AMENDED IN ASSEMBLY JULY 17, 2025

AMENDED IN ASSEMBLY JUNE 26, 2025

AMENDED IN ASSEMBLY JUNE 10, 2025

AMENDED IN SENATE APRIL 22, 2025

AMENDED IN SENATE APRIL 21, 2025

SENATE BILL No. 862

Introduced by Committee on Health (Senators Menjivar (Chair), Durazo, Gonzalez, Grove, Limón, Padilla, Richardson, Rubio, Valladares, Weber Pierson, and Wiener)

March 17, 2025

An act to amend Sections 232.7 and 49421 of the Education Code, to amend Sections 1279.6, 1337.3, 120960, 127410, 131365, and 131370 of the Health and Safety Code, to amend Sections 10119.6 and 10123.1991 of the Insurance Code, and to amend Sections 5610, 5771.1, 5814, 5830, 5835, 5835.2, 5840.6, 5847, 5892, 5892.1, 5897, 5899, 14132.85, and 14184.201 of the Welfare and Institutions Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

SB 862, as amended, Committee on Health. Health.

(1) Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, established the Mental Health Services Oversight and Accountability Commission to oversee the implementation of the MHSA. Existing law specifies the composition of the 16-member commission, including the Attorney General or their designee, the Superintendent of Public Instruction or their designee,

specified members of the Legislature, and 12 members appointed by the Governor, as prescribed.

Existing law, the Behavioral Health Services Act (BHSA), an initiative measure enacted by the voters as Proposition 1 at the March 5, 2024, statewide primary election, recast the MHSA by, among other things, renaming the commission to the Behavioral Health Services Oversight and Accountability Commission and changing its composition and duties.

This bill would make technical changes to reflect the correct name of the commission.

(2) Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health. Existing law requires a health facility to develop, implement, and comply with a patient safety plan to improve the health and safety of patients and to reduce preventable patient safety events. Existing law requires a patient safety plan to contain specified elements, including, but not limited to, a reporting system for patient safety events that allows anyone involved to make a report of a patient safety event to the health facility and a process for a team of facility staff to conduct analyses related to root causes of patient safety events. Existing law, commencing January 1, 2026, and biannually thereafter, requires a health facility to submit a patient safety plan to the department. A violation of these provisions is a crime.

This bill would instead require a health facility to submit a patient safety plan to the department biennially. The bill would also make technical corrections to those provisions. By changing the frequency that a health facility is required to submit a patient safety plan, the violation of which is a crime, this bill would impose a state-mandated local program.

(3) Existing law establishes the State Department of Public Health and sets forth its powers and duties to license and administer health facilities, as defined, including skilled nursing facilities and intermediate care facilities. Existing law requires the department to prepare and maintain a list of approved training programs for nurse assistant certification, which are required to include a precertification training program consisting of at least 60 classroom hours of training on basic nursing skills, patient safety and rights, the social and psychological problems of patients, and elder abuse recognition and reporting and at least 100 hours of supervised and on-the-job training clinical practice. Existing law requires at least 2 hours of the 60 hours of classroom

training and at least 4 hours of the 100 hours of the supervised clinical training to address the special needs of persons with developmental and mental disorders, including intellectual disability, Alzheimer's disease, cerebral palsy, epilepsy, dementia, Parkinson's disease, and mental illness. A violation of these provisions is a crime.

This bill would require that at least 2 of the 60 hours of classroom training address the special needs of persons with Alzheimer's disease and related dementias. By changing the definition of a crime, this bill would impose a state-mandated local program.

(4) Existing law authorizes the State Public Health Officer, to the extent allowable under federal law, and upon the availability of funds, to expend moneys from the continuously appropriated AIDS Drug Assistance Program (ADAP) Rebate Fund for a program to cover the costs of prescribed ADAP formulary medications for the prevention of HIV infection and other specified costs.

This bill would make technical corrections to a related provision.

(5) Existing law requires a hospital, as defined, to maintain an understandable written policy regarding discount payments for financially qualified patients as well as a written charity care policy, and requires a hospital to negotiate the terms of a discount payment plan with an eligible patient, as specified. Existing law requires each hospital to provide patients with written notice, provided at the time of service, about the availability of the hospital's discount payment and charity care policies, and other additional information.

This bill would authorize, with the exception of emergency room visits, a hospital to provide the written notice in either hard copy or, if the patient has previously consented to receive electronic communications, using the patient's preferred electronic notification method. The bill would require the written notice related to an emergency room visit to be provided in hard copy. The bill would require, if the notice is provided electronically, the notice to be sent separately from any other electronic communications and to prominently indicate in the subject line that the notice is related to the hospital's discount and charity care policies.

(6) Existing law authorizes the State Department of Public Health to develop and administer a syndromic surveillance program and, subject to an appropriation, to either designate an existing system or to create a new system that would be required, at a minimum, to provide public health practitioners access to an electronic health system to rapidly

collect, evaluate, share, and store syndromic surveillance data, as specified.

This bill would make technical corrections to related provisions.

(7) Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a large group disability insurance policy and a small group disability insurance policy, except as specified, issued, amended, or renewed on or after ~~July 1, 2025,~~ *January 1, 2026,* to provide coverage for the diagnosis and treatment of infertility and fertility services, as specified.

This bill would instead require a large group health insurance policy and a small group health insurance policy, except ~~a specialized disability insurance policy,~~ *as specified,* to offer the above-described ~~services, as specified, and would make technical corrections to those provisions.~~ *services.*

(8) Existing law requires an insurer to provide an insured with an annual electronic notice regarding the benefits of a behavioral health and wellness screening, as defined, for children and adolescents 8 to 18 years of age.

This bill would make technical changes to those provisions.

(9) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires, commencing January 1, 2022, that Community-Based Adult Services (CBAS) 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.

This bill would make a technical correction to this provision.

(10) Existing law, subject to any necessary federal approvals, sets forth various Medi-Cal provisions relating to complex rehabilitation technology (CRT), which is a form of durable medical equipment, including, but not limited to, complex rehabilitation manual and power wheelchairs. Existing law requires a CRT provider to comply with certain standards, including requiring a qualified rehabilitation technology professional to be physically present for the evaluation.

This bill would make a technical correction to this provision.

(11) 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 no reimbursement is required by this act for a specified reason.

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

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

SECTION 1. Section 232.7 of the Education Code is amended to read:

232.7. (a) (1) (A) On or before June 30, 2025, the State Department of Education, in consultation with the California Health and Human Services Agency, the Behavioral Health Services Oversight and Accountability Commission, and other relevant stakeholders, shall develop and post on its internet website a model policy and resources about body shaming that is appropriate for schools that serve pupils in kindergarten or any of grades 1 to 12, inclusive, and that local educational agencies may use to educate staff and pupils about the issue of body shaming.

(B) The State Department of Education, in consultation with the California Health and Human Services Agency, the Behavioral Health Services Oversight and Accountability Commission, and other relevant stakeholders, may use existing resources or frameworks, or both, about body shaming or body image, or both, to meet the requirements of subparagraph (A).

(2) Local educational agencies are encouraged to inform teachers, staff, parents, and pupils about the resources developed pursuant to subdivision (a), including, but not limited to, by providing information in pupil and employee handbooks and making the information available on each schoolsite's internet website.

(b) For purposes of this article, the following definitions apply:

(1) "Body shaming" means the action or practice of mocking or stigmatizing a person by making critical comments or observations about the shape, size, or appearance of the person's body.

(2) "Local educational agency" means a school district, county office of education, or charter school.

SEC. 2. Section 49421 of the Education Code is amended to read:

49421. (a) The sum of five million dollars ($5,000,000) is hereby appropriated from the General Fund to the Superintendent on a one-time basis for the School Health Demonstration Project. The School Health Demonstration Project is hereby established in the office as a pilot project to expand comprehensive health and mental health services to public school pupils by providing local educational agencies with intensive assistance and support to build the capacity for long-term sustainability by leveraging multiple revenue sources. For these purposes, the project is intended to provide training and technical assistance on the requirements for health care provider participation in the Medi-Cal program pursuant to Article 1.3 (commencing with Section 14043) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code to enable local educational agencies to participate in, contract with, and conduct billing and claiming in the Medi-Cal program through all of the following:

(1) The Local Educational Agency Medi-Cal Billing Option Program.

(2) The School-Based Medi-Cal Administrative Activities Program.

(3) Contracting or entering into a memorandum of understanding with Medi-Cal managed care plans as a participating Medi-Cal managed care plan contracting provider.

(4) Contracting with or entering into a memorandum of understanding with county mental health plans for specialty mental health services, such as through the Early and Periodic Screening, Diagnostic and Treatment Program.

(5) Contracting with community-based providers to deliver health and mental health services to pupils in school through contracts with Medi-Cal managed care plans or county mental health plans.

(b) On or before June 30, 2022, the Superintendent, in consultation with the executive director of the state board and the State Department of Health Care Services, shall select up to three organizations to serve as technical assistance teams for purposes of the pilot project. Technical assistance teams selected to serve shall be a consortia that consists of one or more local educational agencies, county agencies, or community-based organizations with experience in general and special education mental health program and service development, school finance, health care, Medi-Cal

managed care contracting and benefits, Medicaid billing, commercial health insurance, and data analysis. The technical assistance teams are intended to provide hands-on, intensive support for a two-year period to the local educational agencies selected to be pilot participants to create capacity for those local educational agencies to become self-sustaining by securing federal reimbursement and other revenue sources for health and mental health services provided to pupils. In selecting the technical assistance teams, consideration shall be given to demonstrated expertise, including, but not limited to, all of the following:

(1) Knowledge of the process to submit claims through the Local Educational Agency Medi-Cal Billing Option Program, the School-Based Medi-Cal Administrative Activities Program, and drawing down federal reimbursement for Medi-Cal services.

(2) The knowledge and capacity to provide direct, hands-on assistance and support to selected local educational agencies in securing federal reimbursement for health and mental health services provided to pupils, and identifying additional sources of funding through programs identified in subdivision (a).

