervision of a licensed psychiatrist.

(II) If the court finds the conditions described in subclause (I) or (II) of clause (i) to be true, and if pursuant to the opinion offered to the court pursuant to paragraph (2) of subdivision (a) of Section 1369, a licensed

psychologist has opined that treatment with antipsychotic medication may be appropriate for the defendant, the court shall issue an order authorizing treatment by a licensed psychiatrist on an involuntary basis. That treatment may include the administration of antipsychotic medication as needed, to be administered under the direction and supervision of a licensed psychiatrist.

(III) If the court finds the conditions described in subclause (III) of clause (i) to be true, and if pursuant to the opinion offered to the court pursuant to paragraph (2) of subdivision (a) of Section 1369, a psychiatrist has opined that it is appropriate to treat the defendant with antipsychotic medication, the court shall issue an order authorizing the administration of antipsychotic medication as needed, including on an involuntary basis, to be administered under the direction and supervision of a licensed psychiatrist.

(iii) An order authorizing involuntary administration of antipsychotic medication to the defendant when and as prescribed by the defendant's treating psychiatrist at any facility housing the defendant for purposes of this chapter, including a county jail, shall remain in effect when the defendant returns to county custody pursuant to subparagraph (A) of paragraph (1) of subdivision (b) or paragraph (1) of subdivision (c), or pursuant to subparagraph (C) of paragraph (3) of subdivision (a) of Section 1372, but shall be valid for no more than one year, pursuant to subparagraph (A) of paragraph (7). The court shall not order involuntary administration of psychotropic medication under subclause (III) of clause (i) unless the court has first found that the defendant does not meet the criteria for involuntary administration of psychotropic medication under subclause (I) of clause (i) and does not meet the criteria under subclause (II) of clause (i).

(iv) In all cases, the treating hospital, county jail, facility, or program may administer medically appropriate antipsychotic medication prescribed by a psychiatrist in an emergency as described in subdivision (m) of Section 5008 of the Welfare and Institutions Code.

(v) If the court has determined that the defendant has the capacity to make decisions regarding antipsychotic medication, and if the defendant, with advice of their counsel, consents, the court order of commitment shall include confirmation that antipsychotic medication may be given to the defendant as prescribed by a treating psychiatrist pursuant to the defendant's consent. The commitment order shall also indicate that, if the defendant withdraws consent for antipsychotic medication, after the treating psychiatrist complies with the provisions of subparagraph (C), the defendant shall be returned to court for a hearing in accordance with subparagraphs (C) and (D) regarding whether antipsychotic medication shall be administered involuntarily.

(vi) If the court has determined that the defendant has the capacity to make decisions regarding antipsychotic medication and if the defendant, with advice from their counsel, does not consent, the court order for commitment shall indicate that, after the treating psychiatrist complies with the provisions of subparagraph (C), the defendant shall be returned to court for a hearing in accordance with subparagraphs (C) and (D) regarding whether antipsychotic medication shall be administered involuntarily.

(vii) A report made pursuant to paragraph (1) of subdivision (b) shall include a description of antipsychotic medication administered to the defendant and its effects and side effects, including effects on the defendant's appearance or behavior that would affect the defendant's ability to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a reasonable manner. During the time the defendant is confined in a State Department of State Hospitals facility or other treatment facility or placed on outpatient status, either the defendant or the people may request that the court review any order made pursuant to this subdivision. The defendant, to the same extent enjoyed by other patients in the State Department of State Hospitals facility or other treatment facility, shall have the right to contact the patients' rights advocate regarding the defendant's rights under this section.

(C) If the defendant consented to antipsychotic medication as described in clause (iv) of subparagraph (B), but subsequently withdraws their consent, or, if involuntary antipsychotic medication was not ordered pursuant to clause (v) of subparagraph (B), and the treating psychiatrist determines that antipsychotic medication has become medically necessary and appropriate, the treating psychiatrist shall make efforts to obtain informed consent from the defendant for antipsychotic medication. If informed consent is not obtained from the defendant, and the treating psychiatrist is of the opinion that the defendant lacks capacity to make decisions regarding antipsychotic medication based on the conditions described in subclause (I) or (II) of clause (i) of subparagraph (B), the treating psychiatrist shall certify whether the lack of capacity and any applicable conditions described above exist. That certification shall contain an assessment of the current mental status of the defendant and the opinion of the treating psychiatrist that involuntary antipsychotic medication has become medically necessary and appropriate.

(D) (i) If the treating psychiatrist certifies that antipsychotic medication has become medically necessary and appropriate pursuant to subparagraph (C), antipsychotic medication may be administered to the defendant for not more than 21 days, provided, however, that, within 72 hours of the certification, the defendant is provided a medication review hearing before an administrative law judge to be conducted at the facility where the defendant is receiving treatment. The treating psychiatrist shall present the case for the certification for involuntary treatment and the defendant shall be represented by an attorney or a patients' rights advocate. The attorney or patients' rights advocate shall be appointed to meet with the defendant no later than one day prior to the medication review hearing to review the defendant's rights at the medication review hearing, discuss the process, answer questions or concerns regarding involuntary medication or the hearing, assist the defendant in preparing for the hearing and advocating for the defendant's interests at the hearing, review the panel's final determination following the hearing, advise the defendant of their right to judicial review of the panel's decision, and provide the defendant with referral information for legal advice on the subject. The defendant shall also have the following rights with respect to the medication review hearing:

(I) To be given timely access to the defendant's records.

(II) To be present at the hearing, unless the defendant waives that right.

(III) To present evidence at the hearing.

(IV) To question persons presenting evidence supporting involuntary medication.

(V) To make reasonable requests for attendance of witnesses on the defendant's behalf.

(VI) To a hearing conducted in an impartial and informal manner.

(ii) If the administrative law judge determines that the defendant either meets the criteria specified in subclause (I) of clause (i) of subparagraph (B), or meets the criteria specified in subclause (II) of clause (i) of subparagraph (B), antipsychotic medication may continue to be administered to the defendant for the 21-day certification period. Concurrently with the treating psychiatrist's certification, the treating psychiatrist shall file a copy of the certification and a petition with the court for issuance of an order to administer antipsychotic medication beyond the 21-day certification period. For purposes of this subparagraph, the treating psychiatrist shall not be required to pay or deposit any fee for the filing of the petition or other document or paper related to the petition.

(iii) If the administrative law judge disagrees with the certification, medication may not be administered involuntarily until the court determines that antipsychotic medication should be administered pursuant to this section.

(iv) The court shall provide notice to the prosecuting attorney and to the attorney representing the defendant, and shall hold a hearing, no later than 18 days from the date of the certification, to determine whether antipsychotic medication should be ordered beyond the certification period.

(v) If, as a result of the hearing, the court determines that antipsychotic medication should be administered beyond the certification period, the court shall issue an order authorizing the administration of that medication.

(vi) The court shall render its decision on the petition and issue its order no later than three calendar days after the hearing and, in any event, no later than the expiration of the 21-day certification period.

(vii) If the administrative law judge upholds the certification pursuant to clause (ii), the court may, for a period not to exceed 14 days, extend the certification and continue the hearing pursuant to stipulation between the parties or upon a finding of good cause. In determining good cause, the court may review the petition filed with the court, the administrative law judge's order, and any additional testimony needed by the court to determine if it is appropriate to continue medication beyond the 21-day certification and for a period of up to 14 days.

(viii) The district attorney, county counsel, or representative of a facility where a defendant found incompetent to stand trial is committed may petition the court for an order to administer involuntary medication pursuant to the criteria set forth in subclauses (II) and (III) of clause (i) of subparagraph (B). The order is reviewable as provided in paragraph (7).

(3) When the court orders that the defendant be committed to a State Department of State Hospitals facility or other public or private treatment

facility, the court shall provide copies of the following documents prior to the admission of the defendant to the State Department of State Hospitals or other treatment facility where the defendant is to be committed:

(A) The commitment order, which shall include a specification of the charges, an assessment of whether involuntary treatment with antipsychotic medications is warranted, and any orders by the court, pursuant to subparagraph (B) of paragraph (2), authorizing involuntary treatment with antipsychotic medications.

(B) A computation or statement setting forth the maximum term of commitment in accordance with subdivision (c).

(C) (i) A computation or statement setting forth the amount of credit for time served, if any, to be deducted from the maximum term of commitment.

(ii) If a certificate of restoration of competency was filed with the court pursuant to Section 1372 and the court subsequently rejected the certification, a copy of the court order or minute order rejecting the certification shall be provided. The court order shall include a new computation or statement setting forth the amount of credit for time served, if any, to be deducted from the defendant's maximum term of commitment based on the court's rejection of the certification.

(D) State summary criminal history information.

(E) Jail classification records for the defendant's current incarceration.

(F) Arrest reports prepared by the police department or other law enforcement agency.

(G) Court-ordered psychiatric examination or evaluation reports.

(H) The community program director's placement recommendation report.

(I) Records of a finding of mental incompetence pursuant to this chapter arising out of a complaint charging a felony offense specified in Section 290 or a pending Section 1368 proceeding arising out of a charge of a Section 290 offense.

(J) Medical records, including jail mental health records.

(4) When the defendant is committed to a treatment facility pursuant to clause (i) of subparagraph (B) of paragraph (1) or the court makes the findings specified in clause (ii) or (iii) of subparagraph (B) of paragraph (1) to assign the defendant to a treatment facility other than a State Department of State Hospitals facility or other secure treatment facility, the court shall order that notice be given to the appropriate law enforcement agency or agencies having local jurisdiction at the placement facility of a finding of mental incompetence pursuant to this chapter arising out of a charge of a Section 290 offense.

(5) When directing that the defendant be confined in a State Department of State Hospitals facility pursuant to this subdivision, the court shall commit the defendant to the State Department of State Hospitals.

(6) (A) If the defendant is committed or transferred to the State Department of State Hospitals pursuant to this section, the court may, upon receiving the written recommendation of the medical director of the State

Department of State Hospitals facility and the community program director that the defendant be transferred to a public or private treatment facility approved by the community program director, order the defendant transferred to that facility. If the defendant is committed or transferred to a public or private treatment facility approved by the community program director, the court may, upon receiving the written recommendation of the community program director, transfer the defendant to the State Department of State Hospitals or to another public or private treatment facility approved by the community program director. In the event of dismissal of the criminal charges before the defendant recovers competence, the person shall be subject to the applicable provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code). If either the defendant or the prosecutor chooses to contest either kind of order of transfer, a petition may be filed in the court for a hearing, which shall be held if the court determines that sufficient grounds exist. At the hearing, the prosecuting attorney or the defendant may present evidence bearing on the order of transfer. The court shall use the same standards as are used in conducting probation revocation hearings pursuant to Section 1203.2.

Prior to making an order for transfer under this section, the court shall notify the defendant, the attorney of record for the defendant, the prosecuting attorney, and the community program director or a designee.

(B) If the defendant is initially committed to a State Department of State Hospitals facility or secure treatment facility pursuant to clause (ii) or (iii) of subparagraph (B) of paragraph (1) and is subsequently transferred to any other facility, copies of the documents specified in paragraph (3) shall be electronically transferred or taken with the defendant to each subsequent facility to which the defendant is transferred. The transferring facility shall also notify the appropriate law enforcement agency or agencies having local jurisdiction at the site of the new facility that the defendant is a person subject to clause (ii) or (iii) of subparagraph (B) of paragraph (1).

(7) (A) An order by the court authorizing involuntary medication of the defendant shall be valid for no more than one year. The court shall review the order at the time of the review of the initial report and the six-month progress reports pursuant to paragraph (1) of subdivision (b) to determine if the grounds for the authorization remain. In the review, the court shall consider the reports of the treating psychiatrist or psychiatrists and the defendant's patients' rights advocate or attorney. The court may require testimony from the treating psychiatrist and the patients' rights advocate or attorney, if necessary. The court may continue the order authorizing involuntary medication for up to another six months, or vacate the order, or make any other appropriate order.

(B) Within 60 days before the expiration of the one-year involuntary medication order, the district attorney, county counsel, or representative of any facility where a defendant found incompetent to stand trial is committed may petition the committing court for a renewal, subject to the same conditions and requirements as in subparagraph (A). The petition shall

include the basis for involuntary medication set forth in clause (i) of subparagraph (B) of paragraph (2). Notice of the petition shall be provided to the defendant, the defendant's attorney, and the district attorney. The court shall hear and determine whether the defendant continues to meet the criteria set forth in clause (i) of subparagraph (B) of paragraph (2). The hearing on a petition to renew an order for involuntary medication shall be conducted prior to the expiration of the current order.

(8) For purposes of subparagraph (D) of paragraph (2) and paragraph (7), if the treating psychiatrist determines that there is a need, based on preserving their rapport with the defendant or preventing harm, the treating psychiatrist may request that the facility medical director designate another psychiatrist to act in the place of the treating psychiatrist. If the medical director of the facility designates another psychiatrist to act pursuant to this paragraph, the treating psychiatrist shall brief the acting psychiatrist of the relevant facts of the case and the acting psychiatrist shall examine the defendant prior to the hearing.

(b) (1) Within 90 days after a commitment made pursuant to subdivision (a), the medical director of the State Department of State Hospitals facility or other treatment facility to which the defendant is confined shall make a written report to the court and the community program director for the county or region of commitment, or a designee, concerning the defendant's progress toward recovery of mental competence and whether the administration of antipsychotic medication remains necessary.

If the defendant is in county custody, the county jail shall provide access to the defendant for purposes of the State Department of State Hospitals conducting an evaluation of the defendant pursuant to Section 4335.2 of the Welfare and Institutions Code. Based upon this evaluation, the State Department of State Hospitals may make a written report to the court within 90 days of a commitment made pursuant to subdivision (a) concerning the defendant's progress toward recovery of mental incompetence and whether the administration of antipsychotic medication is necessary. If the defendant remains in county custody after the initial 90-day report, the State Department of State Hospitals may conduct an evaluation of the defendant pursuant to Section 4335.2 of the Welfare and Institutions Code and make a written report to the court concerning the defendant's progress toward recovery of mental incompetence and whether the administration of antipsychotic medication is necessary.

If the defendant is on outpatient status, the outpatient treatment staff shall make a written report to the community program director concerning the defendant's progress toward recovery of mental competence. Within 90 days of placement on outpatient status, the community program director shall report to the court on this matter. If the defendant has not recovered mental competence, but the report discloses a substantial likelihood that the defendant will regain mental competence in the foreseeable future, the defendant shall remain in the State Department of State Hospitals facility or other treatment facility or on outpatient status. Thereafter, at six-month intervals or until the defendant becomes mentally competent, if the defendant

is confined in a treatment facility, the medical director of the State Department of State Hospitals facility or person in charge of the facility shall report, in writing, to the court and the community program director or a designee regarding the defendant's progress toward recovery of mental competence and whether the administration of antipsychotic medication remains necessary. If the defendant is on outpatient status, after the initial 90-day report, the outpatient treatment staff shall report to the community program director on the defendant's progress toward recovery, and the community program director shall report to the court on this matter at six-month intervals. A copy of these reports shall be provided to the prosecutor and defense counsel by the court.

(A) If the report indicates that there is no substantial likelihood that the defendant will regain mental competence in the foreseeable future, custody of the defendant shall be transferred without delay to the committing county and shall remain with the county until further order of the court. The defendant shall be returned to the court for proceedings pursuant to paragraph (2) of subdivision (c) no later than 10 days following receipt of the report. The court shall not order the defendant returned to the custody of the State Department of State Hospitals under the same commitment. The court shall transmit a copy of its order to the community program director or a designee.

(B) If the report indicates that there is no substantial likelihood that the defendant will regain mental competence in the foreseeable future, the medical director of the State Department of State Hospitals facility or other treatment facility to which the defendant is confined shall do both of the following:

(i) Promptly notify and provide a copy of the report to the defense counsel and the district attorney.

(ii) Provide a separate notification, in compliance with applicable privacy laws, to the committing county's sheriff that immediate transportation will be needed for the defendant pursuant to subparagraph (A).

(C) If a county does not take custody of a defendant committed to the State Department of State Hospitals within 10 calendar days following notification made pursuant to clause (ii) of subparagraph (B), the county shall be charged the daily rate for a state hospital bed, as established by the State Department of State Hospitals.

(2) The reports made pursuant to paragraph (1) concerning the defendant's progress toward regaining competency shall also consider the issue of involuntary medication. Each report shall include, but not be limited to, all of the following:

(A) Whether or not the defendant has the capacity to make decisions concerning antipsychotic medication.

(B) If the defendant lacks capacity to make decisions concerning antipsychotic medication, whether the defendant risks serious harm to their physical or mental health if not treated with antipsychotic medication.

(C) Whether or not the defendant presents a danger to others if the defendant is not treated with antipsychotic medication.

(D) Whether the defendant has a mental disorder for which medications are the only effective treatment.

(E) Whether there are any side effects from the medication currently being experienced by the defendant that would interfere with the defendant's ability to collaborate with counsel.

(F) Whether there are any effective alternatives to medication.

(G) How quickly the medication is likely to bring the defendant to competency.

(H) Whether the treatment plan includes methods other than medication to restore the defendant to competency.

(I) A statement, if applicable, that no medication is likely to restore the defendant to competency.

(3) After reviewing the reports, the court shall determine if grounds for the involuntary administration of antipsychotic medication exist, whether or not an order was issued at the time of commitment, and shall do one of the following:

(A) If the original grounds for involuntary medication still exist, any order authorizing the treating facility to involuntarily administer antipsychotic medication to the defendant shall remain in effect.

(B) If the original grounds for involuntary medication no longer exist, and there is no other basis for involuntary administration of antipsychotic medication, any order for the involuntary administration of antipsychotic medication shall be vacated.

(C) If the original grounds for involuntary medication no longer exist, and the report states that there is another basis for involuntary administration of antipsychotic medication, the court shall determine whether to vacate the order or issue a new order for the involuntary administration of antipsychotic medication. The court shall consider the opinions in reports submitted pursuant to paragraph (1) of subdivision (b), including any opinions rendered pursuant to Section 4335.2 of the Welfare and Institutions Code. The court may, upon a showing of good cause, set a hearing within 21 days to determine whether the order for the involuntary administration of antipsychotic medication shall be vacated or whether a new order for the involuntary administration of antipsychotic medication shall be issued. The hearing shall proceed as set forth in subparagraph (B) of paragraph (2) of subdivision (a). The court shall require witness testimony to occur remotely, including clinical testimony pursuant to subdivision (d) of Section 4335.2 of the Welfare and Institutions Code. In-person witness testimony shall only be allowed upon a court's finding of good cause.

(D) If the report states a basis for involuntary administration of antipsychotic medication and the court did not issue such order at the time of commitment, the court shall determine whether to issue an order for the involuntary administration of antipsychotic medication. The court shall consider the opinions in reports submitted pursuant to paragraph (1) of subdivision (b), including any opinions rendered pursuant to Section 4335.2 of the Welfare and Institutions Code. The court may, upon a finding of good cause, set a hearing within 21 days to determine whether an order for the

involuntary administration of antipsychotic medication shall be issued. The hearing shall proceed as set forth in subparagraph (B) of paragraph (2) of subdivision (a). The court shall require witness testimony to occur remotely, including clinical testimony pursuant to subdivision (d) of Section 4335.2 of the Welfare and Institutions Code. In-person witness testimony shall only be allowed upon a court's finding of good cause.

(4) If it is determined by the court that treatment for the defendant's mental impairment is not being conducted, the defendant shall be returned to the committing court, and, if the defendant is not in county custody, returned to the custody of the county. The court shall transmit a copy of its order to the community program director or a designee.

(5) At each review by the court specified in this subdivision, the court shall determine if the security level of housing and treatment is appropriate and may make an order in accordance with its determination. If the court determines that the defendant shall continue to be treated in the State Department of State Hospitals facility or on an outpatient basis, the court shall determine issues concerning administration of antipsychotic medication, as set forth in subparagraph (B) of paragraph (2) of subdivision (a).

(c) (1) At the end of two years from the date of commitment or a period of commitment equal to the maximum term of imprisonment provided by law for the most serious offense charged in the information, indictment, or misdemeanor complaint, or the maximum term of imprisonment provided by law for a violation of probation or mandatory supervision, whichever is shorter, but no later than 90 days prior to the expiration of the defendant's term of commitment, a defendant who has not recovered mental competence shall be returned to the committing court, and custody of the defendant shall be transferred without delay to the committing county and shall remain with the county until further order of the court. The court shall not order the defendant returned to the custody of the State Department of State Hospitals under the same commitment. The court shall notify the community program director or a designee of the return and of any resulting court orders.

(2) (A) The medical director of the State Department of State Hospitals facility or other treatment facility to which the defendant is confined shall provide notification, in compliance with applicable privacy laws, to the committing county's sheriff that immediate transportation will be needed for the defendant pursuant to paragraph (1).

(B) If a county does not take custody of a defendant committed to the State Department of State Hospitals within 10 calendar days following notification pursuant to subparagraph (A), the county shall be charged the daily rate for a state hospital bed, as established by the State Department of State Hospitals.

(3) Whenever a defendant is returned to the court pursuant to paragraph (1) or (4) of subdivision (b) or paragraph (1) of this subdivision and it appears to the court that the defendant is gravely disabled, as defined in subparagraph (A) or (B) of paragraph (1) of subdivision (h) of Section 5008 of the Welfare and Institutions Code, the court shall order the conservatorship investigator of the county of commitment of the defendant to initiate

conservatorship proceedings for the defendant pursuant to Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code. Hearings required in the conservatorship proceedings shall be held in the superior court in the county that ordered the commitment. The court shall transmit a copy of the order directing initiation of conservatorship proceedings to the community program director or a designee, the sheriff and the district attorney of the county in which criminal charges are pending, and the defendant's counsel of record. The court shall notify the community program director or a designee, the sheriff and district attorney of the county in which criminal charges are pending, and the defendant's counsel of record of the outcome of the conservatorship proceedings.

(4) If a change in placement is proposed for a defendant who is committed pursuant to subparagraph (A) or (B) of paragraph (1) of subdivision (h) of Section 5008 of the Welfare and Institutions Code, the court shall provide notice and an opportunity to be heard with respect to the proposed placement of the defendant to the sheriff and the district attorney of the county in which the criminal charges or revocation proceedings are pending.

(5) If the defendant is confined in a treatment facility, a copy of any report to the committing court regarding the defendant's progress toward recovery of mental competence shall be provided by the committing court to the prosecutor and to the defense counsel.

(d) With the exception of proceedings alleging a violation of mandatory supervision, the criminal action remains subject to dismissal pursuant to Section 1385. If the criminal action is dismissed, the court shall transmit a copy of the order of dismissal to the community program director or a designee. In a proceeding alleging a violation of mandatory supervision, if the person is not placed under a conservatorship as described in paragraph (3) of subdivision (c), or if a conservatorship is terminated, the court shall reinstate mandatory supervision and may modify the terms and conditions of supervision to include appropriate mental health treatment or refer the matter to a local mental health court, reentry court, or other collaborative justice court available for improving the mental health of the defendant.

(e) If the criminal action against the defendant is dismissed, the defendant shall be released from commitment ordered under this section, but without prejudice to the initiation of proceedings that may be appropriate under the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code).

(f) As used in this chapter, "community program director" means the person, agency, or entity designated by the State Department of State Hospitals pursuant to Section 1605 of this code and Section 4360 of the Welfare and Institutions Code.

(g) For the purpose of this section, "secure treatment facility" does not include, except for State Department of State Hospitals facilities, state developmental centers, and correctional treatment facilities, any facility licensed pursuant to Chapter 2 (commencing with Section 1250) of, Chapter 3 (commencing with Section 1500) of, or Chapter 3.2 (commencing with

Section 1569) of, Division 2 of the Health and Safety Code, or any community board and care facility.

(h) This section does not preclude a defendant from filing a petition for habeas corpus to challenge the continuing validity of an order authorizing a treatment facility or outpatient program to involuntarily administer antipsychotic medication to a person being treated as incompetent to stand trial.

SEC. 44. Section 1370.6 of the Penal Code is amended to read:

1370.6. (a) If a mentally incompetent defendant is admitted to a county jail treatment facility pursuant to Section 1370, the department shall provide restoration of competency treatment at the county jail treatment facility and shall provide payment to the county jail treatment facility for the reasonable costs of the bed during the restoration of competency treatment as well as for the reasonable costs of any necessary medical treatment not provided within the county jail treatment facility, unless otherwise agreed to by the department and the facility.

(1) If the county jail treatment facility is able to provide restoration of competency services, upon approval by the department and subject to funding appropriated in the annual Budget Act, the county jail treatment facility may provide those services and the State Department of State Hospitals may provide payment to the county jail treatment facility for the reasonable costs of the bed during the restoration of competency treatment as well as the reasonable costs of providing restoration of competency services and for any necessary medical treatment not provided within the county jail treatment facility, unless otherwise agreed to by the department and the facility.

(2) Transportation to a county jail treatment facility for admission and from the facility upon the filing of a certificate of restoration of competency, or for transfer of a person to another county jail treatment facility or to a state hospital, shall be provided by the committing county unless otherwise agreed to by the department and the facility.

(3) In the event the State Department of State Hospitals and a county jail treatment facility are determined to be comparatively at fault for any claim, action, loss, or damage which results from their respective obligations under such a contract, each shall indemnify the other to the extent of its comparative fault.

(b) If the community-based residential system is selected by the court pursuant to Section 1370, the State Department of State Hospitals shall provide reimbursement to the community-based residential treatment system for the cost of restoration of competency treatment as negotiated with the State Department of State Hospitals.

(c) The State Department of State Hospitals may provide payment to either a county jail treatment facility or a community-based residential treatment system directly through invoice, or through a contract, at the discretion of the department in accordance with the terms and conditions of the contract or agreement.

SEC. 45. Section 1372 of the Penal Code is amended to read:

1372. (a) (1) If the medical director of a state hospital, a person designated by the State Department of State Hospitals at an entity contracted by the department to provide services to a defendant prior to placement in a treatment program or other facility to which the defendant is committed, or the community program director, county mental health director, or regional center director providing outpatient services, determines that the defendant has regained mental competence, the director or designee shall immediately certify that fact to the court by filing a certificate of restoration with the court by certified mail, return receipt requested, or by confidential electronic transmission. This shall include any certificate of restoration filed by the State Department of State Hospitals based on an evaluation conducted pursuant to Section 4335.2 of the Welfare and Institutions Code. For purposes of this section, the date of filing shall be the date on the return receipt.

(2) The court's order committing an individual to a State Department of State Hospitals facility or other treatment facility pursuant to Section 1370 shall include direction that the sheriff shall redeliver the patient to the court without any further order from the court upon receiving from the state hospital or treatment facility a copy of the certificate of restoration.

(3) The defendant shall be returned to the committing court in the following manner, except that a defendant in county custody that the State Department of State Hospitals has evaluated pursuant to Section 4335.2 of the Welfare and Institutions Code and filed a certificate of restoration with the court shall remain in county custody:

(A) A patient who remains confined in a state hospital or other treatment facility shall be redelivered to the sheriff of the county from which the patient was committed. The sheriff shall immediately return the person from the state hospital or other treatment facility to the court for further proceedings.

(B) The patient who is on outpatient status shall be returned by the sheriff to court through arrangements made by the outpatient treatment supervisor.

(C) In all cases, the patient shall be returned to the committing court no later than 10 days following the filing of a certificate of restoration. The state shall only pay for 10 hospital days for patients following the filing of a certificate of restoration of competency. The State Department of State Hospitals shall report to the fiscal and appropriate policy committees of the Legislature on an annual basis in February, on the number of days that exceed the 10-day limit prescribed in this subparagraph. This report shall include, but not be limited to, a data sheet that itemizes by county the number of days that exceed this 10-day limit during the preceding year.

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

(c) (1) When a defendant is returned to court with a certification that competence has been regained, including a certification of restoration provided pursuant to Section 4335.2 of the Welfare and Institutions Code, the court shall notify either the community program director, the county mental health director, the State Department of State Hospitals, or the regional center director and the Director of Developmental Services, as appropriate, of the date of any hearing on the defendant's competence and whether or not the defendant was found by the court to have recovered competence.

(2) If the court rejects a certificate of restoration, the court shall base its rejection on a written report of an evaluation, conducted by a licensed psychologist or psychiatrist, that the defendant is not competent. The evaluation shall be conducted after the certificate of restoration is filed with the committing court and in compliance with Section 1369. A copy of the written report shall be provided to the department pursuant to paragraph (3) of subdivision (a) of Section 1370. The court shall also provide a copy of the court order or minute order rejecting the certification of restoration to the department, pursuant to clause (ii) of subparagraph (C) of paragraph (3) of subdivision (a) of Section 1370, including any minute orders continuing the hearing for the court's determination.

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

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

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

SEC. 46. Section 1602 of the Penal Code is amended to read:

1602. (a) Before any person subject to the provisions of subdivision (b) of Section 1601 may be placed on outpatient status, the court shall consider all of the following criteria:

(1) In the case of a person who is an inpatient, whether the director of the state hospital or other treatment facility to which the person has been committed advises the court that the defendant will not be a danger to the health and safety of others while on outpatient status, and will benefit from such outpatient status.

(2) In all cases, whether the community program director or a designee, or pursuant to Section 4360.5 of the Welfare and Institutions Code, the independent evaluation panel, advises the court that the defendant will not be a danger to the health and safety of others while on outpatient status, will benefit from such status, and identifies an appropriate program of supervision and treatment.

(b) Prior to determining whether to place the person on outpatient status, the court shall provide actual notice to the prosecutor and defense counsel, and to the victim, and shall hold a hearing at which the court may specifically order outpatient status for the person.

(c) The community program director or a designee, or the independent evaluation panel, shall prepare and submit the evaluation and the treatment plan specified in paragraph (2) of subdivision (a) to the court within 15 calendar days after notification by the court to do so, except that in the case of a person who is an inpatient, the evaluation and treatment plan shall be submitted within 30 calendar days after notification by the court to do so.

(d) Any evaluations and recommendations pursuant to paragraphs (1) and (2) of subdivision (a) shall include review and consideration of complete, available information regarding the circumstances of the criminal offense and the person's prior criminal history.

SEC. 47. Section 1603 of the Penal Code is amended to read:

1603. (a) Before any person subject to subdivision (a) of Section 1601 may be placed on outpatient status the court shall consider all of the following criteria:

(1) Whether the director of the state hospital or other treatment facility to which the person has been committed advises the committing court and the prosecutor that the defendant would no longer be a danger to the health

and safety of others, including themselves, while under supervision and treatment in the community, and will benefit from that status.

(2) Whether the community program director or a designee, or pursuant to Section 4360.5 of the Welfare and Institutions Code, the independent evaluation panel, advises the court that the defendant will benefit from that status, and identifies an appropriate program of supervision and treatment.

(b) (1) Prior to release of a person under subdivision (a), the prosecutor shall provide notice of the hearing date and pending release to the victim or next of kin of the victim of the offense for which the person was committed where a request for the notice has been filed with the court, and after a hearing in court, the court shall specifically approve the recommendation and plan for outpatient status pursuant to Section 1604. The burden shall be on the victim or next of kin to the victim to keep the court apprised of the party's current mailing address.

(2) In any case in which the victim or next of kin to the victim has filed a request for notice with the director of the state hospital or other treatment facility, they shall be notified by the director at the inception of any program in which the committed person would be allowed any type of day release unattended by the staff of the facility.

(c) The community program director, their designee, or the independent evaluation panel, shall prepare and submit the evaluation and the treatment plan specified in paragraph (2) of subdivision (a) to the court within 30 calendar days after notification by the court to do so.

(d) Any evaluations and recommendations pursuant to paragraphs (1) and (2) of subdivision (a) shall include review and consideration of complete, available information regarding the circumstances of the criminal offense and the person's prior criminal history.

SEC. 48. Section 1604 of the Penal Code is amended to read:

1604. (a) Upon receipt by the committing court of the recommendation of the director of the state hospital or other treatment facility to which the person has been committed that the person may be eligible for outpatient status as set forth in subdivision (a)(1) of Section 1602 or 1603, the court shall immediately forward such recommendation to the independent evaluation panel described in Section 4360.5 of the Welfare and Institutions Code, prosecutor, and defense counsel. Notwithstanding any law, the court shall provide copies of the arrest reports and the state summary criminal history information to the panel. The panel shall share the recommendation and copies of the arrest reports and the state summary criminal history information with the community program director or designee.

(b) Within 30 calendar days the community program director, designee, or panel, shall submit to the court and, when appropriate, to the director of the state hospital or other treatment facility, a recommendation regarding the defendant's eligibility for outpatient status, as set forth in subdivision (a)(2) of Section 1602 or 1603 and the recommended plan for outpatient supervision and treatment. The plan shall set forth specific terms and conditions to be followed during outpatient status. The court shall provide copies of this report to the prosecutor and the defense counsel.

(c) The court shall calendar the matter for hearing within 15 judicial days of the receipt of the report described in subdivision (b) and shall give notice of the hearing date to the prosecutor, defense counsel, the panel, and, when appropriate, to the director of the state hospital or other facility. In any hearing conducted pursuant to this section, the court shall consider the circumstances and nature of the criminal offense leading to commitment and shall consider the person's prior criminal history.

(d) The court shall, after a hearing in court, either approve or disapprove the recommendation for outpatient status. If the approval of the court is given, the defendant shall be placed on outpatient status subject to the terms and conditions specified in the supervision and treatment plan. If the outpatient treatment occurs in a county other than the county of commitment, the court shall transmit a copy of the case record to the superior court in the county where outpatient treatment occurs, so that the record will be available if revocation proceedings are initiated pursuant to Section 1608 or 1609.

SEC. 49. Section 2603 of the Penal Code, as amended by Section 11 of Chapter 434 of the Statutes of 2021, is amended to read:

2603. (a) Except as provided in subdivision (b), an inmate confined in a county jail shall not be administered any psychiatric medication without their prior informed consent.

(b) If a psychiatrist determines that an inmate should be treated with psychiatric medication, but the inmate does not consent, the inmate may be involuntarily treated with the medication. Treatment may be given on either a nonemergency basis as provided in subdivision (c), or on an emergency or interim basis as provided in subdivision (d).

(c) A county department of mental health, or other designated county department, may administer involuntary medication on a nonemergency basis only if all of the following conditions have been met:

(1) A psychiatrist or psychologist has determined that the inmate has a serious mental disorder.

(2) A psychiatrist or psychologist has determined that, as a result of that mental disorder, the inmate is gravely disabled and does not have the capacity to refuse treatment with psychiatric medications, or is a danger to self or others.

(3) A psychiatrist has prescribed one or more psychiatric medications for the treatment of the inmate's disorder, has considered the risks, benefits, and treatment alternatives to involuntary medication, and has determined that the treatment alternatives to involuntary medication are unlikely to meet the needs of the patient.

(4) The inmate has been advised of the risks and benefits of, and treatment alternatives to, the psychiatric medication and refuses, or is unable to consent to, the administration of the medication.

(5) The jail has made a documented attempt to locate an available bed for the inmate in a community-based treatment facility in lieu of seeking to administer involuntary medication. The jail shall transfer that inmate to such a facility only if the facility can provide care for the mental health needs, and the physical health needs, if any, of the inmate and upon the

agreement of the facility. In enacting the act that added this paragraph, it is the intent of the Legislature to recognize the lack of community-based beds and the inability of many facilities to accept transfers from correctional facilities.

(6) The inmate is provided a hearing before a superior court judge, a court-appointed commissioner or referee, or a court-appointed hearing officer, as specified in subdivision (c) of Section 5334 of the Welfare and Institutions Code.

(A) If the inmate is in custody awaiting trial, including an inmate whose criminal proceedings are suspended pursuant to Section 1370 or an inmate whose competence has been called into question and is undergoing evaluation pursuant to Section 1369, any hearing pursuant to this section shall be held before, and any requests for ex parte orders shall be submitted to, a judge in the superior court where the criminal case is pending.

(B) A superior court judge may consider whether involuntary medication would prejudice the inmate's defense.

(7) (A) The inmate is provided counsel at least 21 days prior to the hearing, unless emergency or interim medication is being administered pursuant to subdivision (d), in which case the inmate would receive expedited access to counsel.

(B) In the case of an inmate awaiting arraignment, the inmate is provided counsel within 48 hours of the filing of the notice of the hearing with the superior court, unless counsel has previously been appointed.

(C) The hearing shall be held not more than 30 days after the filing of the notice with the superior court, unless counsel for the inmate agrees to extend the date of the hearing.

(8) (A) The inmate and counsel are provided with written notice of the hearing at least 21 days prior to the hearing, unless emergency or interim medication is being administered pursuant to subdivision (d), in which case the inmate would receive an expedited hearing.

(B) The written notice shall do all of the following:

(i) Set forth the diagnosis, the factual basis for the diagnosis, the basis upon which psychiatric medication is recommended, the expected benefits of the medication, any potential side effects and risks to the inmate from the medication, and any alternatives to treatment with the medication.

(ii) Advise the inmate of the right to be present at the hearing, the right to be represented by counsel at all stages of the proceedings, the right to present evidence, and the right to cross-examine witnesses. Counsel for the inmate shall have access to all medical records and files of the inmate, but shall not have access to the confidential section of the inmate's central file which contains materials unrelated to medical treatment.

(iii) Inform the inmate of their right to appeal the determination to the superior court or the court of appeal as specified in subdivisions (e) and (f) of Section 5334 of the Welfare and Institutions Code, and their right to file a petition for writ of habeas corpus with respect to any decision of the county department of mental health, or other designated county department, to continue treatment with involuntary medication after the superior court

judge, court-appointed commissioner or referee, or court-appointed hearing officer has authorized treatment with involuntary medication.

(9) (A) In the hearing described in paragraph (6), the superior court judge, a court-appointed commissioner or referee, or a court-appointed hearing officer determines by clear and convincing evidence that the inmate has a mental illness or disorder, that as a result of that illness the inmate is gravely disabled and lacks the capacity to consent to or refuse treatment with psychiatric medications or is a danger to self or others if not medicated, that there is no less intrusive alternative to involuntary medication, and that the medication is in the inmate's best medical interest.

(B) The superior court judge, court-appointed commissioner or referee, or a court-appointed hearing officer shall not make a finding pursuant to subparagraph (A) of this paragraph that there is no less intrusive alternative to involuntary medication and that the medication is in the inmate's best medical interest, without information from the jail to indicate that neither of the conditions specified in paragraph (5) is present.

(C) If the court makes the findings in subparagraph (A), that administration shall occur in consultation with a psychiatrist who is not involved in the treatment of the inmate at the jail, if available.