(3) Experience working with the department, the State Department of Health Care Services, county health departments, county behavioral health departments, Medi-Cal managed care plans, private health care service plans and health insurers, and the Behavioral Health Services Oversight and Accountability Commission.

(4) Experience in the legally compliant development and sustainable funding of general and special education mental health programs and supports in public schools, including the Multi-Tiered System of Supports, positive behavioral interventions and supports services for children under the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and Section 504 of the federal Rehabilitation Act of 1973 (29 U.S.C. Sec. 794), public school contracting requirements, and relevant state and federal privacy protections.

(c) On or before September 1, 2022, the department, in consultation with the State Department of Health Care Services, shall select up to 25 local educational agencies to serve as pilot participants for a period of two years. In selecting local educational agencies to serve as pilot participants, consideration shall be given to all of the following factors:

(1) Demonstrated need for health and mental health services for pupils.

(2) Commitment of the local educational agency's leadership to expand health and mental health services for all pupils through school-based services, school-connected services, or both.

(3) Willingness to reinvest increased reimbursements gained through the pilot project into direct health and mental health services for pupils.

(4) Unduplicated pupil count.

(5) Geographic diversity of the state.

(6) Mix of urban, suburban, and rural.

(d) A local educational agency selected to serve as a pilot participant pursuant to subdivision (c) shall receive up to one hundred thousand dollars ($100,000) per year for each of the two years it participates in the pilot project. Funds shall be used for contracting with one of the technical assistance teams identified by the department pursuant to subdivision (b), and may also be used to address needs identified by the in-depth analysis conducted by the technical assistance provider.

(e) The technical assistance teams selected pursuant to subdivision (b) shall, under the direction of the department, work with each pilot participant to do all of the following:

(1) Conduct an analysis of all of the following related to the local educational agency:

(A) The need for health and mental health services for pupils.

(B) The current capacity within the local educational agency to meet those needs.

(C) Current participation in the programs identified in paragraphs (1) and (2) of subdivision (a).

(D) The barriers to participating in the programs identified in paragraphs (1) and (2) of subdivision (a).

(E) Any existing partnerships with county agencies or community-based agencies to provide health and mental health services to pupils.

(2) Work with local educational agency staff to establish or expand the expertise necessary to maximize federal reimbursement revenue through an analysis of past claims and review eligible school expenditures to ensure maximum usage of potential Medi-Cal reimbursements, including the Early and Periodic

Screening, Diagnostic, and Treatment services provided to eligible pupils.

(3) Facilitate the exploration of opportunities to collaborate with county mental health plans, Medi-Cal managed care plans, and private health care service plans and health insurers to establish partnerships through memoranda of understanding or other means to coordinate the funding and provision of health and mental health services to pupils.

(4) Complete, and provide to the department, a final report at the conclusion of the pilot project with data on any increases in the level of health and mental health services provided to pupils in the local educational agency, any improved measurable outcomes for pupils, increased funding secured, plans for ongoing sustainability of health and mental health services beyond the pilot project period, and recommendations on maximizing federal reimbursement and other revenue sources to provide effective health and mental health services to pupils.

(f) (1) The department, in consultation with the State Department of Health Care Services, participating local educational agencies, and the technical assistance teams established pursuant to subdivision (b), shall prepare and submit to the relevant policy and fiscal committees of the Legislature on or before January 1, 2025, or six months after the final local educational agency has ended its service as a pilot participant, whichever comes first, a final report of the pilot programs established pursuant to this section. The report shall include, but not be limited to, all of the following:

(A) Best practices developed by local educational agencies that ensure every pupil receives an uninterrupted continuum of effective care services.

(B) Program requirements and support services needed for the Local Educational Agency Medi-Cal Billing Option Program, the School-Based Medi-Cal Administrative Activities Program, and medically necessary federal Early and Periodic Screening, Diagnostic, and Treatment benefits, to ensure ease of use and access for local educational agencies.

(C) Total dollars drawn down from federal sources by local educational agencies participating in the pilot project.

(D) The number of pupils receiving health and mental health services by participating local educational agencies throughout

the course of the pilot project, including breakdowns by subgroups, and measurable improved outcomes for those pupils.

(E) Recommendations for expanding the program statewide, including an estimate of the cost of fully funding an ongoing technical assistance and support program on a statewide basis.

(F) Strategies for working with the State Department of Health Care Services to coordinate, streamline, and prevent the duplication of Medi-Cal covered services.

(G) Recommendations on specific changes needed to state regulations or statute, the need for approval of amendments to the state Medicaid plan or federal waivers, changes to implementation of federal regulations, changes to state agency support and oversight, and associated staffing or funding needed to implement recommendations.

(2) A report to be submitted pursuant to paragraph (1) shall be submitted in compliance with Section 9795 of the Government Code.

(g) The department, in consultation with the technical assistance teams, the State Department of Health Care Services, and the Behavioral Health Services Oversight and Accountability Commission, shall prepare materials for use by local educational agencies in developing the capacity to effectively secure sustainable funding for the delivery of comprehensive health and mental health services to pupils.

(h) The State Department of Health Care Services shall seek federal financial participation for the activities conducted pursuant to this section.

(i) The following definitions apply to this section:

(1) "County mental health plan" means an entity authorized pursuant to Article 5 (commencing with Section 14680) of Chapter 8.8 of Part 3 of Division 9 of the Welfare and Institutions Code.

(2) "Medi-Cal managed care plan" means an 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) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, excluding dental managed care programs developed pursuant to Section 14087.46 of the Welfare and Institutions Code.

(B) Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.82 (commencing with Section 14087.98), Article 2.9 (commencing with Section 14088), or Article 2.91 (commencing with Section 14089) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(C) Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, excluding dental managed care plans.

(D) Chapter 3 (commencing with Section 101675) of Part 4 of Division 101 of the Health and Safety Code.

(j) For purposes of making the computations required by Section 8 of Article XVI of the California Constitution, the appropriation made by subdivision (a) shall be deemed to be "General Fund revenues appropriated for school districts," as defined in subdivision (c) of Section 41202, for the 2020–21 fiscal year, and included within the "total allocations to school districts and community college districts from General Fund proceeds of taxes appropriated pursuant to Article XIII B," as defined in subdivision (e) of Section 41202, for the 2020–21 fiscal year.

SEC. 3. Section 1279.6 of the Health and Safety Code is amended to read:

1279.6. (a) A health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, shall develop, implement, and comply with a patient safety plan for the purpose of improving the health and safety of patients and reducing preventable patient safety events. The patient safety plan shall be developed by the facility in consultation with the facility's various health care professionals.

(b) The patient safety plan required pursuant to subdivision (a) shall, at a minimum, provide for the establishment of all of the following:

(1) A patient safety committee or equivalent committee in composition and function. The committee shall be composed of the facility's various health care professionals, including, but not limited to, physicians, nurses, pharmacists, and administrators. The committee shall do all of the following:

(A) Review and approve the patient safety plan.

(B) Receive and review reports of patient safety events as defined in subdivision (c).

(C) Monitor implementation of corrective actions for patient safety events.

(D) Make recommendations to eliminate future patient safety events.

(E) Review and revise the patient safety plan, at least once a year, but more often if necessary, to evaluate and update the plan and to incorporate advancements in patient safety practices.

(2) A reporting system for patient safety events that allows anyone involved, including, but not limited to, health care practitioners, facility employees, patients, and visitors, to make a report of a patient safety event to the health facility, including anonymous reporting options.

(3) A process for a team of facility staff to conduct analyses, including, but not limited to, root cause analyses of patient safety events. The team shall be composed of the facility's various categories of health care professionals with the appropriate competencies to conduct the required analyses. The process shall also include analyses of patient safety events, including the following sociodemographic factors, to identify disparities in these events:

(A) Age.

(B) Race.

(C) Ethnicity.

(D) Gender identity.

(E) Sexual orientation.

(F) Preferred language spoken.

(G) Disability status.

(H) Payor.

(I) Sex.

(4) For the purposes of paragraph (3), it is the intent of the Legislature that a health facility use the same stratification categories as developed and defined by the Department of Health Care Access and Information for purposes of Section 127372, which is part of the Medical Equity Disclosure Act (Article 3 (commencing with Section 127370) of Chapter 2 of Part 2 of Division 107). With respect to the information set forth in subparagraphs (D) and (E) of paragraph (3), a health facility shall only be required to disclose information that is voluntarily provided by the patient or client.

(5) A reporting process that supports and encourages a culture of safety and reporting patient safety events.

(6) A process for providing ongoing patient safety training for facility personnel and health care practitioners.

(7) A process for addressing racism and discrimination, and their impact on patient health and safety, that includes, but is not limited to:

(A) Monitoring sociodemographic disparities in patient safety events and developing interventions to remedy known disparities.

(B) Encouraging facility staff to report suspected instances of racism and discrimination.

(c) Commencing January 1, 2026, and biennially thereafter, a health facility shall submit a patient safety plan to the department's licensing and certification division.

(1) The department may impose a fine not to exceed five thousand dollars ($5,000) on a health facility for failure to adopt, update, or submit a patient safety plan.

(2) The department may grant a health facility an automatic 60-day extension for submitting a biennial patient safety plan.

(d) The department shall make all patient safety plans submitted by health facilities available to the public on its internet website.

(e) For the purposes of this section, patient safety events shall be defined by the patient safety plan and shall include, but not be limited to, all adverse events or potential adverse events as described in Section 1279.1 that are determined to be preventable, and health-care-associated infections (HAI), as defined in the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor, unless the department accepts the recommendation of the Healthcare Associated Infection Advisory Committee, or its successor, that are determined to be preventable.

SEC. 4. Section 1337.3 of the Health and Safety Code is amended to read:

1337.3. (a) (1) The department shall prepare and maintain a list of approved training programs for nurse assistant certification. The list shall include training programs conducted by skilled nursing facilities or intermediate care facilities, as well as local agencies and education programs. In addition, the list shall include information on whether a training center is currently training nurse assistants, their competency test pass rates, and the number of

nurse assistants they have trained. Clinical portions of the training programs may be obtained as on-the-job training, supervised by a qualified director of staff development or licensed nurse.

(2) No later than December 31, 2025, the department shall solicit applications from vendors to provide the written and oral competency examination of a nurse assistant certification examination in Spanish.

(3) No later than July 1, 2029, the department shall publish on its internet website, and update at least twice annually, a list including all of the following:

(A) All approved training programs, including skilled nursing facilities, intermediate care facilities, and local agencies and education programs.

(B) Whether each training center is currently training nurse assistants.

(C) The competency test pass rates for the previous two years, aggregated by the language in which the test was taken.

(D) The number of nurse assistants trained in the previous two years.

(b) It shall be the duty of the department to inspect a representative sample of training programs. The department shall protect consumers and students in any training program against fraud, misrepresentation, or other practices that may result in improper or excessive payment of funds paid for training programs. In evaluating a training center's training program, the department shall examine each training center's trainees' competency test passage rate, and require each program to maintain an average 60 percent test score passage rate to maintain its participation in the program. The average test score passage rate shall be calculated over a two-year period. If the department determines that a training program is not complying with regulations or is not meeting the competency passage rate requirements, notice thereof in writing shall be immediately given to the program. If the program has not been brought into compliance within a reasonable time, the program may be removed from the approved list and notice thereof in writing given to it. Programs removed under this article shall be afforded an opportunity to request reinstatement of program approval at any time. The department's district offices shall inspect facility-based centers as part of their annual survey.

(c) Notwithstanding Section 1337.1, the approved training program shall consist of at least the following:

(1) A 16-hour orientation program to be given to newly employed nurse assistants prior to providing direct patient care, and consistent with federal training requirements for facilities participating in the Medicare or Medicaid programs.

(2) (A) A precertification training program consisting of at least 60 classroom hours of training on basic nursing skills, patient safety and rights, the social and psychological problems of patients, and elder abuse recognition and reporting pursuant to subdivision (e) of Section 1337.1. The 60 classroom hours of training may be conducted within a skilled nursing facility, an intermediate care facility, or an educational institution or agency. A health facility, educational institution, or local agency may conduct the 60 classroom hours of training in an online or distance learning course format, as approved by the department.

(B) In addition to the 60 classroom hours of training required under subparagraph (A), the precertification program shall also consist of 100 hours of supervised and on-the-job training clinical practice. The 100 hours may consist of normal employment as a nurse assistant under the supervision of either the director of staff development or a licensed nurse qualified to provide nurse assistant training who has no other assigned duties while providing the training.

(3) At least 2 hours of the 60 hours of classroom training shall address the special needs of persons with developmental and mental disorders, including intellectual disability, cerebral palsy, epilepsy, dementia, Parkinson's disease, and mental illness. At least 2 hours of the 60 hours of classroom training shall address the special needs of persons with Alzheimer's disease and related dementias.

(4) At least 4 hours of the 100 hours of supervised clinical training shall address the special needs of persons with developmental and mental disorders, including intellectual disability, cerebral palsy, epilepsy, Alzheimer's disease and related dementias, and Parkinson's disease.

(d) The department, in consultation with the State Department of Education and other appropriate organizations, shall develop criteria for approving training programs, that includes program content for orientation, training, inservice and the examination for testing knowledge and skills related to basic patient care services

and shall develop a plan that identifies and encourages career ladder opportunities for certified nurse assistants. This group shall also recommend, and the department shall adopt, regulation changes necessary to provide for patient care when facilities utilize noncertified nurse assistants who are performing direct patient care. The requirements of this subdivision shall be established by January 1, 1989.

(e) On or before January 1, 2004, the department, in consultation with the State Department of Education, the American Red Cross, and other appropriate organizations, shall do the following:

(1) Review the current examination for approved training programs for certified nurse assistants to ensure the accurate assessment of whether a nurse assistant has obtained the required knowledge and skills related to basic patient care services.

(2) Develop a plan that identifies and encourages career ladder opportunities for certified nurse assistants, including the application of on-the-job postcertification hours to educational credits.

(f) A skilled nursing facility or intermediate care facility shall determine the number of specific clinical hours within each module identified by the department required to meet the requirements of subdivision (d), subject to subdivisions (b) and (c). The facility shall consider the specific hours recommended by the state department when adopting the precertification training program required by this chapter.

(g) This article shall not apply to a program conducted by any church or denomination for the purpose of training the adherents of the church or denomination in the care of the sick in accordance with its religious tenets.

(h) The Chancellor of the California Community Colleges shall provide to the department a standard process for approval of college credit. The department shall make this information available to all training programs in the state.

(i) An online or distance learning nurse assistant training program shall meet the same standards as a traditional, classroom-based program.

(j) An online nurse assistant training program shall contract with a licensed skilled nursing facility or intermediate care facility for the purpose of coordinating and completing the clinical portion of the nurse assistant training program.

~~SEC. 5. Section 120960 of the Health and Safety Code is amended to read:~~

~~120960. (a) The department shall establish uniform standards of financial eligibility for the drugs under the program established under this chapter.~~

~~(b) The financial eligibility standards do not prohibit drugs to an otherwise eligible person whose modified adjusted gross income does not exceed 500 percent of the federal poverty level per year based on family size and household income. However, the director may authorize drugs for a person with an income higher than 500 percent of the federal poverty level per year based on family size and household income if the estimated cost of those drugs in one year is expected to exceed 20 percent of the person's modified adjusted gross income. Beginning January 1, 2025, or as soon as technically feasible thereafter, the financial eligibility standard in this section shall increase to 600 percent of the federal poverty level per year based on family size and household income.~~

~~(c) A county public health department administering this program pursuant to an agreement with the director pursuant to subdivision (b) of Section 120955 shall use no more than 5 percent of total payments that it collects pursuant to this section to cover any administrative costs related to eligibility determinations, reporting requirements, and the collection of payments.~~

~~(d) A county public health department administering this program pursuant to subdivision (b) of Section 120955 shall provide all drugs added to the program pursuant to subdivision (a) of Section 120955 within 60 days of the action of the director.~~

~~(e) For purposes of this section, the following terms shall have the following meanings:~~

~~(1) "Family size" has the meaning given to that term in Section 36B(d)(1) of the Internal Revenue Code of 1986, and shall include same or opposite sex married couples, registered domestic partners, and any tax dependents, as defined by Section 152 of the Internal Revenue Code of 1986, of either spouse or registered domestic partner.~~

~~(2) "Federal poverty level" refers to the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of Section 9902(2) of Title 42 of the United States Code.~~

~~(3) "Household income" means the sum of the applicant's or recipient's modified adjusted gross income, plus the modified adjusted gross income of the applicant's or recipient's spouse or registered domestic partner, and the modified adjusted gross incomes of all other individuals for whom the applicant or recipient, or the applicant's or recipient's spouse or registered domestic partner, is allowed a federal income tax deduction for the taxable year.~~

~~(4) "Internal Revenue Code of 1986" means Title 26 of the United States Code, including all amendments enacted to that code.~~

~~(5) "Modified adjusted gross income" has the meaning given to that term in Section 36B(d)(2)(B) of the Internal Revenue Code of 1986.~~

SEC. 5. Section 120960 of the Health and Safety Code is amended to read:

120960. (a) The department shall establish uniform standards of financial eligibility for the drugs under the program established under this chapter.

(b) ~~Nothing in the~~ *The* financial eligibility standards ~~shall~~ *do not* prohibit drugs to an otherwise eligible person whose modified adjusted gross income does not exceed 500 percent of the federal poverty level per year based on family size and household income. However, the director may authorize drugs for ~~persons with incomes~~ *a person with an income* higher than 500 percent of the federal poverty level per year based on family size and household income if the estimated cost of those drugs in one year is expected to exceed 20 percent of the person's modified adjusted gross income. Beginning January 1, 2025, or as soon as technically feasible thereafter, the financial eligibility standard in this section shall increase to 600 percent of the federal poverty level per year based on family size and household income.

(c) A county public health department administering this program pursuant to an agreement with the director pursuant to subdivision (b) of Section 120955 shall use no more than 5 percent of total payments that it collects pursuant to this section to cover any administrative costs related to eligibility determinations, reporting requirements, and the collection of payments.

(d) A county public health department administering this program pursuant to subdivision (b) of Section 120955 shall

provide all drugs added to the program pursuant to subdivision (a) of Section 120955 within 60 days of the action of the director.

(e) For purposes of this section, the following terms shall have the following meanings:

(1) "Family size" has the meaning given to that term in Section 36B(d)(1) of the Internal Revenue Code of 1986, and shall include same or opposite sex married couples, registered domestic partners, and any tax dependents, as defined by Section 152 of the Internal Revenue Code of 1986, of either spouse or registered domestic partner.

(2) "Federal poverty level" refers to the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of Section 9902(2) of Title 42 of the United States Code.

(3) "Household income" means the sum of the applicant's or recipient's modified adjusted gross income, plus the modified adjusted gross income of the applicant's or recipient's spouse or registered domestic partner, and the modified adjusted gross incomes of all other individuals for whom the applicant or recipient, or the applicant's or recipient's spouse or registered domestic partner, is allowed a federal income tax deduction for the taxable year.

(4) "Internal Revenue Code of 1986" means Title 26 of the United States Code, including all amendments enacted to that code.

(5) "Modified adjusted gross income" has the meaning given to that term in Section 36B(d)(2)(B) of the Internal Revenue Code of 1986.