(D) In the event of any statutory notice issues with either initial or renewal filings by the county department of mental health, or other designated county department, the superior court judge, court-appointed commissioner or referee, or court-appointed hearing officer shall hear arguments as to why the case should be heard, and shall consider factors such as the ability of the inmate's counsel to adequately prepare the case and to confer with the inmate, the continuity of care, and, if applicable, the need for protection of the inmate or institutional staff that would be compromised by a procedural default.

(10) The historical course of the inmate's mental disorder, as determined by available relevant information about the course of the inmate's mental disorder, shall be considered when it has direct bearing on the determination of whether the inmate is a danger to self or others, or is gravely disabled and incompetent to refuse medication as the result of a mental disorder.

(11) An inmate is entitled to file one motion for reconsideration following a determination that they may receive involuntary medication, and may seek a hearing to present new evidence, upon good cause shown. This paragraph does not prevent a court from reviewing, modifying, or terminating an involuntary medication order for an inmate awaiting trial, if there is a showing that the involuntary medication is interfering with the inmate's due process rights in the criminal proceeding.

(d) (1) (A) This section does not prohibit a physician from taking appropriate action in an emergency. An emergency exists when both of the following criteria are met:

(i) There is a sudden and marked change in an inmate's mental condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate or others.

(ii) It is impractical, due to the seriousness of the emergency, to first obtain informed consent.

(B) If psychiatric medication is administered during an emergency, the medication shall only be that which is required to treat the emergency condition and shall be administered for only so long as the emergency continues to exist.

(2) (A) If the clinicians of the county department of mental health, or other designated county department, identify a situation that jeopardizes the inmate's health or well-being as the result of a serious mental illness, and necessitates the continuation of medication beyond the initial 72 hours pending the full mental health hearing, the county department may seek to continue the medication by giving notice to the inmate and their counsel of its intention to seek an ex parte order to allow the continuance of medication pending the full hearing, and filing an ex parte order within the initial 72-hour period. Treatment of the inmate in a facility pursuant to Section 4011.6 shall not be required in order to continue medication under this subdivision unless the treatment is otherwise medically necessary.

(B) The notice shall be served upon the inmate and counsel at the same time the inmate is given the written notice that the involuntary medication proceedings are being initiated and is appointed counsel as provided in subdivision (c).

(C) The order may be issued ex parte upon a showing that, in the absence of the medication, the emergency conditions are likely to recur. The request for an ex parte order shall be supported by an affidavit from the psychiatrist or psychologist showing specific facts.

(D) The inmate and the inmate's appointed counsel shall have two business days to respond to the county department's ex parte request to continue interim medication, and may present facts supported by an affidavit in opposition to the department's request. A superior court judge, a court-appointed commissioner or referee, or a court-appointed hearing officer shall review the ex parte request and shall have three business days to determine the merits of the department's request for an ex parte order.

(E) If an order is issued, the psychiatrist may continue the administration of the medication until the hearing described in paragraph (6) of subdivision (c) is held.

(3) If the county elects to seek an ex parte order pursuant to this subdivision, the county department of mental health, or other designated county department, shall file with the superior court, and serve on the inmate and their counsel, the written notice described in paragraph (8) of subdivision (c) within 72 hours of commencing medication pursuant to this subdivision, unless either of the following occurs:

(A) The inmate gives informed consent to continue the medication.

(B) A psychiatrist determines that the psychiatric medication is not necessary and administration of the medication is discontinued.

(4) If medication is being administered pursuant to this subdivision, the hearing described in paragraph (6) of subdivision (c) shall commence within

21 days of the filing and service of the notice, unless counsel for the inmate agrees to a different period of time.

(5) With the exception of the timeline provisions specified in paragraphs (3) and (4) for providing notice and commencement of the hearing in emergency or interim situations, the inmate shall be entitled to and be given the same due process protections as specified in subdivision (c). The county department of mental health, or other designated county department, shall prove the same elements supporting the involuntary administration of psychiatric medication and the superior court judge, court-appointed commissioner or referee, or court-appointed hearing officer shall be required to make the same findings described in subdivision (c).

(e) (1) (A) An order by the court authorizing involuntary medication of an inmate shall be valid for no more than one year after the date of determination.

(B) Notwithstanding subparagraph (A), in the case of an inmate who is awaiting arraignment, trial, or sentencing, the determination that an inmate may receive involuntary medication shall be valid for no more than 180 days. The court shall review the order at intervals of not more than 60 days to determine whether the grounds for the order remain. At each review, the psychiatrist shall file an affidavit with the court that ordered the involuntary medication affirming that the person who is the subject of the order continues to meet the criteria for involuntary medication. A copy of the affidavit shall be provided to the defendant and the defendant's attorney. In determining whether the criteria for involuntary medication still exist, the court shall consider the affidavit of the psychiatrist or psychiatrists and any supplemental information provided by the defendant's attorney. The court may also require the testimony from the psychiatrist, if necessary. The court, at each review, may continue the order authorizing involuntary medication, vacate the order, or make any other appropriate order.

(2) Notwithstanding subparagraph (A) of paragraph (1), any determination of an inmate's incapacity to refuse treatment with antipsychotic medication made pursuant to this section shall remain in effect only until one of the following occurs, whichever occurs first:

(A) The duration of the inmate's confinement ends, unless, pursuant to Section 1370, the inmate is transferred to a State Department of State Hospitals facility, as defined in Section 4100 of the Welfare and Institutions Code. If the inmate is transferred to such a facility, the order shall remain valid for the period ordered by the court and the facility may administer antipsychotic medication as needed, including on an involuntary basis, if the treating psychiatrist determines that antipsychotic medication is medically necessary and appropriate.

(B) A court determines that the inmate no longer meets the criteria of subdivision (c) or (d), or by any other order of the court.

(3) An inmate's period of confinement may not be extended in order to provide treatment to the inmate with antipsychotic medication pursuant to this section.

(f) This section does not prohibit the court, upon making a determination that an inmate awaiting arraignment, preliminary hearing, trial, sentencing, or a postconviction proceeding to revoke or modify supervision may receive involuntary medication pursuant to subdivision (c) or (d), and, upon ex parte request of the defendant or counsel, from suspending all proceedings in the criminal prosecution, until the court determines that the defendant's medication will not interfere with their ability to meaningfully participate in the criminal proceedings.

(g) If a determination has been made to involuntarily medicate an inmate pursuant to subdivision (c) or (d), the medication shall be discontinued one year after the date of that determination, unless the inmate gives informed consent to the administration of the medication, or unless a new determination is made pursuant to the procedures set forth in subdivision (h).

(h) To renew an existing order allowing involuntary medication, the county department of mental health, or other designated county department, shall file with the superior court, and shall serve on the inmate and their counsel, a written notice indicating the department's intent to renew the existing involuntary medication order.

(1) The request to renew the order shall be filed and served no later than 21 days prior to the expiration of the current order authorizing involuntary medication.

(2) The inmate shall be entitled to, and shall be given, the same due process protections as specified in subdivision (c).

(3) (A) Except as provided in subparagraph (B), renewal orders shall be valid for one year from the date of the hearing.

(B) In the case of an inmate awaiting arraignment, trial, or sentencing, the renewal order shall be valid for no more than 180 days. The court shall review the order at intervals of not more than 60 days to determine whether the grounds for the order remain. At each review, the psychiatrist shall file an affidavit with the court that ordered the involuntary medication affirming that the person who is the subject of the order continues to meet the criteria for involuntary medication. A copy of the affidavit shall be provided to the defendant and the defendant's attorney. In determining whether the criteria for involuntary medication still exist, the court shall consider the affidavit of the psychiatrist or psychiatrists and any supplemental information provided by the defendant's attorney. The court may also require the testimony from the psychiatrist, if necessary. The court, at each review, may continue the order authorizing involuntary medication, vacate the order, or make any other appropriate order.

(4) (A) An order renewing an existing order shall be granted based on clear and convincing evidence that the inmate has a serious mental disorder that requires treatment with psychiatric medication, and that, but for the medication, the inmate would revert to the behavior that was the basis for the prior order authorizing involuntary medication, coupled with evidence that the inmate lacks insight regarding their need for the medication, such

that it is unlikely that the inmate would be able to manage their own medication and treatment regimen. No new acts need be alleged or proven.

(B) The superior court judge, court-appointed commissioner or referee, or a court-appointed hearing officer shall also make a finding that treatment of the inmate in a correctional setting continues to be necessary if neither of the criteria in paragraph (5) of subdivision (c) is present.

(5) If the county department of mental health, or other designated county department, wishes to add a basis to an existing order, it shall give the inmate and the inmate's counsel notice in advance of the hearing via a renewal notice or supplemental petition. Within the renewal notice or supplemental petition, as described in subdivision (h), the county department of mental health, or other designated county department, shall specify what additional basis is being alleged and what qualifying conduct within the past year supports that additional basis. The county department of mental health, or other designated county department, shall prove the additional basis and conduct by clear and convincing evidence at a hearing as specified in subdivision (c).

(6) The hearing on any petition to renew an order for involuntary medication shall be conducted prior to the expiration of the current order.

(i) In the event of a conflict between the provisions of this section and the Administrative Procedure Act (Chapter 4.5 (commencing with Section 11400) of Part 1 of Division 3 of the Government Code), this section shall control.

(j) As used in this section, "inmate" means a person confined in the county jail, including, but not limited to, a person sentenced to imprisonment in a county jail, a person housed in a county jail during or awaiting trial proceedings, and a person who has been booked into a county jail and is awaiting arraignment.

(k) This section does not apply to a person housed in a county jail solely on the basis of an immigration hold, except as it applies to medication provided on an emergency or interim basis as provided in subdivision (d).

(*l*) Each county that administers involuntary medication to an inmate awaiting arraignment, trial, or sentencing, shall file, by January 1, 2021, a written report with the Assembly Committees on Judiciary and Public Safety and the Senate Committee on Public Safety summarizing the following: the number of inmates who received involuntary medication while awaiting arraignment, trial, or sentencing between January 1, 2018, and July 1, 2020; the crime for which those inmates were arrested; the total time those inmates were detained while awaiting arraignment, trial, or sentencing; the duration of the administration of involuntary medication; the number of times, if any, that an existing order for the administration of involuntary medication was renewed; and the reason for termination of the administration of involuntary medication.

(m) This section shall remain in effect only until January 1, 2025, and as of that date is repealed, unless a later enacted statute, which is chaptered before that date, deletes or extends the date.

SEC. 50. Section 4019 of the Penal Code, as amended by Section 4 of Chapter 599 of the Statutes of 2021, is amended to read:

4019. (a) This section applies in all of the following cases:

(1) When a prisoner is confined in or committed to a county jail, industrial farm, or road camp or a city jail, industrial farm, or road camp, including all days of custody from the date of arrest to the date when the sentence commences, under a judgment of imprisonment or of a fine and imprisonment until the fine is paid in a criminal action or proceeding.

(2) When a prisoner is confined in or committed to a county jail, industrial farm, or road camp or a city jail, industrial farm, or road camp as a condition of probation after suspension of imposition of a sentence or suspension of execution of sentence in a criminal action or proceeding.

(3) When a prisoner is confined in or committed to a county jail, industrial farm, or road camp or a city jail, industrial farm, or road camp for a definite period of time for contempt pursuant to a proceeding other than a criminal action or proceeding.

(4) When a prisoner is confined in a county jail, industrial farm, or road camp or a city jail, industrial farm, or road camp following arrest and prior to the imposition of sentence for a felony conviction.

(5) When a prisoner is confined in a county jail, industrial farm, or road camp or a city jail, industrial farm, or road camp as part of custodial sanction imposed following a violation of postrelease community supervision or parole.

(6) When a prisoner is confined in a county jail, industrial farm, or road camp or a city jail, industrial farm, or road camp as a result of a sentence imposed pursuant to subdivision (h) of Section 1170.

(7) When a prisoner participates in a program pursuant to Section 1203.016 or Section 4024.2. Except for prisoners who have already been deemed eligible to receive credits for participation in a program pursuant to Section 1203.016 prior to January 1, 2015, this paragraph shall apply prospectively.

(8) When a prisoner is confined in or committed to a state hospital or other mental health treatment facility, or to a county jail treatment facility.

(b) Subject to subdivision (d), for each four-day period in which a prisoner is confined in or committed to a facility as specified in this section, one day shall be deducted from the prisoner's period of confinement unless it appears by the record that the prisoner has refused to satisfactorily perform labor as assigned by the sheriff, chief of police, or superintendent of an industrial farm or road camp.

(c) For each four-day period in which a prisoner is confined in or committed to a facility as specified in this section, one day shall be deducted from the prisoner's period of confinement unless it appears by the record that the prisoner has not satisfactorily complied with the reasonable rules and regulations established by the sheriff, chief of police, or superintendent of an industrial farm or road camp.

(d) This section does not require the sheriff, chief of police, or superintendent of an industrial farm or road camp to assign labor to a prisoner

if it appears from the record that the prisoner has refused to satisfactorily perform labor as assigned or that the prisoner has not satisfactorily complied with the reasonable rules and regulations of the sheriff, chief of police, or superintendent of an industrial farm or road camp.

(e) A deduction shall not be made under this section unless the person is committed for a period of four days or longer.

(f) It is the intent of the Legislature that if all days are earned under this section, a term of four days will be deemed to have been served for every two days spent in actual custody.

(g) The changes in this section as enacted by the act that added this subdivision shall apply to prisoners who are confined to a county jail, city jail, industrial farm, or road camp for a crime committed on or after the effective date of that act.

(h) The changes to this section enacted by the act that added this subdivision shall apply prospectively and shall apply to prisoners who are confined to a county jail, city jail, industrial farm, or road camp for a crime committed on or after October 1, 2011. Any days earned by a prisoner prior to October 1, 2011, shall be calculated at the rate required by the prior law.

(i) This section shall not apply, and no credits may be earned, for periods of flash incarceration imposed pursuant to Section 3000.08 or 3454.

(j) This section shall become operative on January 1, 2023.

SEC. 51. Section 18914 of the Revenue and Taxation Code is amended to read:

18914. (a) An individual may designate on the tax return that a contribution in excess of the personal income tax liability, if any, be made to the Suicide Prevention Voluntary Tax Contribution Fund established by Section 18915. That designation is to be used as a voluntary contribution on the tax return.

(b) The contributions shall be in full dollar amounts and may be made individually by each signatory on a joint return.

(c) A designation under subdivision (a) shall be made for any taxable year on the original return for that taxable year and once made is irrevocable. If payments and credits reported on the return, together with any other credits associated with the taxpayer's account, do not exceed the taxpayer's liability, the return shall be treated as if no designation has been made.

(d) When another voluntary contribution designation is removed from the tax return, or as soon as space is available, the Franchise Tax Board shall revise the form of the return to include a space labeled the "Suicide Prevention Voluntary Tax Contribution Fund" to allow for the designation permitted. The form shall also include in the instructions information that the contribution may be in the amount of one dollar ($1) or more and that the contribution shall be used to support crisis centers located in the state that are active members of the National Suicide Prevention Lifeline, with priority given to those crisis centers located in rural and desert communities.

(e) A deduction shall be allowed under Article 6 (commencing with Section 17201) of Chapter 3 of Part 10 for any contribution made pursuant to subdivision (a).

SEC. 52. Section 18916 of the Revenue and Taxation Code is amended to read:

18916. (a) Notwithstanding Section 13340 of the Government Code, all money transferred to the Suicide Prevention Voluntary Tax Contribution Fund shall be continuously appropriated and allocated as follows:

(1) To the Franchise Tax Board, the Controller, and the State Department of Health Care Services for reimbursement of all costs incurred by the Franchise Tax Board, the Controller, and the State Department of Health Care Services in connection with their duties under this article.

(2) To the State Department of Health Care Services for disbursement to crisis centers located in the state that are active members of the National Suicide Prevention Lifeline, with priority given to those crisis centers located in rural and desert communities.

(b) For purposes of implementing this article, the State Department of Health Care Services may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this section are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and from the State Administrative Manual and the State Contracting Manual, and are exempt from the review or approval of any division of the Department of General Services.

(c) Money in the Suicide Prevention Voluntary Tax Contribution Fund shall not be used to supplant state General Fund money for any purpose or to supplant state administrative funding pursuant to subdivision (d) of Section 5892 of the Welfare and Institutions Code.

SEC. 53. Section 4335.2 of the Welfare and Institutions Code is amended to read:

4335.2. (a) As used in this section, “department” means the State Department of State Hospitals.

(b) The Legislature finds and declares that the purpose of this section is to establish a program for the department to perform reevaluations primarily through telehealth evaluations for felony incompetent to stand trial (IST) individuals in jail who have been waiting for admission to the department. The goals of this program are:

(1) To permit the department to conduct reevaluations of IST defendants committed to the department and awaiting admission to department facilities.

(2) To reduce the growing list of IST defendants awaiting placement to a department facility for competency restoration treatment.

(3) To help address the significant impacts of the COVID-19 pandemic on the IST waitlist through identification of individuals on the waitlist who have restored to competency in jail, are nonrestorable, are malingering, may be divertible, or have stabilized and are appropriate for outpatient treatment.

(4) To reduce the timeframe for a competency evaluation for IST defendants in jail and reduce unnecessary costly hospitalizations.

(5) To offer expert forensic mental health consultation to assist in identifying ISTs who may be appropriate for community placement. This supports the principles of deinstitutionalization for individuals who can best be supported in the least restrictive setting in the community.

(6) To offer expert medication consultation and technical assistance to local sheriffs to support effective use of psychotropic medications and stabilization of IST defendants awaiting placement to a department facility.

(7) To require courts and local county jails to provide to the department all relevant medical, behavioral, and court records of IST defendants committed to the department for evaluation purposes.

(8) To require local county jails to provide the department access to IST defendants in county jails and for local county jails to ensure the department the ability to provide reevaluations for IST defendants remotely.

(9) To require local county jails to allow the department access to necessary IST defendants' information, including records and collateral information.

(c) The department, or its designee, have the authority and sole discretion to consider and conduct reevaluations for IST defendants committed to and awaiting admission to the department. A reevaluation shall involve a review by a department clinician or contracted clinician of an IST defendant's relevant medical and mental health records, including prior mental health evaluations and an evaluation of the IST defendant by that department clinician or contracted clinician. When conducting the reevaluation, the department or its designee may request defendant's counsel to provide any information bearing on the defendant's capacity to rationally cooperate in their defense that is absent from the records accessible to the court. Defense counsel may provide a written statement of their reasoning for questioning the defendant's mental competence and the time of their most recent contact with the defendant. Any communication between the defendant's counsel and the evaluator is confidential pursuant to Section 954 of the Evidence Code. If not already provided, the court shall provide the department with all IST defendant records pursuant to paragraph (3) of subdivision (a) of Section 1370 of the Penal Code and paragraph (4) of subdivision (a) of Section 1370.01 of the Penal Code, including any updated medical and behavioral health records requested by the department. At the sole discretion of the department, the department clinician or contracted clinician may conduct in person, or video telehealth, evaluations of IST defendants at the local jail for those IST patients awaiting admission to the department. The local jail shall provide the department confidential access to the IST defendant for reevaluation, including establishing and maintaining remote access capabilities at the jail for the department to remotely access the IST defendant.

(d) Reevaluations provided by the department clinician or contracted clinician shall include, but are not limited to, the following:

(1) Evaluations, including assessment of malingering, pursuant to paragraph (1) of subdivision (b) of Section 1370 of the Penal Code,

subdivision (b) of Section 1370.01 of the Penal Code, or paragraph (1) of subdivision (a) of Section 1372 of the Penal Code.

(2) Assessments to determine whether the IST defendant should be referred to the county for further evaluation for potential participation in the county diversion program, if one exists, pursuant to clause (v) of subparagraph (B) of paragraph (1) of subdivision (a) of Section 1370 of the Penal Code or paragraph (2) of subdivision (a) of Section 1370.01 of the Penal Code, or other outpatient treatment program.

(3) Evaluations on whether the IST defendant is substantially unlikely to be restored to competence in the foreseeable future pursuant to paragraph (1) of subdivision (b) of Section 1370 of the Penal Code or subdivision (b) of Section 1370.01 of the Penal Code. Evaluations shall include, if applicable, facts supporting that a defendant appears gravely disabled as described in subparagraph (A) of paragraph (1) of subdivision (h) of Section 5008, which a court may utilize to order a conservatorship investigator to initiate conservatorship proceedings pursuant to paragraph (3) of subdivision (c) of Section 1370 of the Penal Code.

(4) Psychopharmacology evaluations in which a department clinician will identify IST defendants who may need psychotropic medications, a psychopharmacology consultation, or an involuntary medication order.

(5) A written report from the department clinician or contracted clinician of their evaluations of the IST defendant, as well as any conclusions of mental health status and recommendations the clinician may have of placement of the IST defendant.

(e) A court may issue an order authorizing involuntary administration of antipsychotic medication pursuant to paragraphs (2) and (3) of subdivision (b) of Section 1370 of the Penal Code, based on the recommendation made by a department clinician pursuant to paragraph (4) of subdivision (d). If a hearing is ordered by the court pursuant to subparagraph (C) or (D) of paragraph (3) of subdivision (b) of Section 1370 of the Penal Code, the clinician shall be allowed to testify remotely. In-person witness testimony shall only be allowed upon a court's finding of good cause.

(f) Written reports shall be filed with the court in the committing county. That report shall be accepted by courts, either pursuant to paragraph (1) of subdivision (b) of Section 1370 of the Penal Code, subdivision (b) of Section 1370.01 of the Penal Code, or paragraph (1) of subdivision (a) of Section 1372 of the Penal Code.

(g) The department shall provide funding based on a flat rate set by the department to local county jails for reimbursement of information technology support and a portion of staff time utilized to facilitate telehealth interviews and evaluations of felony IST defendants in the jail. One-time funding based on a flat rate set by the department will be made available for reimbursement to the county sheriff upon agreement to facilitate telehealth evaluations in the jail. In addition, a flat rate, set by the department, for reimbursement of each telehealth evaluation conducted by the department for an IST defendant and facilitated by the jail will be paid on a quarterly basis in arrears following conclusion of the telehealth evaluation.

(h) Any contracts awarded to implement this chapter shall be exempt from the requirements contained in the Public Contract Code and the State Administrative Manual and shall not be subject to approval by the Department of General Services.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the state hospitals and the department may implement, interpret, or make specific this section by means of a departmental letter or other similar instruction, as necessary.

(j) The department and any of the designated evaluators shall be provided access to the defendant's medical records, including mental health records for purposes of conducting a reevaluation of the competency status of the defendant.

(k) The department and any of the designated evaluators shall, upon request, be provided prompt and unimpeded collateral consult with local county jail staff, including contractors, for the purpose of determining an IST defendant's behavior, care, progress, and treatment.

SEC. 54. Section 4336 is added to the Welfare and Institutions Code, to read:

4336. (a) As used in this section, "department" means the State Department of State Hospitals.

(b) (1) The department shall implement a growth cap program for all counties for individuals committed pursuant to Section 1370 of the Penal Code. The department shall charge counties penalty payments as described in this subdivision to implement the growth cap program.

(2) The baseline number of individuals determined to be incompetent to stand trial on felony charges for each county shall be the number of felony incompetency determinations made in the 2021–22 fiscal year for each county. For any county with zero felony incompetency to stand trial determinations in the 2021–22 fiscal year, the baseline shall be set at one individual.

(3) (A) Commencing with the 2022–23 fiscal year and each fiscal year thereafter, for each felony incompetent to stand trial determination that exceeds the baseline number identified in paragraph (2), a county shall pay the penalty amount described in subparagraph (C).

(B) The department shall reconcile the total county incompetent to stand trial determinations against the baseline by September 30 each year.

(C) Calculations shall be based on the published per individual rate set forth by the department for state hospital treatment for individuals found incompetent to stand trial on a felony charge, as follows:

(i) Each county shall make penalty payments equivalent to 50 percent of the rate for the 5th, 6th, and 7th individual felony incompetent to stand trial determinations over the baseline, 75 percent of the rate for the 8th and 9th individual felony incompetent to stand trial determinations over the baseline, and 100 percent of the rate for the 10th and all subsequent felony incompetent to stand trial determinations over the baseline.

(ii) (I) Commencing with the 2026–27 fiscal year and each fiscal year thereafter, a county with a felony mental health diversion or

community-based restoration contract with the department shall, for the third and any subsequent individual felony incompetent to stand trial determinations over the baseline, make penalty payments equivalent to 100 percent of the rate.

(II) Commencing with the 2026–27 fiscal year and each fiscal year thereafter, any county without a felony mental health diversion or community-based restoration contract with the department shall, for the third and any subsequent individual felony incompetent to stand trial determinations over the baseline, make penalty payments equivalent to 150 percent of the rate.

(D) Commencing with the 2022–23 fiscal year, the department shall periodically notify the superior court and relevant county agencies of each county, including, but not limited to, the county administrator, behavioral health department, sheriff, public defender, and district attorney of the total number of felony incompetent to stand trial determinations made in that county for the current fiscal year compared to the baseline determination for that county.

(E) Commencing with the 2023–24 fiscal year, each county shall remit payment to the department in an amount equal to the amount identified in the invoice issued to the county administrator or their designee by the department. The penalty payment shall be due no later than 90 days after the date that the invoice is received by the county. The penalty funds shall be collected as revenue by the department and deposited by the Controller into the Mental Health Diversion Fund, created pursuant to subdivision (c).

(F) A county may pay these penalty payments from any local funding source available, including funds received by the county through contracts issued by the department to the county for purposes of serving the felony incompetent to stand trial population.

(G) Commencing with the 2023–24 fiscal year, and each fiscal year thereafter, notwithstanding any other budgetary or accounting requirements, the department shall make the final determination of the proper budgeting and accounting of the penalties received, deposited, and disbursed from the Mental Health Diversion Fund to each county as appropriate.

(c) (1) The Mental Health Diversion Fund is hereby created in the State Treasury. The fund shall receive penalty payments from each county as collected by the department pursuant to this section. All moneys in the fund are reserved and continuously appropriated, without regard to fiscal years. The funds collected in the fund shall be used for the purpose of supporting county activities that will divert individuals with serious mental illnesses away from the criminal justice system and lead to the reduction of felony incompetent to stand trial determinations.

(2) Activities supported by the funds collected in the Mental Health Diversion Fund shall include one or more of the following:

(A) Prebooking mental health diversion to serve those with serious mental illness and prevent their felony arrest. The target population that shall be served are individuals demonstrating psychosis manifesting as hallucinations,

delusions, disorganized thoughts, or disorganized behavior at the time of the interaction.

(B) Postbooking mental health diversion to serve those with serious mental illness and who are likely to be found incompetent to stand trial, to prevent the incompetent to stand trial determination and divert the individual from incarceration. The target population that shall be served are individuals diagnosed with a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including, but not limited to, bipolar disorder, schizophrenia, and schizoaffective disorder but excluding a primary diagnosis of antisocial personality disorder, borderline personality disorder, and pedophilia, and who are presenting non-substance-induced psychotic symptoms.

(C) Reentry services and support to serve those who have been restored to competency following a felony incompetent to stand trial commitment and directly released to the community from jail.

(d) (1) Beginning in the 2024–25 fiscal year, each county that has received funds from the Mental Health Services Fund shall submit an annual report to the department, on or before October 1 of each fiscal year, identifying how funds were used in the prior fiscal year.

(2) The department shall, by no later than July 1, 2024, publish an administrative letter to counties outlining the required form and content of the report.

(3) Annual reports submitted by each county subject to this section shall include, without limitation, the number of individuals served, the services and support provided, and the projected impact to the number of felony incompetent to stand trial determinations by the county.

(e) Commencing with the 2023–24 fiscal year, and each fiscal year thereafter, the department shall submit a schedule to the Controller of disbursements of funds from the Mental Health Diversion Fund to each county. Disbursements for each county shall equal the amount of county payments made to the department in accordance with subdivision (b).

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of a departmental letter or other similar instruction, as necessary.

SEC. 55. Section 4360.5 is added to the Welfare and Institutions Code, to read:

4360.5. (a) The State Department of State Hospitals shall establish a statewide panel of independent evaluators responsible for Forensic Conditional Release Program placement determinations for patients committed to the department and transitioning to community treatment settings for services pursuant to Section 4360.

(b) The purpose of the statewide independent evaluation panel is to identify state hospital patients who are ready for discharge to the Forensic Conditional Release Program pursuant to Section 4360, to promote successful community reintegration. The panel may consist of both contracted and civil service licensed psychologists and licensed social

workers designated by the department. A licensed psychologist or licensed social worker panel member shall evaluate the state hospital patient to determine if the patient is suitable for community outpatient treatment and to determine whether an appropriate placement is available for the patient in the community-based treatment system based upon guidelines provided by the department, including the use of evidence-based risk assessment tools for all community release determinations. The panel member shall provide the court that has jurisdiction over the patient's placement with a written placement recommendation on behalf of the statewide independent evaluation panel.

(c) The statewide independent evaluation panel shall be used either independently or in conjunction with the community program director, designated pursuant to Section 1605 of the Penal Code, to provide placement recommendations for patients committed to the State Department of State Hospitals on appropriateness for the Forensic Conditional Release Program. The department shall determine whether the statewide independent evaluation panel or the community program director, or both, is responsible for case reviews and placement recommendation.

(d) The department shall conduct an evaluation of the effectiveness of the program created pursuant to this section to determine whether to extend the use of the statewide independent evaluation panel after June 30, 2026.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of a departmental letter or other similar instruction, as necessary.

(f) Contracts awarded pursuant to this statute are exempt from the requirements contained in the Public Contract Code and the State Administrative Manual and are not subject to approval by the Department of General Services.

(g) This section shall remain in effect only until June 30, 2026, and as of that date is repealed.

SEC. 56. Section 4361 of the Welfare and Institutions Code is amended to read:

4361. (a) As used in this section, "department" means the State Department of State Hospitals.

(b) The purpose of this chapter is to, subject to appropriation by the Legislature, promote the diversion of individuals with serious mental disorders as prescribed in Chapter 2.8A (commencing with Section 1001.35) of Title 6 of Part 2 of the Penal Code, and to assist counties in providing diversion for individuals with serious mental illnesses who have been found incompetent to stand trial and committed to the department for restoration of competency. In implementing this chapter, the department shall consider local discretion and flexibility in diversion activities that meet the community's needs and provide for the safe and effective treatment of individuals with serious mental disorders across a continuum of care.

(c) (1) Subject to appropriation by the Legislature, the department may solicit proposals from, and may contract with, a county to help fund the

development or expansion of pretrial diversion described in Chapter 2.8A (commencing with Section 1001.35) of Title 6 of Part 2 of the Penal Code, for the population described in subdivision (b) and that meets all of the following criteria:

(A) Participants are individuals diagnosed with a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including, but not limited to, bipolar disorder, schizophrenia, and schizoaffective disorder, but excluding a primary diagnosis of antisocial personality disorder, borderline personality disorder, and pedophilia, and who are presenting non-substance-induced psychotic symptoms, who have been found incompetent to stand trial pursuant to clause (iv) of subparagraph (B) of paragraph (1) of subdivision (a) of Section 1370 of the Penal Code.

(B) There is a significant relationship between the individual's serious mental disorder and the charged offense, or between the individual's conditions of homelessness and the charged offense.

(C) The individual does not pose an unreasonable risk of danger to public safety, as defined in Section 1170.18 of the Penal Code, if treated in the community.

(2) A county submitting a proposal for funding under this chapter shall designate a lead entity to apply for the funds. This lead entity shall show in its proposal that it has support from other county entities or other relevant entities, including courts, that are necessary to provide successful diversion of individuals under the contract.

(d) When evaluating proposals from the county, the department, in consultation with the Council on Criminal Justice and Behavioral Health within the Department of Corrections and Rehabilitation, shall prioritize proposals that demonstrate all of the following:

(1) Provision of clinically appropriate or evidence-based mental health treatment and wraparound services across a continuum of care, as appropriate, to meet the individual needs of the diversion participant. For purposes of this section, "wraparound services" means services provided in addition to the mental health treatment necessary to meet the individual's needs for successfully managing the individual's mental health symptoms and to successfully live in the community. Wraparound services provided by the diversion program shall include appropriate housing, intensive case management, and substance use disorder treatment, and may include, without limitation, forensic assertive community treatment teams, crisis residential services, criminal justice coordination, peer support, and vocational support.

(2) Collaboration between community stakeholders and other partner government agencies in the diversion of individuals with serious mental disorders.

(3) Connection of individuals to services in the community after they have completed diversion as provided in this chapter.

(e) The department may also provide funding in the contract with the county, subject to appropriation by the Legislature, to cover the cost of providing postbooking assessment of defendants who are likely to be found

incompetent to stand trial on felony charges to determine whether the defendant would benefit from diversion as included in the contract.

(f) The department may also provide funding in the contract with the county, subject to appropriation by the Legislature, to cover the cost of in-jail treatment prior to the placement in the community for up to an average of 15 days for defendants who have been approved by the court for diversion as included in the contract.

(g) A county contracted pursuant to this chapter shall report data and outcomes to the department, within 30 days after the end of each quarter, regarding those individuals targeted by the contract and in the program. This subdivision does not preclude the department from specifying reporting formats or from modifying, reducing, or adding data elements or outcome measures from a contracting county, as needed to provide for reporting of effective data and outcome measures. Notwithstanding any other law, but only to the extent not prohibited by federal law, the county shall provide specific patient information to the department for reporting purposes. The patient information is confidential and is not open to public inspection. A contracting county shall, at a minimum, report all of the following:

(1) The number of individuals that the court ordered to postbooking diversion and the length of time for which the defendant has been ordered to diversion.

(2) The number of individuals participating in diversion.

(3) The name, social security number, criminal identification and information (CII) number, date of birth, and demographics of each individual participating in the program. This information is confidential and is not open to public inspection.

(4) The length of time in diversion for each participating individual. This information is confidential and is not open to public inspection.

(5) The types of services and supports provided to each individual participating in diversion. This information is confidential and is not open to public inspection.

(6) The number of days each individual was in jail prior to placement in diversion. This information is confidential and is not open to public inspection.

(7) The number of days that each individual spent in each level of care facility. This information is confidential and is not open to public inspection.

(8) The diagnoses of each individual participating in diversion. This information is confidential and is not open to public inspection.

(9) The nature and felony or misdemeanor classification of the charges for each individual participating in diversion. This information is confidential and is not open to public inspection.

(10) The number of individuals who completed diversion.

(11) The name, social security number, CII number, and birth date of each individual who did not complete diversion and the reasons for not completing. This information is confidential and is not open to public inspection.

(h) Contracts awarded pursuant to this chapter are exempt from the requirements contained in the Public Contract Code and the State Administrative Manual and are not subject to approval by the Department of General Services.

(i) The funds shall not be used to supplant existing services or services reimbursable from an available source but rather to expand upon them or support new services for which existing reimbursement may be limited.

(j) (1) Beginning July 1, 2021, subject to appropriation by the Legislature, the department may amend contracts with a county to fund the expansion of an existing department-funded pretrial diversion as described in Chapter 2.8A (commencing with Section 1001.35) of Title 6 of Part 2 of the Penal Code, for the population described in subdivision (b) and that meets both of the following criteria:

(A) All participants identified for potential diversion are found incompetent to stand trial on a felony charge.

(B) Participants diverted through a program expansion suffer from a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, excluding antisocial personality disorder, borderline personality disorder, and pedophilia.

(2) Counties expanding their programs under this section will not be required to meet any additional match funding requirements.

(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the state hospitals and the department may implement, interpret, or make specific this section by means of a departmental letter or other similar instruction, as necessary.

(*l*) The department shall have access to the arrest records and state summary of criminal history of defendants who are participating or have participated in the diversion program. The information may be used solely for the purpose of looking at the recidivism rate for those patients.

(m) If the defendant is committed directly to a county program in lieu of commitment to the department, counties shall provide the minute order from the court documenting the incompetent to stand trial finding on a felony charge and the original alienist evaluation associated with that finding.

(n) For department-funded diversion programs funded through appropriations made by the Budget Act of 2018 or new county programs funded through the Budget Act of 2021, participants in those county programs may include individuals diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder, who are likely to be found incompetent to stand trial for felony charges, pursuant to Section 1368 of the Penal Code, or who have been found incompetent to stand trial pursuant to clause (iv) of subparagraph (B) of paragraph (1) of subdivision (a) of Section 1370 of the Penal Code, until new funds are dispersed to the county. Counties shall continue to comply with all terms of the contract signed with the department, including matching fund and data reporting requirements.

SEC. 57. Section 4361.7 is added to the Welfare and Institutions Code, to read:

4361.7. (a) Subject to an appropriation by the Legislature for this express purpose, the department may contract for medical, evaluation, and other services as necessary to facilitate early access to treatment for individuals in county jails who have been deemed incompetent to stand trial on a felony charge.

(b) County jails shall allow the department and any of its contractors or designees reasonable access to its facilities and individuals deemed incompetent to stand trial on a felony charge to provide early access treatment.

(c) The department may petition for and participate in involuntary medication hearings pursuant to Section 1370 of the Penal Code for individuals housed in county jails who are being treated by department employees or contractors. Nothing in this section shall remove the ability or responsibility of a jail to utilize existing authority to seek an involuntary medication order for individuals or to provide other medical or mental health care.

(d) Contracts awarded pursuant to this chapter are exempt from the requirements contained in Section 19130 of the Government Code, the Public Contract Code, Section 4101.5 of this code, and the State Administrative Manual. These contracts are not subject to approval by the Department of General Services.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of a departmental letter or other similar instruction, as necessary.

SEC. 58. Section 5325.3 is added to the Welfare and Institutions Code, to read:

5325.3. (a) For purposes of administering antipsychotic medications to a person admitted as a voluntary patient, as described in Section 850 of Title 9 of the California Code of Regulations, or any successor regulation, who consents to receiving those medications, as part of specialty mental health services covered under Medi-Cal or as part of community mental health services, a health facility, or a facility that has a community residential treatment program pursuant to Article 1 (commencing with Section 5670) of Chapter 2.5 of Part 2, shall not be required to obtain the signature of that patient.

(b) For a patient described in subdivision (a), the facility shall maintain a written record containing both of the following:

(1) A notation that the information about informed consent to antipsychotic medications as described in subdivisions (a) to (f), inclusive, of Section 851 of Title 9 of the California Code of Regulations, or any successor regulations, has been discussed with the patient by the prescribing physician.

(2) A notation that the patient understands the nature and effect of the antipsychotic medications and consents to the administration of those medications.

(c) For purposes of this section, "health facility" has the same meaning as set forth in Section 1250 of the Health and Safety Code, except for subdivisions (c), (d), (e), (g), (h), (k), and (m) of that section.

(d) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific this section, in whole or in part, by means of information notices or other similar instructions, without taking any further regulatory action. The notice or other similar instruction shall supersede Section 852 of Title 9 of the California Code of Regulations.