SEC. 6. Section 127410 of the Health and Safety Code is amended to read:

127410. (a) Each hospital shall provide patients with a written notice that shall contain information about availability of the hospital's discount payment and charity care policies, including information about eligibility, as well as contact information for a hospital employee or office from which the person may obtain further information about these policies. The notice shall also include the internet address for the Health Consumer Alliance (https://healthconsumer.org), and shall explain that there are organizations that will help the patient understand the billing and payment process, as well as information regarding Covered California and Medi-Cal presumptive eligibility, if the hospital

participates in the presumptive eligibility program. The notice shall also include the internet address for the hospital's list of shoppable services, pursuant to Section 180.60 of Title 45 of the Code of Federal Regulations. This written notice shall be provided in addition to the estimate provided pursuant to Section 1339.585. The notice shall also be provided to patients who receive emergency or outpatient care and who may be billed for that care, but who were not admitted. The notice shall be provided in English, and in languages other than English. The languages to be provided shall be determined in a manner similar to that required pursuant to Section 12693.30 of the Insurance Code. Written correspondence to the patient required by this article shall also be in the language spoken by the patient, consistent with Section 12693.30 of the Insurance Code and applicable state and federal law.

(b) The written notice shall be provided at the time of service if the patient is conscious and able to receive written notice at that time. If the patient is not able to receive notice at the time of service, the notice shall be provided during the discharge process. If the patient is not admitted, the written notice shall be provided when the patient leaves the facility. If the patient leaves the facility without receiving the written notice, the hospital shall mail the notice to the patient within 72 hours of providing services.

(c) Notice of the hospital's policy for financially qualified and self-pay patients shall be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to, all of the following:

(1) Emergency department, if any.

(2) Billing office.

(3) Admissions office.

(4) Other outpatient settings, including observation units.

(5) Prominently displayed on the hospital's internet website, with a link to the policy itself.

(d) With the exception of emergency room visits, a hospital may provide the written notice described in this section in either hard copy or using the patient's preferred electronic notification method if the patient has previously consented to receive clinical or nonclinical electronic communications about their health care services. The written notice related to an emergency room visit shall be provided to the patient in hard copy. If the notice is provided electronically, the notice shall be sent separately from

any other electronic communications sent to the patient and shall prominently indicate in the subject line that the notice is related to the hospital's discount payment and charity care policies.

SEC. 7. Section 131365 of the Health and Safety Code is amended to read:

131365. (a) (1) The department may develop and administer a syndromic surveillance program.

(2) The purpose of this chapter is to authorize the department to collect public health and medical data in near real time to detect and investigate changes in the occurrence of disease in the population, especially as a result of a disease outbreak or other public health emergency, disaster, or special event and to support responses to emerging public health threats and conditions impacting the health of California residents.

(3) Upon implementation of this chapter, the department shall assign a name to the program.

(b) Subject to an appropriation for this purpose, the department may designate an existing syndromic surveillance system or create a new syndromic surveillance system in order to facilitate the reporting of electronic health data by specified entities pursuant to Section 131370.

(c) The syndromic surveillance system created or designated by the department pursuant to subdivision (b) shall, at a minimum, provide local health departments access to and use of a secure, integrated electronic health system with standardized analytic tools and processes to rapidly collect, evaluate, share, and store syndromic surveillance data.

(d) (1) The list of data elements, electronic transmission standards, data transmission schedule, and instructions pertaining to the program may be modified at any time by the department.

(2) The department shall collaborate with local health departments to determine modifications to be made pursuant to this subdivision.

(3) Modifications made pursuant to this subdivision shall be exempt from the administrative regulation and rulemaking requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code and shall be implemented without being adopted as a regulation, except that the revisions shall be filed with the Secretary of State and printed and published in Title 17 of the California Code of Regulations.

SEC. 8. Section 131370 of the Health and Safety Code is amended to read:

131370. (a) (1) (A) A specified entity shall submit the required data electronically to the syndromic surveillance system adopted by the department in accordance with the schedule, standards, and requirements established by the department.

(B) Notwithstanding subparagraph (A), a specified entity shall submit the required data electronically to a local health department that participates in a syndromic surveillance system or maintains its own system pursuant to subdivision (b).

(C) The department may adopt 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), to specify any other entity that is required to provide data pursuant to this section.

(2) A specified entity shall collect and report data to the department or local syndromic surveillance system, if applicable, as near as possible to real time.

(b) (1) (A) A specified entity may decline to report electronic health data to the department if the local health department in which the specified entity is located participates in a syndromic surveillance system or maintains its own system that has, or by no later than July 1, 2027, will have, the capacity to transmit the specified entity's required electronic health and medical data to the department's designated syndromic surveillance system in near real time and the specified entity reports electronic health and medical data to the local health department's syndromic surveillance system.

(B) The department shall provide guidance and technical assistance to local health departments that participate in a syndromic surveillance system or maintains its own system to develop automated transmission of data from local syndromic surveillance systems into the state system by July 1, 2027.

(2) Notwithstanding paragraph (1), a specified entity is not required to report data to the department only if the local health department reports the entity's required data to the department's designated syndromic surveillance system pursuant to this section by July 1, 2027.

(3) This subdivision does not limit the ability of a local health department to require a specified entity to submit additional data

to the local health department in addition to the data required to be submitted to the department.

(c) The data elements, electronic transmission standards, data transmission schedule, and instructions for the data collection required pursuant to this section include, but are not limited to, any element or requirement adopted for use by the CDC's Public Health Information Network (PHIN) Messaging Guide for Syndromic Surveillance: Emergency Department, Urgent Care, Inpatient and Ambulatory Care Settings, Release 2.0 (April 2015), or any subsequent versions.

(d) No civil or criminal penalty, fine, sanction, or finding, or denial, suspension, or revocation of licensure for any person or facility may be imposed based upon a failure to provide the data elements required pursuant to this chapter, unless the data elements, electronic transmission standards, and data transmission schedule submissions required to be provided by the specified entity was printed in the California Code of Regulations and the department notified the person or facility of the data reporting requirement at least six months prior to the date of the claimed failure to report or submit the data.

~~SEC. 9. Section 10119.6 of the Insurance Code is amended to read:~~

~~10119.6. (a) (1) A large group health insurance policy, except a specialized disability insurance policy, that is issued, amended, or renewed on or after July 1, 2025, shall provide coverage for the diagnosis and treatment of infertility and fertility services, including a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine (ASRM), using single embryo transfer when recommended and medically appropriate.~~

~~(2) A small group health insurance policy, except a specialized disability insurance policy, that is issued, amended, or renewed on or after July 1, 2025, shall offer coverage for the diagnosis and treatment of infertility and fertility services. This paragraph does not require a small group disability insurance policy to provide coverage for infertility services.~~

~~(3) A disability insurer shall include notice of the coverage specified in this section in the insurer's evidence of coverage.~~

~~(b) For purposes of this section, the following definitions apply:~~

~~(1) "Infertility" means a condition or status characterized by any of the following:~~

~~(A) A licensed physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition does not prevent testing and diagnosis before the 12-month or 6-month period to establish infertility in subparagraph (C).~~

~~(B) A person's inability to reproduce either as an individual or with their partner without medical intervention.~~

~~(C) The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse.~~

~~(2) "Regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.~~

~~(c) The policy may not include any of the following:~~

~~(1) An exclusion, limitation, or other restriction on coverage of fertility medications that is different from those imposed on other prescription medications.~~

~~(2) An exclusion or denial of coverage of fertility services based on a covered individual's participation in fertility services provided by or to a third party. For purposes of this section, "third party" includes an oocyte, sperm, or embryo donor, gestational carrier, or surrogate that enables an intended recipient to become a parent.~~

~~(3) A deductible, copayment, coinsurance, benefit maximum, waiting period, or any other limitation on coverage for the diagnosis and treatment of infertility, except as provided in subdivision (a), that is different from those imposed upon benefits for services not related to infertility.~~

~~(d) This section does not deny or restrict an existing right or benefit to coverage and treatment of infertility or fertility services under an existing law, plan, or policy.~~

~~(e) This section applies to every disability insurance policy that is issued, amended, or renewed to residents of this state regardless of the situs of the contract.~~

~~(f) Consistent with Section 10140, coverage for the treatment of infertility and fertility services shall be provided without~~

~~discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation. This subdivision does not interfere with the clinical judgment of a physician and surgeon.~~

~~(g) This section does not apply to a religious employer as defined in Section 10123.196.~~

~~(h) This section does not apply to a health care benefit plan or policy entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code) until July 1, 2027.~~

SEC. 9. Section 10119.6 of the Insurance Code is amended to read:

10119.6. (a) (1) A large group ~~disability~~ *health* insurance ~~policy, except a specialized disability insurance policy,~~ *policy* that is issued, amended, or renewed on or after January 1, 2026, shall provide coverage for the diagnosis and treatment of infertility and fertility services, including a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine (ASRM), using single embryo transfer when recommended and medically appropriate.

(2) A small group ~~disability~~ *health* insurance ~~policy, except a disability insurance policy described in paragraph (4),~~ *policy* that is issued, amended, or renewed on or after January 1, 2026, shall offer coverage for the diagnosis and treatment of infertility and fertility services. This paragraph shall not be construed to require a small group ~~disability~~ *health* insurance policy to provide coverage for infertility services.

(3) A ~~disability~~ *health* insurer shall include notice of the coverage specified in this section in the insurer's evidence of coverage.

(4) This section shall not apply to ~~accident-only, specified disease, hospital indemnity, Medicare supplement,~~ *Medicare supplement* or specialized ~~disability~~ *health* insurance policies.

(b) For purposes of this section, "infertility" means a condition or status characterized by any of the following:

(1) A licensed physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis before the 12-month or 6-month period to establish infertility in paragraph (3).

(2) A person's inability to reproduce either as an individual or with their partner without medical intervention.

(3) The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this section "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

(c) The policy may not include any of the following:

(1) Any exclusion, limitation, or other restriction on coverage of fertility medications that are different from those imposed on other prescription medications.