(2) The department may amend, adopt, or repeal regulations for purposes of implementing this section in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 59. Section 5328 of the Welfare and Institutions Code is amended to read:

5328. (a) All information and records obtained in the course of providing services under Division 4 (commencing with Section 4000), Division 4.1 (commencing with Section 4400), Division 4.5 (commencing with Section 4500), Division 5 (commencing with Section 5000), Division 6 (commencing with Section 6000), or Division 7 (commencing with Section 7100), to either voluntary or involuntary recipients of services are confidential. Information and records obtained in the course of providing similar services to either voluntary or involuntary recipients before 1969 are also confidential. Information and records shall be disclosed only in any of the following cases:

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

(2) If the patient, with the approval of the physician and surgeon, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, or licensed professional clinical counselor, who is in charge of the patient, designates persons to whom information or records may be released, except that this article does not compel a physician and surgeon, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, licensed professional clinical counselor, nurse, attorney, or other professional person to reveal information that has been given to the person in confidence by members of a patient's family. This paragraph does not authorize a licensed marriage and family therapist or licensed professional clinical counselor to provide services or to be in charge of a patient's care beyond the therapist's or counselor's lawful scope of practice.

(3) To the extent necessary for a recipient to make a claim, or for a claim to be made on behalf of a recipient for aid, insurance, or medical assistance to which the recipient may be entitled.

(4) If the recipient of services is a minor, ward, dependent, or conservatee, and the recipient's parent, guardian, guardian ad litem, conservator, or authorized representative designates, in writing, persons to whom records or information may be disclosed, except that this article does not compel a physician and surgeon, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, licensed professional clinical counselor, nurse, attorney, or other professional person to reveal information that has been given to the person in confidence by members of a patient's family.

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

_____

Date

As a condition of doing research concerning persons who have received services from ____ (fill in the facility, agency, or person), I, ____, agree to obtain the prior informed consent of those persons who have received services to the maximum degree possible as determined by the appropriate institutional review board or boards for protection of human subjects reviewing my research, and I further agree not to divulge any information obtained in the course of that research to unauthorized persons, and not to publish or otherwise make public any information regarding persons who have received services such that the person who received services is identifiable.

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

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

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

(8) To the Senate Committee on Rules or the Assembly Committee on Rules for the purposes of legislative investigation authorized by the committee.

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

(10) To the attorney for the patient in any and all proceedings upon presentation of a release of information signed by the patient, except that when the patient is unable to sign the release, the staff of the facility, upon satisfying itself of the identity of the attorney, and of the fact that the attorney does represent the interests of the patient, may release all information and records relating to the patient, except that this article does not compel a physician and surgeon, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, licensed professional clinical counselor, nurse, attorney, or other professional person to reveal information that has been given to the person in confidence by members of a patient's family.

(11) Upon written agreement by a person previously confined in or otherwise treated by a facility, the professional person in charge of the facility or the professional person's designee may release any information, except information that has been given in confidence by members of the person's family, requested by a probation officer charged with the evaluation of the person after the person's conviction of a crime if the professional person in charge of the facility determines that the information is relevant to the evaluation. The agreement shall only be operative until sentence is passed on the crime of which the person was convicted. The confidential information released pursuant to this paragraph shall be transmitted to the court separately from the probation report and shall not be placed in the probation report. The confidential information shall remain confidential except for purposes of sentencing. After sentencing, the confidential information shall be sealed.

(12) (A) Between persons who are trained and qualified to serve on multidisciplinary personnel teams pursuant to subdivision (d) of Section 18951. The information and records sought to be disclosed shall be relevant to the provision of child welfare services or the investigation, prevention, identification, management, or treatment of child abuse or neglect pursuant to Chapter 11 (commencing with Section 18950) of Part 6 of Division 9. Information obtained pursuant to this paragraph shall not be used in any criminal or delinquency proceeding. This paragraph does not prohibit evidence identical to that contained within the records from being admissible in a criminal or delinquency proceeding, if the evidence is derived solely from means other than this paragraph, as permitted by law.

(B) As used in this paragraph, "child welfare services" means those services that are directed at preventing child abuse or neglect.

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

(14) To a committee established in compliance with Section 14725.

(15) In providing information as described in Section 7325.5. This paragraph does not permit the release of any information other than that described in Section 7325.5.

(16) To the county behavioral health director or the director's designee, or to a law enforcement officer, or to the person designated by a law enforcement agency, pursuant to Sections 5152.1 and 5250.1.

(17) If the patient gives consent, information specifically pertaining to the existence of genetically handicapping conditions, as defined in Section 125135 of the Health and Safety Code, may be released to qualified professional persons for purposes of genetic counseling for blood relatives upon request of the blood relative. For purposes of this paragraph, "qualified professional persons" means those persons with the qualifications necessary to carry out the genetic counseling duties under this paragraph as determined by the genetic disease unit established in the State Department of Health Care Services under Section 125000 of the Health and Safety Code. If the patient does not respond or cannot respond to a request for permission to release information pursuant to this paragraph after reasonable attempts have been made over a two-week period to get a response, the information may be released upon request of the blood relative.

(18) If the patient, in the opinion of the patient's psychotherapist, presents a serious danger of violence to a reasonably foreseeable victim or victims, then any of the information or records specified in this section may be released to that person or persons and to law enforcement agencies and county child welfare agencies as the psychotherapist determines is needed for the protection of that person or persons. For purposes of this paragraph, "psychotherapist" has the same meaning as provided in Section 1010 of the Evidence Code.

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

(B) For purposes of this paragraph, "designated officer" and "emergency response employee" have the same meaning as these terms are used in the federal Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (Public Law 101-381; 42 U.S.C. Sec. 201).

(C) The designated officer shall be subject to the confidentiality requirements specified in Section 120980 of the Health and Safety Code, and may be personally liable for unauthorized release of any identifying information about the HIV results. Further, the designated officer shall inform the exposed emergency response employee that the employee is also subject to the confidentiality requirements specified in Section 120980 of the Health and Safety Code, and may be personally liable for unauthorized release of any identifying information about the HIV test results.

(20) (A) To a law enforcement officer who personally lodges with a facility, as defined in subparagraph (B), a warrant of arrest or an abstract of a warrant showing that the person sought is wanted for a serious felony, as defined in Section 1192.7 of the Penal Code, or a violent felony, as defined in Section 667.5 of the Penal Code. The information sought and released shall be limited to whether or not the person named in the arrest warrant is

presently confined in the facility. This subparagraph shall be implemented with minimum disruption to health facility operations and patients, in accordance with Section 5212. If the law enforcement officer is informed that the person named in the warrant is confined in the facility, the officer may not enter the facility to arrest the person without obtaining a valid search warrant or the permission of staff of the facility.

(B) For purposes of subparagraph (A), a facility means all of the following:

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

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

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

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

(v) A mental health rehabilitation center, as described in Section 5675.

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

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

(22) (A) When an employee is served with a notice of adverse action, as defined in Section 19570 of the Government Code, all of the following information and records may be released:

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

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

(iii) The information described in clauses (i) and (ii) may be released only if both of the following conditions are met:

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

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

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

(ib) Requires the employee and the employee's legal representative to return to the appointing authority all records provided to them under this paragraph, including, but not limited to, all records and documents from any source containing confidential information protected by this section, and all copies of those records and documents, within 10 days of the date that the adverse action becomes final, except for the actual records and documents or copies thereof that are no longer in the possession of the employee or the employee's legal representative because they were submitted to the administrative tribunal as a component of an appeal from the adverse action.

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

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

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

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

(E) For purposes of this paragraph, an adverse action becomes final when the employee fails to answer within the time specified in Section 19575 of the Government Code, or, after filing an answer, withdraws the appeal, or,

upon exhaustion of the administrative appeal or of the judicial review remedies as otherwise provided by law.

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

(24) During the provision of emergency services and care, as defined in Section 1317.1 of the Health and Safety Code, the communication of patient information between a physician and surgeon, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, licensed professional clinical counselor, nurse, emergency medical personnel at the scene of an emergency or in an emergency medical transport vehicle, or other professional person or emergency medical personnel at a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(25) To a business associate or for health care operations purposes, in accordance with Part 160 (commencing with Section 160.101) and Part 164 (commencing with Section 164.102) of Subchapter C of Subtitle A of Title 45 of the Code of Federal Regulations.

(26) To authorized personnel who are employed by the California Victim Compensation Board for the purposes of verifying the identity and eligibility of individuals claiming compensation pursuant to the Forced or Involuntary Sterilization Compensation Program described in Chapter 1.6 (commencing with Section 24210) of Division 20 of the Health and Safety Code. The California Victim Compensation Board shall maintain the confidentiality of any information or records received from the department in accordance with Part 160 (commencing with Section 160.101) and Part 164 (commencing with Section 164.102) of Subchapter C of Subtitle A of Title 45 of the Code of Federal Regulations and this section. Public disclosure of aggregated claimant information or the annual report required under subdivision (b) of Section 24211 of the Health and Safety Code is not a violation of this section.

(27) To parties to a judicial or administrative proceeding as permitted by law, and who satisfy the requirements under Part 164 (commencing with Section 164.512(e)) of Subchapter C of Subtitle A of Title 45 of the Code of Federal Regulations, except that this paragraph shall not be construed to affect any rights or privileges provided under law of any party or nonparty.

(b) Notwithstanding subdivision (a), patient information and records may, as necessary, be provided to and discussed with district attorneys for purposes of commitment, recommitment, or petitions for release proceedings for patients committed under Sections 1026, 1370, 1600, 2962, and 2972 of the Penal Code and Section 6600 of this code.

(c) The amendment of paragraph (4) of subdivision (a) enacted at the 1970 Regular Session of the Legislature does not constitute a change in, but is declaratory of, the preexisting law.

(d) This section is not limited by Section 5150.05 or 5332.

SEC. 60. Section 5848.5 of the Welfare and Institutions Code is amended to read:

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

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

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

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

(4) Recent reports have called attention to a continuing problem of inappropriate and unnecessary utilization of hospital emergency rooms in California due to limited community-based services for individuals in psychological distress and acute psychiatric crisis. Hospitals report that 70 percent of people taken to emergency rooms for psychiatric evaluation can be stabilized and transferred to a less intensive level of crisis care. Law enforcement personnel report that their personnel need to stay with people in the emergency room waiting area until a placement is found, and that less intensive levels of care tend not to be available.

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

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

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

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

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

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

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

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

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

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

(8) Provide a complete continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state. The funds included in the 2016 Budget Act for the purpose of developing the continuum of mental health crisis services for children and youth 21 years of age and under shall be for the following objectives:

(A) Provide a continuum of crisis services for children and youth 21 years of age and under, regardless of where they live in the state.

(B) Provide for early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.

(C) Expand the continuum of community-based services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness-, resiliency-, and recovery-oriented.

(D) Add at least 200 mobile crisis support teams.

(E) Add at least 120 crisis stabilization services and beds and crisis residential treatment beds to increase capacity at the local level to improve access to mental health crisis services and address unmet mental health care needs.

(F) Add triage personnel to provide intensive case management and linkage to services for individuals with mental health care disorders at various points of access, such as at designated community-based service points, homeless shelters, schools, and clinics.

(G) Expand family respite care to help families and sustain caregiver health and well-being.

(H) Expand family supportive training and related services designed to help families participate in the planning process, access services, and navigate programs.

(I) Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services.

(J) Reduce recidivism and mitigate unnecessary expenditures of local law enforcement.

(K) Provide local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for children and youth 21 years of age and under with mental health disorders.

(c) Through appropriations provided in the annual Budget Act for this purpose, it is the intent of the Legislature to authorize the California Health Facilities Financing Authority, hereafter referred to as the authority, and the Mental Health Services Oversight and Accountability Commission, hereafter referred to as the commission, to administer competitive selection

processes or a sole-source contracting process as provided in this section for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, and specified personnel resources.

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

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

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

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

(C) Crisis residential treatment, as authorized by Sections 14021.4, 14680, and 14684 and as provided at a children's crisis residential program, as defined in Section 1502 of the Health and Safety Code.

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

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

(2) The authority shall develop selection criteria to expand local resources, including those described in paragraph (1), and processes for awarding grants after consulting with representatives and interested stakeholders from the mental health community, including, but not limited to, the County Behavioral Health Directors Association of California, service providers, consumer organizations, and other appropriate interests, such as health care providers and law enforcement, as determined by the authority. The authority shall ensure that grants result in cost-effective expansion of the number of community-based crisis resources in regions and communities selected for funding. The authority shall also take into account at least the following criteria and factors when selecting recipients of grants and determining the amount of grant awards:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before May 1, 2014, and on or before May 1, 2015,

on the progress of implementation, that include, but are not limited to, the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

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

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(10) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

(e) Of the funds specified in paragraph (8) of subdivision (b), it is the intent of the Legislature to authorize the authority to administer competitive selection processes as provided in this section for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, family respite care, family supportive training and related services, and triage personnel resources for children and youth 21 years of age and under.

(f) Funds appropriated by the Legislature to the authority to address crisis services for children and youth 21 years of age and under for the purposes of this section shall be made available to selected counties or counties acting jointly. The authority may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively support this designation and collaboration in lieu of a county government directly receiving grant funds.

(1) Grant awards made by the authority shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase capacity for client assistance and crisis services for children and youth 21 years of age and under in the following areas:

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

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

(C) Crisis residential treatment, as authorized by Sections 14021.4, 14680, and 14684 and as provided at a children's crisis residential program, as defined in Section 1502 of the Health and Safety Code.

(D) Mobile crisis support teams, including the purchase of equipment and vehicles.

(E) Family respite care.

(2) The authority shall develop selection criteria to expand local resources, including those described in paragraph (1), and processes for awarding grants after consulting with representatives and interested stakeholders from the mental health community, including, but not limited to, county mental health directors, service providers, consumer organizations, and other appropriate interests, such as health care providers and law enforcement,

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

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

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

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

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

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

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

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

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

(I) Ability to measure key outcomes, including utilization of services, health and mental health outcomes, and cost benefit of the project.

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

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

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

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

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

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

(9) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before January 10, 2018, and annually thereafter, on the progress of implementation, that include, but are not limited to, the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

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

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(10) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

(g) Funds appropriated by the Legislature to the commission for purposes of this section shall be allocated to support crisis prevention, early intervention, and crisis response strategies, as determined by the commission with input from peers, county behavioral health agencies, community-based organizations, and others. In allocating these funds, the commission shall consult with the California Health and Human Services Agency and other state agencies as needed, in order to leverage existing funds and share best practices, and shall take into consideration data on populations at risk for experiencing a mental health crisis, including the needs of early childhood, children and youth, transition-age youth, adults, and older adults. These funds shall be made available to selected entities, including, but not limited to, counties, counties acting jointly, city mental health departments, other local governmental agencies and community-based organizations such as health care providers, hospitals, health systems, childcare providers, early childhood education providers, and other entities, as determined by the commission through a competitive selection process or a sole-source process, as determined by the commission. The commission may utilize a sole-source process when it determines, during a public hearing, that it is in the public interest to do so and would address barriers to participation for local governmental agencies, including small counties, other local agencies, and community-based organizations, or is aligned with the goals of this section. It is the intent of the Legislature for these funds to be allocated in an efficient

manner to encourage prevention, early intervention, and receipt of needed services for individuals with mental health needs, or who are at risk of needing crisis services, and to assist in navigating the local service sector to improve efficiencies and the delivery of services. The commission shall consider existing data sources for populations who are at higher risk for experiencing a mental health crisis when allocating these funds.

(1) Funding may be used to support services, supports, education, and training that are offered in person, by telephone, by videoconference, or by telehealth with the individual in need of assistance, their significant support person, or others, and may be provided anywhere in the community. These service and related activities may include, but are not limited to, the following:

(A) Communication, coordination, and referral.

(B) Monitoring service delivery to ensure the individual accesses and receives services.

(C) Monitoring the individual's progress.

(D) Providing placement service assistance and service plan development.

(E) Education and training.

(F) Innovative, best practice, evidence-based, and related approaches to support crisis prevention, early intervention, and crisis response.

(2) The commission shall take into account at least the following criteria and factors when selecting recipients and determining the amount of grant awards as follows:

(A) Description of need, including potential gaps in local service connections.

(B) Description of funding request, including use of peers and peer support.

(C) Description of how funding will be used to facilitate linkage and access to services, including objectives and anticipated outcomes.

(D) Ability to obtain federal Medicaid reimbursement, when applicable.

(E) Ability to administer an effective service program and the degree to which local agencies and service providers will support and collaborate with the effort.

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

(3) The commission shall determine maximum grant awards, and shall take into consideration the level of need, population to be served, and related criteria, as described in paragraph (2), and shall reflect reasonable costs.

(4) Funds awarded by the commission for purposes of this section may be used to supplement, but not supplant, existing financial and resource commitments of the entities that receive the grant.

(5) Notwithstanding any other law, a county, counties acting jointly, a city mental health department, a community-based organization, or other entity that receives an award of funds for the purpose of supporting crisis prevention, early intervention, and crisis response strategies pursuant to this

subdivision may be required to provide a matching contribution of local funds. The commission may, at its discretion, allow and approve grants that include matching funds, in whole or in part, to enhance the impact of limited public funding. Matching fund requirements shall not be designed in a manner that will prevent participation from local agencies, community-based organizations, or other entities that are eligible to participate in the funding opportunities created by this section.

(6) Notwithstanding any other law, the commission, without taking any further regulatory action, may implement, interpret, or make specific this section by means of informational letters, bulletins, or similar instructions.

SEC. 61. Section 5961.5 of the Welfare and Institutions Code is amended to read:

5961.5. (a) As a component of the initiative, the State Department of Health Care Services shall develop and select evidence-based interventions and community-defined promising practices to improve outcomes for children and youth with, or at high risk for, behavioral health conditions.

(b) Prior to selecting the evidence-based interventions, as described in subdivision (a), the department shall establish a workgroup comprised of subject matter experts and affected stakeholders to consider evidence-based interventions based on robust evidence for effectiveness, impact on racial equity, and sustainability.

(c) The department, or its contracted vendor, shall provide competitive grants to entities it deems qualified to support the implementation of the evidence-based interventions and community-defined promising practices developed pursuant to subdivision (a).

(d) Subject to subdivision (e), entities eligible to receive grants pursuant to this section may include Medi-Cal behavioral health delivery systems, city mental health authorities, tribal entities, health care service plans, Medi-Cal managed care plans, community-based organizations, and behavioral health providers.

(e) The department shall determine the eligibility criteria, grant application process, and methodology for the distribution of funds appropriated for the purposes described in this section to those entities it deems qualified.

(f) As a condition of funding, grant recipients shall share standardized data, in a manner and form determined by the department.

(g) For purposes of this section, “Medi-Cal behavioral health delivery system” shall have the same meaning as specified in subdivision (i) of Section 14184.101.

SEC. 62. Section 7276 of the Welfare and Institutions Code is amended to read:

7276. (a) The charge for the care and treatment of all persons who have mental health disorders at state hospitals for whom there is liability to pay therefor shall be determined pursuant to Section 4025. The Director of State Hospitals, or the director’s designee, may reduce, cancel, or remit the amount to be paid by the estate liable for the care and treatment of a person who has a mental health disorder and who is a patient at a state hospital, on

satisfactory proof that the estate is unable to pay the cost of that care and treatment or that the amount is uncollectible. If there has been a payment under this section, and the payment or any part thereof is refunded because of the death, leave of absence, or discharge of a patient of the hospital, that amount shall be paid by the hospital or the State Department of State Hospitals to the person who made the payment upon demand, and in the statement to the Controller the amounts refunded shall be itemized and the aggregate deducted from the amount to be paid into the State Treasury, as provided by law. If a person dies at any time while their estate is liable for their care and treatment at a state hospital, the claim for the amount due may be presented to the executor or administrator of their estate, and paid as a preferred claim, with the same rank in order of preference, as claims for expenses of last illness.

(b) (1) The State Department of State Hospitals shall develop and implement a financial assistance program that may reduce or cancel the amount that a patient owes for the cost of care and treatment. The financial assistance program shall provide a process for a patient to apply for financial assistance and the criteria used by the department to determine whether a patient is eligible for a waiver of all costs or discounted payment. The determination of need for financial assistance shall be based upon criteria set forth by the department.

(2) Criteria in determining a patient's eligibility for the financial assistance program shall be based on a patient's income, including their monetary assets. If the patient's income is determined to be at or below 300 percent of the federal poverty level, the patient shall be granted full relief of their cost of care and treatment.

(3) (A) If a patient does not qualify for full relief pursuant to paragraph (2), there shall be a sliding scale of debt relief for patients with an income above 300 percent of the federal poverty level, including payment plans.

(B) The department may develop reasonable payment plans suitable to the patient's ability to pay, as determined through the department's review of an application for financial assistance.

(C) The department and the patient shall negotiate the terms of the payment plan and take into consideration the patient's income, public benefit participation, employment and banking information, or other income to assess against the federal poverty level, as well as liabilities, including, but not limited to, child support, restitution, and essential living expenses. The department shall make all reasonable efforts to determine a patient's ability to pay.

(D) If the department and the patient cannot agree on the payment plan, the department shall use the reasonable payment plan described in subdivision (i) of Section 127400 of the Health and Safety Code.

(4) The department shall make its financial assistance program policy available to the public on the department's internet website.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may

implement, interpret, or make specific this section by means of a departmental letter or other similar instruction, as necessary.

SEC. 63. Section 7279 of the Welfare and Institutions Code is amended to read:

7279. If any person committed to a state mental hospital has sufficient estate for the purpose, the guardian or conservator of the person's estate shall pay for the person's care, support, maintenance, and necessary expenses at the state hospital to the extent the estate is available after taking into account essential living expenses and other financial liabilities. The payment may be enforced by the order of the judge of the superior court where the guardianship or conservatorship proceedings are pending. On the filing of a petition therein by the department showing that the guardian or conservator has failed, refused, or neglected to pay for that care, support, maintenance, and expenses, the court, by order, shall direct the payment by the guardian or conservator. The order may be enforced in the same manner as are other orders of the court.

SEC. 64. Section 7281 of the Welfare and Institutions Code is amended to read:

7281. There is at each institution under the jurisdiction of the State Department of State Hospitals and at each institution under the jurisdiction of the State Department of Developmental Services, a fund known as the patients' personal deposit fund. Any funds coming into the possession of the superintendent, belonging to any patient in that institution, shall be deposited in the name of that patient in the patients' personal deposit fund, except that if a guardian or conservator of the estate is appointed for the patient then the guardian or conservator shall have the right to demand and receive the funds. Only for patients at an institution under the jurisdiction of the State Department of Developmental Services, whenever the sum belonging to any one patient, deposited in the patients' personal deposit fund, exceeds the sum of five hundred dollars ($500), the excess may be applied to the payment of the care, support, maintenance, and medical attention of the patient. After the death of the patient, any sum remaining in the patient's personal deposit account in excess of burial costs may be applied for payment of care, support, maintenance, and medical attention. Any of the funds belonging to a patient deposited in the patients' personal deposit fund may be used for the purchase of personal incidentals for the patient or may be applied in an amount not exceeding five hundred dollars ($500) to the payment of the patient's burial expenses.

SEC. 65. Section 7284 of the Welfare and Institutions Code is repealed.

SEC. 66. Section 7285 of the Welfare and Institutions Code is repealed.

SEC. 67. Section 7286 of the Welfare and Institutions Code is repealed.

SEC. 68. Section 7287 of the Welfare and Institutions Code is repealed.

SEC. 69. Section 7290 of the Welfare and Institutions Code is amended to read:

7290. The State Department of Developmental Services may enter into a special agreement, secured by a properly executed bond, with the relatives, guardian, conservator, or friend of any patient for the patient's care, support,

maintenance, or other expenses at the institution. The agreement and bond shall be to the people of the State of California and action to enforce the same may be brought by the department. All charges due under this section, including the monthly rate for the patient's care and treatment, as established by or pursuant to law, shall be collected monthly. No patient, however, shall be permitted to occupy more than one room in any state institution.

SEC. 70. Section 7291 of the Welfare and Institutions Code is repealed.

SEC. 71. Section 7292 of the Welfare and Institutions Code is repealed.

SEC. 72. Section 14005.12 of the Welfare and Institutions Code is amended to read:

14005.12. (a) For the purposes of Sections 14005.4 and 14005.7, the department shall establish the income levels for maintenance need at the lowest levels that reasonably permit medically needy persons to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under Title XIX of the federal Social Security Act. It is the intent of the Legislature that the income levels for maintenance need for medically needy aged, blind, and disabled adults, in particular, shall be based upon amounts that adequately reflect their needs.

(1) Subject to paragraph (2), reductions in the maximum aid payment levels set forth in subdivision (a) of Section 11450 in the 1991–92 fiscal year, and thereafter, shall not result in a reduction in the income levels for maintenance under this section.

(2) (A) The department shall seek any necessary federal authorization for maintaining the income levels for maintenance at the levels in effect June 30, 1991.

(B) If federal authorization is not obtained, medically needy persons shall not be required to pay the difference between the share of cost as determined based on the payment levels in effect on June 30, 1991, under Section 11450, and the share of cost as determined based on the payment levels in effect on July 1, 1991, and thereafter.

(3) Any medically needy person who was eligible for benefits under this chapter as categorically needy for the calendar month immediately preceding the effective date of the reductions in the minimum basic standards of adequate care for the Aid to Families with Dependent Children program as set forth in Section 11452.018 made in the 1995–96 Regular Session of the Legislature shall not be responsible for paying their share of cost if all of the following apply:

(A) The person had eligibility as categorically needy terminated by the reductions in the minimum basic standards of adequate care.

(B) The person, but for the reductions, would be eligible to continue receiving benefits under this chapter as categorically needy.

(C) The person is ineligible to receive benefits without a share of cost as a medically needy person pursuant to paragraph (1) or (2).

(b) In the case of a single individual, the amount of the income level for maintenance per month shall be 80 percent of the highest amount that would ordinarily be paid to a family of two persons, without any income or

resources, under subdivision (a) of Section 11450, multiplied by the federal financial participation rate.

(c) In the case of a family of two adults, the income level for maintenance per month shall be the highest amount that would ordinarily be paid to a family of three persons without income or resources under subdivision (a) of Section 11450, multiplied by the federal financial participation rate.

(d) For the purposes of Sections 14005.4 and 14005.7, for a person in a medical institution or nursing facility, or for a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization pursuant to Chapter 8.75 (commencing with Section 14591), the amount considered as required for maintenance per month shall be computed in accordance with, and for those purposes required by, Title XIX of the federal Social Security Act, and regulations adopted pursuant thereto. Those amounts shall be computed pursuant to regulations that include providing for the following purposes:

(1) Personal and incidental needs in the amount of not less than thirty-five dollars ($35) per month while a patient. The department may, by regulation, increase this amount as necessitated by increasing costs of personal and incidental needs. A long-term health care facility shall not charge an individual for the laundry services or periodic hair care specified in Section 14110.4.

(2) The upkeep and maintenance of the home.

(3) The support and care of their minor children, or any disabled relative for whose support they have contributed regularly, if there is no community spouse.

(4) If the person is an institutionalized spouse, for the support and care of their community spouse, minor or dependent children, dependent parents, or dependent siblings of either spouse, provided the individuals are residing with the community spouse.

(5) The community spouse monthly income allowance shall be established at the maximum amount permitted in accordance with Section 1924(d)(1)(B) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(B)).

(6) The family allowance for each family member residing with the community spouse shall be computed in accordance with the formula established in Section 1924(d)(1)(C) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(C)).

(e) For the purposes of Sections 14005.4 and 14005.7, with regard to a person in a licensed community care facility, the amount considered as required for maintenance per month shall be computed pursuant to regulations adopted by the department that provide for the support and care of their spouse, minor children, or any disabled relative for whose support they have contributed regularly.

(f) The income levels for maintenance per month, except as specified in subdivisions (b) to (d), inclusive, shall be equal to the highest amounts that would ordinarily be paid to a family of the same size without any income

or resources under subdivision (a) of Section 11450, multiplied by the federal financial participation rate.

(g) The "federal financial participation rate," as used in this section, shall mean 133 ⅓ percent, or such other rate set forth in Section 1903 of the federal Social Security Act (42 U.S.C. Sec. 1396(b)), or its successor provisions.

(h) The income levels for maintenance per month shall not be decreased to reflect the presence in the household of persons receiving forms of aid other than Medi-Cal.

(i) When family members maintain separate residences, but eligibility is determined as a single unit under Section 14008, the income levels for maintenance per month shall be established for each household in accordance with subdivisions (b) to (h), inclusive. The total of these levels shall be the level for the single eligibility unit.

(j) The income levels for maintenance per month established pursuant to subdivisions (b) to (i), inclusive, shall be calculated on an annual basis, rounded to the next higher multiple of one hundred dollars ($100), and then prorated.

(k) If the conditions described in paragraph (2) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the department pursuant to paragraph (3) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 73. Section 14005.12 is added to the Welfare and Institutions Code, to read:

14005.12. (a) For the purposes of Sections 14005.4 and 14005.7, the department shall establish the income levels for maintenance need at the lowest levels that reasonably permit medically needy persons to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under Title XIX of the federal Social Security Act. It is the intent of the Legislature that the income levels for maintenance need for medically needy aged, blind, and disabled adults, in particular, shall be based upon amounts that adequately reflect their needs.

(1) Subject to paragraph (2), reductions in the maximum aid payment levels set forth in subdivision (a) of Section 11450 in the 1991–92 fiscal year, and thereafter, shall not result in a reduction in the income levels for maintenance under this section.

(2) (A) The department shall seek any necessary federal authorization for maintaining the income levels for maintenance at the levels in effect June 30, 1991, and, commencing no sooner than January 1, 2025, as described in subdivision (b).

(B) If federal authorization is not obtained, medically needy persons shall not be required to pay the difference between the share of cost as determined based on the payment levels in effect on June 30, 1991, under

Section 11450, and the share of cost as determined based on the payment levels in effect on July 1, 1991, and thereafter.

(3) Any medically needy person who was eligible for benefits under this chapter as categorically needy for the calendar month immediately preceding the effective date of the reductions in the minimum basic standards of adequate care for the Aid to Families with Dependent Children program as set forth in Section 11452.018 made in the 1995–96 Regular Session of the Legislature shall not be responsible for paying their share of cost if all of the following apply:

(A) The person had eligibility as categorically needy terminated by the reductions in the minimum basic standards of adequate care.

(B) The person, but for the reductions, would be eligible to continue receiving benefits under this chapter as categorically needy.

(C) The person is ineligible to receive benefits without a share of cost as a medically needy person pursuant to paragraph (1) or (2).

(b) (1) Effective no sooner than January 1, 2025, and to the extent the department determines the conditions described in paragraph (2) have been met, the amount of the income level for maintenance per month shall be equal to the income limit for Medi-Cal without a share of cost for individuals described in Section 1396a(m)(1)(A) of Title 42 of the United States Code, as that income limit is calculated pursuant to paragraph (3) of subdivision (c) of Section 14005.40.

(2) Implementation of this section is contingent on both of the following conditions:

(A) All necessary federal approvals have been obtained by the department.

(B) The Legislature has appropriated funding to implement this section after a determination that ongoing General Fund resources are available to support the ongoing implementation of this section in the 2024–25 fiscal year and subsequent fiscal years.

(3) The department shall issue a declaration certifying the date that all conditions in paragraph (2) have been met. The department shall post the declaration on its internet website and provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(c) For the purposes of Sections 14005.4 and 14005.7, for a person in a medical institution or nursing facility, or for a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization pursuant to Chapter 8.75 (commencing with Section 14591), the amount considered as required for maintenance per month shall be computed in accordance with, and for those purposes required by, Title XIX of the federal Social Security Act, and regulations adopted pursuant thereto. Those amounts shall be computed pursuant to regulations that include providing for the following purposes:

(1) Personal and incidental needs in the amount of not less than thirty-five dollars ($35) per month while a patient. The department may, by regulation, increase this amount as necessitated by increasing costs of personal and incidental needs. A long-term health care facility shall not charge an

individual for the laundry services or periodic hair care specified in Section 14110.4.

(2) The upkeep and maintenance of the home.

(3) The support and care of their minor children, or any disabled relative for whose support they have contributed regularly, if there is no community spouse.

(4) If the person is an institutionalized spouse, for the support and care of their community spouse, minor or dependent children, dependent parents, or dependent siblings of either spouse, provided the individuals are residing with the community spouse.

(5) The community spouse monthly income allowance shall be established at the maximum amount permitted in accordance with Section 1924(d)(1)(B) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(B)).

(6) The family allowance for each family member residing with the community spouse shall be computed in accordance with the formula established in Section 1924(d)(1)(C) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396r-5(d)(1)(C)).

(d) For the purposes of Sections 14005.4 and 14005.7, with regard to a person in a licensed community care facility, the amount considered as required for maintenance per month shall be computed pursuant to regulations adopted by the department that provide for the support and care of their spouse, minor children, or any disabled relative for whose support they have contributed regularly.

(e) The income levels for maintenance per month shall not be decreased to reflect the presence in the household of persons receiving forms of aid other than Medi-Cal.

(f) When family members maintain separate residences, but eligibility is determined as a single unit under Section 14008, the income levels for maintenance per month shall be established for each household in accordance with subdivisions (b) to (e), inclusive. The total of these levels shall be the level for the single eligibility unit.

(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-county letters, provider bulletins or notices, policy letters, or other similar instructions, without taking any further regulatory action. Within two calendar years of implementing subdivision (d) of Section 14005.12, the department shall adopt, amend, or repeal any necessary regulations.

(h) This section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (3) of subdivision (b), whichever is later.

SEC. 74. Section 14005.13 of the Welfare and Institutions Code is amended to read:

14005.13. (a) Notwithstanding Section 14005.12, when an individual residing in a long-term care facility would incur a share of cost for services under this chapter due to income that exceeds that allowed for the incidental

and personal needs of the individual, a specified portion of the individual's earned income from therapeutic wages shall be exempt. Therapeutic wages are wages earned by the individual under all of the following conditions:

(1) A physician who does not have a financial interest in the long-term care facility in which the individual resides, and who is in charge of the individual's case, prescribes work as therapy for the individual.

(2) The individual must be employed within the same long-term care facility where they reside.

(3) The individual's employment does not displace any existing employees.

(4) The individual has resided in a long-term care facility for a continuous period commencing at least five years prior to the date of the addition of this section as originally adopted during the 1983–84 Regular Session.

(b) The amount of earned income from therapeutic wages that shall be exempt shall be the lesser of 70 percent of the gross therapeutic wages or 70 percent of the maintenance level for a noninstitutionalized person or family of corresponding size as described in subdivision (b), (c), or (e) of Section 14005.12.

(c) The provisions of this section shall be given retroactive effect for the period commencing June 1, 1983.

(d) This section shall not become operative unless and until the necessary waivers are obtained from the United States Department of Health and Human Services.

(e) The director shall adopt regulations implementing this section as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the purposes of the Administrative Procedure Act, the adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted by the department in order to implement this section shall not be subject to the review and approval of the Office of Administrative Law. These regulations shall become effective immediately upon filing with the Secretary of State.

(f) If the conditions described in paragraph (2) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the department pursuant to paragraph (3) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 75. Section 14005.13 is added to the Welfare and Institutions Code, to read:

14005.13. (a) Notwithstanding Section 14005.12, when an individual residing in a long-term care facility would incur a share of cost for services under this chapter due to income that exceeds that allowed for the incidental

and personal needs of the individual, a specified portion of the individual's earned income from therapeutic wages shall be exempt. Therapeutic wages are wages earned by the individual under all of the following conditions:

(1) A physician who does not have a financial interest in the long-term care facility in which the individual resides, and who is in charge of the individual's case, prescribes work as therapy for the individual.

(2) The individual must be employed within the same long-term care facility where they reside.

(3) The individual's employment does not displace any existing employees.

(4) The individual has resided in a long-term care facility for a continuous period commencing at least five years prior to the date of the addition of this section as originally adopted during the 1983–84 Regular Session.

(b) The amount of earned income from therapeutic wages that shall be exempt shall be the lesser of 70 percent of the gross therapeutic wages or 70 percent of the maintenance level as described in subdivision (b) of Section 14005.12.

(c) The provisions of this section shall be given retroactive effect for the period commencing June 1, 1983.

(d) This section shall not become operative unless and until the necessary waivers are obtained from the United States Department of Health and Human Services.

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-county letters, provider bulletins or notices, policy letters, or other similar instructions, without taking any further regulatory action. Within two calendar years of implementing subdivision (d) of Section 14005.12, the department shall adopt, amend, or repeal any necessary regulations.

(f) If the conditions described in paragraph (2) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the department pursuant to paragraph (3) of subdivision (b) of Section 14005.12, as added by Section 73 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 76. Section 14005.22 of the Welfare and Institutions Code is amended to read:

14005.22. (a) A pregnant individual is eligible for full-scope Medi-Cal benefits under Section 435.116(d)(2) of Title 42 of the Code of Federal Regulations if their income is less than or equal to 109 percent of the federal poverty level, and, effective January 1, 2022, less than or equal to 208 percent of the federal poverty level before the application of the 5-percent income disregard pursuant to subdivision (b) of Section 14005.64, as determined, counted, and valued in accordance with the requirements of Section 1396a(e)(14) of Title 42 of the United States Code, as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148)

and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments, and the individual meets all other eligibility requirements.

(b) To the extent permitted by state and federal law, an individual eligible under this section shall be required to enroll in a Medi-Cal managed care health plan in those counties in which a Medi-Cal managed care health plan is available.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted.

(d) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 77. Section 14005.225 of the Welfare and Institutions Code is repealed.

SEC. 78. Section 14005.255 is added to the Welfare and Institutions Code, to read:

14005.255. (a) (1) Notwithstanding Section 14005.25, subject to paragraph (2) and subdivision (d), a child shall be continuously eligible for Medi-Cal up to, five years of age.

(2) A redetermination of Medi-Cal eligibility shall not be conducted before the child reaches five years of age, unless the department or county possesses facts indicating that the family has requested the child's voluntary disenrollment, the child is deceased, the child is no longer a state resident, or the child's original enrollment was based on a state or county error or on fraud, abuse, or perjury attributed to the child or the child's representative.

(b) (1) Implementation of this section is contingent on all of the following conditions:

(A) All necessary federal approvals have been obtained by the department pursuant to subdivision (c).

(B) The Legislature has appropriated funding to implement this section after a determination that ongoing General Fund resources are available to support the ongoing implementation of this section in the 2024–25 fiscal year and subsequent fiscal years.

(C) The department has determined that systems have been programmed to implement this section.