(2) Any exclusion or denial of coverage of any fertility services based on a covered individual's participation in fertility services provided by or to a third party. For purposes of this section, "third party" includes an oocyte, sperm, or embryo donor, gestational carrier, or surrogate that enables an intended recipient to become a parent.

(3) Any deductible, copayment, coinsurance, benefit maximum, waiting period, or any other limitation on coverage for the diagnosis and treatment of infertility, except as provided in subdivision (a) that are different from those imposed upon benefits for services not related to infertility.

(d) This section does not in any way deny or restrict any existing right or benefit to coverage and treatment of infertility or fertility services under an existing law, plan, or policy.

(e) This section applies to every ~~disability~~ *health* insurance policy that is issued, amended, or renewed to residents of this state regardless of the situs of the contract.

(f) Consistent with Section 10140, coverage for the treatment of infertility and fertility services shall be provided without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity,

genetic information, marital status, national origin, race, religion, sex, or sexual orientation. This subdivision shall not be construed to interfere with the clinical judgment of a physician and surgeon.

(g) This section shall not apply to a religious employer, as defined in Section 10123.196.

(h) This section shall not apply to a health care benefit plan or policy entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code) until July 1, 2027.

(i) (1) Until January 1, 2027, the commissioner may issue guidance regarding compliance with this section, and that guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(2) The department shall consult with the Department of Managed Health Care and stakeholders in issuing the guidance specified in paragraph (1).

SEC. 10. Section 10123.1991 of the Insurance Code is amended to read:

10123.1991. (a) (1) A health insurer shall provide to insureds a written or electronic notice regarding the benefits of a behavioral health and wellness screening for children and adolescents 8 to 18 years of age.

(2) "Behavioral health and wellness screening" means a screening, test, or assessment to identify indicators or symptoms of behavioral health issues in an individual, including, but not limited to, depression or anxiety.

(b) The notice shall provide information regarding the benefits of behavioral health and wellness screenings for both depression and anxiety.

(c) A health insurer shall provide notice pursuant to this section annually.

(d) This section does not apply to Medi-Cal managed care that contracts with the State Department of Health Care Services entered into pursuant to Chapter 7 (commencing with Section 14000) of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 11. Section 5610 of the Welfare and Institutions Code, as amended by Section 24 of Chapter 790 of the Statutes of 2023, is amended to read:

5610. (a) Each county mental health system shall comply with reporting requirements developed by the State Department of Health Care Services, in consultation with the California Behavioral Health Planning Council and the Behavioral Health Services Oversight and Accountability Commission, which shall be uniform and simplified. The department shall review existing data requirements to eliminate unnecessary requirements and consolidate requirements that are necessary. These requirements shall provide comparability between counties in reports.

(b) The department shall develop, in consultation with the Performance Outcome Committee, the California Behavioral Health Planning Council, and the Behavioral Health Services Oversight and Accountability Commission, pursuant to Section 5611, and with the California Health and Human Services Agency, uniform definitions and formats for a statewide, nonduplicative client-based information system that includes all information necessary to meet federal mental health grant requirements and state and federal Medicaid reporting requirements, and any other state requirements established by law. The data system, including performance outcome measures reported pursuant to Section 5613, shall be developed by July 1, 1992.

(c) Unless determined necessary by the department to comply with federal law and regulations, the data system developed pursuant to subdivision (b) shall not be more costly than that in place during the 1990–91 fiscal year.

(d) (1) The department shall develop unique client identifiers that permit development of client-specific cost and outcome measures and related research and analysis.

(2) The department's collection and use of client information, and the development and use of client identifiers, shall be consistent with clients' constitutional and statutory rights to privacy and confidentiality.

(3) Data reported to the department may include name and other personal identifiers. That information is confidential and subject to Section 5328 and any other state and federal laws regarding confidential client information.

(4) Personal client identifiers reported to the department shall be protected to ensure confidentiality during transmission and storage through encryption and other appropriate means.

(5) Information reported to the department may be shared with local public mental health agencies submitting records for the same person and that information is subject to Section 5328.

(e) All client information reported to the department pursuant to Chapter 2 (commencing with Section 4030) of Part 1 of Division 4, Sections 5328 to 5772, inclusive, Chapter 8.9 (commencing with Section 14700) of Part 3 of Division 9, and any other state and federal laws regarding reporting requirements, consistent with Section 5328, shall not be used for purposes other than those purposes expressly stated in the reporting requirements referred to in this subdivision.

(f) The department may adopt emergency regulations to implement this section in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of emergency regulations to implement this section that are filed with the Office of Administrative Law within one year of the date on which the act that added this subdivision took effect shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare and shall remain in effect for no more than 180 days.

(g) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 12. Section 5771.1 of the Welfare and Institutions Code, as amended by Section 33 of Chapter 790 of the Statutes of 2023, is amended to read:

5771.1. (a) The members of the Behavioral Health Services Oversight and Accountability Commission established pursuant to Section 5845 are members of the California Behavioral Health Planning Council. They serve in an ex officio capacity when the council is performing its statutory duties pursuant to Section 5772. This membership does not affect the composition requirements for the council specified in Section 5771.

(b) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 13. Section 5814 of the Welfare and Institutions Code is amended to read:

5814. (a) (1) This part shall be implemented only to the extent that funds are appropriated for purposes of this part. To the extent that funds are made available, the first priority shall go to maintain funding for the existing programs that meet adult system of care contract goals. The next priority for funding shall be given to counties with a high incidence of persons who have a serious mental health condition and are homeless or at risk of homelessness, and meet the criteria developed pursuant to paragraphs (3) and (4).

(2) The Director of Health Care Services shall establish a methodology for awarding grants under this part consistent with the legislative intent expressed in Section 5802, and in consultation with the advisory committee established in this subdivision.

(3) (A) The Director of Health Care Services shall establish an advisory committee for the purpose of providing advice regarding the development of criteria for the award of grants, and the identification of specific performance measures for evaluating the effectiveness of grants. The committee shall review evaluation reports and make findings on evidence-based best practices and recommendations for grant conditions. At not less than one meeting annually, the advisory committee shall provide to the director written comments on the performance of each of the county programs. Upon request by the department, each participating county that is the subject of a comment shall provide a written response to the comment. The department shall comment on each of these responses at a subsequent meeting.

(B) The committee shall include, but not be limited to, representatives from state, county, and community veterans' services and disabled veterans outreach programs, supportive housing and other housing assistance programs, law enforcement, county mental health and private providers of local mental health services and mental health outreach services, the Department of Corrections and Rehabilitation, local substance use disorder services providers, the Department of Rehabilitation, providers of

local employment services, the State Department of Social Services, the Department of Housing and Community Development, a service provider to transition youth, the United Advocates for Children of California, the California Mental Health Advocates for Children and Youth, the Mental Health Association of California, the California Alliance for the Mentally Ill, the California Network of Mental Health Clients, the California Behavioral Health Planning Council, the Behavioral Health Services Oversight and Accountability Commission, and other appropriate entities.

(4) The criteria for the award of grants shall include, but not be limited to, all of the following:

(A) A description of a comprehensive strategic plan for providing outreach, prevention, intervention, and evaluation in a cost-appropriate manner corresponding to the criteria specified in subdivision (c).

(B) A description of the local population to be served, ability to administer an effective service program, and the degree to which local agencies and advocates will support and collaborate with program efforts.

(C) A description of efforts to maximize the use of other state, federal, and local funds or services that can support and enhance the effectiveness of these programs.

(5) In order to reduce the cost of providing supportive housing for clients, counties that receive a grant pursuant to this part after January 1, 2004, shall enter into contracts with sponsors of supportive housing projects to the greatest extent possible. Participating counties are encouraged to commit a portion of their grants to rental assistance for a specified number of housing units in exchange for the counties' clients having the right of first refusal to rent the assisted units.

(b) In each year in which additional funding is provided by the annual Budget Act, the State Department of Health Care Services shall establish programs that offer individual counties sufficient funds to comprehensively serve adults with a serious mental health condition who are homeless, recently released from a county jail or the state prison, or others who are untreated, unstable, and at significant risk of incarceration or homelessness unless treatment is provided to them. In consultation with the advisory committee established pursuant to paragraph (3) of subdivision (a), the

department shall report to the Legislature on or before May 1 of each year in which additional funding is provided, and shall evaluate, at a minimum, the effectiveness of the strategies in providing successful outreach and reducing homelessness, involvement with local law enforcement, and other measures identified by the department. The evaluation shall include for each program funded in the current fiscal year as much of the following as available information permits:

(1) The number of persons served, and of those, the number who receive extensive community mental health services.

(2) The number of persons who are able to maintain housing, including the type of housing and whether it is emergency, transitional, or permanent housing, as defined by the department.

(3) (A) The amount of grant funding spent on each type of housing.

(B) Other local, state, or federal funds or programs used to house clients.

(4) The number of persons with contacts with local law enforcement and the extent to which local and state incarceration has been reduced or avoided.

(5) The number of persons participating in employment service programs including competitive employment.

(6) The number of persons contacted in outreach efforts who appear to have a serious mental health condition, as described in Section 5600.3, who have refused treatment after completion of all applicable outreach measures.

(7) The amount of hospitalization that has been reduced or avoided.

(8) The extent to which veterans identified through these programs' outreach are receiving federally funded veterans' services for which they are eligible.

(9) The extent to which programs funded for three or more years are making a measurable and significant difference on the street, in hospitals, and in jails, as compared to other counties or as compared to those counties in previous years.

(10) For those who have been enrolled in this program for at least two years and who were enrolled in Medi-Cal prior to, and at the time they were enrolled in, this program, a comparison of their Medi-Cal hospitalizations and other Medi-Cal costs for the

two years prior to enrollment and the two years after enrollment in this program.

(11) The number of persons served who were and were not receiving Medi-Cal benefits in the 12-month period prior to enrollment and, to the extent possible, the number of emergency room visits and other medical costs for those not enrolled in Medi-Cal in the prior 12-month period.