(2) The department shall issue a declaration certifying the date that all conditions in paragraph (1) have been met. The department shall post the declaration on its internet website and provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(c) This section shall be implemented only to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, through all-county letters or similar instructions, without taking any further regulatory action.

(e) This section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (b), whichever is later.

SEC. 79. Section 14005.26 of the Welfare and Institutions Code is amended to read:

14005.26. (a) (1) Except as provided in subdivision (b), the department shall exercise the option pursuant to Section 1902(a)(l0)(A)(ii)(XIV) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIV)) to provide full-scope benefits with no share of cost under this chapter and Chapter 8 (commencing with Section 14200) to optional targeted low-income children pursuant to Section 1905(u)(2)(B) of the federal Social Security Act (42 U.S.C. Sec. 1396d(u)(2)(B)), with family incomes up to and including 200 percent of the federal poverty level. The department shall seek federal approval of a state plan amendment to implement this subdivision.

(2) (A) Pursuant to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)), the department shall adopt the option to use less restrictive income and resource methodologies to exempt all resources and disregard income at or above 200 percent and up to and including 250 percent of the federal poverty level for the individuals described in paragraph (1). The department shall seek federal approval of a state plan amendment to implement this subdivision.

(B) This paragraph shall be inoperative on January 1, 2014.

(b) Effective January 1, 2014, the federal poverty level percentage income eligibility threshold used pursuant to subdivision (c) of Section 14005.64 to determine eligibility for medical assistance under subdivision (a) shall equal 261 percent of the federal poverty level.

(c) For purposes of carrying out the provisions of this section, the department may adopt the option pursuant to Section 1902(e)(13) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(13)) to rely upon findings of the Managed Risk Medical Insurance Board (MRMIB) regarding one or more components of eligibility.

(d) (1) (A) Except as provided in subparagraph (B) and subparagraph (D) of paragraph (2), the department shall exercise the option pursuant to Section 1916A of the federal Social Security Act (42 U.S.C. Sec. 1396o-1) to impose premiums for individuals described in subdivision (a) whose family income has been determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a). The department shall not impose premiums under this subdivision for individuals described in subdivision (a) whose family income has been determined to be at or below 150 percent of the federal poverty level, after application of

the income disregard pursuant to paragraph (2) of subdivision (a). The department shall obtain federal approval for the implementation of this subdivision.

(B) Except as provided in subparagraph (D) of paragraph (2), the department shall impose a premium pursuant to subparagraph (A) for individuals whose family income has been determined to be above 160 percent and up to and including 261 percent of the federal poverty level, as determined, counted, and valued in accordance with the requirements of Section 14005.64.

(2) (A) Monthly premiums imposed under this section shall equal thirteen dollars ($13) per child with a maximum contribution of thirty-nine dollars ($39) per family.

(B) Families that pay three months of required premiums in advance shall receive the fourth consecutive month of coverage with no premium required. For purposes of the discount provided by this subparagraph, family contributions paid in the Healthy Families Program for children transitioned to Medi-Cal pursuant to Section 14005.27 shall be credited as Medi-Cal premiums paid.

(C) Families that pay the required premium by an approved means of electronic funds transfer, including credit card payment, shall receive a 25-percent discount from the required premium. If the department and the Managed Risk Medical Insurance Board determine that it is feasible, the department shall treat an authorization for electronic funds transfer or credit card payment to the Healthy Families Program as an authorization for electronic funds transfer or credit card payment to Medi-Cal.

(D) (i) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this section to the contrary, the department may elect not to impose premiums for an applicable coverage period on individuals whose family income has been determined to be above 160 percent and up to and including 261 percent of the federal poverty level as described in this subdivision.

(ii) If the department elects to not impose premiums for an applicable coverage period pursuant to clause (i) or elects to reinstate such premiums for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.

(e) This section shall be implemented only to the extent that all necessary federal approvals and waivers described in this section have been obtained and the enhanced rate of federal financial participation under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.) is available for targeted low-income children pursuant to that act.

(f) The department shall not enroll targeted low-income children described in this section in the Medi-Cal program until all necessary federal approvals and waivers have been obtained, and no sooner than January 1, 2013.

(g) (1) (A) Except as provided in subparagraph (B), to the extent the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is not fully operational, for the purposes of implementing

this section, for individuals described in subdivision (a) whose family income has been determined to be up to and including 150 percent of the federal poverty level, as determined pursuant to paragraph (2) of subdivision (a), the department shall utilize the budgeting methodology for this population as contained in the November 2011 Medi-Cal Local Assistance Estimate for Medi-Cal county administration costs for eligibility operations.

(B) Effective January 1, 2014, to the extent the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is not fully operational, for purposes of implementing this section for individuals whose family income has been determined to be up to and including 160 percent of the federal poverty level, the department shall utilize the budgeting methodology for this population as contained in the November 2011 Medi-Cal Local Assistance Estimate for Medi-Cal county administration costs for eligibility operations.

(2) (A) Except as provided in subparagraph (B), for purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the individuals whose family income is determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a). In developing an estimate for this activity, the department shall consider the projected number of final eligibility determinations each county will process and projected county costs. Within 60 days of the passage of the annual Budget Act, the department shall notify each county of their allocation for this activity based upon the amount allotted in the annual Budget Act for this purpose.

(B) Effective January 1, 2014, for purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the individuals whose family income is determined to be above 160 percent and up to and including 261 percent of the federal poverty level.

(h) When the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is fully operational, the new budget methodology shall be utilized to reimburse counties for eligibility determinations made for individuals pursuant to this section.

(i) Eligibility determinations and annual redeterminations made pursuant to this section shall be performed by county eligibility workers.

(j) In conducting eligibility determinations for individuals pursuant to this section and Section 14005.27, the following reporting and performance standards shall apply to all counties:

(1) Counties shall report to the department, in a manner and for a time period prescribed by the department, in consultation with the County Welfare Directors Association, the number of applications processed on a monthly basis, a breakout of the applications based on income using the federal percentage of poverty levels, the final disposition of each application, including information on the approved Medi-Cal program, if applicable, and the average number of days it took to make the final eligibility

determination for applications submitted directly to the county and from the single point of entry (SPE).

(2) Notwithstanding any other law, the following performance standards shall be applied to counties regarding eligibility determinations for individuals eligible pursuant to this section:

(A) For children whose applications are received by the county human services department from the SPE, the following standards shall apply:

(i) Applications for children who are granted accelerated enrollment by the SPE shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(ii) Applications for children who are not granted accelerated enrollment by the SPE due to the existence of an already active Medi-Cal case shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(iii) For applications for children who are not described in clause (i) or (ii), 90 percent shall be processed within 10 working days of being received, complete and without client errors.

(iv) If an application described in this section also contains adults, and the adult applicants are required to submit additional information beyond the information provided for the children, the county shall process the eligibility for the child or children without delay, consistent with this section while gathering the necessary information to process eligibility for the adults.

(B) The department, in consultation with the County Welfare Directors Association, shall develop reporting requirements for the counties to provide regular data to the state regarding the timeliness and outcomes of applications processed by the counties that are received from the SPE.

(C) Performance thresholds and corrective action standards as set forth in Section 14154 shall apply.

(D) For applications submitted directly to the county, these applications shall be processed by the counties in accordance with the performance standards established under subdivision (d) of Section 14154.

(3) This subdivision shall be implemented no sooner than January 1, 2013.

(4) Twelve months after implementation of this section pursuant to subdivision (f), the department shall provide enrollment information regarding individuals determined eligible pursuant to subdivision (a) to the fiscal and appropriate policy committees of the Legislature.

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

(2) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code,

the department shall adopt emergency regulations implementing this section no later than July 1, 2014. The department may thereafter readopt the emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(*l*) To implement this section, the department may enter into and continue contracts with the Healthy Families Program administrative vendor, for the purposes of implementing and maintaining the necessary systems and activities for providing health care coverage to optional targeted low-income children in the Medi-Cal program for purposes of accelerated enrollment application processing by single point of entry, noneligibility-related case maintenance and premium collection, maintenance of the Health-E-App Web portal, call center staffing and operations, certified application assistant services, and reporting capabilities. To further implement this section, the department may also enter into a contract with the Health Care Options Broker of the department for purposes of managed care enrollment activities. The contracts entered into or amended under this section may initially be completed on a noncompetitive bid basis and are exempt from the Public Contract Code. Contracts thereafter shall be entered into or amended on a competitive bid basis and shall be subject to the Public Contract Code.

(m) (1) If at any time the director determines that this section or any part of this section may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state, the director shall give notice to the fiscal and policy committees of the Legislature and to the Department of Finance. After giving notice, this section or any part of this section shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement this section or a part or parts thereof, in order to receive federal financial participation, any increase in the federal medical assistance percentage available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state.

(2) The director shall retain the declaration described in paragraph (1), shall provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and shall post the declaration on the department's internet website.

(3) In the event that the director makes a determination under paragraph (1) and this section ceases to be implemented, the children shall be enrolled back into the Healthy Families Program.

SEC. 80. Section 14005.37 of the Welfare and Institutions Code is amended to read:

14005.37. (a) Except as provided in Section 14005.39, a county shall perform redeterminations of eligibility for Medi-Cal beneficiaries every 12 months and shall promptly redetermine eligibility whenever the county receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits. The procedures for redetermining Medi-Cal eligibility described in this section shall apply to all Medi-Cal beneficiaries.

(b) Loss of eligibility for cash aid under that program shall not result in a redetermination under this section unless the reason for the loss of eligibility is one that would result in the need for a redetermination for a person whose eligibility for Medi-Cal under Section 14005.30 was determined without a concurrent determination of eligibility for cash aid under the CalWORKs program.

(c) A loss of contact, as evidenced by the return of mail marked in such a way as to indicate that it could not be delivered to the intended recipient or that there was no forwarding address, shall require a prompt redetermination according to the procedures set forth in this section.

(d) Except as otherwise provided in this section, Medi-Cal eligibility shall continue during the redetermination process described in this section and a beneficiary's Medi-Cal eligibility shall not be terminated under this section until the county makes a specific determination based on facts clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal benefits under any basis and due process rights guaranteed under this division have been met. For the purposes of this subdivision, for a beneficiary who is subject to the use of MAGI-based financial methods, the determination of whether the beneficiary is eligible for Medi-Cal benefits under any basis shall include, but is not limited to, a determination of eligibility for Medi-Cal benefits on a basis that is exempt from the use of MAGI-based financial methods only if either of the following occurs:

(1) The county assesses the beneficiary as being potentially eligible under a program that is exempt from the use of MAGI-based financial methods, including, but not limited to, on the basis of age, blindness, disability, or the need for long-term care services and supports.

(2) The beneficiary requests that the county determine whether the beneficiary is eligible for Medi-Cal benefits on a basis that is exempt from the use of MAGI-based financial methods.

(e) (1) For purposes of acquiring information necessary to conduct the eligibility redeterminations described in this section, a county shall gather information available to the county that is relevant to the beneficiary's Medi-Cal eligibility prior to contacting the beneficiary. Sources for these efforts shall include information contained in the beneficiary's file or other information, including more recent information available to the county, including, but not limited to, Medi-Cal, CalWORKs, and CalFresh case files of the beneficiary or of any of their immediate family members, which are open, or were closed within the last 90 days, information accessed

through any databases accessed under Sections 435.948, 435.949, and 435.956 of Title 42 of the Code of Federal Regulations, and, wherever feasible, other sources of relevant information reasonably available to the county or to the county via the department.

(2) In the case of an annual redetermination, if, based upon information obtained pursuant to paragraph (1), the county is able to make a determination of continued eligibility, the county shall notify the beneficiary of both of the following:

(A) The eligibility determination and the information it is based on.

(B) That the beneficiary is required to inform the county via the internet, by telephone, by mail, in person, or through other commonly available electronic means, in counties where such electronic communication is available, if any information contained in the notice is inaccurate but that the beneficiary is not required to sign and return the notice if all information provided on the notice is accurate.

(3) The county shall make all reasonable efforts not to send multiple notices during the same time period about eligibility. The notice of eligibility renewal shall contain other related information such as if the beneficiary is in a new Medi-Cal program.

(4) In the case of a redetermination due to a change in circumstances, if a county determines that the change in circumstances does not affect the beneficiary's eligibility status, the county shall not send the beneficiary a notice unless required to do so by federal law.

(f) (1) In the case of an annual eligibility redetermination, if the county is unable to determine continued eligibility based on the information obtained pursuant to paragraph (1) of subdivision (e), the beneficiary shall be so informed and shall be provided with an annual renewal form, at least 60 days before the beneficiary's annual redetermination date, that is prepopulated with information that the county has obtained and that identifies any additional information needed by the county to determine eligibility. The form shall include all of the following:

(A) The requirement that the beneficiary provide any necessary information to the county within 60 days of the date that the form is sent to the beneficiary.

(B) That the beneficiary may respond to the county via the internet, by mail, by telephone, in person, or through other commonly available electronic means if those means are available in that county.

(C) That if the beneficiary chooses to return the form to the county in person or via mail, the beneficiary shall sign the form in order for it to be considered complete.

(D) The telephone number to call in order to obtain more information.

(2) The county shall attempt to contact the beneficiary via the internet, by telephone, or through other commonly available electronic means, if those means are available in that county, during the 60-day period after the prepopulated form is mailed to the beneficiary to collect the necessary information if the beneficiary has not responded to the request for additional information or has provided an incomplete response.

(3) If the beneficiary has not provided any response to the written request for information sent pursuant to paragraph (1) within 60 days from the date the form is sent, the county shall terminate the beneficiary's eligibility for Medi-Cal benefits following the provision of timely notice.

(4) If the beneficiary responds to the written request for information during the 60-day period pursuant to paragraph (1) but the information provided is incomplete, the county shall follow the procedures set forth in paragraph (3) of subdivision (g) to work with the beneficiary to complete the information.

(5) (A) The form required by this subdivision shall be developed by the department in consultation with the counties and representatives of eligibility workers and consumers.

(B) For beneficiaries whose eligibility is not determined using MAGI-based financial methods, the county may use existing renewal forms until the state develops prepopulated renewal forms to provide to beneficiaries. The department shall develop prepopulated renewal forms for use with beneficiaries whose eligibility is not determined using MAGI-based financial methods by January 1, 2015.

(g) (1) In the case of a redetermination due to change in circumstances, if a county cannot obtain sufficient information to redetermine eligibility pursuant to subdivision (e), the county shall send to the beneficiary a form that states the information needed to redetermine eligibility. The county shall only request information related to the change in circumstances. The county shall not request information or documentation that has been previously provided by the beneficiary, that is not absolutely necessary to complete the eligibility determination, or that is not subject to change. The county shall only request information for nonapplicants necessary to make an eligibility determination or for a purpose directly related to the administration of the state Medicaid plan. The form shall advise the individual to provide any necessary information to the county via the internet, by telephone, by mail, in person, or through other commonly available electronic means. The beneficiary is not required to sign or return the form. The form shall include a telephone number to call in order to obtain more information. Future revisions to the form shall be developed by the department in consultation with the counties, representatives of consumers, and eligibility workers. A Medi-Cal beneficiary shall have 30 days from the date the form is mailed pursuant to this subdivision to respond.

(2) If the purpose for a redetermination under this section is a loss of contact with the Medi-Cal beneficiary, as evidenced by the return of mail marked in such a way as to indicate that it could not be delivered to the intended recipient or that there was no forwarding address, a return of the form described in this subdivision marked as undeliverable shall result in an immediate notice of action terminating Medi-Cal eligibility.

(3) During the 30-day period after the date of mailing of a form to the Medi-Cal beneficiary pursuant to this subdivision, the county shall attempt to contact the beneficiary by telephone, in writing, or other commonly available electronic means, in counties where such electronic communication

is available, to request the necessary information if the beneficiary has not responded to the request for additional information or has provided an incomplete response. If the beneficiary does not supply the necessary information to the county within the 30-day limit, a 10-day notice of termination of Medi-Cal eligibility shall be sent.

(h) Beneficiaries shall be required to report any change in circumstances that may affect their eligibility within 10 calendar days following the date the change occurred.

(i) If, within 90 days of a Medi-Cal beneficiary's eligibility termination date or a change in eligibility status due to the beneficiary's failure to provide needed information, the discontinued beneficiary submits to the county a signed and completed form or otherwise provides the needed information to the county, eligibility shall be redetermined in a timely manner by the county without requiring a new application. The beneficiary shall be entitled to request a Medi-Cal eligibility determination for any of the three months immediately prior to the month in which the beneficiary provided the needed information to the county, in accordance with Section 14019.

(j) If the information available to the county pursuant to the redetermination procedures of this section does not indicate a basis of eligibility, Medi-Cal benefits may be terminated so long as due process requirements have otherwise been met.

(k) The department shall, with the counties and representatives of consumers, including those with disabilities, and Medi-Cal eligibility workers, develop a timeframe for redetermination of Medi-Cal eligibility based upon disability, including ex parte review, the redetermination forms described in subdivisions (f) and (g), timeframes for responding to county or state requests for additional information, and the forms and procedures to be used. The forms and procedures shall be as consumer-friendly as possible for people with disabilities. The timeframe shall provide a reasonable and adequate opportunity for the Medi-Cal beneficiary to obtain and submit medical records and other information needed to establish eligibility for Medi-Cal based upon disability.

(*l*) The county shall consider blindness as continuing until the reviewing physician determines that a beneficiary's vision has improved beyond the applicable definition of blindness contained in the plan.

(m) The county shall consider disability as continuing until the review team determines that a beneficiary's disability no longer meets the applicable definition of disability contained in the plan.

(n) In the case of a redetermination due to a change in circumstances, if a county determines that the beneficiary remains eligible for Medi-Cal benefits, the county shall begin a new 12-month eligibility period.

(o) For individuals determined ineligible for Medi-Cal by a county following the redetermination procedures set forth in this section, the county shall determine eligibility for other insurance affordability programs, and, if the individual is found to be eligible, the county shall, as appropriate, transfer the individual's electronic account to other insurance affordability programs via a secure electronic interface.

(p) Any renewal form or notice shall be accessible to persons who are limited-English proficient and persons with disabilities consistent with all federal and state requirements.

(q) The requirements to provide information in subdivisions (e) and (g), and to report changes in circumstances in subdivision (h), may be provided through any of the modes of submission allowed in Section 435.907(a) of Title 42 of the Code of Federal Regulations, including an internet website identified by the department, telephone, mail, in person, and other commonly available electronic means as authorized by the department.

(r) Forms required to be signed by a beneficiary pursuant to this section shall be signed under penalty of perjury. Electronic signatures, telephonic signatures, and handwritten signatures transmitted by electronic transmission shall be accepted.

(s) For purposes of this section, "MAGI-based financial methods" means income calculated using the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code, and as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any subsequent amendments.

(t) When contacting a beneficiary under paragraphs (2) and (4) of subdivision (f), and paragraph (3) of subdivision (g), a county shall first attempt to use the method of contact identified by the beneficiary as the preferred method of contact, if a method has been identified.

(u) The department shall seek federal approval to extend the annual redetermination date under this section for a three-month period for those Medi-Cal beneficiaries whose annual redeterminations are scheduled to occur between January 1, 2014, and March 31, 2014.

(v) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(w) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

(x) This section shall become operative on January 1, 2014.

SEC. 81. Section 14005.64 of the Welfare and Institutions Code is amended to read:

14005.64. (a) Effective January 1, 2014, and notwithstanding any other law, when determining eligibility for Medi-Cal benefits, an applicant's or

beneficiary's income and resources shall be determined, counted, and valued in accordance with the requirements of Section 1902(e)(14) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(14)), as added by the ACA, which prohibits the use of an assets or resources test for individuals whose income eligibility is determined based on modified adjusted gross income.

(b) When determining the eligibility of applicants and beneficiaries using the MAGI-based financial methods, the 5-percent income disregard required under Section 1902(e)(14)(B)(I) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(14)(B)(I)) shall be applied.

(c) (1) The department shall establish income eligibility thresholds for those Medi-Cal eligibility groups whose eligibility will be determined using MAGI-based financial methods. The income eligibility thresholds shall be developed using the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code and in conformity with Section 1396a(gg) of Title 42 of the United States Code as added by the ACA.

(2) In utilizing state data or the national standard methodology with Survey of Income and Program Participation data to develop the converted modified adjusted gross income standard for Medi-Cal applicants and beneficiaries, the department shall ensure that the financial methodology used for identifying the equivalent income eligibility threshold preserves Medi-Cal eligibility for applicants and beneficiaries to the extent required by federal law. The department shall report to the Legislature on the expected changes in income eligibility thresholds using the chosen methodology for individuals whose income is determined on the basis of a converted dollar amount or federal poverty level percentage. The department shall convene stakeholders, including the Legislature, counties, and consumer advocates regarding the results of the converted standards and shall review with them the information used for the specific calculations before adopting its final methodology for the equivalent income eligibility threshold level.

(3) The income eligibility threshold levels required under this subdivision shall be as follows for the identified coverage groups:

(A) For those pregnant individuals and infants eligible under Sections 435.116 and 435.118 of Title 42 of the Code of Federal Regulations, respectively, 208 percent of the federal poverty level.

(B) For those children one to five years of age, inclusive, eligible under Section 1396a(a)(10)(A)(i)(VI) of Title 42 of the United States Code, 142 percent of the federal poverty level.

(C) For those children 6 to 18 years of age, inclusive, eligible under Section 1396a(a)(10)(A)(i)(VII) of Title 42 of the United States Code, 133 percent of the federal poverty level.

(d) The department shall include individuals under 19 years of age, or in the case of full-time students, under 21 years of age, in the household for purposes of determining eligibility under Section 1396a(e)(14) of Title 42 of the United States Code, as added by the ACA.

(e) For purposes of this section, the following definitions shall apply:

(1) "ACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148) as originally enacted and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(2) "MAGI-based financial methods" means income calculated using the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code, and as added by the ACA.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(g) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 82. Section 14007.8 of the Welfare and Institutions Code is amended to read:

14007.8. (a) (1) An individual who is 25 years of age or younger, and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(2) (A) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this subparagraph, but no sooner than May 1, 2022, an individual who is 50 years of age or older, and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(B) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this subparagraph, but no later than January 1, 2024, an individual who is 26 to 49 years of age, inclusive, and who does not have satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(C) The effective date of enrollment into the Medi-Cal program for an individual described in this paragraph, and enrolled in the Medi-Cal program pursuant to subdivision (d) of Section 14007.5, shall be on the same day on

which the systems are operational to begin processing new applications pursuant to the director's determination described in either subparagraph (A) or (B), as applicable.

(3) (A) An individual enrolled in the Medi-Cal program pursuant to this section and subdivision (d) of Section 14007.5 shall not be required to file a new application for the Medi-Cal program.

(B) The enrollment specified in subparagraph (A) shall be conducted pursuant to an eligibility and enrollment plan, and shall include outreach strategies developed by the department in consultation with interested stakeholders, including, but not limited to, counties, health care service plans, health care providers, consumer advocates, and the Legislature.

(C) (i) For individuals described in subparagraph (B) of paragraph (2), the eligibility and enrollment plan shall enable, to the maximum extent the department determines possible, an individual to maintain their primary care provider or medical home as their assigned primary care provider in the Medi-Cal managed care health plan provider network without disruption, if the provider is a contracted network provider with that Medi-Cal managed care health plan. The department shall work with counties, Medi-Cal managed care health plans, health care providers, consumer advocates, and other interested stakeholders, to identify and maintain that linkage, to the maximum extent the department determines possible.

(ii) This subparagraph does not limit the ability of an individual enrolled in Medi-Cal pursuant to subparagraph (B) of paragraph (2) to select either, or both, a different primary care provider or, if there is more than one Medi-Cal managed care health plan available in the county where they reside, a different Medi-Cal managed care health plan, consistent with subdivision (g) of Section 14087.305 and paragraph (7) of subdivision (d) of Section 14089.

(D) The department shall provide monthly updates to the appropriate policy and fiscal committees of the Legislature on the status of the implementation of this section.

(b) To the extent permitted by state and federal law, an individual eligible under this section shall be required to enroll in a Medi-Cal managed care health plan. Enrollment in a Medi-Cal managed care health plan shall not preclude a beneficiary from being enrolled in any other children's Medi-Cal specialty program that they would otherwise be eligible for.

(c) (1) The department shall maximize federal financial participation in implementing this section to the extent allowable. For purposes of implementing this section, the department shall claim federal financial participation to the extent that the department determines it is available.

(2) To the extent that federal financial participation is unavailable, the department shall implement this section using state funds appropriated for this purpose.

(d) This section shall be implemented only to the extent it is in compliance with Section 1621(d) of Title 8 of the United States Code.

(e) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department,

without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) Notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(f) In implementing this section, the department may contract, as necessary, on a bid or nonbid basis. This subdivision establishes an accelerated process for issuing contracts pursuant to this section. Those contracts, and any other contracts entered into pursuant to this subdivision, may be on a noncompetitive bid basis and shall be exempt from both of the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Review or approval of contracts by the Department of General Services.

SEC. 83. Section 14007.9 of the Welfare and Institutions Code, as amended by Section 32 of Chapter 5 of the 4th Extraordinary Session of the Statutes of 2009, is amended to read:

14007.9. (a) The department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XIII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII)). In order to be eligible for benefits under this section, an individual shall be required to meet all of the following requirements:

(1) The individual's net countable income is less than 250 percent of the federal poverty level for one person or, if the deeming of spousal income applies to the individual, the individual's net countable income is less than 250 percent of the federal poverty level for two persons.

(2) The individual is disabled under Title II of the Social Security Act (Subch. 2 (commencing with Sec. 401), Ch. 7, Title 42 U.S.C.), Title XVI of the Social Security Act (Subch. 16 (commencing with Sec. 1381), Ch. 7, Title 42, U.S.C.), or Section 1902(v) of the Social Security Act (42 U.S.C. Sec. 1396a(v)). An individual shall be determined to be eligible under this section without regard to the individual's ability to engage in, or actual engagement in, substantial gainful activity, as defined in Section 223(d)(4) of the Social Security Act (42 U.S.C. Sec. 423(d)(4)).

(3) Except as otherwise provided in this section, the individual's net nonexempt resources, which shall be determined in accordance with the methodology used under Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), are not in excess of the limits provided for under those provisions.

(b) (1) Countable income shall be determined under Section 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), except that the individual's disability income, including all federal and state disability benefits and private disability insurance, shall be exempted. Resources excluded under Section 1613 of the federal Social Security Act (42 U.S.C. Sec. 1382b) shall be disregarded.

(2) Resources in the form of employer or individual retirement arrangements authorized under the Internal Revenue Code shall be exempted as authorized by Section 1902(r) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)).

(3) (A) For the purposes of calculating countable income under this section, an income exemption shall be applied as necessary to adjust the income standard so that it is the same as the income standard that was in place on May 1, 2009.

(B) This additional income exemption shall cease to be implemented when the SSI/SSP program payment levels increase beyond those in effect on May 1, 2009.

(C) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this paragraph by means of an all-county letter or similar instruction without taking regulatory action.

(c) Medi-Cal benefits provided under this chapter pursuant to this section shall be available in the same amount, duration, and scope as those benefits are available for persons who are eligible for Medi-Cal benefits as categorically needy persons and as specified in Section 14007.5.

(d) Individuals eligible for Medi-Cal benefits under this section shall be subject to the payment of premiums determined under this subdivision, except as provided in subdivision (j). The department shall establish sliding-scale premiums that are based on countable income, with a minimum premium of twenty dollars ($20) per month and a maximum premium of two hundred fifty dollars ($250) per month, and shall, by regulations, annually adjust the premiums. Prior to adjustment of any premiums pursuant to this subdivision, the department shall submit a report of proposed premium adjustments to the appropriate committees of the Legislature as part of the annual budget act process.

(e) The department shall adopt regulations specifying the process for discontinuance of eligibility under this section for nonpayment of premiums for more than two months by a beneficiary.

(f) In order to implement the collection of premiums under this section, the department may develop and execute a contract with a public or private entity to collect premiums, or may amend any existing or future premium-collection contract that it has executed. Notwithstanding any other provision of law, any contract developed and executed or amended pursuant to this subdivision is exempt from the approval of the Director of General Services and from the Public Contract Code.

(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the

Government Code, the department shall implement, without taking any regulatory action, this section by means of an all-county letter or similar instruction. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

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

(i) Subject to subdivision (h), this section shall be implemented commencing April 1, 2000.

(j) (1) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this section to the contrary, the department may elect not to impose premiums on individuals eligible under this section for an applicable coverage period.

(2) If the department elects to not impose premiums for an applicable coverage period pursuant to paragraph (1) or elects to reinstate such premiums for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.

SEC. 84. Section 14007.9 of the Welfare and Institutions Code, as amended by Section 91 of Chapter 3 of the Statutes of 2011, is amended to read:

14007.9. (a) (1) The department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XIII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII)). In order to be eligible for benefits under this section, an individual shall be required to meet all of the following requirements:

(A) The individual's net countable income is less than 250 percent of the federal poverty level for one person or, if the deeming of spousal income applies to the individual, the individual's net countable income is less than 250 percent of the federal poverty level for two persons.

(B) The individual is disabled under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 et seq.), Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), or Section 1902(v) of the federal Social Security Act (42 U.S.C. Sec. 1396a(v)). An individual shall be determined to be eligible under this section without regard to their ability to engage in, or actual engagement in, substantial gainful activity, as defined in Section 223(d)(4) of the federal Social Security Act (42 U.S.C. Sec. 423(d)(4)).

(C) Except as otherwise provided in this section, the individual's net nonexempt resources, which shall be determined in accordance with the methodology used under Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), are not in excess of the limits provided for under those provisions.

(2) To the extent federal financial participation is available, an individual otherwise eligible under this section, but who is temporarily unemployed,

may elect to remain on Medi-Cal under this section for up to 26 weeks, provided the individual continues to pay premiums during the temporary period of unemployment, for coverage periods in which premiums are imposed.

(b) (1) Countable income shall be determined under Section 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), except that the individual's disability income, including all federal and state disability benefits and private disability insurance, shall be exempted. Resources excluded under Section 1613 of the federal Social Security Act (42 U.S.C. Sec. 1382b) shall be disregarded.

(2) Resources in the form of employer or individual retirement arrangements authorized under the Internal Revenue Code shall be exempted as authorized by Section 1902(r) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)).

(3) (A) For the purposes of calculating countable income under this section, an income exemption shall be applied as necessary to adjust the income standard so that it is the same as the income standard that was in place on May 1, 2009.

(B) This additional income exemption shall cease to be implemented when the SSI/SSP program payment levels increase beyond those in effect on May 1, 2009.

(C) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this paragraph by means of an all-county letter or similar instruction without taking regulatory action.

(4) Retained earned income of an eligible individual who is receiving health care benefits under this section shall be considered an exempt resource when held in a separately identifiable account and not commingled with other resources, as authorized by Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)).

(5) Social security disability income that converts to social security retirement income upon the retirement of an individual, including any increases in the amount of that income, shall be exempt. The department shall submit a state plan amendment for this specific exemption, and the exemption shall be implemented only if, and to the extent that, the state plan amendment is approved.

(c) All resources exempted pursuant to paragraph (2) of subdivision (b) for an individual who is receiving health care benefits under this section shall continue to be exempt under any other Medi-Cal program that is subject to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)) under which the beneficiary later becomes eligible for medical assistance where that eligibility is based on age, blindness, or disability. The department shall submit a state plan amendment for this specific exemption, and the exemption shall be implemented only if, and to the extent that, the state plan amendment is approved.

(d) After an individual is determined eligible for Medi-Cal benefits under this section, the individual's countable income, as determined under Section

1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), shall be used to determine the amount of the individual's required premium payment, as described in subdivision (f), when applicable. Disability income and converted retirement income made exempt under paragraphs (1) and (5), respectively, of subdivision (b) for eligibility purposes shall be considered countable income for purposes of determining the amount of the required premium payment.

(e) Medi-Cal benefits provided under this chapter pursuant to this section shall be available in the same amount, duration, and scope as those benefits are available for persons who are eligible for Medi-Cal benefits as categorically needy persons and as specified in Section 14007.5.

(f) (1) Individuals eligible for Medi-Cal benefits under this section shall be subject to the payment of premiums determined under this subdivision, except as provided in subdivision (m). Each individual shall pay a monthly premium that is equal to 5 percent of their individual countable income, as described in subdivision (d), or if the deeming of spousal income of an ineligible spouse applies, a monthly premium that is equal to 5 percent of the total countable income of both spouses, except that the minimum premium payment per eligible individual shall be twenty dollars ($20) per month, and the maximum premium payment per eligible individual shall be two hundred fifty dollars ($250) per month.

(2) The amendments made to this subdivision by Chapter 282 of the Statutes of 2009 shall be implemented no later than 90 days after the operative date specified in paragraph (2) of subdivision (k).

(g) In order to implement the collection of premiums under this section, the department may develop and execute a contract with a public or private entity to collect premiums, or may amend any existing or future premium-collection contract that it has executed. Notwithstanding any other provision of law, any contract developed and executed or amended pursuant to this subdivision is exempt from the approval of the Director of General Services and from the Public Contract Code.

(h) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement, without taking any regulatory action, this section by means of an all-county letter or similar instruction. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(i) Notwithstanding any other law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation is available pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and only to the extent that the department seeks and obtains approval of all necessary Medicaid state plan amendments.

(j) If any provision of this section, or its application, is held invalid by a final judicial determination, it shall cease to be implemented. A determination of invalidity shall not affect other provisions or applications

of this section that can be given effect without the implementation of the invalid provision or application.

(k) (1) Except as provided in paragraph (2), the amendments made to this section by Chapter 282 of the Statutes of 2009 shall not become operative until 30 days after the date that the increase in the state's federal medical assistance percentage (FMAP) pursuant to the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5) is no longer available under that act or any extension of that act.

(2) The amendments made to this section by Chapter 282 of the Statutes of 2009 contained in subdivisions (d) and (f) shall not become operative until 30 days after the date that the director executes a declaration stating that the implementation of subdivisions (d) and (f) will not jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148) or any amendment or extension of that act, any increase in the FMAP available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state.

(3) If at any time the director determines that the statement in the declaration executed pursuant to paragraph (2) may no longer be accurate, the director shall give notice to the Joint Legislative Budget Committee and to the Department of Finance. After giving notice, the amendments made to this section by Chapter 282 of the Statutes of 2009 contained in subdivisions (d) and (f) shall become inoperative on the date that the director executes a declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement subdivisions (d) and (f) in order to receive federal financial participation, any increase in the FMAP available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state, in which case, subdivision (d) of this section, as stated by Section 32 of Chapter 5 of the Fourth Extraordinary Session of the Statutes of 2009, shall be operative.

(4) The director shall post a declaration made pursuant to paragraph (2) or (3) on the department's internet website and the director shall send the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(*l*) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement subdivision (k) by means of all-county letters or similar instruction, without taking regulatory action.

(m) (1) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this section to the contrary, the department may elect not to impose premiums on individuals eligible under this section for an applicable coverage period.

(2) If the department elects to not impose premiums for an applicable coverage period pursuant to paragraph (1) or elects to reinstate such

premiums for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.

SEC. 85. Section 14011.10 of the Welfare and Institutions Code is amended to read:

14011.10. (a) Except as provided in Sections 14053.7, 14053.8, and 14184.800, benefits provided under this chapter to an individual who is an inmate of a public institution shall be suspended in accordance with Section 1396d(a)(31)(A) of Title 42 of the United States Code as provided in subdivisions (c), (d), and (e).

(b) A county welfare department shall notify the department within 10 days of receiving information that an individual on Medi-Cal in the county is or will be an inmate of a public institution.

(c) Until October 1, 2020, if an individual is a Medi-Cal beneficiary on the date they become an inmate of a public institution, their benefits under this chapter and under Chapter 8 (commencing with Section 14200) shall be suspended effective the date they become an inmate of a public institution. The suspension shall end on the date they are no longer an inmate of a public institution or one year from the date they become an inmate of a public institution, whichever is sooner.

(d) Commencing October 1, 2020, and through December 31, 2022, inclusive, if an individual is a Medi-Cal beneficiary on the date they become an inmate of a public institution, their benefits under this chapter and under Chapter 8 (commencing with Section 14200) shall be suspended effective the date they become an inmate of a public institution. The suspension shall end according to the following:

(1) For an individual who is not defined as a juvenile under Section 1396a(nn)(1)(A) or 1396a(nn)(1)(B) of Title 42 of the United States Code, the suspension shall end on the date the individual is no longer an inmate of a public institution or one year from the date the individual becomes an inmate of a public institution, whichever is sooner.

(2) For an individual who is defined as a juvenile under Section 1396a(nn)(1)(A) or 1396a(nn)(1)(B) of Title 42 of the United States Code, the suspension shall end in accordance with Section 1396a(a)(84) of Title 42 of the United States Code, or one year from the date the individual becomes an inmate of a public institution, whichever is later.

(e) (1) Commencing January 1, 2023, if an individual is a Medi-Cal beneficiary on the date they become an inmate of a public institution, their benefits under this chapter and under Chapter 8 (commencing with Section 14200) shall be suspended effective the date they become an inmate of a public institution.

(2) For an individual who is defined as a juvenile under Section 1396a(nn)(1)(A) or 1396a(nn)(1)(B) of Title 42 of the United States Code, and for an individual who is not defined as a juvenile under these sections to the extent permissible under federal law, the suspension shall end on the

date the individual is no longer an inmate of a public institution, if otherwise eligible.

(f) The department, in consultation with stakeholders, including the County Welfare Directors Association of California and advocates, shall develop and implement a redetermination of eligibility, to the extent required by federal law, pursuant to Section 14005.37, for individuals referenced in paragraph (2) of subdivision (d) and subdivision (e) whose eligibility is suspended pursuant to this section.

(g) This section does not create a state-funded benefit or program. Health care services under this chapter and Chapter 8 (commencing with Section 14200) shall not be available to inmates of public institutions whose Medi-Cal benefits have been suspended under this section.

(h) This section shall be implemented only if and to the extent allowed by federal law. This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approval of state plan amendments or other federal approvals have been obtained.

(i) This section shall be implemented on January 1, 2010, or the date when all necessary federal approvals are obtained, whichever is later.

(j) By January 1, 2010, or the date when all necessary federal approvals are obtained, whichever is later, the department, in consultation with the Chief Probation Officers of California and the County Welfare Directors Association of California, shall establish the protocols and procedures necessary to implement this section, including any needed changes to the protocols and procedures previously established to implement Section 14029.5.

(k) The department shall determine whether federal financial participation will be jeopardized by implementing this section and shall implement this section only if and to the extent that federal financial participation is not jeopardized.

(*l*) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all-county letters or similar instructions without taking regulatory action. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(m) Notwithstanding any other law, commencing no sooner than July 1, 2021, the department, in consultation with representatives of county welfare departments, the Statewide Automated Welfare System and other interested stakeholders, shall initiate the planning process to prioritize the automation of Medi-Cal suspensions for incarcerated individuals into the California Healthcare Eligibility, Enrollment, and Retention System, as set forth in this section. This change shall be reflected in both the California Healthcare Eligibility, Enrollment, and Retention System 24-Month Roadmap Initiatives and the County Eligibility Worker Dashboard.

SEC. 86. Section 14011.66 of the Welfare and Institutions Code is amended to read:

14011.66. (a) Effective January 1, 2014, the department shall provide Medi-Cal benefits during a presumptive eligibility period to individuals who have been determined eligible on the basis of preliminary information by a qualified hospital in accordance with Section 1396a(a)(47)(B) of Title 42 of the United States Code and as set forth in this section.

(b) A hospital may only make presumptive eligibility determinations under this section if it complies with all of following:

(1) It is a participating provider under the state plan or under a federal waiver under Section 1315 of Title 42 of the United States Code.

(2) It has notified the department in writing that it has elected to be a qualified entity for the purpose of making presumptive eligibility determinations.

(3) It agrees to make presumptive eligibility determinations consistent with all applicable policies and procedures.

(4) It has not been disqualified to make presumptive eligibility determinations by the department.

(c) Qualified hospitals may only make presumptive eligibility determinations based upon income for children, pregnant women, parents and other caretaker relatives, and other adults, whose income is calculated using the applicable MAGI-based income standard or for individuals who are 65 years of age or older, blind, or disabled whose income is not calculated using the applicable MAGI-based income standard for which federal approval is obtained pursuant to subdivision (g).

(d) The department shall establish a process for determining whether a hospital should be disqualified from being able to make presumptive eligibility determinations under this section.

(e) For purposes of this section, "MAGI-based income" means income calculated using the financial methodologies described in Section 1396a(e)(14) of Title 42 of the United States Code, as added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and any subsequent amendments.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. The department shall adopt regulations by July 1, 2017, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(g) This section shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 87. Section 14011.7 of the Welfare and Institutions Code is amended to read:

14011.7. (a) To the extent allowed under federal law and only if federal financial participation is available, the department shall exercise the option provided in Section 1396r-1a of Title 42 of the United States Code and the option provided in Section 1397gg(e)(1)(D) of Title 42 of the United States Code to implement a program for preenrollment of children into the Medi-Cal program. Upon the exercise of both of the federal options described in this subdivision, the department shall implement the Children's Presumptive Eligibility Program for the preenrollment of children into the Medi-Cal program.

(b) (1) Before July 1, 2003, the department shall develop an electronic application to serve as the application for the Children's Presumptive Eligibility Program, to the extent allowed under federal law.

(2) The department may, at its option, also use the electronic application developed pursuant to paragraph (1), as a means to enroll newborns into the Medi-Cal program as is authorized under Section 1396a(e)(4) of Title 42 of the United States Code.

(c) (1) The department may designate, as necessary, Medi-Cal providers as qualified entities who are authorized to determine eligibility for preenrollment into the Medi-Cal program as authorized under this section.

(2) The provider shall assist the parent or guardian of the child seeking eligibility for preenrollment into the Medi-Cal program in completing the electronic application.

(d) The electronic application developed pursuant to subdivision (b) may only be filed when the child is in need of Medi-Cal.

(e) (1) The electronic application developed pursuant to subdivision (b) shall request all information necessary for a provider to make an immediate determination as to whether a child meets the eligibility requirements for preenrollment into the Medi-Cal program pursuant to the federal options described in Section 1396r-1a or 1397gg(e)(1)(D) of Title 42 of the United States Code.

(2) (A) If the electronic application indicates that the child is seeking eligibility for no cost full-scope Medi-Cal benefits, the department shall mail to the child's parent or guardian a followup application for Medi-Cal program eligibility. The parent or guardian of the child shall be advised to complete and submit to the appropriate entity the followup application.

(B) The followup application, at a minimum, shall include all notices and forms necessary for the Medi-Cal program eligibility determination under state and federal law, including, but not limited to, any information and documentation that is required for the joint application package described in Section 14011.1.

(C) The date of application for the Medi-Cal program is the date the completed followup application is submitted with the appropriate entity by the parent or guardian.

(3) Upon making a determination pursuant to paragraph (1) that a child is eligible, the CHDP provider shall inform the child's parent or guardian of both of the following:

(A) That the child has been determined to be eligible for preenrollment into the Medi-Cal program.

(B) That if the child has been determined to be eligible for preenrollment into the Medi-Cal program, the period of preenrollment eligibility will end on the last day of the month following the month in which the determination of preenrollment eligibility is made, unless the parent or guardian completes and returns to the appropriate entity the followup application described in paragraph (2) on or before that date.

(4) If the followup application described in paragraph (2) is submitted on or before the last day of the month following the month in which a determination is made that the child is eligible for preenrollment into the Medi-Cal program, the period of preenrollment eligibility shall continue until the completion of the determination process for the applicable program or programs.

(f) The department shall seek approval of any amendments to the state plan, necessary to implement this section, for purposes of funding under Title XIX (42 U.S.C. 1396 et seq.) and Title XXI (42 U.S.C. 1397aa et seq.) of the Social Security Act. Notwithstanding any other provision of law and only when all necessary federal approvals have been obtained, this section shall be implemented only to the extent federal financial participation is available.

(g) To implement this section, the department may contract with public or private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary, only if services provided under the program are specifically identified and reimbursed in a manner that appropriately claims federal financial reimbursement. Contracts, including the Medi-Cal fiscal intermediary contracts and contract amendments, any system change pursuant to a change order, and any project or systems development notice shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Chapter 7 (commencing with Section 11700) of Part 1 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and any policies, procedures, or regulations authorized by these laws.

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all-county letters or similar instructions, without taking any further regulatory action. Thereafter, the department shall adopt regulations, as necessary, to implement this section in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 88. Section 14087.46 of the Welfare and Institutions Code is amended to read:

14087.46. (a) The department shall implement a dental managed care program for Medi-Cal beneficiaries to achieve major cost savings, while ensuring access and quality of care, pursuant to this section.

(b) The department shall issue a request for proposals and award contracts on a competitive basis to one or more dental health care service contractors licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) in each county or region that the department determines to be feasible. The department may contract with county organized health systems.

(c) To ensure access and continuity of care, the department shall award contracts to plans that agree to negotiate in good faith and subcontract with any provider who agrees to provide dental services to Medi-Cal beneficiaries at a reimbursement rate comparable to that paid by the plan to other participating providers. A plan shall contract whenever feasible with traditional and safety net providers of dental services to Medi-Cal beneficiaries. In evaluating the plans, the department shall assign favorable weighting to contractors that include traditional and safety net providers.

(d) The department shall implement a process to inform each Medi-Cal beneficiary of their choice of participating dentists and to allow a beneficiary to choose or change their participating dentist.

(e) The department shall make every effort to achieve operational contracts to place Medi-Cal beneficiaries in dental managed care by October 1, 1995. The department may determine which counties or categories of Medi-Cal beneficiaries are to be included in the dental managed care program. If the department has achieved one or more operational managed care contracts in a county or region, fee-for-service dental services shall not be an option for selection by a beneficiary, except that the department may provide for fee-for-service dental care if needed to ensure adequate access in rural or underserved areas, or for unique populations.

(f) The department shall require a participating plan to provide, at a minimum, the full scope of dental benefits pursuant to state and federal law.

(g) In order to achieve maximum cost savings, the Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Therefore, contracts under this section shall be exempt from the Public Contract Code.

(h) A Medi-Cal beneficiary shall be able to receive their dental care from federally qualified health centers and rural health clinics certified pursuant to Public Law 95-210 that provide dental care in their service area. At the time of informing the Medi-Cal beneficiary of their choice of participating dentists, the beneficiary shall be informed of this option. Federally qualified health centers and rural health clinics shall continue to be reimbursed for dental services through the medical payment system in accordance with federal regulations.

(i) The department shall monitor the implementation of dental managed care, and for each of the first three years of implementation, shall annually evaluate the program on a county-by-county basis in terms of access, quality of care, and cost savings. The evaluation shall be provided to the Legislature within 120 days of the close of each of the three fiscal years.

(j) The department shall seek federal waivers necessary to allow for federal financial participation in the program implemented pursuant to this section. This article shall not be implemented unless and until the director has executed a declaration, to be retained by the director, that approval of all necessary federal waivers have been obtained by the department.

(k) Notwithstanding any other law, to the extent any necessary federal approvals are obtained, the department shall extend the dental managed care contracts, which are in effect on the effective date of the act that added this subdivision, for the provision of covered dental services authorized under this section pursuant to all of the following:

(1) These existing contracts shall be extended through December 31, 2023, or through the calendar day immediately preceding the effective date for the new dental managed care contracts described in paragraph (3), to the extent that effective date is later than January 1, 2024.

(2) Contract extensions shall be secured on a sole source basis.

(3) The department shall conduct a competitive bid and procurement process to award new dental managed care contracts, commencing on an effective date of January 1, 2024, subject to the department obtaining all necessary federal approvals for the contracts.

(4) If new dental managed care contracts have not taken effect on or before July 1, 2024, the department shall provide an update to the Legislature detailing the specific circumstances that contributed to the delay and an expected commencement date for the new contracts.

(5) Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(*l*) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of information notices, plan letters, or other similar instructions, without taking any further regulatory action.

SEC. 89. Section 14105.075 of the Welfare and Institutions Code is amended to read:

14105.075. (a) (1) Notwithstanding any other law, for dates of service on or after August 1, 2016, payments to intermediate care facilities for the developmentally disabled that are licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and to facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20,

as determined by the applicable methodology for setting reimbursement rates for those facilities, shall be the reimbursement rates that were applicable to those facilities in the 2008–09 rate year, increased by 3.7 percent. Payments to the facilities pursuant to this section shall also include the projected cost of complying with new state or federal mandates to the extent applicable to the reimbursement methodology associated with the type of facility.

(2) Notwithstanding paragraph (1) and Sections 14105.191 and 14105.192, and for dates of service on or after August 1, 2021, the reimbursement rates for intermediate care facilities for the developmentally disabled and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to Section 14132.20 shall be determined without applying to that rate any reduction, limitation, or increase, including the 3.7-percent increase, specified in paragraph (1), as described in this section or Sections 14105.191 and 14105.192.

(b) (1) For dates of service on or after August 1, 2021, and for each rate year thereafter, the department shall calculate and publish the reimbursement rates, as specified in paragraph (2) of subdivision (a), plus the projected cost of complying with new state or federal mandates.

(2) For the 2021–22 fiscal year, and for each fiscal year thereafter, the reimbursement rates for intermediate care facilities for the developmentally disabled or facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to Section 14132.20, or both, shall account for, and be inclusive of, supplemental payments, as described under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, or Proposition 56, if the Budget Act of that fiscal year appropriates funds from the Healthcare Treatment Fund, as established pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, to the department to make those supplemental payments to these facilities.

(3) For dates of service on or after August 1, 2021, the reimbursement rate established for an intermediate care facility for the developmentally disabled or a facility providing continuous skilled nursing care to developmentally disabled individuals pursuant to Section 14132.20 shall be the greater of that facility's reimbursement rate established pursuant to paragraphs (1) and (2), or the approved Medi-Cal State Plan reimbursement rate, inclusive of the temporary increased Medicaid payments associated with the COVID-19 Public Health Emergency, plus the Proposition 56 supplemental payment amount, in effect for that facility on the last day of the COVID-19 Public Health Emergency.

(c) In implementing this section, the department shall seek any federal approvals it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(d) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section, in whole

or in part, by means of provider bulletins or other similar instructions, without taking regulatory action.

(e) (1) The department may modify any methodology or provision specified in this section to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized, only if that modification does not violate the spirit, purposes, and intent of this section.

(2) If the department determines that a modification is necessary pursuant to paragraph (1), the department shall consult with affected providers and stakeholders to the extent practicable.

SEC. 90. Section 14105.192 of the Welfare and Institutions Code is amended to read:

14105.192. (a) The Legislature finds and declares all of the following:

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

(2) In order to minimize the need for drastically cutting enrollment standards or benefits during times of economic crisis, it is crucial to find areas within the Medi-Cal program that have reimbursement levels higher than required under the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and may be reduced in accordance with federal law.

(3) The Medi-Cal program delivers its services and benefits to Medi-Cal beneficiaries through a wide variety of health care providers, some of which deliver care via managed care or other contract models while others do so through fee-for-service arrangements.

(4) The setting of rates within the Medi-Cal program is complex and subject to close supervision by the United States Department of Health and Human Services.

(5) As the single state agency for the Medicaid program in California, the department has unique expertise that can inform decisions that set or adjust reimbursement methodologies and levels consistent with the requirements of federal law.

(b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and consistent with federal and state law and policies, including exemptions contained in the act that added this section, provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services, and products.

(c) Notwithstanding any other law, the director shall adjust provider payments, as specified in this section.

(d) (1) Except as otherwise provided in this section, payments shall be reduced by 10 percent for Medi-Cal fee-for-service benefits for dates of service on and after June 1, 2011.

(2) For managed health care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except contracts with Senior Care Action Network and AIDS Healthcare Foundation, payments shall be reduced by the actuarial equivalent amount of the payment reductions specified in this section pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.

(3) Payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after June 1, 2011. This paragraph shall not apply to inpatient hospital services provided in a hospital that is paid under contract pursuant to Article 2.6 (commencing with Section 14081).

(4) (A) Notwithstanding any other law, the director may adjust the payments specified in paragraphs (1) and (3) with respect to one or more categories of Medi-Cal providers, or for one or more products or services rendered, or any combination thereof, if the resulting reductions to any category of Medi-Cal providers, in the aggregate, total no more than 10 percent.

(B) The adjustments authorized in subparagraph (A) shall be implemented only if the director determines that, for each affected product, service, or provider category, the payments resulting from the adjustment comply with subdivision (m).

(e) Notwithstanding this section, payments to hospitals that are not under contract with the department pursuant to Article 2.6 (commencing with Section 14081) for inpatient hospital services provided to Medi-Cal beneficiaries and that are subject to former Section 14166.245 shall be governed by that section.

(f) Notwithstanding this section, both of the following apply:

(1) Payments to providers that are paid pursuant to Article 3.8 (commencing with Section 14126) shall be governed by that article.

(2) (A) Subject to subparagraph (B), for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates for intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, as determined by the applicable methodology for setting reimbursement rates for these facilities, shall not exceed the reimbursement rates that were applicable to providers in the 2008–09 rate year.

(B) (i) If Section 14105.07 is added to the Welfare and Institutions Code during the 2011–12 Regular Session of the Legislature, subparagraph (A) shall become inoperative.

(ii) If Section 14105.07 is added to the Welfare and Institutions Code during the 2011–12 Regular Session of the Legislature, then for dates of service on and after June 1, 2011, payments to intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, and facilities providing

continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20, shall be governed by the applicable methodology for setting reimbursement rates for these facilities and by Section 14105.07.

(g) The department may enter into contracts with a vendor for the purposes of implementing this section on a bid or nonbid basis. In order to achieve maximum cost savings, the Legislature declares that an expedited process for contracts under this subdivision is necessary. Therefore, contracts entered into to implement this section and all contract amendments and change orders shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 Division 2 of the Public Contract Code.

(h) To the extent applicable, all of the following services, facilities, and payments shall be exempt from the payment reductions specified in subdivision (d):

(1) Acute hospital inpatient services that are paid under contracts pursuant to Article 2.6 (commencing with Section 14081).

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver pursuant to subsection (a) of Section 1115 of the federal Social Security Act (42 U.S.C. Sec. 1315(a)).

(3) Rural health clinic services.

(4) Payments to facilities owned or operated by the State Department of State Hospitals or the State Department of Developmental Services.

(5) Hospice services.

(6) Contract services, as designated by the director pursuant to subdivision (k).

(7) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations. This paragraph shall apply to payments described in paragraph (3) of subdivision (d) only to the extent that they are also exempt from reduction pursuant to subdivision (*l*).

(8) Services pursuant to local assistance contracts and interagency agreements to the extent the funding is not included in the funds appropriated to the department in the annual Budget Act.

(9) Breast and cervical cancer treatment provided pursuant to Section 14007.71 and as described in paragraph (3) of subdivision (a) of Section 14105.18 or Article 1.5 (commencing with Section 104160) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code.

(10) The Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to subdivision (aa) of Section 14132.

(11) (A) Effective for dates of service on or after July 1, 2015, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later, dental services and applicable ancillary services.

(B) For dental managed care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200),

payments pursuant to contract amendments or change orders effective on or after July 1, 2015, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later.

(12) For dates of service on and after January 1, 2022, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later, providers of complex rehabilitation technology and complex rehabilitation technology services, as described in Section 14132.85.

(13) For dates of service on and after July 1, 2022, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later, all of the following services and providers:

(A) Nurses, including certified nurse-midwives, nurse anesthetists, certified pediatric nurse practitioners, certified family nurse practitioners, and group certified pediatric nurse practitioners.

(B) Alternative birth centers as described in Section 14148.8.

(C) Audiologists and hearing aid dispensers as described in Section 14105.49 of this code and Section 51319 of Title 22 of the California Code of Regulations.

(D) Respiratory care providers as described in Section 51316 of Title 22 of the California Code of Regulations.

(E) Durable medical equipment, as described in Section 51160 of Title 22 of the California Code of Regulations.

(F) Chronic dialysis clinics.

(G) Emergency medical air transportation services as described in Section 76000.10 of the Government Code.

(H) Nonemergency medical transportation services as described in Section 51323 of Title 22 of the California Code of Regulations.

(I) Doula services as described in Section 14132.24.

(J) Community health worker services as described in the approved Medi-Cal State Plan.

(K) Durable medical equipment and related supplies or accessories, as described in Section 14105.48 and Section 51160 of Title 22 of the California Code of Regulations, that is a continuous glucose monitoring system or continuous glucose monitoring system supplies and accessories, as determined by the department.

(L) Health care services delivered via remote patient monitoring, authorized pursuant to subparagraph (B) of paragraph (1) of subdivision (f) of Section 14124.12.

(M) Asthma prevention services as described in the approved Medi-Cal State Plan.

(N) Dyadic services as described in Section 14132.755.

(O) Medication therapy management services as described in Section 14132.969.

(P) Clinical laboratory services, as defined in Section 51137.2 of Title 22 of the California Code of Regulations, that are 2019 Novel Coronavirus (COVID-19) diagnostic testing or specimen collection services, as determined by the department.

(Q) Blood banks, as described in Section 51052 of Title 22 of the California Code of Regulations.

(R) Occupational therapy, as described in Section 51085 of the California Code of Regulations.

(S) Orthotists, as described in Section 51101 of Title 22 of the California Code of Regulations.

(T) Psychologists, as described in Section 51099 of Title 22 of the California Code of Regulations.

(U) Medical social work or medical social services, as described in Section 51147 of Title 22 of the California Code of Regulations.

(V) Speech pathologists, as described in Section 51095 of Title 22 of the California Code of Regulations.

(W) Outpatient heroin detoxification services, as described in Section 51116 of Title 22 of the California Code of Regulations.

(X) Dispensing opticians, as described in Section 51090 of Title 22 of the California Code of Regulations.

(Y) Optometrists, including optometry groups, as described in Section 51091 of Title 22 of the California Code of Regulations.

(Z) Acupuncturists, as described in Section 51074 of Title 22 of the California Code of Regulations.

(AA) Portable imaging services, as described in Section 51193.1 of Title 22 of the California Code of Regulations.

(AB) The following primary care or specialty clinics, as determined by the department:

(i) Community clinics, as defined in Section 1204 of the Health and Safety Code.

(ii) Free clinics, as defined in Section 1204 of the Health and Safety Code.

(iii) Surgical clinics, as defined in Section 1204 of the Health and Safety Code.

(iv) Rehabilitation clinics, as defined in Section 1204 of the Health and Safety Code.

(v) Clinics exempt from licensure under Section 1206 of the Health and Safety Code, including nonhospital county-operated community clinics.

(AC) Services provided under the California Children's Services Program, established pursuant to Article 5 (commencing with Section 123845) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and under the Genetically Handicapped Persons Program, established pursuant to Article 1 (commencing with Section 125125) of Chapter 2 of Part 5 of Division 106 of the Health and Safety Code, as determined by the department.

(14) For dates of service on and after January 1, 2023, or the effective date of any necessary federal approvals as required by subdivisions (n) and (o), whichever is later, both of the following providers:

(A) Podiatrists, as described in Section 51075 of Title 22 of the California code of Regulations.

(B) Prosthetists, as described in Section 51103 of Title 22 of the California Code of Regulations.

(i) Subject to the exception for services listed in subdivision (h), the payment reductions required by subdivision (d) shall apply to the benefits rendered by any provider who may be authorized to bill for the service, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse-midwives, nurse anesthetists, and organized outpatient clinics.

(j) Notwithstanding any other law, for dates of service on and after June 1, 2011, Medi-Cal reimbursement rates applicable to the following classes of providers shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008–09 rate year, as described in subdivision (f) of Section 14105.191, reduced by 10 percent:

(1) Intermediate care facilities, excluding those facilities identified in paragraph (2) of subdivision (f). For purposes of this section, "intermediate care facility" has the same meaning as defined in Section 51118 of Title 22 of the California Code of Regulations.

(2) Skilled nursing facilities that are distinct parts of general acute care hospitals. For purposes of this section, "distinct part" has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(3) Rural swing-bed facilities.

(4) Subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this paragraph, "subacute care unit" has the same meaning as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(5) Pediatric subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this paragraph, "pediatric subacute care unit" has the same meaning as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(6) Adult day health care centers.

(7) Freestanding pediatric subacute care units, as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer this section by means of provider bulletins or similar instructions, without taking regulatory action.

(*l*) The reductions described in this section shall apply only to payments for services when the General Fund share of the payment is paid with funds directly appropriated to the department in the annual Budget Act and shall not apply to payments for services paid with funds appropriated to other departments or agencies.

(m) Notwithstanding this section, the payment reductions and adjustments provided for in subdivision (d) shall be implemented only if the director determines that the payments that result from the application of this section comply with applicable federal Medicaid program requirements and that federal financial participation will be available.

(1) In determining whether federal financial participation is available, the director shall determine whether the payments comply with applicable

federal Medicaid program requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(2) To the extent that the director determines that the payments do not comply with the federal Medicaid program requirements or that federal financial participation is not available with respect to any payment that is reduced pursuant to this section, the director shall retain the discretion to not implement the particular payment reduction or adjustment and may adjust the payment as necessary to comply with federal Medicaid program requirements.

(n) The department shall seek any necessary federal approvals for the implementation of this section.

(o) (1) The payment reductions and adjustments set forth in this section shall not be implemented until federal approval is obtained.

(2) To the extent that federal approval is obtained for one or more of the payment reductions and adjustments in this section and Section 14105.07, the payment reductions and adjustments set forth in Section 14105.191 shall cease to be implemented for the same services provided by the same class of providers. If there is a conflict between this section and Section 14105.191, other than the provisions setting forth a payment reduction or adjustment, this section shall govern.

(3) When federal approval is obtained, the payments resulting from the application of this section shall be implemented retroactively to June 1, 2011, or on any other date or dates, as may be applicable.

(4) The director may clarify the application of this subdivision by means of provider bulletins or similar instructions, pursuant to subdivision (k).

(p) Adjustments to pharmacy drug product payment pursuant to this section shall no longer apply when the department determines that the average acquisition cost methodology pursuant to Section 14105.45 has been fully implemented and the department's pharmacy budget reduction targets, consistent with payment reduction levels pursuant to this section, have been met.

SEC. 91. Section 14105.197 is added to the Welfare and Institutions Code, to read:

14105.197. (a) For dates of service on and after July 1, 2022, or the effective date of any necessary federal approvals as required by subdivision (b), whichever is later, the reimbursement rates or payments for all of the following services and providers may be maintained, using General Fund or other state funds appropriated to the department as the state share, at the payment levels in effect on December 31, 2021, including supplemental payments or rate increases, or both, as applicable, under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56, an initiative measure approved at the November 8, 2016, statewide general election) that were implemented with funds from the Healthcare Treatment Fund, as established pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code:

(1) Case management services provided under the Medi-Cal HIV/AIDS Waiver Program.

(2) Targeted payments for qualifying providers of Community-Based Adult Services (CBAS), as described in Section 14186.3 and subdivision (d) of Section 14184.201, based on criteria established and updated by the department, which may include, but need not be limited to, higher operating costs for CBAS providers in certain areas of the state.

(3) Developmental screenings for individuals zero to three years of age, inclusive, as described in Section 14132.195.

(4) Adverse Childhood Experiences (ACEs) trauma screenings.

(5) Nonemergency medical transportation.

(6) Home health providers of medically necessary in-home services for children and adults in the Medi-Cal fee-for-service system or through home and community-based services waivers.

(7) Pediatric day health care facilities in the Medi-Cal fee-for-service system.

(b) In implementing this section, the department shall seek any federal approvals it deems necessary. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(c) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section, in whole or in part, by means of provider bulletins or other similar instructions, without taking any further regulatory action.

(d) The department shall develop the eligibility criteria, methodologies, and parameters for the payments and rate increases maintained pursuant to subdivision (a), and may revise the eligibility criteria, methodologies, and parameters, for purposes including, but not limited to, obtaining or maintaining any necessary federal approvals as required by subdivision (b).

SEC. 92. Section 14105.2 of the Welfare and Institutions Code is amended to read:

14105.2. (a) The allowable markup payable for the dispensing of medical supplies by assistive device and sickroom supply dealers and pharmacies shall not exceed 23 percent of the estimated acquisition cost of the item dispensed, as defined by the department.

(b) Payment for diabetic testing supplies shall not exceed the estimated acquisition cost of the item dispensed, as defined by the department, plus a fee equal to the maximum professional fee component used in the payment for legend generic drug types.

(c) In determining the estimated acquisition costs of products pursuant to this section, the department shall consider provider related costs of the product that include, but are not limited to, shipping, handling, storage, and delivery.

(d) This section shall remain in effect only until July 1, 2022, and as of that date is repealed.

SEC. 93. Section 14105.2 is added to the Welfare and Institutions Code, to read:

14105.2. (a) The allowable markup payable for the dispensing of medical supplies, including diabetic supplies except as indicated in subdivision (b), by assistive device and sickroom supply dealers and pharmacies shall not exceed 23 percent of the estimated acquisition cost of the item dispensed, as defined by the department.

(b) Payment for diabetic test strips, lancets, and insulin syringes shall not exceed the estimated acquisition cost of the item dispensed, as defined by the department, plus a fee equal to the maximum professional fee component used in the payment for legend generic drug types.

(c) In determining the estimated acquisition costs of products pursuant to this section, the department shall consider provider related costs of the product that include, but are not limited to, shipping, handling, storage, and delivery.

(d) This section shall become operative on July 1, 2022.

SEC. 94. Section 14105.48 of the Welfare and Institutions Code is amended to read:

14105.48. (a) The department shall establish a list of covered services and maximum allowable reimbursement rates for durable medical equipment, as defined in Section 51160 of Title 22 of the California Code of Regulations, and the list shall be published in provider manuals. The list shall specify utilization controls to be applied to each type of durable medical equipment.

(b) Reimbursement for durable medical equipment, except wheelchairs, wheelchair accessories, and speech-generating devices and related accessories, shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, (2) an amount that does not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare Program for the same or similar item or service, or (3) the guaranteed acquisition cost negotiated by means of the contracting process provided for pursuant to Section 14105.3 plus a percentage markup to be established by the department.

(c) Reimbursement for wheelchairs, wheelchair accessories, and speech-generating devices and related accessories shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, (2) an amount that does not exceed 100 percent of the lowest maximum allowance for California established by the federal Medicare Program for the same or similar item or service, or (3) the guaranteed acquisition cost negotiated by means of the contracting process provided for pursuant to Section 14105.3 plus a percentage markup to be established by the department.

(d) Reimbursement for all durable medical equipment billed to the Medi-Cal program utilizing codes with no specified maximum allowable rate shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, (2) the guaranteed acquisition cost negotiated by means of the contracting process provided for pursuant to Section 14105.3 plus a percentage markup to be established by the department, (3) the actual acquisition cost plus a markup to be established by the department, (4) the manufacturer’s suggested retail

purchase price on or prior to the date of service, and documented by a printed catalog or a hard copy of an electronic catalog page showing that price, reduced by a percentage discount not to exceed 20 percent, or not to exceed 15 percent for wheelchairs and wheelchair accessories if the provider employs or contracts with a qualified rehabilitation technology professional, as defined in Section 14132.85, or (5) a price established through targeted product-specific cost containment provisions developed with providers.

(e) Reimbursement for all durable medical equipment supplies and accessories billed to the Medi-Cal program shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, or (2) the acquisition cost plus a 23 percent markup.

(f) (1) Commencing January 1, 2007, reimbursement for oxygen delivery systems and oxygen contents shall utilize national HCPCS codes, and shall be the lesser of (1) the amount billed pursuant to Section 51008.1 of Title 22 of the California Code of Regulations, (2) an amount that does not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare Program for the same or a similar item or service, or (3) the guaranteed acquisition cost negotiated by means of the contracting process provided for pursuant to Section 14105.3, plus a percentage markup to be established by the department.

(2) Effective July 1, 2022, reimbursement for durable medical equipment that is considered to be oxygen and respiratory equipment, as determined by the department, shall not exceed 100 percent of the lowest maximum allowance for California established by the federal Medicare Program for the same or similar item or service.

(g) Within six months of the effective date of the act that added this subdivision, the department shall review utilization of services and equipment resulting from the changes to this section made by that act, and shall assess whether the changes are contributing to inappropriate use of those services or equipment. If the department's review finds an increase in inappropriate use of those services or equipment, the Department of Finance shall notify the Joint Legislative Budget Committee of the State Department of Health Services' findings and recommended changes to ensure program integrity.

(h) Any regulation in Division 3 of Title 22 of the California Code of Regulations that contains provisions for reimbursement rates for durable medical equipment shall be amended or repealed effective for dates of service on or after the date of the act adding this section.

(i) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section, in whole or in part, by means of provider bulletins or other similar instructions, without taking any further regulatory action.

(j) The department shall consult with interested parties and appropriate stakeholders in implementing this section with respect to all of the following:

(1) Notifying the provider representatives of the proposed change.

(2) Scheduling at least one meeting to discuss the change.

(3) Allowing for written input regarding the change.

(4) Providing advance notice on the implementation and effective date of the change.

(k) The department may require providers of durable medical equipment to appeal Medicare denials for dually eligible beneficiaries as a condition of Medi-Cal payment.

SEC. 95. Section 14124.12 of the Welfare and Institutions Code is amended to read:

14124.12. (a) (1) Notwithstanding any other law, for the duration of the COVID-19 emergency period, the department shall implement any federal Medicaid program waiver or flexibility approved by the federal Centers for Medicare and Medicaid Services related to the COVID-19 public health emergency. This includes, but is not limited to, any waiver or flexibility approved pursuant to Sections 1315, 1320b-5, or 1396n of Title 42 of the United States Code, or the Medi-Cal state plan. Any request for a federal Medicaid program waiver or flexibility shall be subject to Department of Finance approval before the department submits that request to the federal Centers for Medicare and Medicaid Services.

(2) During the COVID-19 emergency period, and through December 31, 2022, for any extended waiver or flexibility described in subdivision (f), if there is a conflict between this chapter, Chapter 8 (commencing with Section 14200), Chapter 8.8 (commencing with Section 14600), or Chapter 8.9 (commencing with Section 14700), and any approved federal waiver or flexibility, as described in paragraph (1), the approved federal waiver or flexibility shall control over any conflict in the specified state law.

(b) (1) To the extent that federal financial participation is available, the department, subject to Department of Finance approval, shall exercise its option under Section 1396a(a)(10)(A)(ii)(XXIII) of Title 42 of the United States Code to extend the medical assistance, as described in Section 1396a(a)(10)(A)(ii)(XVIII) of Title 42 of the United States Code, to uninsured individuals, as defined in Section 1396a(ss) of Title 42 of the United States Code, for the duration of the COVID-19 emergency period.

(2) The department, subject to Department of Finance approval, may seek federal approval pursuant to Section 1315 of Title 42 of the United States Code to extend the medical assistance afforded to uninsured individuals pursuant to paragraph (1) to include COVID-19-related treatment services that are otherwise covered for full-scope Medi-Cal beneficiaries, as defined by the department. If federal financial participation is unavailable, the department, subject to Department of Finance approval, may elect to implement this paragraph on a state-only funding basis, and subject to an appropriation by the Legislature.

(c) Notwithstanding any other law, the department shall seek to maximize federal financial participation for Medi-Cal expenditures that it determines to be available for the COVID-19 public health emergency, and shall comply with any federal requirements and conditions for receipt of that federal financial participation. This includes, but is not limited to, the temporary increase in the federal medical assistance percentage made available pursuant

to Section 6008 of the federal Families First Coronavirus Response Act (Public Law 116-127).

(d) Due to the impact of the COVID-19 public health emergency on the department's ongoing administration of the Medi-Cal program, the department may seek any federal approvals it deems necessary for any number of temporary extensions of all or select components of the California Medi-Cal 2020 Demonstration (No. 11-W-00193/9) pursuant to Article 5.5 (commencing with Section 14184), which is scheduled to expire on December 31, 2020. If the department elects to seek any extension, the department shall determine the length of time for the extension sought and whether to seek an extension for the entirety of the demonstration or select components of the demonstration. In implementing this subdivision, the department, to the extent practicable, shall consult with affected stakeholder entities before seeking a temporary extension.

(e) The department, subject to Department of Finance approval, shall seek any federal approvals it deems necessary to implement this section or to maintain sufficient access to covered benefits under the Medi-Cal program during the COVID-19 emergency period. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(f) (1) (A) The department shall seek any federal approvals it deems necessary to extend the approved waiver or flexibility implemented pursuant to subdivision (a), as of July 1, 2021, that are related to the delivery and reimbursement of services via telehealth modalities in the Medi-Cal program. Subject to subdivision (e), the department shall implement those extended waivers or flexibilities for which federal approval is obtained, to commence on the first calendar day immediately following the last calendar day of the federal COVID-19 public health emergency period, and through December 31, 2022.

(B) Subject to subdivision (e), the department may authorize the use of remote patient monitoring as an allowable telehealth modality for covered health care services and provider types it deems appropriate for dates of service on or after July 1, 2021. The department may establish a fee schedule for applicable health care services delivered via remote patient monitoring.

(2) (A) For purposes of informing the 2022–23 proposed Governor's Budget, released in January 2022, the department shall convene an advisory group consisting of consultants, subject matter experts, and other affected stakeholders to provide recommendations to inform the department in establishing and adopting billing and utilization management protocols for telehealth modalities to increase access and equity and reduce disparities in the Medi-Cal program. The advisory group shall analyze the impact of telehealth in increased access for patients, changes in health quality outcomes and utilization, best practices for the appropriate mix of in-person visits and telehealth, and the benefits or liabilities of any practice or care model changes that have resulted from telephonic visits.

(B) The advisory group shall include representatives of the California Medical Association, the California Primary Care Association, the California

Association of Public Hospitals, the County Behavioral Health Directors Association, Medi-Cal managed care plans, Planned Parenthood Affiliates of California, Essential Access Health, and other subject matter experts or other affected stakeholders as identified by the department.

(3) For purposes of implementing this subdivision, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this paragraph shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(4) Nothing in this subdivision shall be construed to limit coverage of, and reimbursement for, telehealth modalities that are the type authorized by the department prior to the COVID-19 emergency period and described in the Medi-Cal State Plan, the Medi-Cal provider manual, or other departmental guidance.

(g) (1) Notwithstanding any other law, subject to appropriation by the Legislature and Section 11.95 of the Budget Act of 2021, the department shall implement those activities and expenditures to enhance, expand, or strengthen home and community-based services (HCBS) under the Medi-Cal program that are approved by the federal Centers for Medicare and Medicaid Services pursuant to Section 9817 of the federal American Rescue Plan Act of 2021 (Public Law 117-2) and associated federal guidance.

(2) Notwithstanding any other law, the department shall comply with any federal requirements and conditions as necessary to claim the increased federal medical assistance percentage for eligible HCBS expenditures pursuant to Section 9817 of the federal American Rescue Plan Act of 2021 (Public Law 117-2) and associated federal guidance.

(3) Notwithstanding any other law, stipends or payments received by an individual from initiatives included in the approved HCBS spending plan described in this subdivision shall not be considered income or resources for purposes of determining the individual's, or any member of their household's, eligibility for benefits or assistance, or the amount or extent of benefits or assistance, under any state or local benefit or assistance program, to the extent permitted under federal law and, where applicable, to the extent any necessary federal approvals are obtained.

(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, the State Department of Social Services, the California Department of Aging, the State Department of Public Health, the State Department of Developmental Services, the State Department of Rehabilitation, and the Department of Health Care Access and Information, as applicable, may implement, interpret, or make specific this subdivision and any HCBS activity described in paragraph (1) by means of all-county letters, plan

letters, provider bulletins, or other similar instructions, without taking any further regulatory action.

(5) For purposes of implementing this subdivision and any HCBS activity described in paragraph (1), the department, the State Department of Social Services, the California Department of Aging, the State Department of Public Health, the State Department of Developmental Services, the State Department of Rehabilitation, and the Department of Health Care Access and Information, as applicable, may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this paragraph, and the implementation of any HCBS activity described in paragraph (1), shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Chapters 7 (commencing with Section 9530) and 7.5 (commencing with Section 9540) of Division 8.5 of this code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(6) Any funding made available to the Traumatic Brain Injury Program in the State Department of Rehabilitation pursuant to paragraph (1) shall be exempted from subdivision (b) of Section 4355, subdivision (b) of Section 4357, and subdivision (c) of Section 4357.1.

(h) Notwithstanding any other law, upon expiration of the COVID-19 emergency period and subject to subdivision (e), the department shall continue to reimburse the administration of a COVID-19 vaccine at 100 percent of the Medicare national equivalent rates in effect at the time the vaccine is administered and without any geographic adjustment.

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

(j) For purposes of this section, the following definitions apply:

(1) "COVID-19 emergency period" has the same meaning as "emergency period" as defined in Section 1320b-5(g)(1)(B) of Title 42 of the United States Code, unless otherwise defined in federal law or any federal approval obtained pursuant to this section.

(2) "COVID-19 public health emergency" means the Public Health Emergency declared by the Secretary of the United States Department of Health and Human Services on January 31, 2020, pursuant to Section 247d of Title 42 of the United States Code, and entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," including any subsequent renewal of that declaration.