(c) To the extent that state savings associated with providing integrated services for persons with a mental health condition are quantified, it is the intent of the Legislature to capture those savings in order to provide integrated services to additional adults.

(d) Each project shall include outreach and service grants in accordance with a contract between the state and approved counties that reflects the number of anticipated contacts with people who are homeless or at risk of homelessness, and the number of those who have a serious mental health condition and who are likely to be successfully referred for treatment and will remain in treatment as necessary.

(e) All counties that receive funding shall be subject to specific terms and conditions of oversight and training, which shall be developed by the department, in consultation with the advisory committee.

(f) (1) As used in this part, "receiving extensive mental health services" means having a personal services coordinator, as described in subdivision (b) of Section 5806, and having an individual personal service plan, as described in subdivision (c) of Section 5806.

(2) The funding provided pursuant to this part shall be sufficient to provide mental health services, medically necessary medications to treat severe mental illnesses, alcohol and drug services, transportation, supportive housing and other housing assistance, vocational rehabilitation and supported employment services, money management assistance for accessing other health care and obtaining federal income and housing support, accessing veterans' services, stipends, and other incentives to attract and retain sufficient numbers of qualified professionals as necessary to provide the necessary levels of these services. These grants shall, however, pay for only that portion of the costs of those services not otherwise provided by federal funds or other state funds.

(3) Methods used by counties to contract for services pursuant to paragraph (2) shall promote prompt and flexible use of funds, consistent with the scope of services for which the county has contracted with each provider.

(g) Contracts awarded pursuant to this part shall be exempt from the Public Contract Code and the state administrative manual and shall not be subject to the approval of the Department of General Services.

(h) Notwithstanding any other provision of law, funds awarded to counties pursuant to this part and Part 4 (commencing with Section 5850) shall not require a local match in funds.

SEC. 14. Section 5830 of the Welfare and Institutions Code, as amended by Section 42 of Chapter 790 of the Statutes of 2023, is amended to read:

5830. County mental health programs shall develop plans for innovative programs to be funded pursuant to paragraph (4) of subdivision (a) of Section 5892.

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

(1) To increase access to underserved groups.

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

(3) To promote interagency collaboration.

(4) To increase access to services, including, but not limited to, services provided through permanent supportive housing.

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

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

(A) Increase access to underserved groups, which may include providing access through the provision of permanent supportive housing.

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

(C) Promote interagency and community collaboration.

(D) Increase access to services, which may include providing access through the provision of permanent supportive housing.

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

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

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

(C) Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in nonmental health contexts or settings.

(D) Participating in a housing program designed to stabilize a person's living situation while also providing supportive services on site.

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

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

(2) Advocacy.

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

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

(5) System development.

(6) Public education efforts.

(7) Research. If research is chosen for an innovative project, the county mental health program shall consider, but is not required to implement, research of the brain and its physical and biochemical processes that may have broad applications, but that have specific potential for understanding, treating, and managing mental illness, including, but not limited to, research through the Cal-BRAIN program pursuant to Section 92986 of the Education Code or other collaborative, public-private initiatives designed to map the dynamics of neuron activity.

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

(9) Permanent supportive housing development.

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

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

(f) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 15. Section 5835 of the Welfare and Institutions Code, as amended by Section 45 of Chapter 790 of the Statutes of 2023, is amended to read:

5835. (a) This part shall be known, and may be cited, as the Early Psychosis Intervention Plus (EPI Plus) Program to encompass early psychosis and mood disorder detection and intervention.

(b) As used in this part, the following definitions shall apply:

(1) "Commission" means the Behavioral Health Services Oversight and Accountability Commission established pursuant to Section 5845.

(2) "Early psychosis and mood disorder detection and intervention" refers to a program that utilizes evidence-based approaches and services to identify and support clinical and functional recovery of individuals by reducing the severity of first, or early, episode psychotic symptoms, other early markers of serious mental illness, such as mood disorders, keeping individuals in school or at work, and putting them on a path to better health and wellness. This may include, but is not limited to, all of the following:

(A) Focused outreach to at-risk and in-need populations as applicable.

(B) Recovery-oriented psychotherapy, including cognitive behavioral therapy focusing on cooccurring disorders.

(C) Family psychoeducation and support.

(D) Supported education and employment.

(E) Pharmacotherapy and primary care coordination.

(F) Use of innovative technology for mental health information feedback access that can provide a valued and unique opportunity to assist individuals with mental health needs and to optimize care.

(G) Case management.

(3) "County" includes a city receiving funds pursuant to Section 5701.5.

(c) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 16. Section 5835.2 of the Welfare and Institutions Code, as amended by Section 47 of Chapter 790 of the Statutes of 2023, is amended to read:

5835.2. (a) There is hereby established an advisory committee to the commission. The Behavioral Health Services Oversight and Accountability Commission shall accept nominations and applications to the committee, and the chair of the Behavioral Health Services Oversight and Accountability Commission shall appoint members to the committee, unless otherwise specified. Membership on the committee shall be as follows:

(1) The chair of the Behavioral Health Services Oversight and Accountability Commission, or their designee, who shall serve as the chair of the committee.

(2) The president of the County Behavioral Health Directors Association of California, or their designee.

(3) The director of a county behavioral health department that administers an early psychosis and mood disorder detection and intervention-type program in their county.

(4) A representative from a nonprofit community mental health organization that focuses on service delivery to transition-aged youth and young adults.

(5) A psychiatrist or psychologist.

(6) A representative from the Behavioral Health Center of Excellence at the University of California, Davis, or a representative from a similar entity with expertise from within the University of California system.

(7) A representative from a health plan participating in the Medi-Cal managed care program and the employer-based health care market.

(8) A representative from the medical technologies industry who is knowledgeable in advances in technology related to the use of innovative social media and mental health information feedback access.

(9) A representative knowledgeable in evidence-based practices as they pertain to the operations of an early psychosis and mood disorder detection and intervention-type program, including knowledge of other states' experiences.

(10) A representative who is a parent or guardian caring for a young child with a mental illness.

(11) An at-large representative identified by the chair.

(12) A representative who is a person with lived experience of a mental illness.

(13) A primary care provider from a licensed primary care clinic that provides integrated primary and behavioral health care.

(b) The advisory committee shall be convened by the chair and shall, at a minimum, do all of the following:

(1) Provide advice and guidance broadly on approaches to early psychosis and mood disorder detection and intervention programs from an evidence-based perspective.

(2) Review and make recommendations on the commission's guidelines or any regulations in the development, design, selection of awards pursuant to this part, and the implementation or oversight of the early psychosis and mood disorder detection and intervention competitive selection process established pursuant to this part.

(3) Assist and advise the commission in the overall evaluation of the early psychosis and mood disorder detection and intervention competitive selection process.

(4) Provide advice and guidance as requested and directed by the chair.

(5) Recommend a core set of standardized clinical and outcome measures that the funded programs would be required to collect, subject to future revision. A free data sharing portal shall be available to all participating programs.

(6) Inform the funded programs about the potential to participate in clinical research studies.

(c) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 17. Section 5840.6 of the Welfare and Institutions Code, as amended by Section 40 of Chapter 40 of the Statutes of 2024, is amended to read:

5840.6. For purposes of this chapter, the following definitions shall apply:

(a) "Commission" means the Behavioral Health Services Oversight and Accountability Commission established pursuant to Section 5845.

(b) "County" also includes a city receiving funds pursuant to Section 5701.5.

(c) "Prevention and early intervention funds" means funds from the Behavioral Health Services Fund allocated for prevention and early intervention programs pursuant to paragraph (1) of subdivision (a) of Section 5892.

(d) "Childhood trauma prevention and early intervention" refers to a program that targets children exposed to, or who are at risk of exposure to, adverse and traumatic childhood events and prolonged toxic stress in order to deal with the early origins of mental health needs and prevent long-term mental health concerns. This may include, but is not limited to, all of the following:

(1) Focused outreach and early intervention to at-risk and in-need populations.

(2) Implementation of appropriate trauma and developmental screening and assessment tools with linkages to early intervention services to children that qualify for these services.

(3) Collaborative, strengths-based approaches that appreciate the resilience of trauma survivors and support their parents and caregivers when appropriate.

(4) Support from peer support specialists and community health workers trained to provide mental health services.

(5) Multigenerational family engagement, education, and support for navigation and service referrals across systems that aid the healthy development of children and families.

(6) Linkages to primary care health settings, including, but not limited to, federally qualified health centers, rural health centers, community-based providers, school-based health centers, and school-based programs.

(7) Leveraging the healing value of traditional cultural connections, including policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served and recognition of historical trauma.

(8) Coordinated and blended funding streams to ensure individuals and families experiencing toxic stress have comprehensive and integrated supports across systems.

(e) "Early psychosis and mood disorder detection and intervention" has the same meaning as set forth in paragraph (2) of subdivision (b) of Section 5835 and may include programming across the age span.

(f) "Youth outreach and engagement" means strategies that target secondary school and transition age youth, with a priority

on partnerships with college mental health programs that educate and engage students and provide either on-campus, off-campus, or linkages to mental health services not provided through the campus to students who are attending colleges and universities, including, but not limited to, public community colleges. Outreach and engagement may include, but is not limited to, all of the following:

(1) Meeting the mental health needs of students that cannot be met through existing education funds.

(2) Establishing direct linkages for students to community-based mental health services.

(3) Addressing direct services, including, but not limited to, increasing college mental health staff-to-student ratios and decreasing wait times.

(4) Participating in evidence-based and community-defined best practice programs for mental health services.

(5) Serving underserved and vulnerable populations, including, but not limited to, lesbian, gay, bisexual, transgender, and queer persons, victims of domestic violence and sexual abuse, and veterans.

(6) Establishing direct linkages for students to community-based mental health services for which reimbursement is available through the students' health coverage.

(7) Reducing racial disparities in access to mental health services.

(8) Funding mental health stigma reduction training and activities.

(9) Providing college employees and students with education and training in early identification, intervention, and referral of students with mental health needs.