SEC. 96. Section 14132.100 of the Welfare and Institutions Code is amended to read:

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d(a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accordance with the definition of "visit" set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1 thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accordance with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(F) Any changes in any of the services described in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites.

(G) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in subdivision (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

(I) Any changes in the scope of a project approved by the federal Health Resources and Services Administration (HRSA).

(3) A change in costs is not, in and of itself, a scope-of-service change, unless all of the following apply:

(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of services defined in subdivisions (a) and (b), as applicable.

(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section 413) of Subchapter B of Chapter 4 of Title 42 of the Code of Federal Regulations, or its successor.

(C) The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75-percent threshold shall be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

(4) An FQHC or RHC may submit requests for scope-of-service changes once per fiscal year, only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(5) An FQHC or RHC shall submit a scope-of-service rate change request within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a scope-of-service rate change request within 90 days of the beginning of the following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change shall be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to "fiscal year" shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision (*l*). These supplemental payments shall be determined separately from the scope-of-service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include both of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant, two hundred thousand dollars ($200,000) or 1 percent of a facility's total costs, whichever is less.

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) (1) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal practitioner, as defined in Section 51179.7 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a four-hour

day of attendance at an adult day health care center, and any other provider identified in the state plan's definition of an FQHC or RHC visit.

(2) (A) A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist.

(B) Notwithstanding subdivision (e), if an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice, or a marriage and family therapist for the purposes of establishing its FQHC or RHC rate chooses to bill these services as a separate visit, the FQHC or RHC shall apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, shall bill these services as a separate visit. However, multiple encounters with dental professionals or marriage and family therapists that take place on the same day shall constitute a single visit. The department shall develop the appropriate forms to determine which FQHC's or RHC's rates shall be adjusted and to facilitate the calculation of the adjusted rates. An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this subparagraph shall not constitute a change in scope of service within the meaning of subdivision (e). An FQHC or RHC that applies for an adjustment to its rate pursuant to this subparagraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment for visits between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist has been approved. Any approved increase or decrease in the provider's rate shall be made within six months after the date of receipt of the department's rate adjustment forms pursuant to this subparagraph and shall be retroactive to the beginning of the fiscal year in which the FQHC or RHC submits the request, but in no case shall the effective date be earlier than January 1, 2008.

(C) An FQHC or RHC that does not provide dental hygienist, dental hygienist in alternative practice, or marriage and family therapist services, and later elects to add these services and bill these services as a separate visit, shall process the addition of these services as a change in scope of service pursuant to subdivision (e).

(3) Notwithstanding any other provision of this section, no later than July 1, 2018, a visit shall include a marriage and family therapist.

(4) (A) (i) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using video synchronous interaction, when services delivered through that interaction meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were

delivered via a face-to-face encounter. An FQHC or RHC is not precluded from establishing a new patient relationship through video synchronous interaction. An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from that FQHC pursuant to HRSA requirements.

(ii) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using audio-only synchronous interaction, when services delivered through that modality meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

(iii) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using an asynchronous store and forward modality, when services delivered through that modality meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

(iv) An FQHC or RHC may not establish a new patient relationship using an audio-only synchronous interaction. Notwithstanding this prohibition, the department may provide for specific exceptions to this prohibition, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(v) An FQHC or RHC is not precluded from establishing a new patient relationship through an asynchronous store and forward modality, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, if the visit meets all of the following conditions:

(I) The patient is physically present at an originating site that is a licensed or intermittent site of the FQHC or RHC at the time the service is performed.

(II) The individual who creates the patient records at the originating site is an employee or contractor of the FQHC or RHC, or other person lawfully authorized by the FQHC or RHC to create a patient record.

(III) The FQHC or RHC determines that the billing provider is able to meet the applicable standard of care.

(IV) An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from that FQHC pursuant to HRSA requirements.

(B) (i) Pursuant to an effective date designated by the department that is no sooner than January 1, 2024, an FQHC or RHC furnishing applicable health care services via audio-only synchronous interaction shall also offer those same health care services via video synchronous interaction to preserve beneficiary choice.

(ii) The department may provide specific exceptions to the requirement specified in clause (i), based on an FQHC's or RHC's access to requisite technologies, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(iii) Effective on the date designated by the department pursuant to clause (i), an FQHC or RHC furnishing services through video synchronous interaction or audio-only synchronous interaction shall also do one of the following:

(I) Offer those services via in-person, face-to-face contact.

(II) Arrange for a referral to, and a facilitation of, in-person care that does not require a patient to independently contact a different provider to arrange for that care.

(iv) In addition to any existing law requiring beneficiary consent to telehealth, including, but not limited to, subdivision (b) of Section 2290.5 of the Business and Professions Code, all of the following shall be communicated by an FQHC or RHC to a Medi-Cal beneficiary, in writing or verbally, on at least one occasion prior to, or concurrent with, initiating the delivery of one or more health care services via telehealth to a Medi-Cal beneficiary: an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit; an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for nonmedical transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the FQHC or RHC.

(I) The FQHC or RHC shall document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received.

(II) The department shall develop, in consultation with affected stakeholders, model language for purposes of the communication described in this subparagraph.

(C) The department shall seek any federal approvals it deems necessary to implement this paragraph. This paragraph shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized.

(D) This paragraph shall be operative on January 1, 2023, or on the operative date or dates reflected in the applicable federal approvals obtained by the department pursuant to subparagraph (C), whichever is later. This paragraph shall not be construed to limit coverage of, and reimbursement for, covered telehealth services provided before the operative date of this paragraph.

(E) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this paragraph by means of all-county letters, plan letters, provider manuals, information notices, provider bulletins, and similar instructions, without taking any further regulatory action.

(F) Telehealth modalities authorized pursuant to this paragraph shall be subject to the billing, reimbursement, and utilization management policies imposed by the department.

(G) Services delivered via telehealth modalities described in this paragraph shall comply with the privacy and security requirements contained in the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, the Medicaid state plan, and any other applicable state and federal statutes and regulations.

(5) For purposes of this section, "physician" shall be interpreted in a manner consistent with the federal Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a physician and surgeon, osteopath, podiatrist, dentist, optometrist, and chiropractor.

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity, as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code, the Medicare Program, or the Child Health and Disability Prevention (CHDP) Program, the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) Provided that the following entities are not operating as intermittent clinics, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, each entity shall have its reimbursement rate established in accordance with one of the methods outlined in paragraph (2) or (3), as selected by the FQHC or RHC:

(A) An entity that first qualifies as an FQHC or RHC in 2001 or later.

(B) A newly licensed facility at a new location added to an existing FQHC or RHC.

(C) An entity that is an existing FQHC or RHC that is relocated to a new site.

(2) (A) An FQHC or RHC that adds a new licensed location to its existing primary care license under paragraph (1) of subdivision (b) of Section 1212 of the Health and Safety Code may elect to have the reimbursement rate for the new location established in accordance with paragraph (3), or notwithstanding subdivision (e), an FQHC or RHC may choose to have one PPS rate for all locations that appear on its primary care license determined by submitting a change in scope of service request if both of the following requirements are met:

(i) The change in scope of service request includes the costs and visits for those locations for the first full fiscal year immediately following the date the new location is added to the FQHC's or RHC's existing licensee.

(ii) The FQHC or RHC submits the change in scope of service request within 90 days after the FQHC's or RHC's first full fiscal year.

(B) The FQHC's or RHC's single PPS rate for those locations shall be calculated based on the total costs and total visits of those locations and shall be determined based on the following:

(i) An audit in accordance with Section 14170.

(ii) Rate changes based on a change in scope of service request shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successors.

(iii) Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(C) Except as specified in subdivision (j), this paragraph does not apply to a location that was added to an existing primary care clinic license by the State Department of Public Health, whether by a regional district office or the centralized application unit, prior to January 1, 2017.

(3) If an FQHC or RHC does not elect to have the PPS rate determined by a change in scope of service request, the FQHC or RHC shall have the reimbursement rate established for any of the entities identified in paragraph (1) or (2) in accordance with one of the following methods at the election of the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing

FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(4) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously submitted an annual utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs.

(5) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its FQHC or RHC enrollment approval, and the department shall reconcile the difference between the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

(j) (1) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, in a mobile unit as defined by paragraph (2) of subdivision (b) of Section 1765.105 of the Health and Safety Code, or at the election of the FQHC or RHC and subject to paragraph (2), a location added to an existing primary care clinic license by the State Department of Public Health prior to January 1, 2017, shall be billed by and reimbursed at the same rate as the FQHC or RHC that either established the intermittent clinic site or mobile unit, or that held the clinic license to which the location was added prior to January 1, 2017.

(2) If an FQHC or RHC with at least one additional location on its primary care clinic license that was added by the State Department of Public Health prior to January 1, 2017, applies for an adjustment to its per-visit rate based

on a change in the scope of services provided by the FQHC or RHC as described in subdivision (e), all locations on the FQHC's or RHC's primary care clinic license shall be subject to a scope-of-service adjustment in accordance with either paragraph (2) or (3) of subdivision (i), as selected by the FQHC or RHC.

(3) This subdivision does not preclude or otherwise limit the right of the FQHC or RHC to request a scope-of-service adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes. An FQHC or RHC that reverses its election under this subdivision shall revert to its prior rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable scope-of-service adjustments as provided in subdivision (e).

(*l*) Reimbursement for Drug Medi-Cal services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC may elect to have Drug Medi-Cal services reimbursed directly from a county or the department under contract with the FQHC or RHC pursuant to paragraph (4).

(2) (A) For an FQHC or RHC to receive reimbursement for Drug Medi-Cal services directly from the county or the department under contract with the FQHC or RHC pursuant to paragraph (4), costs associated with providing Drug Medi-Cal services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing Drug Medi-Cal services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering Drug Medi-Cal services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver Drug Medi-Cal services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering Drug Medi-Cal services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing Drug Medi-Cal services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the Drug Medi-Cal services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering Drug Medi-Cal services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change request shall include a full fiscal year of activity that does not include Drug Medi-Cal services costs.

(B) An FQHC or RHC may submit requests for scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope-of-service change request under this subdivision approved by the department shall be retroactive to the first day that Drug Medi-Cal services were rendered and reimbursement for Drug Medi-Cal services was received outside of the PPS rate, but in no case shall the effective date be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for Drug Medi-Cal services outside of the PPS rate when the FQHC or RHC obtains approval as a Drug Medi-Cal provider and enters into a contract with a county or the department to provide these services pursuant to paragraph (4).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(F) For purposes of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and Drug Medi-Cal services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate and the FQHC or RHC is approved as a Drug Medi-Cal provider, an FQHC or RHC shall not bill the PPS rate for any Drug Medi-Cal services provided pursuant to a contract entered into with a county or the department pursuant to paragraph (4).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) Reimbursement for Drug Medi-Cal services shall be determined according to subparagraph (A) or (B), depending on whether the services are provided in a county that participates in the Drug Medi-Cal organized delivery system (DMC-ODS).

(A) In a county that participates in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county or county designee and the FQHC or RHC. If the county or county designee refuses to contract with the FQHC or RHC, the FQHC or RHC may follow the contract denial process set forth in the Special Terms and Conditions.

(B) In a county that does not participate in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon

contract entered into between the county and the FQHC or RHC. If the county refuses to contract with the FQHC or RHC, the FQHC or RHC may request to contract directly with the department and shall be reimbursed for those services at the Drug Medi-Cal fee-for-service rate.

(5) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments for Drug Medi-Cal services made pursuant to this subdivision.

(6) For purposes of this subdivision, the following definitions apply:

(A) "Drug Medi-Cal organized delivery system" or "DMC-ODS" means the Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions.

(B) "Special Terms and Conditions" has the same meaning as set forth in subdivision (o) of Section 14184.10.

(m) Reimbursement for specialty mental health services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC and one or more mental health plans that contract with the department pursuant to Section 14712 may mutually elect to enter into a contract to have the FQHC or RHC provide specialty mental health services to Medi-Cal beneficiaries as part of the mental health plan's network.

(2) (A) For an FQHC or RHC to receive reimbursement for specialty mental health services pursuant to a contract entered into with the mental health plan under paragraph (1), the costs associated with providing specialty mental health services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing specialty mental health services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering specialty mental health services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver specialty mental health services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering specialty mental health services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing specialty mental health services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the specialty mental health services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering specialty mental health services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change

request shall include a full fiscal year of activity that does not include specialty mental health costs.

(B) An FQHC or RHC may submit requests for a scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope-of-service change request under this subdivision approved by the department is retroactive to the first day that specialty mental health services were rendered and reimbursement for specialty mental health services was received outside of the PPS rate, but the effective date shall not be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for specialty mental health services outside of the PPS rate when the FQHC or RHC contracts with a mental health plan to provide these services pursuant to paragraph (1).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(F) For the purpose of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and specialty mental health services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate, an FQHC or RHC shall not bill the PPS rate for any specialty mental health services that are provided pursuant to a contract entered into with a mental health plan pursuant to paragraph (1).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments made for specialty mental health services under this subdivision.

(n) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, scope-of-service changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under all other provisions of law of this state.

(o) The department shall promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for

Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

(p) The department shall implement this section only to the extent that federal financial participation is available.

(q) Notwithstanding any other law, the director may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific subdivisions (*l*) and (m) by means of a provider bulletin or similar instruction. The department shall notify and consult with interested parties and appropriate stakeholders in implementing, interpreting, or making specific the provisions of subdivisions (*l*) and (m), including all of the following:

(1) Notifying provider representatives in writing of the proposed action or change. The notice shall occur, and the applicable draft provider bulletin or similar instruction, shall be made available at least 10 business days prior to the meeting described in paragraph (2).

(2) Scheduling at least one meeting with interested parties and appropriate stakeholders to discuss the proposed action or change.

(3) Allowing for written input regarding the proposed action or change, to which the department shall provide summary written responses in conjunction with the issuance of the applicable final written provider bulletin or similar instruction.

(4) Providing at least 60 days advance notice of the effective date of the proposed action or change.

SEC. 97. Section 14132.57 is added to the Welfare and Institutions Code, to read:

14132.57. (a) (1) The department shall seek all necessary federal approvals to exercise the option described in Section 1396w-6 of Title 42 of the United States Code, to provide qualifying community-based mobile crisis intervention services to eligible Medi-Cal beneficiaries experiencing a mental health or substance use disorder crisis.

(2) Qualifying community-based mobile crisis intervention services shall be available to eligible Medi-Cal beneficiaries exclusively through a Medi-Cal behavioral health delivery system.

(b) The department shall comply with any federal requirements and conditions for receipt of the increased federal medical assistance percentage described in Section 1396w-6(c) of Title 42 of the United States Code and any associated federal regulations or guidance for qualifying community-based mobile crisis intervention services.

(c) Subject to obtaining the federal approvals described in subdivision (a), the department shall do all of the following:

(1) Establish requirements for the receipt of qualifying community-based mobile crisis intervention services by eligible Medi-Cal beneficiaries experiencing a mental health or substance use disorder crisis, including, but not limited to, utilization controls.

(2) Establish requirements for authorized providers of qualifying community-based mobile crisis intervention services.

(3) Oversee and enforce the requirements and guidelines developed pursuant to this section.

(d) For the purposes of implementing this section, including, but not limited to, providing training and technical assistance, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(e) Subject to federal approval, this section shall be implemented no sooner than January, 1, 2023, and shall be implemented up to the end of the five-year period specified in Section 1396w-6 of Title 42 of the United States Code.

(f) This section shall be implemented only to the extent that any necessary federal approvals have been obtained and federal financial participation is available and not otherwise jeopardized.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions, without taking any further regulatory action. To the extent practicable, the department shall consult with interested stakeholders when issuing guidance pursuant to this subdivision.

(h) For purposes of this section, the following definitions apply:

(1) "Medi-Cal behavioral health delivery system" has the same meaning as set forth in subdivision (i) of Section 14184.101.

(2) "Qualifying community-based mobile crisis intervention services" has the same meaning as set forth in Section 1396w-6(b) of Title 42 of the United States Code.

SEC. 98. Section 14132.725 of the Welfare and Institutions Code is repealed.

SEC. 99. Section 14132.725 is added to the Welfare and Institutions Code, to read:

14132.725. (a) For purposes of this section, the following definitions apply:

(1) "Border community" means border areas adjacent to the State of California where it is customary practice for California residents to use medical resources in adjacent areas outside the state. Under these circumstances, program controls and limitations are the same as for services rendered by health care providers within the state.

(2) "Health care provider" has the same meaning as set forth in paragraph (3) of subdivision (a) of Section 2290.5 of the Business and Professions Code, and shall be either enrolled as a Medi-Cal rendering provider, or a nonphysician medical practitioner affiliated with an enrolled Medi-Cal

provider group. “Health care provider” also includes any provider type designated by the department pursuant to subparagraph (A) of paragraph (2) of subdivision (b). The enrolled Medi-Cal provider or provider group for which the health care provider renders services via telehealth shall meet all Medi-Cal requirements and shall be located in the state or a border community.

(3) “Health care service plan” has the same meaning as set forth in subdivision (f) of Section 1345 of the Health and Safety Code.

(4) “Medi-Cal managed care plan” has the same meaning as set forth in subdivision (j) of Section 14184.101.

(5) “Network provider” has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(6) “Telehealth” has the same meaning as set forth in paragraph (6) of subdivision (a) of Section 2290.5 of the Business and Professions Code.

(b) (1) Subject to subdivision (k), in-person, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for covered health care services and provider types designated by the department, when provided by video synchronous interaction, asynchronous store and forward, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet the applicable standard of care and meet the requirements of the service code being billed.

(2) (A) In implementing this section, the department shall designate and periodically update the covered health care services and provider types, including required licensing and credentialing criteria, as applicable, which may be appropriately delivered via the telehealth modalities described in this subdivision.

(B) Applicable health care services appropriately provided through video synchronous interaction, asynchronous store and forward, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities are subject to billing, reimbursement, and utilization management policies imposed by the department. Subject to subdivision (k), utilization management protocols adopted by the department pursuant to this section shall be consistent with, and no more restrictive than, those authorized for health care service plans pursuant to Section 1374.13 of the Health and Safety Code.

(c) (1) (A) Pursuant to an effective date designated by the department that is no sooner than January 1, 2024, a Medi-Cal provider furnishing applicable health care services via audio-only synchronous interaction shall also offer those same health care services via video synchronous interaction to preserve beneficiary choice.

(B) The department may provide specific exceptions to the requirement specified in subparagraph (A), based on a Medi-Cal provider’s access to requisite technologies, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(2) Effective on the date designated by the department pursuant to paragraph (1), a provider furnishing services through video synchronous interaction or audio-only synchronous interaction shall also do one of the following:

(A) Offer those services via in-person, face-to-face contact.

(B) Arrange for a referral to, and a facilitation of, in-person care that does not require a patient to independently contact a different provider to arrange for that care.

(3) In implementing this subdivision, the department shall consider additional recommendations from affected stakeholders regarding the need to maintain access to in-person services without unduly restricting access to telehealth services.

(4) A health care provider may establish a new patient relationship with a Medi-Cal beneficiary via video synchronous interaction consistent with any requirements imposed by the department.

(5) A health care provider shall not establish a new patient relationship with a Medi-Cal beneficiary via asynchronous store and forward, telephonic (audio-only) synchronous interaction, remote patient monitoring, or other virtual communication modalities, except as set forth in paragraph (4) of subdivision (g) of Section 14132.100. Notwithstanding this prohibition, the department may provide for specific exceptions to this prohibition, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(6) Subject to subdivision (k), the department may establish separate fee schedules for applicable health care services delivered via remote patient monitoring or other permissible virtual communication modalities.

(7) This subdivision does not apply to Medi-Cal covered services delivered by providers via any telehealth modality to eligible inmates in state prisons, county jails, or youth correctional facilities.

(d) In addition to any existing law requiring beneficiary consent to telehealth, including, but not limited to, subdivision (b) of Section 2290.5 of the Business and Professions Code, all of the following shall be communicated by a health care provider to a Medi-Cal beneficiary, in writing or verbally, on at least one occasion prior to, or concurrent with, initiating the delivery of one or more health care services via telehealth to a Medi-Cal beneficiary: an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit; an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider.

(1) The provider shall document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received.

(2) The department shall develop, in consultation with affected stakeholders, model language for purposes of the communication described in this subdivision.

(3) This subdivision does not apply to Medi-Cal covered services delivered by providers via any telehealth modality to eligible inmates in state prisons, county jails, or youth correctional facilities.

(e) (1) The department shall develop, in consultation with affected stakeholders, an informational notice to be distributed to fee-for-service Medi-Cal beneficiaries and for use by Medi-Cal managed care plans in communicating to their enrollees. Information in the notice shall include, but not be limited to, all of the following:

(A) The availability of Medi-Cal covered telehealth services.

(B) The beneficiary's right to access all medically necessary covered services through in-person, face-to-face visits, and a provider's and Medi-Cal managed care plan's responsibility to offer or arrange for that in-person care, as applicable.

(C) An explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn by the Medi-Cal beneficiary at any time without affecting their ability to access covered Medi-Cal services in the future.

(D) An explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted.

(E) Notification of the beneficiary's right to make complaints about the offer of telehealth services in lieu of in-person care or about the quality of care delivered through telehealth.

(2) The informational notice shall be translated into threshold languages determined by the department pursuant to subdivision (b) of Section 14029.91 and provided in a format that is culturally and linguistically appropriate.

(3) This subdivision does not apply to Medi-Cal covered services delivered by providers via any telehealth modality to eligible inmates in state prisons, county jails, or youth correctional facilities.

(f) (1) Subject to subdivision (k), the department shall reimburse health care providers of applicable health care services delivered via video synchronous interaction, synchronous audio-only modality, or asynchronous store and forward, as applicable, at payment amounts that are not less than the amounts the provider would receive if the services were delivered via in-person, face-to-face contact, so long as the services or settings meet the applicable standard of care and meet the requirements of the service code being billed.

(2) Subject to subdivision (k), for applicable health care services appropriately provided by a network provider via video synchronous interaction, audio-only synchronous interaction modality, or asynchronous

store and forward, as applicable, to an enrollee of a Medi-Cal managed care plan, the Medi-Cal managed care plan shall reimburse the network provider at payment amounts that are not less than the amounts the network provider would have received if the services were delivered via in-person, face-to-face contact, unless the Medi-Cal managed care plan and network provider mutually agree to reimbursement in different amounts.

(g) On or before January 1, 2023, the department shall develop a research and evaluation plan that does all of the following:

(1) Proposes strategies to analyze the relationship between telehealth and the following: access to care, access to in-person care, quality of care, and Medi-Cal program costs, utilization, and program integrity.

(2) Examines issues using an equity framework that includes stratification by available geographic and demographic factors, including, but not limited to, race, ethnicity, primary language, age, and gender, to understand inequities and disparities in care.

(3) Prioritizes research and evaluation questions that directly inform Medi-Cal policy.

(h) Applicable health care services provided through asynchronous store and forward, video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities as described in this section shall comply with the privacy and security requirements contained in the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, the Medicaid State Plan, and any other applicable state and federal statutes and regulations.

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

(j) Consistent with the requirements of this section and subject to subdivision (k), a PACE organization approved by the department pursuant to Chapter 8.75 (commencing with Section 14591) may use video telehealth to conduct initial assessments and annual re-assessments for eligibility for enrollment in the PACE program.

(k) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(*l*) This section shall be operative on January 1, 2023, or on the operative date or dates reflected in the applicable federal approvals obtained by the department pursuant to subdivision (k), whichever is later.

(m) This section does not apply to health care services provided via telehealth in an FQHC or RHC visit as described in paragraph (4) of subdivision (g) of Section 14132.100.

SEC. 100. Section 14132.731 of the Welfare and Institutions Code is repealed.

SEC. 101. Section 14132.731 is added to the Welfare and Institutions Code, to read:

14132.731. (a) A county that enters into a Drug Medi-Cal Treatment Program contract with the department in accordance with Section 14124.20, or the department if entering into a Drug Medi-Cal Treatment Program contract directly with providers or as otherwise described in Section 14124.21, shall reimburse Drug Medi-Cal certified providers for medically necessary Drug Medi-Cal reimbursable services, as defined in Section 14124.24, provided by a licensed practitioner of the healing arts, or a registered or certified alcohol or other drug counselor or other individual authorized by the department to provide Drug Medi-Cal reimbursable services when those services meet the standard of care, meet the requirements of the service code being billed, and are delivered through video synchronous interaction or audio-only synchronous interaction.

(b) A Drug Medi-Cal certified provider shall not establish a new patient relationship with a Medi-Cal beneficiary via asynchronous store and forward, audio-only synchronous interaction, remote patient monitoring, or other virtual communication modalities, except as set forth in paragraph (4) of subdivision (g) of Section 14132.100. Notwithstanding this prohibition, the department may provide for specific exceptions to this prohibition, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(c) Drug Medi-Cal reimbursable services provided through a video synchronous interaction or an audio-only synchronous interaction pursuant to subdivision (a) shall be subject to billing, reimbursement, and utilization management policies imposed by the department.

(d) Drug Medi-Cal reimbursable services provided through a video synchronous interaction or an audio-only synchronous interaction shall be provided in compliance with the privacy and security requirements contained in the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, Part 2 of Title 42 of the Code of Federal Regulations, the Medicaid State Plan, and any other applicable state and federal statutes and regulations.

(e) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available.

(f) The department shall adopt regulations by July 1, 2024, to implement this section in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(g) Notwithstanding the rulemaking provisions of the Administrative Procedure Act, the department may, if it deems it appropriate, implement, interpret, or make specific this section by means of provider bulletins, written guidelines, or similar instructions from the department, until regulations are adopted.

SEC. 102. Section 14132.88 of the Welfare and Institutions Code is amended to read:

14132.88. (a) Notwithstanding subdivision (h) of Section 14132 and to the extent funds are made available in the annual Budget Act for this purpose, the following are covered benefits for beneficiaries 21 years of age or older under this chapter:

(1) One dental prophylaxis cleaning per year.

(2) One initial dental examination by a dentist.

(b) The following are covered benefits for beneficiaries under 21 years of age under this chapter:

(1) Two dental prophylaxis cleanings per year.

(2) Two periodic dental examinations per year.

(c) For persons 21 years of age or older, laboratory-processed crowns on posterior teeth are a covered benefit when medically necessary to restore a posterior tooth back to normal function based on the criteria specified in the Medi-Cal Dental Manual of Criteria.

(d) Any prefabricated crown made from ADA-approved materials may be used on posterior teeth and may be reimbursed as a stainless steel crown.

(e) Covered dental benefits and accompanying criteria for receipt of those dental benefits under the Medi-Cal program shall be identified in the Medi-Cal Dental Manual of Criteria. Notwithstanding subdivision (h) of Section 14132, the department shall evaluate all covered dental benefits, including those listed in this section and in the Medi-Cal Dental Manual of Criteria, for evidence-based practices consistent with the American Academy of Pediatric Dentistry and the American Dental Association guidelines.

(f) (1) Except as provided in paragraph (2), the department shall require pretreatment radiograph documentation on posttreatment claims to establish the medical necessity for dental restorations. The pretreatment documentation required under this subdivision is intended to reduce fraudulent claims for unnecessary dental fillings. In order to avoid any undue barriers to accessing dental care, the department shall stipulate that the pretreatment radiograph documentation for posttreatment claims will be required only when there are four or more dental fillings being completed in any 12-month period.

(2) For any beneficiary who is under four years of age, or who, regardless of age, has a developmental disability, as defined in subdivision (a) of Section 4512, radiographs or photographs that indicate decay on any tooth surface shall be considered sufficient documentation to establish the medical necessity for treatment provided.

(3) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of provider bulletins, plan letters, or other similar instructions, without taking regulatory action.

(g) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available.

SEC. 103. Section 14132.98 of the Welfare and Institutions Code is amended to read:

14132.98. (a) For a beneficiary diagnosed with cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer or for

any other qualifying clinical trial, as defined by Section 1396d(gg)(2) of Title 42 of the United States Code, the Medi-Cal program shall provide coverage for all routine patient care costs related to the clinical trial if the beneficiary's treating physician, who is providing covered health care services to the beneficiary under the Medi-Cal program, recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the beneficiary. For purposes of this section, a clinical trial's endpoints shall not be defined exclusively to test toxicity, but shall have a therapeutic intent.

(b) (1) In accordance with Section 1396d(gg)(1) of Title 42 of the United States Code, "routine patient care costs" means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the Medi-Cal program if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including:

(A) Health care services typically provided absent a clinical trial.

(B) Health care services required solely for the provision of the investigational drug, item, device, or service.

(C) Health care services required for the clinically appropriate monitoring of the investigational item or service.

(D) Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.

(E) Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

(2) For purposes of this section, "routine patient care costs" does not include the costs associated with the provision of any of the following:

(A) Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.

(B) Services other than health care services, such as travel, housing, companion expenses, and other nonclinical expenses, that a beneficiary may require as a result of the treatment being provided for purposes of the clinical trial, except as required under the Medicaid Program (42 U.S.C. Sec. 1396a et seq.).

(C) Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.

(D) Health care items or services that, except for the fact that they are being provided in a clinical trial, are not otherwise covered by the Medi-Cal program.

(E) Health care services customarily provided by the research sponsors free of charge for any beneficiary in the trial.

(c) The treatment shall be provided in a qualifying clinical trial, which means a clinical trial, in any clinical phase of development, that is conducted in relation to the prevention, detection, or treatment of any serious or

life-threatening disease or condition and is described in Section 1396d(gg)(2)(A) of Title 42 of the United States Code.

(d) This section does not prohibit the Medi-Cal program from restricting coverage for clinical trials to participating hospitals and physicians in California unless the protocol for the clinical trial is not provided for at a California hospital or by a California physician.

(e) The provision of services when required by this section shall not, in itself, give rise to liability on the part of the Medi-Cal program.

(f) This section shall be implemented only to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized.

(g) The amendments made to this section by the act that added this subdivision shall become effective on July 1, 2022.

SEC. 104. The heading of Article 4.1 (commencing with Section 14138.1) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code is amended to read:

Article 4.1. Federally Qualified Health Center Alternative Payment Model Project

SEC. 105. Section 14138.1 of the Welfare and Institutions Code is amended to read:

14138.1. For purposes of this article, the following definitions apply:

(a) "Alternative encounter" means an encounter provided by the participating FQHC that is approved by the department for the APM project, but that is not recognized as a billable visit as described in subdivision (g) of Section 14132.100. The department, in consultation with participating FQHCs, shall develop a list of approved alternative encounters for the APM project, which may be updated from time to time.

(b) "Alternative payment methodology" (APM) has the same meaning as specified in Section 1396a(bb)(6) of Title 42 of the United States Code.

(c) "APM aid category" means a Medi-Cal category of aid designated by the department. For all its APM enrollees in an APM aid category, a participating FQHC site shall receive compensation as described under the APM project. The APM aid categories may include, but are not limited to, all of the following categories of aid:

(1) Adults.

(2) Children.

(3) Seniors and persons with disabilities.

(4) The adult expansion population eligible pursuant to Section 14005.60.

(d) "APM enrollee" means a member who is assigned by a principal health plan or subcontracting payer to a participating FQHC for primary care services and who is within one of the designated APM aid categories.

(e) "APM project" means the project authorized by this article.

(f) "APM scope of services" means the scope of services for a participating FQHC for which it is entitled to receive a per-visit rate pursuant

to Section 14132.100, but only to the extent those services are covered pursuant to the contract between the department and the applicable principal health plan.

(g) "APM supplemental capitation" means an APM aid category-specific PMPM amount that is paid by the department to a principal health plan having one or more participating FQHCs in its provider network.

(h) "Clinic-specific PMPM" means the monthly, per assigned member, capitated amount the principal health plan or subcontracting payer is required to pay to the participating FQHC for the APM scope of services. The clinic-specific PMPM is exclusive of any incentive payments and shall be developed to reflect the amount the participating FQHC would have received under the prospective payment system methodology set forth in Section 14132.100.

(i) "FQHC" means any community or public "federally qualified health center," as defined in Section 1396d(*l*)(2)(B) of Title 42 of the United States Code and providing services as defined in Section 1396d(a)(2)(C) of Title 42 of the United States Code.

(j) "Member" means a Medi-Cal beneficiary who is enrolled with a principal health plan, including those beneficiaries delegated to a subcontracting payer.

(k) "Participating FQHC" means an FQHC participating in the APM project at one or more of the FQHC's sites. "Participating FQHC" also refers to an FQHC's site that is participating in the APM project.

(*l*) "PMPM" and "per member per month" both mean a monthly payment made for providing or arranging health care services for a member and may refer to a payment by the department to a principal health plan, or by a principal health plan to a subcontracting payer, or by a principal health plan or subcontracting payer to an FQHC, or from and to other entities as specified in this article.

(m) "Principal health plan" means a Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101, within a county in which the APM project is implemented.

(n) "Subcontracting payer" means an organization or entity that subcontracts directly or indirectly with a principal health plan to provide or arrange for the care of its members and contains one or more participating FQHCs in its provider network.

(o) "Traditional encounter" means an encounter that is recognized as a billable visit, as described in subdivision (g) of Section 14132.100 or the approved Medi-Cal State Plan.

(p) "Traditional wrap-around payment" means the supplemental payments payable to an FQHC in the absence of the APM project with respect to services provided to Medi-Cal managed care enrollees, which are made by the department pursuant to subdivision (e) of Section 14087.325 and subdivision (h) of Section 14132.100.

SEC. 106. Section 14138.10 of the Welfare and Institutions Code is repealed.

SEC. 107. Section 14138.10 is added to the Welfare and Institutions Code, to read:

14138.10. The Legislature finds and declares all of the following:

(a) Health care today is more than a face-to-face visit with a provider, but rather a whole-person approach, often including a physician, a care team of other health care providers, technology inside and outside of a health center, and wellness activities, including nutrition and exercise classes, all of which are designed to be more easily incorporated into a patient's daily life.

(b) Accessible health care in a manner that fits a patient's needs is important for improving patient satisfaction, building trust, and ultimately improving health outcomes.

(c) FQHCs are essential community providers, providing high-quality, cost-effective comprehensive primary care services to underserved communities.

(d) Today, FQHCs face certain restrictions because the current payment structure reimburses an FQHC only when there is a traditional encounter with a provider. Current law prohibits payment for both a primary care visit and mental health visit on the same day.

(e) A more practical approach financially incentivizes FQHCs to provide the right care at the right time. Restructuring the current visit-based, fee-for-service model with a capitated equivalent affords FQHCs the assurance of payment and the flexibility to deliver care in the most appropriate patient-centered manner.

(f) A reformed payment methodology will enable FQHCs to take advantage of alternative encounters. Alternative encounters, such as group visits and email consultations, are effective care delivery methods and contribute to a patient's overall health and well-being.

(g) An alternative payment methodology for FQHCs, designed and implemented as permitted by federal law, should do all of the following:

(1) Provide patient-centered care delivery options to California's expansive Medi-Cal population.

(2) Promote cost efficiencies, and improve population health and patient satisfaction.

(3) Improve the capacity of FQHCs to deliver high-quality care to a population growing in numbers and in complexity of needs.

(4) Transition away from a payment system that rewards volume with a flexible alternative that recognizes the value added when Medi-Cal beneficiaries are able to more easily access the care they need and when providers are able to deliver care in the most appropriate manner to patients.

(5) Promote timely, accurate, complete, and systemic reporting of alternative encounters at FQHCs.

(6) Implement the APM where the FQHC receives at least the same amount of funding it would receive under the current payment system, and in a manner that does not disrupt patient care or threaten FQHC viability.

SEC. 108. Section 14138.11 of the Welfare and Institutions Code is repealed.

SEC. 109. Section 14138.12 of the Welfare and Institutions Code is amended to read:

14138.12. (a) (1) The department shall authorize a payment reform project for FQHCs using an APM in accordance with this article.

(2) Implementation of the APM project shall begin no sooner than January 1, 2024, subject to any necessary federal approvals.

(3) Before implementation of an APM project for a participating FQHC site, the department shall notify the FQHC site in writing of the applicable draft clinic-specific PMPM rate(s) for the participating FQHC site. A participating FQHC, with respect to one or more sites of its choosing, may opt to withdraw its participation in the project subject to a notice requirement as determined by the department, but not less than 120 days before implementation of an APM project.

(4) At least 90 days prior to implementation of an APM project for a participating FQHC site, the department shall notify a principal health plan in writing of the principal health plan's specific APM supplemental capitation rates for the participating FQHC. The notification from the department to the principal health plan shall be based on the rates submitted by the department for federal approval. If the APM supplemental capitation rates are modified after the notification to a principal health plan, the department shall notify a principal health plan of the revised rates.

(5) At least 90 days prior to implementation of an APM project for a participating FQHC site, the department shall notify a principal health plan and the FQHC site in writing of the clinic-specific PMPM rate for the participating FQHC site.

(b) The APM project shall comply with federal APM requirements and the department shall file a state plan amendment and seek any federal approvals as necessary for the implementation of this article. Nothing in this article shall be construed to authorize the department to seek federal approval to affirmatively waive Section 1396a(bb)(6) of Title 42 of the United States Code.

(c) Nothing in this article shall be construed to limit or eliminate services provided by FQHCs as covered benefits in the Medi-Cal program.

SEC. 110. Section 14138.13 of the Welfare and Institutions Code is amended to read:

14138.13. (a) The department shall notify every FQHC in the state of the APM project and shall invite any interested FQHC to apply for participation in the APM with respect to one or more of the FQHC's sites. Consistent with federal law, the state plan amendment described in subdivision (b) of Section 14138.12 shall specify that the department and each participating FQHC voluntarily agrees to the APM.

(b) (1) The department shall develop, in consultation with interested FQHCs and principal health plans and consistent with federal law, the eligibility criteria to be used in evaluating applications from interested FQHCs for participation in the project, which shall include, but need not be limited to, the following:

(A) The FQHC has the demonstrated ability to collect and submit encounter data in a form and manner that satisfies department requirements.

(B) The FQHC is in good standing with the relevant state and federal regulators.

(C) The FQHC has the financial and administrative capacity to undertake payment reform.

(2) In addition to the criteria listed in paragraph (1), the department may take into consideration the number of APM enrollees assigned by a plan at each FQHC site as an eligibility requirement for FQHC participation.

(3) In accordance with the process and criteria developed pursuant to paragraphs (1) and (2), the department shall approve or deny an interested FQHC site application for participation in the project. The department, at its sole discretion, may limit the number of participating FQHCs in the project and the number of counties in which the project will operate.

(4) All principal health plans and applicable subcontracting payers are required to participate in the APM project pursuant to this article to the extent that one or more contracted FQHC sites located in the plan's county are selected to participate in the project.

(c) The APM shall be applied only with respect to a participating FQHC for services the FQHC provides to its APM enrollees that are within its APM scope of services.

(d) Payment to the participating FQHC shall continue to be governed by the provisions of Sections 14087.325 and 14132.100 for services provided with respect to a person who is a Medi-Cal beneficiary, but who is not a Medi-Cal beneficiary within a designated APM aid category.

(e) Payment to the participating FQHC for furnishing services within the scope of the APM to a Medi-Cal beneficiary within a designated APM aid category who is enrolled with a Medi-Cal managed care plan that is not contracted with the FQHC shall be at the per-visit rate determined pursuant to Section 14132.100.

(f) After implementation of an APM project, a participating FQHC, with respect to one or more sites of its choosing, may opt to discontinue its participation in the project subject to a notice requirement of no less than 180 days before the beginning of the next managed care rating period.

SEC. 111. Section 14138.14 of the Welfare and Institutions Code is amended to read:

14138.14. (a) A participating FQHC shall be compensated for the APM scope of services provided to its APM enrollees pursuant to this section.

(b) A participating FQHC shall receive from the principal health plan or applicable subcontracting payer reimbursement for each APM enrollee in the form of a clinic-specific PMPM. The department shall determine the clinic-specific PMPM taking into account all the following factors:

(1) Historical utilization of applicable FQHC services in each APM aid category.

(2) The participating FQHC's prospective payment system rate and applicable adjustments relevant for the fiscal year, such as annual rate adjustments.

(3) The projected mix of assigned members across the APM aid categories.

(4) Other trend and utilization adjustments as appropriate in order to reflect the level of reimbursement that would have been received by the participating FQHCs in the absence of the APM project.

(c) A participating FQHC and applicable principal health plan or subcontracting payer may enter into arrangements in which the clinic-specific PMPM amount required in subdivision (b) is paid in more than one capitated increment, as long as the total per-member capitation each month received by the participating FQHC is at least equal to the clinic-specific PMPM.

(d) In cases where a subcontracting payer is involved, the principal health plan shall demonstrate and certify to the department that it has contracts or other arrangements in place that provide for meeting the requirements in subdivision (b) and to the extent that the subcontracting payer fails to comply with the applicable requirements in this article, the principal health plan shall then be responsible to ensure the participating FQHC receives all payments due under this article in a timely manner.

(e) The department shall adjust the amounts in subdivision (b) as necessary to account for any change to the prospective payment system rate for participating FQHCs, including changes resulting from a change in the Medicare Economic Index pursuant to subdivision (d) of Section 14132.100, any changes in the FQHC's scope of services pursuant to subdivision (e) of Section 14132.100, and changes in the projected mix of assigned members across APM aid categories.

(f) An FQHC site participating in the APM project shall not receive traditional wrap-around payments for visits within the APM scope of services it provides to its APM enrollees for any service period in which it participates in the APM project. A participating FQHC site shall not be entitled to make a reconciliation request pursuant to Section 14132.100 or 14087.325 in connection with visits within the APM scope of services provided to APM enrollees for any service period in which it participates in the APM project.

(g) A principal health plan or subcontracting payer shall not terminate a contract with a participating FQHC for the specific purpose of circumventing the payment obligations implemented pursuant to this section.

(h) FQHCs shall have the right to pursue any available remedy against Medi-Cal managed care plans or subcontracting payers, including judicial review, as appropriate in connection with the requirements of this section.

SEC. 112. Section 14138.15 of the Welfare and Institutions Code is amended to read:

14138.15. (a) A principal health plan shall be compensated by the department for the APM scope of services provided to its APM enrollees pursuant to this section.

(b) For each principal health plan that contains at least one participating FQHC in its provider network, the department shall determine an APM supplemental capitation amount for each APM aid category to be paid by the department to the principal health plan, which shall be expressed as a PMPM amount. This supplemental capitation amount will be in addition to

the funding for the APM scope of services already contained in the principal health plan's capitated rates paid by the department and shall be actuarially sound in accordance with Section 438.4 of Title 42 of the Code of Federal Regulations. The department shall determine the APM supplemental capitation amount for each APM aid category, taking into account all of the following factors:

(1) The clinic-specific PMPM amounts for each participating FQHC in the plan's network.

(2) The funding for the APM scope of services already contained in the principal health plan's capitated rates.

(3) The historical wrap-around payments paid by the department for participating FQHCs for assigned members in each APM aid category.

(4) As applicable, the likely distribution of members among multiple participating FQHCs.

(c) The principal health plan shall report to the department, in a form to be determined by the department in consultation with the principal health plan, the number of APM enrollees for each APM aid category in the plan each month.

(d) The department shall pay each principal health plan its applicable APM supplemental capitation amount for the number of APM enrollees for each APM aid category reported by the principal health plan pursuant to subdivision (c), and shall appropriately fund each principal health plan to pay the per-visit rate for unassigned Medi-Cal beneficiaries described in subdivision (e) of Section 14138.13.

(e) The department, in consultation with the principal health plans, shall develop methods to verify the information reported pursuant to subdivision (c), and may adjust the payments made pursuant to subdivision (d) as appropriate to reflect the verified number of APM enrollees for each APM aid category.

(f) The department shall adjust the amounts in subdivision (b) as necessary to account for any change to the prospective payment system rate for participating FQHCs, including changes resulting from a change in the Medicare Economic Index pursuant to subdivision (d) of Section 14132.100, any changes in the FQHC's scope of services pursuant to subdivision (e) of Section 14132.100, and changes in the projected mix of assigned members across applicable APM aid categories.

SEC. 113. Section 14138.16 of the Welfare and Institutions Code is amended to read:

14138.16. (a) For the duration of the APM project, the department shall establish a risk corridor structure for the principal health plans relating only to the APM supplemental capitation payments pursuant to Section 14138.15, to the extent consistent with principles of actuarial soundness and in accordance with Section 438.6(b)(1) of Title 42 of the Code of Federal Regulations.

(b) The risk sharing of the costs under this section shall be constructed by the department with input from affected stakeholders so that it is symmetrical with respect to risk and profit. The department shall develop

and specify the terms of the risk corridor in a form and manner specified by the department through all-plan letters or other technical guidance that shall be deemed incorporated into the contracts between each affected principal health plan and the department.

SEC. 114. Section 14138.17 of the Welfare and Institutions Code is amended to read:

14138.17. (a) In order to ensure participating FQHCs have an incentive to manage visits and costs, while at the same time exercising a reasonable amount of flexibility to deliver care in the most efficient and quality driven manner, for the duration of the APM project the department shall, in accordance with this subdivision, establish a payment adjustment structure. The payment adjustment structure shall be developed with stakeholder input and shall meet the requirements of Section 1396a(bb)(6) of Title 42 of the United States Code and Part 438 (commencing with Section 438.1) of Subchapter C of Chapter IV of Title 42 of the Code of Federal Regulations.

(b) The payment adjustment structure shall be applicable on a site-specific basis.

(c) The payment adjustment structure shall permit an aggregate adjustment to the payments received when actual utilization of services for a participating FQHC's site exceeds or falls below expectations that were reflected within the calculation of the rates developed pursuant to Sections 14138.14 and 14138.15. For purposes of this payment adjustment structure, both actual and expected utilization shall be expressed as the total number of traditional encounters that would be recognized pursuant to subdivision (h) of Section 14132.100 for the APM enrollees of the participating FQHC's site across all APM aid categories and averaged on a per member per year basis.

(d) An adjustment pursuant to this section shall occur no more than once per year per participating FQHC's site during the APM project, and shall be requested within 90 days of the close of the rating period, except when additional time is permitted by the department. All adjustments shall be subject to approval by the department.

(1) An adjustment to payments in the case of higher than expected utilization shall be triggered when utilization exceeds projections in any year. If an adjustment is required in a given year, the participating FQHC site shall receive an aggregate payment adjustment from the principal health plan or applicable subcontracting payer that is based upon the difference between its actual utilization for the year and the projected utilization for the year. The payment adjustment in each instance shall be calculated as follows:

(A) The actual total utilization, expressed as traditional encounters, for the actual APM enrollees for the applicable year shall be determined.

(B) The projected total utilization contained in the clinic-specific PMPMs for the actual APM enrollees for the applicable year shall be determined.

(C) The amount in subparagraph (B) shall be subtracted from the amount in subparagraph (A).

(D) The amount in subparagraph(C) shall be multiplied by the per-visit rate that was determined pursuant to Section 14132.100 for the participating FQHC site yielding the payment adjustment for the participating FQHC site. The payment adjustment shall be paid to the participating FQHC site by the principal health plan, or subcontracting payer, as applicable, in one aggregate payment.

(2) To incentivize care delivery in ways that may vary from traditional delivery of care, participating FQHCs shall have the flexibility to experience a lower than expected visit utilization of up to 30 percent of projected utilization. The department shall develop, with input from affected stakeholders, objective criteria to ensure minimum standards for access and quality. If an FQHC site does not meet those established quality and access standards, the participating FQHC shall be required to return a portion of PMPM revenue based on a formula developed by the department with input from affected stakeholders. A participating FQHC shall not receive revenue lower than the amount calculated as follows:

(A) The actual total utilization, expressed as traditional encounters, for the applicable year shall be determined.

(B) The amount in subparagraph (A) shall be multiplied by the per-visit rate that was determined pursuant to Section 14132.100 for the participating FQHC site yielding the payment adjustment for the participating FQHC site.

(e) Any adjustment made pursuant to this section may only be requested by a principal health plan, subcontracting payer, participating FQHC, or the department.

SEC. 115. Section 14138.18 of the Welfare and Institutions Code is repealed.

SEC. 116. Section 14138.18 is added to the Welfare and Institutions Code, to read:

14138.18. (a) This article shall be implemented only to the extent that any necessary federal approvals have been obtained and federal financial participation is available and not otherwise jeopardized.

(b) (1) The department may modify any methodology or other provision specified in this article to the extent it deems necessary to meet the requirements of federal law or regulations, to obtain or maintain federal approval, or to ensure federal financial participation is available or is not otherwise jeopardized, if the modification does not violate the spirit, purposes, and intent of this article.

(2) If the department determines that a modification is necessary pursuant to paragraph (1), the department shall consult with interested FQHCs and principal health plans to the extent practicable.

(3) In the event of a modification made pursuant to this subdivision, the department shall notify affected FQHCs, principal health plans, the Joint Legislative Budget Committee, and the relevant policy and fiscal committees of the Legislature within 10 business days of the modification.

SEC. 117. Section 14138.19 of the Welfare and Institutions Code is repealed.

SEC. 118. Section 14138.21 of the Welfare and Institutions Code is repealed.

SEC. 119. Section 14138.21 is added to the Welfare and Institutions Code, to read:

14138.21. This article shall not be deemed to affect the amounts paid or the reimbursement methodology applicable to FQHCs for dental services and for services that are provided outside the scope of a contract between the department and an applicable principal health plan that is in effect as of January 1, 2024, or for any other amounts for which the FQHC may be eligible outside of the prospective payment rate, including, but not limited to, incentives or supplemental payments.

SEC. 120. Section 14138.22 of the Welfare and Institutions Code is repealed.

SEC. 121. Section 14138.22 is added to the Welfare and Institutions Code, to read:

14138.22. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking any further regulatory action.

SEC. 122. Section 14138.23 of the Welfare and Institutions Code is amended to read:

14138.23. For purposes of implementing this article, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including, but not limited to, contracts for the purpose of obtaining subject matter expertise or other technical assistance. Any contract entered into or amended pursuant to this section shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

SEC. 123. Section 14148 of the Welfare and Institutions Code is amended to read:

14148. (a) (1) (A) Except as provided in subparagraph (B), the department shall adopt the federal option provided under Section 4101 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) to extend eligibility for medical assistance under Medicaid to all pregnant individuals and infants with family incomes not in excess of 185 percent of the federal poverty level.

(B) Effective January 1, 2014, the federal poverty level percentage income eligibility threshold used pursuant to subdivision (c) of Section 14005.64 to determine eligibility for medical assistance under this section pursuant to subparagraph (A) shall equal 208 percent of the federal poverty level.

(C) Effective January 1, 2022, eligibility for medical assistance to pregnant individuals with family incomes not in excess of 208 percent of the federal poverty level, before the application of the 5-percent income

disregard pursuant to subdivision (b) of Section 14005.64, shall be as described in Section 14005.22.

(2) If a premium is imposed, the amount of the premium shall not exceed 10 percent of the amount by which the family's income, less actual child care costs, exceeds 150 percent of the federal poverty level as provided in Section 1916(c) of the federal Social Security Act (42 U.S.C. Sec. 1396o(c)) as determined, counted, and valued in accordance with the requirements of Section 14005.64. The department shall implement this section by emergency regulation.

(b) Upon order of the Department of Finance, the Controller shall transfer funds from Item 4260-101-001 of the Budget Act of 1988 to Item 4260-111-001 of the Budget Act of 1988 during the 1988–89 fiscal year for the purpose of funding outreach efforts for perinatal services.

(c) Notwithstanding subdivision (a), the state may limit implementation of this section during the 1988–89 fiscal year, based upon the availability of department funds. The department may use maternal and child health funds to finance the increased costs of implementing an expansion of Medi-Cal eligibility to pregnant individuals and to children with incomes of up to 185 percent of federal poverty levels if both of the following conditions exist:

(1) The department has allocated for expenditure at least sixteen million dollars ($16,000,000) in funds redirected from the Medi-Cal program for that expansion.

(2) If, and to the extent, the department determines that estimates of costs based on actual data indicate that the funds are needed to cover costs.

(d) To assist Medi-Cal eligible pregnant individuals in receiving prenatal care promptly, all pregnant individuals applying for Medi-Cal shall be determined to have an immediate need. Counties, within existing resources, shall expedite the eligibility determination process for all pregnant individuals on the basis of their immediate needs. Upon determination of eligibility, a Medi-Cal card shall be issued immediately.

(e) The amendments made to subdivision (a) by Senate Bill 508 during the 2013–14 Regular Session shall be implemented only if and to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 124. Section 14148.8 of the Welfare and Institutions Code is amended to read:

14148.8. (a) (1) The State Department of Health Care Services shall provide Medi-Cal reimbursements to alternative birth centers for facility-related delivery costs at a statewide all-inclusive rate per delivery that shall not exceed 80 percent of the average Medi-Cal reimbursement received by general acute care hospitals with Medi-Cal contracts and shall be based on an average hospital length of stay of 1.7 days. The reimbursement rate shall be updated annually and shall be based on the California Medical Assistance Commission's annually published legislative report of average contract rates for general acute care hospitals with Medi-Cal contracts. However, the reimbursement shall not exceed the

alternative birth center's charges to any non-Medi-Cal patient for similar services. This paragraph shall apply to Medi-Cal reimbursement for facility-related delivery costs of alternative birth centers until the effective date of any necessary federal approval obtained by the department pursuant to paragraph (2).

(2) Effective no earlier than July 1, 2017, the department shall reimburse facility-related Medi-Cal delivery costs of eligible alternative birth centers based on a statewide all-inclusive rate per delivery that shall not exceed 80 percent of the average diagnosis-related groups (DRG) Level 1 rates received by general acute care hospitals pursuant to Section 14105.28 and the applicable provisions of the Medi-Cal State Plan. Reimbursement pursuant to this paragraph shall not exceed the alternative birth center's charges to any non-Medi-Cal patient for similar services. The department shall seek any federal approvals necessary to implement this paragraph. This paragraph shall not be implemented until any necessary federal approvals are obtained. This paragraph shall not be construed to make inoperative any existing payment reductions that are applicable to alternative birth center services, including, but not limited to, the payment reductions imposed pursuant to Section 14105.192, subject to paragraph (3).

(3) Effective July 1, 2022, or the effective date specified in any necessary federal approvals obtained by the department to implement subparagraph (B) of paragraph (13) of subdivision (h) of Section 14105.192, whichever is later, reimbursement to alternative birth centers shall be exempt from the payment reductions imposed by subdivision (d) of Section 14105.192.

(b) In order to be eligible for reimbursement pursuant to this section, an alternative birth center shall satisfy the following criteria as determined by the state department:

(1) The facility shall meet all applicable requirements of Section 1204.3 of the Health and Safety Code.

(2) The facility shall be currently certified as a Comprehensive Perinatal Services Program (CPSP) provider pursuant to Section 14134.5.

(3) The facility may utilize licensed midwives, certified nurse midwives, certified nurse practitioners, and clinical nurse specialists when appropriate.

(4) The facility shall meet the standards for certification established by the National Association of Childbearing Centers, or at least equivalent standards as determined by the department, including those relating to the proximity and involvement of hospitals, obstetricians, and pediatricians.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action.

(d) This section does not alter the scope of practice for any health care professional or authorize the delivery of health care services in a setting or in a manner not authorized by the Health and Safety Code or the Business and Professions Code.

(e) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

SEC. 125. Section 14170.8 of the Welfare and Institutions Code is amended to read:

14170.8. (a) Notwithstanding any other provision of law, every primary supplier of pharmaceuticals, medical equipment, or supplies shall maintain accounting records to demonstrate the manufacture, assembly, purchase, or acquisition and subsequent sale, of any pharmaceuticals, or medical equipment, or supplies to providers, as defined in Section 14043.1. Accounting records shall include, but not be limited to, inventory records, general ledgers, financial statements, purchase and sales journals and invoices, prescription records, bills of lading, and delivery records. For purposes of this section the term "primary suppliers" shall mean any manufacturer, principal labeler, assembler, wholesaler, or retailer.

(b) Accounting records maintained pursuant to subdivision (a) shall be subject to audit or examination by the department or its agents. This audit or examination may include, but is not limited to, verification of what was claimed by the provider. These accounting records shall be maintained for 10 years from the date of sale or the date of service.

(c) This section shall not apply to any clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code or to any manufacturer of prescription drugs registered with the federal Food and Drug Administration in accordance with Section 510 of the Food, Drug, and Cosmetic Act (21 U.S.C. Sec. 360).

SEC. 126. Section 14184.201 of the Welfare and Institutions Code is amended to read:

14184.201. (a) Notwithstanding any other law, the department shall standardize those applicable covered Medi-Cal benefits provided by Medi-Cal managed care plans under comprehensive risk contracts with the department on a statewide basis and across all models of Medi-Cal managed care in accordance with this section and the CalAIM Terms and Conditions.

(b) (1) Notwithstanding any other law, commencing January 1, 2023, subject to subdivision (f) of Section 14184.102, the department shall include, or continue to include, skilled nursing facility services as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan.

(2) For contract periods from January 1, 2023, to December 31, 2025, inclusive, during which paragraph (1) is implemented, each Medi-Cal managed care plan shall reimburse a network provider furnishing skilled nursing facility services to a Medi-Cal beneficiary enrolled in that plan, and each network provider of skilled nursing facility services shall accept the payment amount the network provider of skilled nursing facility services would be paid for those services in the Medi-Cal fee-for-service delivery system, as defined by the department in the Medi-Cal State Plan and guidance issued pursuant to subdivision (d) of Section 14184.102. For contract periods commencing on or after January 1, 2026, during which paragraph (1) is implemented, the department may elect to continue the

payment requirement described in this paragraph, subject to subdivision (f) of Section 14184.102.

(3) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (2) as applicable. The department may require Medi-Cal managed care plans and network providers of skilled nursing facility services to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(c) (1) Notwithstanding any other law, commencing July 1, 2023, subject to subdivision (f) of Section 14184.102, the department shall include, or continue to include, institutional long-term care services not described in subdivision (b) as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan.

(2) For contract periods from July 1, 2023, to December 31, 2025, inclusive, during which paragraph (1) is implemented, each Medi-Cal managed care plan shall reimburse a network provider furnishing institutional long-term care services not described in subdivision (b) to a Medi-Cal beneficiary enrolled in that plan, and each network provider of institutional long-term care services not described in subdivision (b) shall accept the payment amount the network provider of institutional long-term care services would be paid for those services in the Medi-Cal fee-for-service delivery system, as defined by the department in the Medi-Cal State Plan and guidance issued pursuant to subdivision (d) of Section 14184.102. For contract periods commencing on or after January 1, 2026, during which paragraph (1) is implemented, the department may elect to continue the payment requirement described in this paragraph, subject to subdivision (f) of Section 14184.102.

(3) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (2), as applicable. The department may require Medi-Cal managed care plans and network providers of institutional long-term care services to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(4) The department shall convene, in collaboration with the State Department of Developmental Services (DDS), a workgroup to address transition of intermediate care facility/developmentally disabled (ICF/DD) facilities, and Intermediate Care Facility for the Developmentally Disabled-Nursing (ICF/DD-N) and Intermediate Care Facility for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes from the Medi-Cal fee-for-service delivery system to the Medi-Cal managed care delivery system to ensure a smooth transition to CalAIM.

(d) (1) Notwithstanding any other law, commencing January 1, 2022, the department shall include donor and recipient organ transplant surgeries,

as described in Section 14132.69 and in the CalAIM Terms and Conditions, and donor and recipient bone marrow transplants, as described in Section 14133.8 and in the CalAIM Terms and Conditions, as capitated benefits in the comprehensive risk contract with each Medi-Cal managed care plan.

(2) For contract periods from January 1, 2022, to December 31, 2024, inclusive, during which paragraph (1) is implemented, each applicable Medi-Cal managed care plan shall reimburse a provider furnishing organ or bone marrow transplant surgeries to a Medi-Cal beneficiary enrolled in that plan, and each provider of organ or bone marrow transplant surgeries shall accept the payment amount the provider of organ or bone marrow transplant surgeries would be paid for those services in the Medi-Cal fee-for-service delivery system, as defined by the department in the Medi-Cal State Plan and guidance issued pursuant to subdivision (d) of Section 14184.102. For contract periods commencing on or after January 1, 2025, during which paragraph (1) is implemented, the department may elect to continue the payment requirement described in this paragraph, subject to subdivision (f) of Section 14184.102.

(3) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to a Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (2) as applicable. The department may require Medi-Cal managed care plans and providers of organ or bone marrow transplant surgeries to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(e) (1) Notwithstanding any other law, commencing January 1, 2022, Community-Based Adult Services (CBAS), as described in Section 14186.3, shall continue to be available as a capitated benefit for a qualified Medi-Cal beneficiary under a comprehensive risk contract with an applicable Medi-Cal managed care plan, in accordance with the CalAIM Terms and Conditions.

(2) CBAS shall only be available as a covered Medi-Cal benefit for a qualified Medi-Cal beneficiary under a comprehensive risk contract with an applicable Medi-Cal managed care plan. Medi-Cal beneficiaries who are eligible for CBAS shall enroll in an applicable Medi-Cal managed care plan in order to receive those services, except for beneficiaries exempt from mandatory enrollment in a Medi-Cal managed care plan pursuant to the CalAIM Terms and Conditions and Section 14184.200.

(3) CBAS shall be delivered in accordance with applicable state and federal law, including, but not limited to, the federal home and community-based settings regulations set forth in Sections 441.301(c)(4), 441.530(a)(1), and 441.710(a)(1) of Title 42 of the Code of Federal Regulations, and related subregulatory guidance and any amendment issued thereto.

(4) For contract periods during which paragraph (1) is implemented, each applicable Medi-Cal managed care plan shall reimburse a network provider furnishing CBAS to a Medi-Cal beneficiary enrolled in that plan, and each network provider of CBAS shall accept the payment amount the network

provider of CBAS would be paid for the service in the Medi-Cal fee-for-service delivery system, as defined by the department in guidance issued pursuant to subdivision (d) of Section 14184.102, unless the Medi-Cal managed plan and network provider mutually agree to reimbursement in a different amount.

(5) For contract periods during which paragraph (1) is implemented, capitation rates paid by the department to an applicable Medi-Cal managed care plan shall be actuarially sound and shall account for the payment levels described in paragraph (4) as applicable. The department may require applicable Medi-Cal managed care plans and network providers of CBAS to submit information the department deems necessary to implement this subdivision, at the times and in the form and manner specified by the department.

(f) Notwithstanding any other law, including, but not limited to, subdivision (a), the department may not transfer responsibility for specialty mental health services in the Counties of Sacramento and Solano from the Medi-Cal managed care plan responsible for those services on July 1, 2022, in those counties until no sooner than all of the following requirements have been met:

(1) The requirements of Section 14184.403 have been implemented.

(2) Each county and Medi-Cal managed care plan has submitted to the department a transition plan that contains provisions for continuity of care or the transfer of care.

(3) Notice has been provided to affected beneficiaries, including the ability of beneficiaries to request continuity of care pursuant to mental health and substance use disorder information notices issued by the department.

(g) For purposes of this section, the following definitions apply:

(1) "Comprehensive risk contract" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(2) "Institutional long-term care services" has the same meaning as set forth in the CalAIM Terms and Conditions and, subject to subdivision (f) of Section 14184.102, includes at a minimum all of the following:

(A) Skilled nursing facility services.

(B) Subacute facility services.

(C) Pediatric subacute facility services.

(D) Intermediate care facility services.

(3) "Network provider" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

SEC. 127. Section 14184.206 of the Welfare and Institutions Code is amended to read:

14184.206. (a) Commencing January 1, 2022, and subject to subdivision (f) of Section 14184.102, a Medi-Cal managed care plan may elect to cover those community supports approved by the department as cost effective and medically appropriate in the comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services, in accordance with the CalAIM Terms and Conditions.

(b) (1) Approved community supports pursuant to this section shall be available only to beneficiaries enrolled in a Medi-Cal managed care plan under a comprehensive risk contract, subject to paragraph (2).

(2) Approved community supports shall not supplant other covered Medi-Cal benefits that are not the responsibility of the Medi-Cal managed care plan under the comprehensive risk contract, including, but not limited to, in-home supportive services provided pursuant to Article 7 (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.

(3) An enrolled Medi-Cal beneficiary shall not be required by their Medi-Cal managed care plan to use the community support.

(c) Subject to subdivision (f) of Section 14184.102, community supports that the department may approve include, but need not be limited to, all of the following when authorized by the department in the comprehensive risk contract with each Medi-Cal managed care plan and to the extent the department determines that the community support is a cost-effective and medically appropriate substitute for the applicable covered Medi-Cal benefit under the comprehensive risk contract:

(1) Housing transition navigation services.

(2) Housing deposits.

(3) Housing tenancy and sustaining services.

(4) Short-term post-hospitalization housing.

(5) Recuperative care or medical respite.

(6) Respite.

(7) Day habilitation programs.

(8) Nursing facility transition or diversion to assisted living facilities, including, but not limited to, residential care facilities for the elderly or adult residential facilities.

(9) Nursing facility transition to a home.

(10) Personal care and homemaker services.

(11) Environmental accessibility adaptations or home modifications.

(12) Medically supportive food and nutrition services, including medically tailored meals.

(13) Sobering centers.

(14) Asthma remediation.

(d) The department shall publicly post on its internet website a list of which community supports are offered to enrollees by each Medi-Cal managed care plan.

(e) A Medi-Cal managed care plan shall provide information on the available community supports in its member handbook and plan website, including any limitations on community supports on the plan website.

(f) The department shall develop, in consultation with Medi-Cal managed care plans and other appropriate stakeholders, a monitoring plan and reporting template for the implementation of community supports pursuant to this section. The department shall annually publish a public report on reported community supports utilization data, populations served, and

demographic data, stratified by age, sex, race, ethnicity, and languages spoken, to the extent statistically reliant data are available.

(g) The department shall conduct an independent evaluation of the effectiveness of community supports in accordance with the parameters and timeframes specified in the CalAIM Terms and Conditions.

(h) The department shall take into account the utilization and actual cost of community supports in developing capitation rates.

(i) For purposes of this section, the following definitions apply:

(1) "Community supports" means those alternative services and settings approved in the CalAIM Terms and Conditions and administered according to paragraph (2) of subsection (e) of Section 438.3 of Title 42 of the Code of Federal Regulations.

(2) "Comprehensive risk contract" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

SEC. 128. Section 14184.400 of the Welfare and Institutions Code is amended to read:

14184.400. (a) Commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, the department shall continue to implement the Specialty Mental Health Services Program described in part in Chapter 8.9 (commencing with Section 14700), as a component of CalAIM and in accordance with this article and the CalAIM Terms and Conditions.

(b) Each mental health plan contracting with the department to provide specialty mental health services pursuant to Chapter 8.9 (commencing with Section 14700) shall comply with all applicable CalAIM Terms and Conditions and any guidance issued by the department pursuant to subdivision (d) of Section 14184.102.

(c) (1) As a component of the Specialty Mental Health Services Program described in this section, the department, in consultation with counties and other affected stakeholders, may seek federal approval for a demonstration project under Section 1315(a) of Title 42 of the United States Code, which may include receipt of federal financial participation for services furnished to Medi-Cal beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as institutions for mental diseases. The department may elect to seek approval for this demonstration project to operate on a statewide basis or on a county-by-county basis.

(2) Notwithstanding any other law, to the extent that the department receives the necessary federal approvals to implement the demonstration project described in paragraph (1), and subject to approval by the Department of Finance, the department shall implement the demonstration in accordance with the terms of the federal approval and only to the extent that federal financial participation is available and is not otherwise jeopardized.

(3) For purposes of this subdivision, "institution for mental diseases" has the same meaning as set forth in Section 1396d(i) of Title 42 of the United States Code.

SEC. 129. Section 14184.405 of the Welfare and Institutions Code is amended to read:

14184.405. (a) Subject to appropriation, the department shall establish, implement, and administer the Behavioral Health Quality Improvement Program to provide grants to qualified Medi-Cal behavioral health delivery systems for purposes of preparing those entities and their contracting health care providers for implementation of CalAIM behavioral health components described in this article and for other purposes related to Medi-Cal behavioral health delivery systems as specified in an annual Budget Act or enacted legislation providing appropriations related to those acts.

(b) The department shall, in consultation with representatives of the Medi-Cal behavioral health delivery systems, determine the eligibility criteria, grant application process, and methodology for distribution of the moneys appropriated to the department for the purposes described in this section to Medi-Cal behavioral health delivery systems that the department deems qualified.

(c) This section shall be implemented only if, and to the extent that, the department determines that federal financial participation is not jeopardized.

SEC. 130. Section 14184.800 of the Welfare and Institutions Code is amended to read:

14184.800. (a) Notwithstanding any other law, commencing no sooner than January 1, 2023, a qualifying inmate of a public institution shall be eligible to receive targeted Medi-Cal services for 90 days, or the number of days approved in the CalAIM Terms and Conditions with respect to an eligible population of qualifying inmates if different than 90 days, prior to the date they are released from a public institution, if otherwise eligible for those services under this chapter and subject to subdivision (f) of Section 14184.102.

(b) Targeted Medi-Cal services made available to qualifying inmates pursuant to subdivision (a) shall be limited to those services approved in the CalAIM Terms and Conditions.

(c) To the extent federal approval is obtained to implement this section, the department shall arrange for an independent, third-party evaluation of the hypotheses and outcomes associated with providing targeted Medi-Cal services to qualifying inmates as described in the CalAIM Terms and Conditions. The department shall post the evaluation report on its internet website following submission to the federal Centers for Medicare and Medicaid Services.

SEC. 131. Section 14186.3 of the Welfare and Institutions Code is amended to read:

14186.3. (a) (1) No sooner than July 1, 2012, Community-Based Adult Services (CBAS) shall be a Medi-Cal benefit covered under every managed care health plan contract and available only through managed care health plans. Medi-Cal beneficiaries who are eligible for CBAS shall enroll in a managed care health plan in order to receive those services, except for beneficiaries exempt under subdivision (c) of Section 14186.2 or in counties or geographic regions where Medi-Cal benefits are not covered through managed care health plans. Notwithstanding subdivision (a) of Section 14186.2 and pursuant to the provisions of an approved federal waiver or

plan amendment, the provision of CBAS as a Medi-Cal benefit through a managed care health plan shall not be limited to Coordinated Care Initiative counties.

(2) Managed care health plans shall determine a member's medical need for CBAS using the assessment tool and eligibility criteria established pursuant to the provisions of an approved federal waiver or amendments and shall approve the number of days of attendance and monitor treatment plans of their members. Managed care health plans shall reauthorize CBAS in compliance with criteria established pursuant to the provisions of the approved federal waiver or amendment requirements.

(3) CBAS shall be delivered in accordance with applicable state and federal law including, but not limited to, the federal Home and Community-Based Settings regulations described in Sections 441.301(c)(4), 441.530(a)(1), and 441.710(a)(1) of Title 42 of the Code of Federal Regulations, and related subregulatory guidance and any amendment issued thereto.

(4) Commencing January 1, 2022, subject to subdivision (f) of Section 14184.102, CBAS shall continue to be available as a Medi-Cal benefit only through managed care health plans in accordance with subdivision (e) of Section 14184.201.

(b) (1) Beginning in the 2012 calendar year, managed care health plans shall collaborate with MSSP providers to begin development of an integrated, person-centered care management and care coordination model and explore how the MSSP program model may be adapted to managed care while maintaining the efficacy of the MSSP model. The California Department of Aging and the department shall work with the MSSP site association and managed care health plans to develop a template contract to be used by managed care health plans contracting with MSSP sites in Coordinated Care Initiative counties.

(2) Notwithstanding the implementation date authorized in paragraph (1) of subdivision (a) of Section 14186.2, no later than December 31, 2017, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of paragraph (4), whichever is earlier:

(A) Multipurpose Senior Services Program (MSSP) services shall be a Medi-Cal benefit available only through managed care health plans, except for beneficiaries exempt under subdivision (c) of Section 14186.2 in Coordinated Care Initiative counties.

(B) Managed care health plans shall contract with all county and nonprofit organizations that are designated providers of MSSP services for the provision of MSSP case management and waiver services. These contracts shall provide for all of the following:

(i) Managed care health plans shall allocate to the MSSP providers the same level of funding they would have otherwise received under their MSSP contract with the California Department of Aging.

(ii) MSSP providers shall continue to meet all existing federal waiver standards and program requirements, which include maintaining the contracted service levels.

(iii) Managed care plans and MSSP providers shall share confidential beneficiary data with one another, as necessary to implement the provisions of this section.

(C) The California Department of Aging shall continue to contract with all designated MSSP sites, including those in the counties participating in the demonstration project, and perform MSSP waiver oversight and monitoring.

(D) The California Department of Aging and the department, in consultation with MSSP providers, managed care health plans, and stakeholders, shall develop service fee structures, services, and person-centered care coordination models that shall be effective June 2013, for the provision of care coordination and home- and community-based services to beneficiaries who are enrolled in managed care health plans but not enrolled in MSSP, and who may have care coordination and service needs that are similar to MSSP participants. The service fees for MSSP providers and MSSP services for any additional beneficiaries and additional services for existing MSSP beneficiaries shall be based upon, and consistent with, the rates and services delivered in MSSP.

(3) In the 2014 calendar year, the provisions of paragraph (2) shall continue. In addition, managed care health plans shall work in collaboration with MSSP providers to begin development of an integrated, person-centered care management and care coordination model that works within the context of managed care and explore which portions of the MSSP program model may be adapted to managed care while maintaining the integrity and efficacy of the MSSP model.

(4) (A) No sooner than December 31, 2019, or on the date the managed care health plans and MSSP providers jointly satisfy the readiness criteria developed pursuant to subparagraph (D) of this paragraph, whichever is earlier, MSSP services in Coordinated Care Initiative counties shall transition from a federal waiver pursuant to Section 1915(c) under the federal Social Security Act (42 U.S.C. Sec. 1396n(c)) to a benefit administered and allocated by managed care health plans.

(B) No later than January 1, 2014, the department, in consultation with the California Department of Aging and the Department of Managed Health Care, and with stakeholder input, shall submit a transition plan to the Legislature to describe how subparagraph (A) shall be implemented. The plan shall incorporate the principles of the MSSP in the managed care benefit, and shall include provisions to ensure seamless transitions and continuity of care. Managed care health plans shall, in partnership with local MSSP providers, conduct a local stakeholder process to develop recommendations that the department shall consider when developing the transition plan.

(C) No later than 90 days before the implementation of subparagraph (A), the department, in consultation with the California Department of Aging

and the Department of Managed Health Care, and with stakeholder input, shall submit a transition plan to the Legislature that includes steps to address concerns, if any, raised by stakeholders subsequent to the plan developed pursuant to subparagraph (B).

(D) Before MSSP services transition to a benefit administered and allocated by managed care health plans pursuant to subparagraph (A) of paragraph (2), the California Department of Aging and the department, in consultation with MSSP providers, managed care health plans, and stakeholders, shall develop readiness criteria for the transition. The readiness criteria shall include, but are not limited to, the mutual agreement of the affected managed care health plans and MSSP providers to the transition date. The department shall evaluate the readiness of the managed care health plans and MSSP providers to commence the transition of MSSP services to managed care health plans.

(E) At least 30 days before the MSSP services transition to a benefit administered and allocated by managed care health plans in Coordinated Care Initiative counties, the department shall notify the appropriate policy and fiscal committees of the Legislature of its intent to transition the MSSP services to managed care health plans.

(5) Notwithstanding any other law, this subdivision shall be operative only through December 31, 2021.

(c) (1) Not sooner than March 1, 2013, or on the date that any necessary federal approvals or waivers are obtained, whichever is later, nursing facility services and subacute facility services shall be Medi-Cal benefits available only through managed care health plans.

(2) Managed care health plans shall authorize utilization of nursing facility services or subacute facility services for their members when medically necessary. The managed care health plan shall maintain the standards for determining levels of care and authorization of services for both Medicare and Medi-Cal services that are consistent with policies established by the federal Centers for Medicare and Medicaid Services and consistent with the criteria for authorization of Medi-Cal services specified in Section 51003 of Title 22 of the California Code of Regulations, which includes utilization of the "Manual of Criteria for Medi-Cal Authorization," published by the department in January 1982, last revised April 11, 2011.

(3) The managed care health plan shall maintain continuity of care for beneficiaries by recognizing any prior treatment authorization made by the department for not less than six months following enrollment of a beneficiary into the health plan.

(4) When a managed care health plan has authorized services in a facility and there is a change in the beneficiary's condition under which the facility determines that the facility may no longer meet the needs of the beneficiary, the beneficiary's health has improved sufficiently so the resident no longer needs the services provided by the facility, or the health or safety of individuals in the facility is endangered by the beneficiary, the managed care health plan shall arrange and coordinate a discharge of the beneficiary

and continue to pay the facility the applicable rate until the beneficiary is successfully discharged and transitioned into an appropriate setting.

(5) The managed care health plan shall pay providers, including institutional providers, in accordance with the prompt payment provisions contained in each health plan's contracts with the department, including the ability to accept and pay electronic claims.

(d) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(e) (1) Notwithstanding any other law, this section shall remain operative only through December 31, 2022.