(10) Interventions for youth with signs of behavioral or emotional problems who are at risk of, or have had any, contact with the juvenile justice system.

(11) Integrated youth mental health programming.

(12) Suicide prevention programming.

(g) "Culturally competent and linguistically appropriate prevention and intervention" refers to a program that creates critical linkages with community-based organizations, including, but not limited to, clinics licensed or operated under subdivision (a) of Section 1204 of the Health and Safety Code, or clinics exempt

from clinic licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code.

(1) "Culturally competent and linguistically appropriate" means the ability to reach underserved cultural populations and address specific barriers related to racial, ethnic, cultural, language, gender, age, economic, or other disparities in mental health services access, quality, and outcomes.

(2) "Underserved cultural populations" means those who are unlikely to seek help from any traditional mental health service because of stigma, lack of knowledge, or other barriers, including members of ethnically and racially diverse communities, members of the gay, lesbian, bisexual, and transgender communities, and veterans, across their lifespans.

(h) "Strategies targeting the mental health needs of older adults" means, but is not limited to, all of the following:

(1) Outreach and engagement strategies that target caregivers, victims of elder abuse, and individuals who live alone.

(2) Suicide prevention programming.

(3) Outreach to older adults who are isolated.

(4) Early identification programming of mental health symptoms and disorders, including, but not limited to, anxiety, depression, and psychosis.

(i) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 18. Section 5847 of the Welfare and Institutions Code is amended to read:

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

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

(b) The three-year program and expenditure plan shall be based on available unspent funds and estimated revenue allocations provided by the state and in accordance with established stakeholder engagement and planning requirements, as required

in Section 5848. The three-year program and expenditure plan and annual updates shall include all of the following:

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

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

(3) A program for services to adults and seniors in accordance with Part 3 (commencing with Section 5800).

(4) A program for innovations in accordance with Part 3.2 (commencing with Section 5830).

(5) A program for technological needs and capital facilities needed to provide services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting, such as permanent supportive housing.

(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the education and training programs established pursuant to Part 3.1 (commencing with Section 5820).

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults, and seniors that it is currently serving pursuant to Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act, Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs, and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act, during years in which revenues for the Behavioral Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(8) Certification by the county behavioral health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements.

(9) Certification by the county behavioral health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act.

(c) The programs established pursuant to paragraphs (2) and (3) of subdivision (b) shall include services to address the needs of transition age youth 16 to 25 years of age, inclusive. In implementing this subdivision, county mental health programs shall consider the needs of transition age foster youth.

(d) Each year, the State Department of Health Care Services shall inform the County Behavioral Health Directors Association of California and the Behavioral Health Services Oversight and Accountability Commission of the methodology used for revenue allocation to the counties.

(e) Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800) for adults and seniors, Part 3.2 (commencing with Section 5830) for innovative programs, Part 3.6 (commencing with Section 5840) for prevention and early intervention programs, and Part 4 (commencing with Section 5850) for services for children, and updates to the plans developed pursuant to this section. Each expenditure update shall indicate the number of children, adults, and seniors to be served pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (7) of subdivision (b) for services pursuant to paragraphs (2) and (3) of subdivision (b) in years in which the allocation of funds for services pursuant to subdivision (e) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

(g) The department shall post on its internet website the three-year program and expenditure plans submitted by every county pursuant to subdivision (a) in a timely manner.

(h) (1) Notwithstanding subdivision (a), a county that is unable to complete and submit a three-year program and expenditure plan or annual update for the 2020–21 or 2021–22 fiscal years due to the COVID-19 Public Health Emergency may extend the effective timeframe of its currently approved three-year plan or annual update to include the 2020–21 and 2021–22 fiscal years. The county shall submit a three-year program and expenditure plan or annual update to the Behavioral Health Services Oversight and Accountability Commission and the State Department of Health Care Services by July 1, 2022.

(2) For purposes of this subdivision, "COVID-19 Public Health Emergency" means the federal Public Health Emergency declaration made pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020, entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," and any renewal of that declaration.

(i) Notwithstanding paragraph (7) of subdivision (b) and subdivision (f), a county may, during the 2020–21 and 2021–22 fiscal years, use funds from its prudent reserve for prevention and early intervention programs created in accordance with Part 3.6 (commencing with Section 5840) and for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(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 subdivisions (h) and (i) of this section and subdivision (i) of Section 5892 by means of all-county letters or other similar instructions.

(k) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 19. Section 5892 of the Welfare and Institutions Code, as amended by Section 48 of Chapter 40 of the Statutes of 2024, is amended to read:

5892. (a) To promote efficient implementation of this act, the county shall use funds distributed from the Behavioral Health Services Fund as follows:

(1) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840).

(2) The expenditure for prevention and early intervention may be increased in a county in which the department determines that the increase will decrease the need and cost for additional services to persons with severe mental illness in that county by an amount at least commensurate with the proposed increase.

(3) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(4) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5963.03.

(b) (1) Programs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five fiscal years pursuant to this section.

(2) A county shall calculate a maximum amount it establishes as the prudent reserve for its Local Behavioral Health Services Fund, not to exceed 33 percent of the average of the total funds distributed to the county pursuant to subdivision (c) of Section 5891 in the preceding five years.

(3) A county with a population of less than 200,000 shall calculate a maximum amount it establishes as the prudent reserve

for its Local Behavioral Health Services Fund, not to exceed 25 percent of the average of the total funds distributed to the county pursuant to subdivision (c) of Section 5891 in the preceding five years.

(c) Notwithstanding subdivision (a) of Section 5891, the allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Sections 5847 and 5963.03. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the Local Behavioral Health Services Fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850).

(d) (1) Notwithstanding subdivision (a) of Section 5891, the allocations pursuant to subdivision (a) may include funding to improve plan operations, quality outcomes, fiscal and programmatic data reporting, and monitoring of subcontractor compliance for all county behavioral health programs, including, but not limited to, programs administered by a Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101, and programs funded by the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other Substance Abuse and Mental Health Services Administration grants.

(2) The total of these costs shall not exceed 2 percent of the total of annual revenues received for the Local Behavioral Health Services Fund.

(3) A county may commence use of funding pursuant to this paragraph on July 1, 2025.

(e) (1) (A) Prior to making the allocations pursuant to subdivisions (a), (b), (c), and (d), funds shall be reserved for state directed purposes for the California Health and Human Services Agency, the State Department of Health Care Services, the California Behavioral Health Planning Council, the Department of Health Care Access and Information, the Behavioral Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency.

(B) These costs shall not exceed 5 percent of the total of annual revenues received for the fund.

(C) The costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services.

(D) The amounts allocated for state directed purposes shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850).

(E) The amount of funds available for the purposes of this subdivision in any fiscal year is subject to appropriation in the annual Budget Act.

(2) Prior to making the allocations pursuant to subdivisions (a), (b), (c), and (d), funds shall be reserved for the costs of the Department of Health Care Access and Information to administer a behavioral health workforce initiative in collaboration with the California Health and Human Services Agency. Funding for this purpose shall not exceed thirty-six million dollars ($36,000,000). The amount of funds available for the purposes of this subdivision in any fiscal year is subject to appropriation in the annual Budget Act.

(f) Each county shall place all funds received from the State Behavioral Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future fiscal years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) (1) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county that have not been spent for their authorized purpose within three years, and the interest accruing on those funds, shall revert to the state to be deposited into the Reversion Account, hereby established in the fund, and available for other counties in future years, provided,

however, that funds, including interest accrued on those funds, for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the Reversion Account.

(2) (A) If a county receives approval from the Behavioral Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) so long as they are encumbered under the terms of the approved project plan, including any subsequent amendments approved by the commission, or until three years after the date of approval, whichever is later.

(B) Subparagraph (A) applies to all plans for innovative programs that have received commission approval and are in the process at the time of enactment of the act that added this subparagraph, and to all plans that receive commission approval thereafter.

(3) Notwithstanding paragraph (1), funds allocated to a county with a population of less than 200,000 that have not been spent for their authorized purpose within five years shall revert to the state as described in paragraph (1).

(4) (A) Notwithstanding paragraphs (1) and (2), if a county with a population of less than 200,000 receives approval from the Behavioral Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) so long as they are encumbered under the terms of the approved project plan, including any subsequent amendments approved by the commission, or until five years after the date of approval, whichever is later.

(B) Subparagraph (A) applies to all plans for innovative programs that have received commission approval and are in the process at the time of enactment of the act that added this subparagraph, and to all plans that receive commission approval thereafter.

(i) Notwithstanding subdivision (h) and Section 5892.1, unspent funds allocated to a county, and interest accruing on those funds,

which are subject to reversion as of July 1, 2019, and July 1, 2020, shall be subject to reversion on July 1, 2021.

(j) If there are revenues available in the fund after the State Department of Health Care Services has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, the department, in consultation with counties, shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the department's plan that furthers the purposes of this act.

(k) This section shall become operative on January 1, 2025, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

(*l*) This section shall become inoperative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

SEC. 20. Section 5892.1 of the Welfare and Institutions Code, as amended by Section 96 of Chapter 790 of the Statutes of 2023, is amended to read:

5892.1. (a) All unspent funds subject to reversion pursuant to subdivision (h) of Section 5892 as of July 1, 2017, are deemed to have been reverted to the fund and reallocated to the county of origin for the purposes for which they were originally allocated.

(b) (1) The department shall, on or before July 1, 2018, in consultation with counties and other stakeholders, prepare a report to the Legislature identifying the amounts that were subject to reversion prior to July 1, 2017, including to which purposes the unspent funds were allocated pursuant to Section 5892.

(2) Prior to the preparation of the report referenced in paragraph (1), the department shall provide to counties the amounts it has determined are subject to reversion, and provide a process for counties to appeal this determination.

(c) (1) By July 1, 2018, each county with unspent funds subject to reversion that are deemed reverted and reallocated pursuant to subdivision (a) shall prepare a plan to expend these funds on or before July 1, 2020. The plan shall be submitted to the commission for review.