(2) This section shall remain in effect only until January 1, 2025, and as of that date is repealed.

SEC. 132. Section 14197 of the Welfare and Institutions Code is amended to read:

14197. (a) It is the intent of the Legislature that the department implement and monitor compliance with the time or distance requirements set forth in Sections 438.68, 438.206, and 438.207 of Title 42 of the Code of Federal Regulations and this section, to ensure that all Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as those standards were enacted in May 2016.

(b) Commencing January 1, 2018, for covered benefits under its contract, as applicable, a Medi-Cal managed care plan shall maintain a network of providers that are located within the following time or distance standards for the following services:

(1) For primary care, both adult and pediatric, 10 miles or 30 minutes from the beneficiary's place of residence.

(2) For hospitals, 15 miles or 30 minutes from the beneficiary's place of residence.

(3) For dental services provided by a Medi-Cal managed care plan, 10 miles or 30 minutes from the beneficiary's place of residence.

(4) For obstetrics and gynecology primary care, 10 miles or 30 minutes from the beneficiary's place of residence.

(c) Commencing July 1, 2018, for the covered benefits under its contracts, as applicable, a Medi-Cal managed care plan shall maintain a network of providers that are located within the following time or distance standards for the following services:

(1) For specialists, as defined in subdivision (i), adult and pediatric, including obstetric and gynecology specialty care, as follows:

(A) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(2) For pharmacy services, 10 miles or 30 minutes from the beneficiary's place of residence.

(3) For outpatient mental health services, as follows:

(A) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(4) (A) For outpatient substance use disorder services other than opioid treatment programs, as follows:

(i) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(ii) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(iii) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

(B) For opioid treatment programs, as follows:

(i) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(ii) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(iii) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(iv) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(d) (1) (A) A Medi-Cal managed care plan shall comply with the appointment time standards developed pursuant to Section 1367.03 of the Health and Safety Code, Section 1300.67.2.2 of Title 28 of the California Code of Regulations, subject to any authorized exceptions in Section 1300.67.2.2 of Title 28 of the California Code of Regulations, and the standards set forth in contracts entered into between the department and Medi-Cal managed care plans.

(B) Commencing July 1, 2018, subparagraph (A) applies to Medi-Cal managed care plans that are not, as of January 1, 2018, subject to the appointment time standards described in subparagraph (A).

(2) A Medi-Cal managed care plan shall comply with the following availability standards for skilled nursing facility services and intermediate care facility services, as follows:

(A) Within five business days of the request for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Within seven business days of the request for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Within 14 calendar days of the request for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Within 14 calendar days of the request for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(3) A county Drug Medi-Cal organized delivery system shall provide an appointment within three business days to an opioid treatment program.

(4) A dental managed care plan shall provide an appointment within four weeks of a request for routine pediatric dental services and within 30 calendar days of a request for specialist pediatric dental services.

(e) The department may authorize a Medi-Cal managed care plan to use clinically appropriate video synchronous interaction, as defined in paragraph (5) of subdivision (a) of Section 2290.5 of the Business and Professions

Code, as a means of demonstrating compliance with the time or distance standards established pursuant to this section, as defined by the department.

(f) (1) The department may develop policies for granting credit in the determination of compliance with time or distance standards established pursuant to this section when Medi-Cal managed care plans contract with specified providers to use clinically appropriate video synchronous interaction, as defined in paragraph (5) of subdivision (a) of Section 2290.5 of the Business and Professions Code.

(2) The department, upon request of a Medi-Cal managed care plan, may authorize alternative access standards for the time or distance standards established under this section if either of the following occur:

(A) The requesting Medi-Cal managed care plan has exhausted all other reasonable options to obtain providers to meet the applicable standard.

(B) The department determines that the requesting Medi-Cal managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

(3) (A) If a Medi-Cal managed care plan cannot meet the time or distance standards set forth in this section, the Medi-Cal managed care plan shall submit a request for alternative access standards to the department, in the form and manner specified by the department.

(B) An alternative access standard request may be submitted at the same time as the Medi-Cal managed care plan submits its annual demonstration of compliance with time or distance standards, if known at that time and at any time the Medi-Cal managed care plan is unable to meet time or distance standards.

(C) A Medi-Cal managed care plan is not required to submit a previously approved alternative access standard request to the department for review and approval on an annual basis, unless the Medi-Cal managed care plan requires modifications to its previously approved request. However, the Medi-Cal managed care plan shall submit this previously approved alternative access standard request to the department at least every three years for review and approval when the plan is required to demonstrate compliance with time or distance standards.

(D) A Medi-Cal managed care plan shall close out any corrective action plan deficiencies in a timely manner to ensure beneficiary access is adequate and shall continually work to improve access in its provider network.

(4) A request for alternative access standards shall be approved or denied on a ZIP Code and provider type, including specialty type, basis by the department within 90 days of submission of the request. The Medi-Cal managed care plan shall also include a description of the reasons justifying the alternative access standards based on those facts and circumstances. Effective no sooner than contract periods commencing on or after July 1, 2020, the Medi-Cal managed care plan shall include a description on how the Medi-Cal managed care plan intends to arrange for beneficiaries to access covered services if the health care provider is located outside of the time or distance standards specified in subdivision (c). The department may stop the 90-day timeframe, on one or more occasions as necessary, in the

event of an incomplete submission or to obtain additional information from the Medi-Cal managed care plan requesting the alternative access standards. Upon submission of sufficient additional information to the department, the 90-day timeframe shall resume at the same point in time it was previously stopped, except if there is less than 30 days remaining in which case the department shall approve or deny the request within 30 days of submission of sufficient additional information. If the department rejects the Medi-Cal managed care plan's proposal, the department shall inform the Medi-Cal managed care plan of the department's reason for rejecting the proposal. The department shall post any approved alternative access standards on its internet website.

(5) As part of the department's evaluation of a request submitted by a Medi-Cal managed care plan to utilize an alternative access standard pursuant to this subdivision, the department shall evaluate and determine whether the resulting time or distance is reasonable to expect a beneficiary to travel to receive care.

(6) The department may authorize a Medi-Cal managed care plan to use clinically appropriate video synchronous interaction, as defined in paragraph (5) of subdivision (a) of Section 2290.5 of the Business and Professions Code, as part of an alternative access standard request.

(g) (1) Effective for contract periods commencing on or after July 1, 2018, a Medi-Cal managed care plan shall, on an annual basis and when requested by the department, demonstrate to the department the Medi-Cal managed care plan's compliance with the time or distance and appointment time standards developed pursuant to this section. The report shall measure compliance separately for adult and pediatric services for primary care, behavioral health, and core specialist services.

(2) Effective for contract periods commencing on or after July 1, 2020, the Medi-Cal managed care plan shall demonstrate, on an annual basis, and when requested by the department, to the department how the Medi-Cal managed care plan arranged for the delivery of Medi-Cal covered services to Medi-Cal enrollees, such as through the use of either Medi-Cal covered transportation or clinically appropriate video synchronous interaction, as specified in paragraph(6) of subdivision (f), if the enrollees of a Medi-Cal managed care plan needed to obtain health care services from a health care provider or a facility located outside of the time or distance standards, as specified in subdivision (c).

The report shall measure compliance separately for adult and pediatric services for primary care, behavioral health, and core specialist services.

(3) Effective for contract periods commencing on or after July 1, 2018, the department shall evaluate on an annual basis a Medi-Cal managed care plan's compliance with the time or distance and appointment time standards implemented pursuant to this section. This evaluation may include, but need not be limited to, annual and random surveys, investigation of complaints, grievances, or other indicia of noncompliance. Nothing in this subdivision shall be construed to limit the appeal rights of a Medi-Cal managed care plan under its contracts with the department.

(4) The department shall publish annually on its internet website a report that details the department's findings in evaluating a Medi-Cal managed care plan's compliance under paragraph (2). At a minimum, the department shall specify in this report those Medi-Cal managed care plans, if any, that were subject to a corrective action plan due to noncompliance with the time or distance and appointment time standards implemented pursuant to this section during the applicable year and the basis for the department's finding of noncompliance. The report shall include a Medi-Cal managed care plan's response to the corrective plan, if available.

(h) The department shall consult with Medi-Cal managed care plans, including dental managed care plans, mental health plans, and Drug Medi-Cal Organized Delivery System programs, health care providers, consumers, providers and consumers of long-term services and supports, and organizations representing Medi-Cal beneficiaries in the implementation of the requirements of this section.

(i) For purposes of this section, the following definitions apply:

(1) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(A) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(B) Article 2.8 (commencing with Section 14087.5).

(C) Article 2.81 (commencing with Section 14087.96).

(D) Article 2.82 (commencing with Section 14087.98).

(E) Article 2.9 (commencing with Section 14088).

(F) Article 2.91 (commencing with Section 14089).

(G) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(H) Chapter 8.9 (commencing with Section 14700).

(I) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184) or a successor demonstration or waiver, as applicable.

(2) "Specialist" means any of the following:

(A) Cardiology/interventional cardiology.

(B) Nephrology.

(C) Dermatology.

(D) Neurology.

(E) Endocrinology.

(F) Ophthalmology.

(G) Ear, nose, and throat/otolaryngology.

(H) Orthopedic surgery.

(I) Gastroenterology.

(J) Physical medicine and rehabilitation.

(K) General surgery.

(L) Psychiatry.

(M) Hematology.

(N) Oncology.

(O) Pulmonology.

(P) HIV/AIDS specialists/infectious diseases.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted.

(k) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(*l*) This section shall remain in effect only until January 1, 2026, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2026, deletes or extends that date.

SEC. 133. Section 14197.04 of the Welfare and Institutions Code is amended to read:

14197.04. (a) (1) A Medi-Cal managed care plan that has received approval from the department to utilize an alternative access standard pursuant to subdivision (f) of Section 14197, upon the request of an enrollee who is required to travel farther than the time or distance standards, as established in subdivision (c) of Section 14197, shall assist that enrollee in obtaining an appointment with an appropriate specialist provider within the time or distance standards established pursuant to subdivision (c) of Section 14197 and the appointment time standards established pursuant to subdivision (d) of Section 14197.

(2) For purposes of complying with the requirement to assist an enrollee, as specified in paragraph (1), a Medi-Cal managed care plan shall do either of the following:

(A) Make its best effort to establish a member-specific case agreement, at the Medi-Cal fee-for-service rate or a rate mutually agreed upon by the specialist provider and the plan, with an appropriate specialist provider within the time or distance standards established pursuant to subdivision (c) of Section 14197 and the appointment time standards established pursuant to subdivision (d) of Section 14197.

(B) Arrange for an appointment with a network specialist provider within the time or distance standards established pursuant to subdivision (c) of Section 14197, and the appointment time standards established pursuant to subdivision (d) of Section 14197.

(3) The requirements of paragraph (1) shall not apply if there is not a specialist provider with an office location within the applicable time or distance standards in relation to the area within which the enrollee resides or the Medi-Cal managed care plan has attempted to establish a member-specific case agreement with the specialist provider for any enrollee pursuant to subparagraph (A) of paragraph (2) in the most recent fiscal year and the provider refused to enter into a member-specific case agreement.

(b) If a specialist provider is unavailable to render necessary health care services pursuant to subdivision (a) to an enrollee within the time or distance standards established pursuant to subdivision (c) of Section 14197 and the appointment time standards established pursuant to subdivision (d) of Section 14197, as specified in subdivision (a), the Medi-Cal managed care plan or the Medi-Cal fee-for-service program, as determined appropriate by the department, shall arrange for Medi-Cal covered transportation for an enrollee to obtain covered Medi-Cal services pursuant to Section 14132.

(c) A Medi-Cal managed care plan that has received approval from the department to utilize an alternative access standard pursuant to subdivision (f) of Section 14197 shall inform its affected members of the approved alternative access standards in a manner and timeframe, as determined by the department.

(d) (1) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(A) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(B) Article 2.8 (commencing with Section 14087.5).

(C) Article 2.81 (commencing with Section 14087.96).

(D) Article 2.82 (commencing with Section 14087.98).

(E) Article 2.91 (commencing with Section 14089).

(F) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(G) Chapter 8.9 (commencing with Section 14700).

(H) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184) or a successor demonstration or waiver, as applicable.

(2) "Specialist provider" has the same meaning as "specialist" as defined in paragraph (2) of subdivision (i) of Section 14197.

SEC. 134. Section 14197.2 of the Welfare and Institutions Code is amended to read:

14197.2. (a) This section implements the state option in subsection (j) of Section 438.8 of Title 42 of the Code of Federal Regulations.

(b) Commencing July 1, 2019, a Medi-Cal managed care plan shall comply with a minimum 85 percent medical loss ratio (MLR) consistent with Section 438.8 of Title 42 of the Code of Federal Regulations. The ratio shall be calculated and reported for each MLR reporting year by the Medi-Cal managed care plan consistent with Section 438.8 of Title 42 of the Code of Federal Regulations.

(c) (1) Effective for contract rating periods commencing on or after July 1, 2023, a Medi-Cal managed care plan shall provide a remittance for an MLR reporting year if the ratio for that MLR reporting year does not meet the minimum MLR standard of 85 percent. The department shall determine the remittance amount on a plan-specific basis for each rating region of the

plan and shall calculate the federal and nonfederal share amounts associated with each remittance.

(2) After the department returns the requisite federal share amounts associated with any remittance funds collected in any applicable fiscal year to the federal Centers for Medicare and Medicaid Services, the remaining amounts remitted by a Medi-Cal managed care plan pursuant to this section shall be transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division 107 of the Health and Safety Code and, notwithstanding Section 128555 of the Health and Safety Code, shall not be used to provide funding for the Physician Volunteer Program.

(d) Except as otherwise required under this section, and until June 30, 2022, the requirements under this section do not apply to a health care service plan under a subcontract with a Medi-Cal managed care plan to provide covered health care services to Medi-Cal beneficiaries enrolled in the Medi-Cal managed care plan. This subdivision shall be inoperative on July 1, 2022.

(e) The department shall post on its internet website all of the following information:

(1) The aggregate MLR of all Medi-Cal managed care plans.

(2) The MLR of each Medi-Cal managed care plan, and, as applicable, the MLR of each subcontractor plan or other delegated entity, under contract with the Medi-Cal managed care plan, that is required to report an MLR pursuant to the CalAIM Terms and Conditions.

(3) Any required remittances owed by each Medi-Cal managed care plan, and, as applicable, any required remittances owed by each subcontractor plan or other delegated entity to that Medi-Cal managed care plan pursuant to the CalAIM Terms and Conditions.

(f) For purposes of this section, the following definitions apply:

(1) "Medical loss ratio (MLR) reporting year" shall have the same meaning as that term is defined in Section 438.8 of Title 42 of the Code of Federal Regulations.

(2) (A) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(i) Article 2.7 (commencing with Section 14087.3).

(ii) Article 2.8 (commencing with Section 14087.5).

(iii) Article 2.81 (commencing with Section 14087.96).

(iv) Article 2.82 (commencing with Section 14087.98).

(v) Article 2.91 (commencing with Section 14089).

(vi) Article 1 (commencing with Section 14200) of Chapter 8.

(vii) Article 7 (commencing with Section 14490) of Chapter 8.

(B) For purposes of the remittance requirement described in subdivision (c), "Medi-Cal managed care plan" does not include dental managed care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200). This subparagraph shall be inoperative on January 1, 2024.

(3) "CalAIM Terms and Conditions" shall have the same meaning as that term is defined in subdivision (c) of Section 14184.101.

(g) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, by means of plan letters, plan or provider bulletins, or similar instructions, without taking any further regulatory action.

SEC. 135. Section 15826 of the Welfare and Institutions Code is amended to read:

15826. (a) The department shall administer the program and may do all of the following:

(1) Determine eligibility criteria for the program. These criteria shall include the requirements set forth in Section 15832.

(2) Determine the eligibility of applicants.

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

(4) Determine subscriber contribution amounts schedules, subject to the following:

(A) Subscriber contributions for Access-linked infants shall not be greater than those applicable on March 23, 2010, for infants enrolled pursuant to clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 of the Insurance Code.

(B) Subscriber contributions for mothers shall conform with the maintenance of effort requirements under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act.

(C) (i) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this chapter to the contrary, the department may elect not to impose subscriber contributions for purposes of this program as described in Section 15849 for an applicable coverage period,

(ii) If the department elects to not impose subscriber contributions for an applicable coverage period pursuant to clause (i) or elects to reinstate such subscriber contributions for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.

(5) Provide coverage through Medi-Cal delivery systems and contract for the administration of the program and the enrollment of subscribers. Any contract entered into pursuant to this chapter shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The department shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on projected and actual subscriber enrollments in a total amount not to exceed the amount appropriated for the program.

(6) Authorize expenditures to pay program expenses that exceed subscriber contributions, and to administer the program as necessary.

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

(8) (A) Issue rules and regulations as necessary to administer the program.

(B) During the 2011–12 to 2014–15 fiscal years, inclusive, the adoption and readoption of regulations pursuant to this chapter shall be deemed to be an emergency that calls for immediate action to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that the department describe facts showing the need for immediate action and from review by the Office of Administrative Law.

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

(b) This section shall become operative on July 1, 2014.

SEC. 136. Section 15832 of the Welfare and Institutions Code is amended to read:

15832. (a) To be eligible to participate in the program, a person shall meet all of the requirements in either paragraph (1) or (2):

(1) (A) Be a woman who is pregnant or in her postpartum period as specified in Section 15840 and who is a resident of the state. A person who is a member of a federally recognized California Indian tribe is a resident of the state for these purposes.

(B) Have a household income that is above 208 percent of the official federal poverty level but does not exceed 317 percent of the official federal poverty level.

(C) Agree to the payment of the complete subscriber contribution. A federally recognized California Indian tribal government may make the subscriber contributions on behalf of a member of the tribe only if a contribution on behalf of members of federally recognized California Indian tribes does not limit or preclude federal financial participation under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.). If a federally recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health care delivery options available in the county where the member resides.

(2) (A) Be a child under two years of age who is delivered by a mother enrolled in the program under this chapter. Except as stated in this section, these infants shall be automatically enrolled in the program.

(B) For the applicable month, not be enrolled in employer-sponsored health care coverage, or have been enrolled in that health care coverage in the prior three months or enrolled in full-scope Medi-Cal without a share of cost. Exceptions may be identified in regulations or other guidance and shall, at minimum, include all exceptions applicable to the Healthy Families Program on and after March 23, 2010.

(C) Be subject to subscriber contributions as determined by the department.

(3) For infants identified in paragraph (2), all of the following shall apply:

(A) Enrollment in the program shall cover the first 12 months of the infant's life unless the infant is determined eligible for Medi-Cal benefits under Section 14005.26. An infant shall be screened for eligibility under Section 14005.26 immediately after the infant is born. If the infant is eligible under Section 14005.26, the infant shall be automatically enrolled in the Medi-Cal program on that basis.

(B) (i) At the end of the 12 months, as a condition of continued eligibility, the subscriber shall provide income information. The infant shall be disenrolled from the program if the annual household income exceeds 317 percent of the federal poverty level, or if the infant is eligible for full-scope Medi-Cal with no share of cost.

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

(C) At the end of their first and second year in the program, infants shall be screened for eligibility for the Medi-Cal program.

(4) If at any time the director determines that the eligibility criteria established under this chapter for the program may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), any amendment or extension of that act, or any similar federal legislation affecting federal financial participation, the director may alter the eligibility criteria to the extent necessary for the state to receive that federal financial participation.

(b) If the conditions described in paragraph (1) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 137. Section 15832 is added to the Welfare and Institutions Code, to read:

15832. (a) To be eligible to participate in the program, a person shall meet all of the requirements in either paragraph (1) or (2):

(1) (A) Be a person who is pregnant or in the postpartum period as specified in Section 15840 and who is a resident of the state. A person who is a member of a federally recognized California Indian tribe is a resident of the state for these purposes.

(B) Have a household income that is above 208 percent of the official federal poverty level but does not exceed 317 percent of the official federal poverty level.

(C) Agree to the payment of the complete subscriber contribution. A federally recognized California Indian tribal government may make the subscriber contributions on behalf of a member of the tribe only if a contribution on behalf of members of federally recognized California Indian tribes does not limit or preclude federal financial participation under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.). If a federally recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health care delivery options available in the county where the member resides.

(2) (A) Be a child under two years of age who is delivered by a mother enrolled in the program under this chapter. Except as stated in this section, these infants shall be automatically enrolled in the program.

(B) For the applicable month, not be enrolled in employer-sponsored health care coverage, or have been enrolled in that health care coverage in the prior three months or enrolled in full-scope Medi-Cal without a share of cost. Exceptions may be identified in regulations or other guidance and shall, at minimum, include all exceptions applicable to the Healthy Families Program on and after March 23, 2010.

(C) Be subject to subscriber contributions as determined by the department.

(3) For infants identified in paragraph (2), all of the following shall apply:

(A) Enrollment in the program shall cover the first 12 months of the infant's life unless the infant is determined eligible for Medi-Cal benefits under Section 14005.26. An infant shall be screened for eligibility under Section 14005.26 immediately after the infant is born. If the infant is eligible under Section 14005.26, the infant shall be automatically enrolled in the Medi-Cal program on that basis.

(B) (i) At the end of the 12 months, the infant shall remain continuously eligible for the Medi-Cal program until they are five years of age. A redetermination of Medi-Cal eligibility shall not be conducted before the child reaches five years of age, except as specified in Section 14005.255. This clause shall be implemented to the extent that any necessary federal approvals are obtained and federal financial participation is available. The department shall seek any necessary federal approvals to implement this clause.

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

(C) At the end of their first and second year in the program, and subsequent years, up to five years of age, the child shall be screened for eligibility for the Medi-Cal program.

(4) If at any time the director determines that the eligibility criteria established under this chapter for the program may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), any amendment or extension of that act, or any similar federal legislation affecting federal financial participation, the director may alter the eligibility criteria to the extent necessary for the state to receive that federal financial participation.

(b) (1) Implementation of this section is contingent on all of the following conditions:

(A) All necessary federal approvals have been obtained by the department pursuant to subdivision (d).

(B) The Legislature has appropriated funding to implement this section after a determination that ongoing General Fund resources are available to support the ongoing implementation of this section in the 2024–25 fiscal year and subsequent fiscal years.

(C) The department has determined that systems have been programmed to implement this section.

(2) The department shall issue a declaration certifying the date that all conditions in paragraph (1) have been met. The department shall post the declaration on its internet website and provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section, in whole or in part, through all-county letters or similar instructions, without taking any further regulatory action.

(d) This section shall be implemented only to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized.

(e) This section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (b), whichever is later.

SEC. 138. Section 15840 of the Welfare and Institutions Code is amended to read:

15840. (a) (1) At a minimum, coverage provided pursuant to this chapter shall be provided to subscribers during one pregnancy, and until the end of

the month in which the 60th day after pregnancy occurs, and to eligible children less than two years of age who were born of a pregnancy covered under this program or the Access for Infants and Mothers program under former Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code to a woman enrolled in the Access for Infants and Mothers program.

(2) (A) Upon the effective date reflected in any necessary federal approvals obtained by the department pursuant to subdivision (c) of Section 14005.185, a subscriber described in paragraph (1) shall be eligible for an additional 10-month period following the 60-day postpartum period, for a total of 12 months of continuous eligibility after the end of pregnancy.

(B) This paragraph shall be implemented only if, and to the extent that, any necessary federal approvals are obtained pursuant to Section 14005.185 and federal financial participation is available, and subject to an annual appropriation by the Legislature for this purpose.

(b) Coverage provided pursuant to this chapter shall include, at a minimum, those services required to be provided by health care service plans approved by the Secretary of Health and Human Services as a federally qualified health care service plan pursuant to Section 417.101 of Title 42 of the Code of Federal Regulations.

(c) Medically necessary prescription drugs shall be a required benefit in the coverage provided pursuant to this chapter.

(d) To the extent required pursuant to Section 15818 to comply with paragraph (1) of subdivision (b) of Section 30122 of the Revenue and Taxation Code, health education services related to tobacco use shall be a benefit in the coverage provided under this chapter.

(e) If the conditions described in paragraph (1) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, have been met, this section shall become inoperative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 139. Section 15840 is added to the Welfare and Institutions Code, to read:

15840. (a) (1) At a minimum, coverage provided pursuant to this chapter shall be provided to subscribers during one pregnancy, and until the end of the month in which the 60th day after pregnancy occurs, and to eligible children less than two years of age, or less than five years of age pursuant to Section 15832, who were born of a pregnancy covered under this program or the Access for Infants and Mothers program under former Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code to a person enrolled in the Access for Infants and Mothers program.

(2) (A) Upon the effective date reflected in any necessary federal approvals obtained by the department pursuant to subdivision (c) of Section 14005.185, a subscriber described in paragraph (1) shall be eligible for an

additional 10-month period following the 60-day postpartum period, for a total of 12 months of continuous eligibility after the end of pregnancy.

(B) This paragraph shall be implemented only if, and to the extent that, any necessary federal approvals are obtained pursuant to Section 14005.185 and federal financial participation is available, and subject to an annual appropriation by the Legislature for this purpose.

(b) Coverage provided pursuant to this chapter shall include, at a minimum, those services required to be provided by health care service plans approved by the Secretary of Health and Human Services as a federally qualified health care service plan pursuant to Section 417.101 of Title 42 of the Code of Federal Regulations.

(c) Medically necessary prescription drugs shall be a required benefit in the coverage provided pursuant to this chapter.

(d) To the extent required pursuant to Section 15818 to comply with paragraph (1) of subdivision (b) of Section 30122 of the Revenue and Taxation Code, health education services related to tobacco use shall be a benefit in the coverage provided under this chapter.

(e) This section shall become operative on January 1, 2025, or the date certified by the department pursuant to paragraph (2) of subdivision (b) of Section 15832, as added by Section 137 of the act that added this subdivision, whichever is later, and shall be repealed on January 1 directly following that date.

SEC. 140. Section 15849 is added to the Welfare and Institutions Code, to read:

15849. (a) Effective July 1, 2022, to the extent allowable under federal law, notwithstanding the provisions of this chapter to the contrary, the department may elect not to impose subscriber contributions for purposes of coverage as described in this chapter, including, but not limited to, subscriber contributions for Access-linked infants, for an applicable coverage period.

(b) If the department elects to not impose subscriber contributions for an applicable coverage period pursuant to subdivision (a) or elects to reinstate such subscriber contributions for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.

SEC. 141. Section 15854 of the Welfare and Institutions Code is amended to read:

15854. (a) The department, in consultation with other appropriate parties, shall establish the criteria for evaluating an applicant's proposal, which shall include, but not be limited to, the following:

(1) The extent to which the program described in the proposal provides comprehensive coverage, including health, dental, and vision benefits.

(2) Whether the proposal includes a promotional component to notify the public of its provision of health insurance to eligible children.

(3) The simplicity of the proposal's procedures for applying to participate and for determining eligibility for participation in its program.

(4) The extent to which the proposal provides for coordination and conformity with benefits provided through the Medi-Cal program.

(5) The extent to which the proposal provides for coordination and conformity with existing Medi-Cal administrative entities in order to prevent administrative duplication and fragmentation.

(6) The ability of the health care providers designated in the proposal to serve the eligible population and the extent to which the proposal includes traditional and safety net providers, as defined by the department.

(7) The extent to which the proposal intends to work with the school districts and county offices of education.

(8) The total amount of funds available to the applicant to implement the program described in its proposal, and the percentage of this amount proposed for administrative costs as well as the cost to the state to administer the proposal.

(9) The extent to which the proposal seeks to minimize the substitution of private employer health insurance coverage for health benefits provided through a governmental source.

(10) The extent to which local resources may be available after the depletion of federal funds to continue any current program expansions for persons covered under local health care financing programs or for expanded benefits.

(11) For the purposes of defining an applicant's eligibility for funding under this chapter, the following shall apply:

(A) The same income methodology shall be used for the proposed program that is currently used for the Medi-Cal program.

(B) Only participating Medi-Cal managed care plans may be used. However, the department may permit exceptions to this requirement consistent with the purpose, of this chapter.

(b) The department may, in its sole discretion, approve or disapprove projects for funding pursuant to this chapter on an annual basis.

(c) To the extent that an applicant's proposal pursuant to this chapter provides for health plan or administrative services under a contract entered into by the department or at rates negotiated for the applicant by the department, a contract entered into by the department or by an applicant shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services to the same extent as contracts entered into pursuant to subdivision (p) of Section 14005.26. The department and the applicant shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on the projected or actual subscriber enrollments to a total amount not to exceed the amount appropriated for the project, including family contributions, when applicable.

SEC. 142. Section 15854.5 is added to the Welfare and Institutions Code, to read:

15854.5. (a) Effective July 1, 2022, to the extent allowable under federal law, and notwithstanding the provisions of this chapter to the contrary, the

department may elect not to impose subscriber contributions for purposes of coverage as described in this chapter for an applicable coverage period.

(b) If the department elects to not impose subscriber contributions for an applicable coverage period pursuant to subdivision (a) or elects to reinstate such subscriber contributions for a subsequent coverage period, the department shall specify that election in the published Medi-Cal Local Assistance Estimate for the impacted state fiscal year or years, subject to appropriation by the annual Budget Act.

SEC. 143. Section 16501.3 of the Welfare and Institutions Code is amended to read:

16501.3. (a) The State Department of Social Services shall establish and maintain a program of public health nursing in the child welfare services program that meets the federal requirements for the provision of health care to minor and nonminor dependents in foster care consistent with Section 30026.5 of the Government Code. The purpose of the public health nursing program shall be to promote and enhance the physical, mental, dental, and developmental well-being of children in the child welfare system.

(b) Under this program, counties shall use the services of a foster care public health nurse. The foster care public health nurse shall work with the appropriate child welfare services workers to coordinate health care services and serve as a liaison with health care professionals and other providers of health-related services. This shall include coordination with county mental health plans and local health jurisdictions, as appropriate. In order to fulfill these duties, the foster care public health nurse shall have access to the child's medical, dental, and mental health care information, in a manner that is consistent with all relevant privacy requirements.

(c) The duties of a foster care public health nurse shall include, but need not be limited to, the following:

(1) Documenting that each child in foster care receives initial and followup health screenings that meet reasonable standards of medical practice.

(2) Collecting health information and other relevant data on each foster child as available, receiving all collected information to determine appropriate referral and services, and expediting referrals to providers in the community for early intervention services, specialty services, dental care, mental health services, and other health-related services necessary for the child.

(3) Participating in medical care planning and coordinating for the child. This may include, but is not limited to, assisting case workers in arranging for comprehensive health and mental health assessments, interpreting the results of health assessments or evaluations for the purpose of case planning and coordination, facilitating the acquisition of any necessary court authorizations for procedures or medications, monitoring and oversight of psychotropic medications, advocating for the health care needs of the child, and ensuring the creation of linkage among various providers of care.

(4) Providing followup contact to assess the child's progress in meeting treatment goals.

(5) At the request of and under the direction of a nonminor dependent, as described in subdivision (v) of Section 11400, assisting the nonminor dependent in accessing physical health and mental health care, coordinating the delivery of health and mental health care services, advocating for the health and mental health care that meets the needs of the nonminor dependent, assisting the nonminor dependent to make informed decisions about the nonminor dependent's health care by, at a minimum, providing educational materials, and assisting the nonminor dependent to assume responsibility for their ongoing physical and mental health care management.

(d) (1) The services provided by foster care public health nurses under this section shall be limited to those for which reimbursement may be claimed under Title XIX of the federal Social Security Act at an enhanced rate for services delivered by skilled professional medical personnel. Notwithstanding any other law, this section shall be implemented only if, and to the extent that, the State Department of Health Care Services determines that federal financial participation, as provided under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), is available.

(2) The department, the State Department of Health Care Services, counties, and cities, as applicable, shall maximize the use of federal funds in implementing this section, including using permissible state or local funds to match funds claimable under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) for allowable expenditures made pursuant to this section.

(e) (1) The State Department of Health Care Services shall seek any necessary federal approvals for child welfare agencies to appropriately claim enhanced federal Title XIX funds for services provided pursuant to this section.

(2) Commencing in the fiscal year immediately following the fiscal year in which the necessary federal approval pursuant to paragraph (1) is secured, county child welfare agencies shall provide health care oversight and coordination services pursuant to this section, and may accomplish this through agreements with local public health agencies.

(f) The State Department of Health Care Services may, at its discretion, enter into contracts, or amend existing contracts, with a California county, city, or city and county to facilitate local administration of the program described in this section. Notwithstanding any other law, contracts entered into or amended pursuant to this subdivision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and are exempt from the review or approval of any division of the Department of General Services.

(g) (1) Notwithstanding Section 10101, prior to the 2011–12 fiscal year, there shall be no required county match of the nonfederal cost of this program.

(2) Commencing in the 2011–12 fiscal year, and each fiscal year thereafter, funding and expenditures for programs and activities under this

section shall be in accordance with the requirements provided in Sections 30025 and 30026.5 of the Government Code.

(h) A city that operates an independent health agency may elect to administer the program described in this section with the approval of the State Department of Health Care Services. In this instance, the powers granted a governing body of a county shall be vested in the governing body of the city.

(i) Public health nurses shall receive training developed pursuant to subdivision (d) of Section 16501.4.

SEC. 144. Chapter 16.5 (commencing with Section 18998) is added to Part 6 of Division 9 of the Welfare and Institutions Code, to read:

Chapter 16.5. Community Health Workers

18998. For purposes of this chapter, the following terms have the following meanings:

(a) "Community-defined" means a set of practices that communities have used and found to yield positive results, as determined by community consensus over time. These practices may or may not have been measured empirically, but have reached a level of acceptance by the community.

(b) "Community health worker" means a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. A community health worker is a frontline health worker either trusted by, or who has a close understanding of, the community served. Community health workers include Promotores, Promotores de Salud, Community Health Representatives, navigators, and other nonlicensed health workers with the qualifications developed pursuant to this chapter, including violence prevention professionals. A community health worker's lived experience shall align with and provide a connection to the community being served.

(c) "Core competencies" means the foundational and essential knowledge, skills, and abilities required for community health workers, which include all of the following:

(1) Communication skills.
(2) Interpersonal and relationship-building skills.
(3) Service coordination and navigation skills.
(4) Capacity building skills.
(5) Advocacy skills.
(6) Education and facilitation skills.
(7) Individual and community assessment skills.
(8) Outreach skills.
(9) Professional skills and conduct.
(10) Evaluation and research skills.

(11) Knowledge base, including knowledge of basic public health principles, and social determinants of health and related disparities, of the community to be served.

(d) "Cultural competence" means a set of congruent behaviors, attitudes, and policies that come together in a system or agency that enables that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates, at all levels, the importance of language and culture, intersecting identities, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs to provide services in a culturally competent manner.

(e) "Department" means the Department of Health Care Access and Information.

(f) "Lived experience" means personal knowledge of a specific health condition or circumstance, which may include, but not be limited to, Alzheimer's and other related dementia, climate impact on health, disability, foster system placement, homelessness, justice involved, LGBTQ+ status, mental health conditions, substance use, military service, pregnancy, and birth. A community health worker may draw on their lived experience to assist other individuals with navigation to treatment and services. A community health worker with lived experience involving a behavioral health or other health condition may need additional training on how to appropriately use this lived experience to assist other individuals with their recovery from that condition.

(g) "Specialty certificate" means the next level of training that concentrates on specific program focus areas, with learning objectives and topics tailored to the skills required for distinct program and population needs.

18998.1. On or before July 1, 2023, the department shall do all of the following:

(a) Develop statewide requirements for community health worker certificate programs in consultation with stakeholders, including, but not limited to, the State Department of Health Care Services, the State Department of Public Health, community health workers, Promotores and Promotores de Salud, or representative organizations. In developing the requirements, the department shall do all of the following:

(1) Consult evidenced-based and community-defined materials.

(2) Determine necessary curriculum to meet certificate program objectives.

(3) Determine criteria for specialty certificate programs and specialized training requirements that build on the lived experience of community health workers.

(4) Determine a structure of statewide oversight that reduces barriers to training.

(5) Determine how past experience as a community health worker may provide a pathway to certification, and how to verify past experience.

(b) Approve statewide requirements for the development of certificate programs for community health workers.

(c) Approve the curriculum required for programs to certify community health workers.

(d) Review, approve, or renew evidence-based curricula and community-defined curricula for core competencies, specialized programs, and training.

18998.2. (a) An organization may seek approval of a community health worker certificate program in accordance with this chapter and any standards approved by the department. In administering an approved community health worker certificate program, the organization shall oversee and enforce the requirements developed pursuant to this chapter.

(b) An organization that seeks approval or renewal of a community health worker certificate program shall do all of the following:

(1) Submit a community health worker certificate program plan describing how the community health worker certificate program meets the state requirements for the training and certificate of community health workers.

(2) Submit to periodic reviews to ensure adherence to state requirements.

(3) Submit annual community health worker certificate program reports on participant training and employment. The annual report shall include data determined by the department, in consultation with stakeholders, as needed, to ensure the certificate curriculum maintains community health worker diversity and addresses future workforce needs.

18998.3. (a) The department, in consultation with stakeholders, may request that an individual who is either enrolled in, or who has completed, a community health worker certificate program submit data consistent with Section 502 of the Business and Professions Code.

(b) The department's identification and specification of the data is exempt until June 30, 2024, from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(c) The department shall determine the frequency and manner of data submission consistent with this section to ensure program needs are met.

(d) The department shall maintain the privacy of data provided consistent with all relevant federal and state laws.

18998.4. The department may contract with a vendor or vendors to implement this chapter.

18998.5. Except as provided in Section 18998.3, and notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this chapter by means of policy letters, provider bulletins, or other similar instructions, without taking regulatory action. The department shall consult with affected stakeholders before acting pursuant to this section.

SEC. 145. The provisions of this measure are severable. If any provision of this measure or its application is held invalid, that invalidity shall not

affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 146. The Legislature finds and declares that Section 16 of this act, which adds Section 123452 to the Health and Safety Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

The public interest to protect the privacy of patients of abortion services outweighs the public's right of access to that information.

SEC. 147. The Legislature finds and declares that Section 19 of this act, which adds Chapter 2.6 (commencing with Section 127500) to Part 2 of Division 107 of the Health and Safety Code, imposes limitations on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

This act balances the need for a government agency to obtain proprietary business information and private health care data with the public interest in monitoring the cost, quality, equity, and accessibility of health care services.

SEC. 148. The Legislature finds and declares that Sections 24 and 25 of this act, which amend Section 127696 of the Health and Safety Code, impose a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to protect proprietary and confidential information regarding manufacturer or distribution costs and drug pricing, utilization, and rebates, it is necessary for that information to remain confidential.

SEC. 149. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 150. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article

IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

O