(2) A county with unspent funds that are deemed reverted and reallocated pursuant to subdivision (a) that has not prepared and submitted a plan to the commission pursuant to paragraph (1) as

of January 1, 2019, shall remit the unspent funds to the state pursuant to paragraph (1) of subdivision (h) of Section 5892 no later than July 1, 2019.

(d) Funds included in the plan required pursuant to subdivision (c) that are not spent as of July 1, 2020, shall revert to the state pursuant to paragraph (1) of subdivision (h) of Section 5892.

(e) Notwithstanding subdivision (d), innovation funds included in the plan required pursuant to subdivision (c) that are not spent by July 1, 2020, or the end of the project plan approved by the Behavioral Health Services Oversight and Accountability Commission pursuant to subdivision (e) of Section 5830, whichever is later, shall revert to the state pursuant to subdivision (h) of Section 5892.

(f) (1) The requirement for submitting a report imposed under subdivision (b) is inoperative on July 1, 2022, pursuant to Section 10231.5 of the Government Code.

(2) A report to be submitted pursuant to subdivision (b) shall be submitted in compliance with Section 9795 of the Government Code.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific this section, Section 5899.1, and subdivision (h) of Section 5892, by means of all-county letters or other similar instructions, until applicable regulations are adopted in accordance with Section 5898, or until July 1, 2019, whichever occurs first. The all-county letters or other similar instructions shall be issued only after the department provides the opportunity for public participation and comments.

(h) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 21. Section 5897 of the Welfare and Institutions Code, as amended by Section 104 of Chapter 790 of the Statutes of 2023, is amended to read:

5897. (a) Notwithstanding any other state law, the State Department of Health Care Services shall implement the mental health services provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4

(commencing with Section 5850) through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. For purposes of this section, a county mental health program includes a city receiving funds pursuant to Section 5701.5.

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of those mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) through the county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2.

(d) The department shall conduct program reviews of performance contracts to determine compliance. Each county performance contract shall be reviewed at least once every three years, subject to available funding for this purpose.

(e) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific timeline to achieve improvements. The department shall post on its internet website any plans of correction requested and the related findings.

(f) Contracts awarded by the State Department of Health Care Services, the State Department of Public Health, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, and the Behavioral Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with Section 5800), Part 3.1 (commencing with Section 5820), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and Part 4.5 (commencing with Section 5890), may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to those contracts.

(g) For purposes of Section 14712, the allocation of funds pursuant to Section 5892 that are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the State Department of Health Care Services of the anticipated county matching funds needed for community mental health programs.

(h) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 22. Section 5899 of the Welfare and Institutions Code is amended to read:

5899. (a) (1) The State Department of Health Care Services, in consultation with the Behavioral Health Services Oversight and Accountability Commission and the County Behavioral Health Directors Association of California, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report.

(2) The instructions shall include a requirement that the county certify the accuracy of this report.

(3) With the exception of expenditures and receipts related to the capital facilities and technology needs component described in paragraph (6) of subdivision (d), each county shall adhere to uniform accounting standards and procedures that conform to the Generally Accepted Accounting Principles prescribed by the Controller pursuant to Section 30200 of the Government Code when accounting for receipts and expenditures of Mental Health Services Act (MHSA) funds in preparing the report.

(4) Counties shall report receipts and expenditures related to capital facilities and technology needs using the cash basis of accounting, which recognizes expenditures at the time payment is made.

(5) Each county shall electronically submit the report to the department and to the Behavioral Health Services Oversight and Accountability Commission.

(6) The department and the commission shall annually post each county’s report in a text-searchable format on its internet website in a timely manner.

(b) The department, in consultation with the commission and the County Behavioral Health Directors Association of California,

shall revise the instructions described in subdivision (a) by July 1, 2017, and as needed thereafter, to improve the timely and accurate submission of county revenue and expenditure data.

(c) The purpose of the Annual Mental Health Services Act Revenue and Expenditure Report is as follows:

(1) Identify the expenditures of MHSA funds that were distributed to each county.

(2) Quantify the amount of additional funds generated for the mental health system as a result of the MHSA.

(3) Identify unexpended funds and interest earned on MHSA funds.

(4) Determine reversion amounts, if applicable, from prior fiscal year distributions.

(d) This report is intended to provide information that allows for the evaluation of all of the following:

(1) Children's systems of care.

(2) Prevention and early intervention strategies.

(3) Innovative projects.

(4) Workforce education and training.

(5) Adults and older adults systems of care.

(6) Capital facilities and technology needs.

(e) If a county does not submit the annual revenue and expenditure report described in subdivision (a) by the required deadline, the department may withhold MHSA funds until the reports are submitted.

(f) A county shall also report the amount of MHSA funds that were spent on mental health services for veterans.

(g) By October 1, 2018, and by October 1 of each subsequent year, the department shall, in consultation with counties, publish on its internet website a report detailing funds subject to reversion by county and by originally allocated purpose. The report also shall include the date on which the funds will revert to the Behavioral Health Services Fund.

(h) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

SEC. 23. Section 14132.85 of the Welfare and Institutions Code is amended to read:

14132.85. (a) For purposes of this section, the following definitions apply:

(1) "Complex needs patient" means an individual with a diagnosis or medical condition that results in significant physical impairment or functional limitation. "Complex needs patient" includes, but is not limited to, individuals with spinal cord injury, traumatic brain injury, cerebral palsy, muscular dystrophy, spina bifida, osteogenesis imperfecta, arthrogryposis, amyotrophic lateral sclerosis, multiple sclerosis, demyelinating disease, myelopathy, myopathy, progressive muscular atrophy, anterior horn cell disease, post-polio syndrome, cerebellar degeneration, dystonia, Huntington's disease, spinocerebellar disease, and the types of amputation, paralysis, or paresis that result in significant physical impairment or functional limitation. "Complex needs patient" does not negate the requirement that an individual meet medical necessity requirements under authority rules to qualify for receiving complex rehabilitation technology.

(2) "Complex rehabilitation technology" means items classified within the federal Medicare Program as of January 1, 2021, as durable medical equipment that are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living identified as medically necessary. These items include, but are not limited to, complex rehabilitation manual and power wheelchairs, power seat elevation or power standing components of power wheelchairs, seating and positioning items, other specialized equipment such as adaptive bath equipment, standing frames, gait trainers, and specialized strollers, and related options and accessories.

(3) "Complex rehabilitation technology services" includes the application of enabling systems designed and assembled to meet the needs of a patient experiencing any permanent or long-term loss or abnormality of physical or anatomical structure or function with respect to mobility or other function or need. These services include, but are not limited to, all of the following:

(A) Evaluating the needs of a patient with a disability, including an assessment of the patient for the purpose of ensuring that the proposed equipment is appropriate.

(B) Documenting medical necessity.

(C) Selecting, fitting, customizing, maintaining, assembling, repairing, replacing, picking up and delivering, and testing equipment and parts.

(D) Training the patient who will use the technology or any individual who assists the patient in using the complex rehabilitation technology.

(4) "Qualified health care professional" means an individual who has no financial relationship to the provider of complex rehabilitation technology and is any of the following:

(A) A physical therapist licensed pursuant to Chapter 5.7 (commencing with Section 2600) of Division 2 of the Business and Professions Code.

(B) An occupational therapist licensed pursuant to Chapter 5.6 (commencing with Section 2570) of Division 2 of the Business and Professions Code.

(C) Other licensed health care professional, approved by the department, and who performs specialty evaluations within the professional's scope of practice.

(5) "Qualified rehabilitation technology professional" means an individual who meets either of the following:

(A) Holds the credential of Assistive Technology Professional (ATP) from the Rehabilitation Engineering and Assistive Technology Society of North America.

(B) Holds the credential of Certified Complex Rehabilitation Technology Supplier (CRTS) from the National Registry of Rehabilitation Technology Suppliers.

(b) A provider of complex rehabilitation technology to a Medi-Cal beneficiary shall comply with all of the following:

(1) Meet the supplier and quality standards established for a durable medical equipment supplier under the federal Medicare Program and be enrolled as a provider in the Medi-Cal program.

(2) Be accredited by a recognized accrediting organization as a supplier of complex rehabilitation technology.

(3) Employ at least one qualified rehabilitation technology professional as a W-2 employee (receiving a W-2 tax form from the provider) for each distribution location.

(4) Have the qualified rehabilitation technology professional physically present for the evaluation, either in person or remotely if necessary, directly involved in determining the specific complex rehabilitation technology appropriate for the patient, and directly

involved with, or closely supervise, the final fitting and delivery of the complex rehabilitation technology.

(5) Maintain a reasonable supply of parts, adequate physical facilities, and qualified service or repair technicians, and provide patients with prompt services and repair for all complex rehabilitation technology supplied.

(6) Provide written information at the time of delivery of complex rehabilitation technology regarding how the patient may receive services and repair.

(c) For complex needs patients receiving a complex rehabilitation manual wheelchair, power wheelchair, or seating component, the patient shall be evaluated, either in person or remotely if necessary, by both of the following:

(1) A qualified health care professional.

(2) A qualified rehabilitation technology professional.

(d) A medical provider shall conduct a physical examination of an individual, either in person or remotely if necessary, before prescribing a power wheelchair or scooter for a Medi-Cal beneficiary. The medical provider shall complete a certificate of medical necessity that documents the medical condition that necessitates the power wheelchair or scooter, and verifies that the patient is capable of using the wheelchair or scooter safely.

(e) The department may adopt utilization controls, including a specialty evaluation by a qualified health care professional, as defined in paragraph (4) of subdivision (a). The department may adopt any other additional utilization controls for complex rehabilitation technology, as appropriate.

(f) The department shall seek any necessary federal approvals for the implementation of 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.

SEC. 24. 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 January 1, 2024, 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 January 1, 2024, 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) 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. 25. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because 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.

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